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EXPLORATION OF PSYCHOTHERAPISTS' ATTITUDES TOWARDS THE ADOPTION OF ARTIFICIAL INTELLIGENCE IN MENTAL HEALTHCARE:

A THEORETICAL THEMATIC ANALYSIS

BY
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Bu çalışma, zihni ve yüreğiyle eşsiz İskender Savaşır'a adanmıştır.
Bana öylesine kıymetli bir topluluğun kapılarını araladı ki,
onların sezgilerini bu çalışmanın dokusuna işleyebilme ayrıcalığına eriştiğim için
her zaman derin bir minnettarlık duyacağım.

TEŞEKKÜR

Bu tez çalışmasının her aşamasında, akademik bilgi ve birikiminin ötesinde, içten yaklaşımı ve yol göstericiliği ile yanımda olan değerli tez danışmanım Doç. Dr. Burçin Akın Sarı'ya en derin teşekkürlerimi sunarım. Benimle aynı heyecanı paylaşması ve bu yoğun çalışma dönemini benim için keyifli bir öğrenme yolculuğuna dönüştürmesi, bu tezin ortaya çıkmasındaki en büyük şanstı. Bunun yanında, nitel araştırma yöntemleri konusundaki vizyonuyla ufkumu açan ve bana bu alanda ilham kaynağı olan değerli hocam Dr. Öğr. Üyesi Tuğba Uyar Suiçmez'e de teşekkürü bir borç bilirim.

Bu çalışmaya katılarak görüşlerini, umutlarını ve endişelerini benimle tüm içtenlikleriyle paylaşan bütün psikoterapistlere ne kadar teşekkür etsem azdır. Yoğun çalışma tempoları arasında bana vakit ayırdıkları ve mesleki deneyimlerini açarak bu araştırmaya ruh kattıkları için her birine minnettarım.

Hayatım boyunca eğitime verdikleri değerle yolumu aydınlatan, bana aşıladıkları etik anlayış ve sorumluluk bilinciyle bugünlere gelmemde büyük emeği olan annem Elif Yeşil ve babam Cumhur Yeşil'e sonsuz teşekkür ederim. İki emekli öğretmen olarak, bana sadece öğrenmenin kıymetini değil, bir işi hakkıyla ve etik değerlere bağlı kalarak yapmanın önemini öğrettikleri için onlara minnettarım.

Bu çalışmanın ortaya çıkmasında çok özel bir yeri olan kardeşim Onur Yeşil'e ayrıca teşekkür etmek isterim. Yapay zekâ konusundaki derin bilgisi, vizyonu ve dur durak bilmeyen entelektüel merakı, benim de bu alana yönelmemdeki en büyük motivasyon kaynaklarından biri oldu. Onunla yaptığımız keyifli sohbetler bana her zaman ilham verdi; desteği ve heyecanı olmasaydı bu çalışma eksik kalırdı.

İş hayatından psikoloji eğitimine geçtiğim dönemde vizyonuyla bana yol gösteren ve işimle eğitimim arasındaki dengeyi yeniden kurmamı sağlayan Pelin Kuzey'e; üniversiteye ayırdığım zamana gösterdikleri sabırla o dönem yanımda olan Erkan Kaptan ve Zeynep Güven'e minnettarım. Eğitimimin ilk senelerinde onlar kadar anlayışlı iş arkadaşlarım olmasaydı, bugün bu tezi yazamamış olabilirdim.

Aynı şekilde, şu andaki iş arkadaşlarım Tolga Sobacı, Duygu Yücesoy ve Hande Bayrak Uzal'a da çok teşekkür ederim. Eğer eğitimime harcadığım zamana gösterdikleri anlayış ve

sarsılmaz destekleri olmasa yüksek lisansımı başarıyla tamamlamam mümkün olmazdı. Tabii ki bu tezi yazmamı mümkün kılan esnek yapısı ve eğitime verdiği destekten dolayı Google çalışma kültürüne de müteşekkirim.

İsimlerini tek tek sayamayacağım ama her biri kalbimde ayrı bir yere sahip olan arkadaşlarım sadece var oldukları için minnettarım. En zor zamanlarımda yükümü hafifleten ve hayatı benim için yaşanır kılan o güzel yol arkadaşlarıma da teşekkür ederim. İkinci üniversite ve yüksek lisans deneyimimde benimle aynı engebeli patikada yürüyen ve karşılaştığım için kendimi çok şanslı saydığım sevgili Gizem Özer'e özel bir parantez açmazsam olmaz. İkimiz de hayatımızın aynı döneminde iş hayatı ve yüksek lisans dengesini birbirimize destek olarak kurmaya çalıştık, bu yoldaşlığın değeri benim için paha biçilmez oldu.

Son olarak, bu uzun yazım sürecinin sessiz ama sadık tanıklarına; çalışma masamdan başımı her kaldırdığımda penceremden bana selam veren ağaçlara, kuşlara ve bahçede her daim oyun oynamak için fırsat kollayan kedilere... Sadece gözlerimi dinlendirmekle kalmayıp, doğanın sadeliğiyle karmaşık düşüncelerimi toparlamama yardımcı oldukları için onlara da minnettarım.

ÖZET

Yeşil, Başak, Psikoterapistlerin Ruh Sağlığı Alanında Yapay Zekâ Kullanılmasına Yönelik Tutumlarının Araştırılması: Teorik bir Tematik Analiz, Başkent Üniversitesi, Sosyal Bilimler Enstitüsü, Klinik Psikoloji Tezli Yüksek Lisans Programı, 2025.

Yapay zekâ (YZ) hızla ruh sağlığı alanına girmekte, ancak Türkiye'de psikoterapistlerin bu teknolojileri nasıl anlamlandırdığı ve değerlendirdiği hakkında hâlâ çok az şey bilinmektedir. Bu nitel çalışma, Teknoloji Kabul Modeli 3'ü (TAM3) kuramsal çerçeve olarak kullanarak psikoterapistlerin psikoterapide YZ'yi benimsemeye ilişkin tutumlarını incelemiştir. Farklı disiplin ve kuramsal yönelimlerden gelen ve farklı YZ uzmanlık seviyelerine sahip 18 psikoterapistle yarı yapılandırılmış görüşmeler yapılmıştır. Araştırmacı, bir yandan klinik psikoloji yüksek lisans öğrencisi, diğer yandan küresel bir teknoloji şirketinde çalışan bir profesyonel olarak ikili bir konuma sahiptir; bu ikili konum, klinik ve teknolojik meselelerdeki duyarlılığını artırmış ve bu durum süreç boyunca sürdürülen refleksif uygulamalarla ele alınmıştır. Veriler, katılımcı anlatılarını TAM3 değişkenleriyle ilişkilendirmeyi ve klinik açıdan anlamlı temalar ortaya çıkarmayı amaçlayan kuramsal tematik analiz ile ele alınmıştır. Üç ana tema belirlenmiştir. "YZ'nin algılanan rol yelpazesi" teması, YZ'nin idari ve klinik destek işlevlerinde "asistan", triyaj ve psikoeğitimde olası bir "halk sağlığı aracı" ve daha tartışmalı bir biçimde "yardımcı terapist" olarak konumlandırılmasını betimlemiştir. "Terapistlerin dijital hazırlık seviyesi ve teorik yönelimi" teması, dijital okuryazarlık seviyesinin ve kuramsal duruşun kabul ya da kuşkuyu nasıl şekillendirdiğini göstermiştir. "Benzer kaygılar ve benimseme için önkoşullar" teması ise etik ve veri mahremiyeti ve güvenliği gibi kritik koşulların yanı sıra özerklik ve beceri kaybı kaygılarını ortaya koymuştur. Genel olarak YZ, insanî bakımın yerine geçmekten çok onu desteklediği ve etik, ilişkisel ve mesleki güvenceler inandırıcı bulunduğu ölçüde kabul edilmiştir. Son olarak bu çalışma; "Dijital Anamnez" ve "Seans Taslakları" uygulamalarının benimsenmesini, bilgilendirilmiş onam süreçlerine şeffaf yapay zeka politikalarının entegre edilmesini klinik uygulamaya yönelik somut öneriler sunmaktadır.

Anahtar Kelimeler: Yapay Zekâ, psikoterapi, TAM3, teknoloji kabulü

ABSTRACT

Yeşil, Başak, Exploration of Psychotherapists' Attitudes Towards the Adoption of Artificial Intelligence in Mental Healthcare: A Theoretical Thematic Analysis, Başkent University, Institute of Social Sciences, Master's in Clinical Psychology with Thesis, 2025.

Artificial intelligence (AI) is rapidly entering mental healthcare, yet little is known about how psychotherapists in Türkiye understand and evaluate these tools. This qualitative study explored psychotherapists' attitudes toward AI adoption in psychotherapy, guided by the Technology Acceptance Model 3 (TAM3). Semi-structured interviews were conducted with 18 psychotherapists from different disciplines, levels of AI expertise, and therapeutic orientations. The researcher occupied a dual position as a clinical psychology student and a professional in a global technology company; this intersectional positionality provided sensitivity to both clinical and technological issues and was addressed through ongoing reflexive practices. Data were analyzed using theoretical thematic analysis to map participants' accounts onto TAM3 constructs. Three overarching themes emerged as part of the data analysis. "The spectrum of AI's perceived role" described AI as an assistant for administrative and clinical support tasks, a possible public health tool for triage and psychoeducation, and a controversial co-therapist. "Therapists' digital readiness and orientation" showed how digital literacy and theoretical stance shaped acceptance or skepticism. "Common concerns and preconditions for adoption" highlighted non-negotiable requirements around ethics, data privacy, alongside worries about loss of clinical autonomy. Overall, AI was accepted when it was perceived as augmenting rather than replacing human care, and when ethical, relational, and professional safeguards were credible. Finally, the study outlines specific recommendations for clinical practice, including the implementation of "Digital Anamnesis" to address shadow AI use, the integration of transparent AI policies in informed consent, and the adoption of "Session Drafts" to balance administrative efficiency with clinical integrity.

Keywords: Artificial intelligence, psychotherapy, TAM3, technology acceptance.

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LIST OF ABBREVIATIONS

AI	Artificial Intelligence
CANX	Computer Anxiety
CBT	Cognitive Behavioral Therapy
CPLAY	Computer Playfulness
CSE	Computer Self-Efficacy
EMDR	Eye Movement Desensitization and Reprocessing
ENJ	Perceived Enjoyment
HCI	Human-Computer Interaction
IMG	Image
IRC	International Rescue Committee
LLM	Large Language Model
NHS	National Health Service
OU	Objective Usability
OUT	Output Quality
PEC	Perceived External Control
PEOU	Perceived Ease of Use
PU	Perceived Usefulness
REL	Job Relevance
RES	Result Demonstrability
SN	Subjective Norm
TAM	Technology Acceptance Model
TAM3	Technology Acceptance Model 3
TPD	Turkish Psychological Association
TÜİK	Turkish Statistical Institution
TÜSEB	Health Institutes of Türkiye
TÜYZE	Türkiye Health Data Research and AI Applications Institute
TUZO	Turkish National Intelligence Scale
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization

1. INTRODUCTION

The 21st century is experiencing a complex mental health crisis globally (Karp & Yach, 2024). According to the latest data from the World Health Organization (WHO), more than 1.1 billion people worldwide were living with a mental health condition in 2021 (WHO, 2025). Other studies indicate that one in three people globally suffer from a mental health condition (AXA, 2025; Rai, 2025; United Nations, 2025; WHO, 2025b, 2025c). These conditions, especially anxiety and depression, are now one of the main causes of disability worldwide, placing a heavy burden on individuals, families, and economies (Karp & Yach, 2024; Rai, 2025; United Nations, 2025; WHO, 2025d). The crisis unevenly affects certain demographics with women and young people reporting higher rates of mental health challenges (AXA, 2025; Karp & Yach, 2024). Suicide has become the second leading cause of death for individuals aged 15 to 29 (Karp & Yach, 2024). The economic impact is also huge. Depression and anxiety alone cost the global economy about $1 trillion each year in lost productivity, and this amount is expected to double by 2030 (Karp & Yach, 2024; Rai, 2025; United Nations, 2025; WHO, 2025c).

In the meantime, global response to this crisis remains critically insufficient. There is a growing gap between the high need for care and the limited services available, made worse by poor infrastructure, low funding, and inequality in healthcare (Karp & Yach, 2024). The WHO's Mental Health Atlas 2024 (WHO, 2025a) shows a concerning stagnation in healthcare investments. Globally, median government spending on mental health has remained at a 2% of total health budgets since 2017 (Rai, 2025; United Nations, 2025; WHO, 2025c, 2025d). This lack of funding is worsened by a serious shortage of mental health workers. There are only about 13 professionals for every 100,000 people worldwide (Rai, 2025; United Nations, 2025; WHO, 2025c, 2025d). Consequently, a huge treatment gap exists, especially in low- and middle-income countries where over 75% of individuals with mental health conditions receive no treatment (UNA-NCA, 2025). As illustrated in Figure 1.1., this is a complex fundamental crisis, and the study argues that possible solutions can only be developed and utilized through latest technological developments.

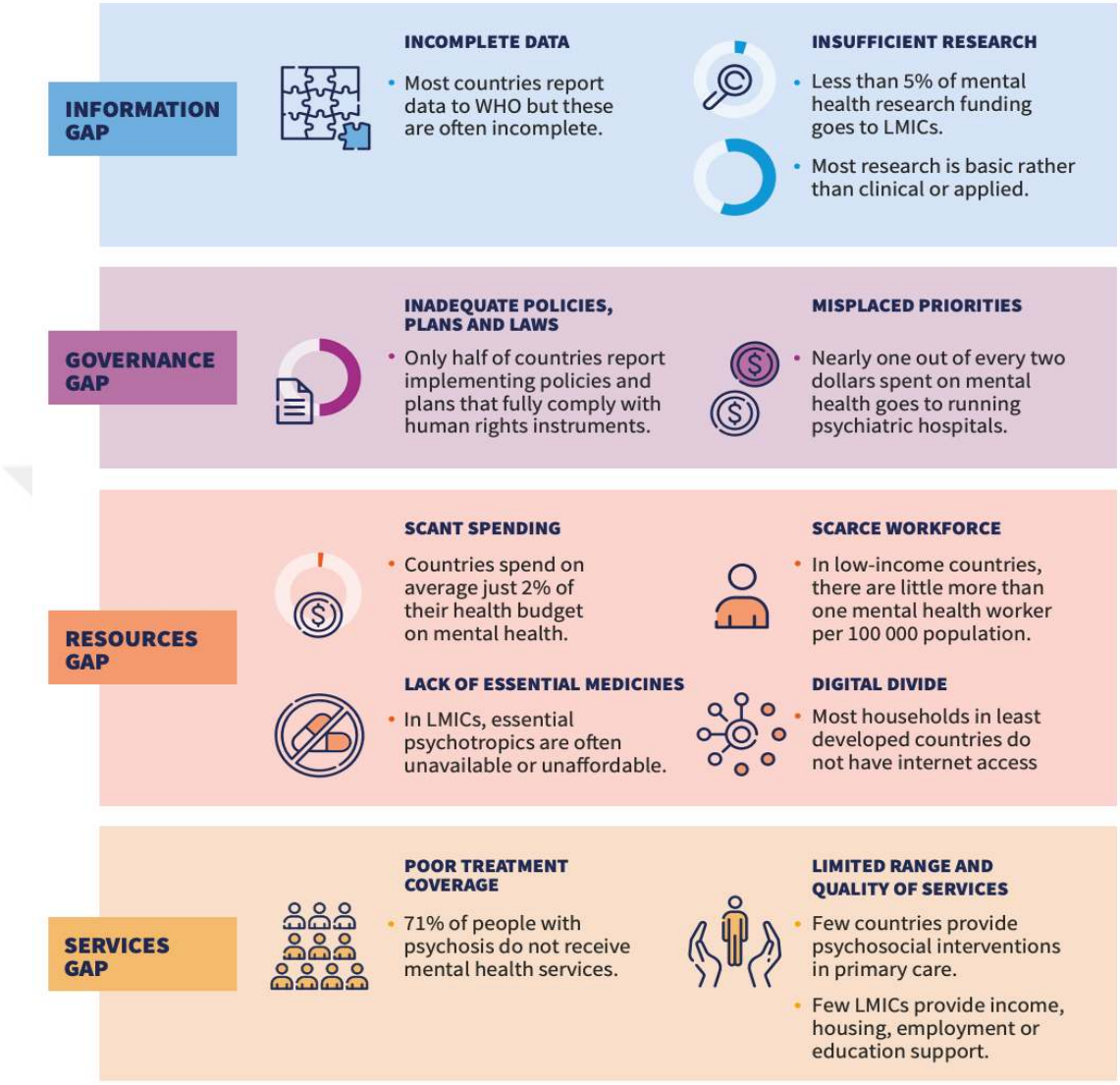


Figure 1.1. A snapshot of key gaps in mental health

Note. From *World mental health today: latest data* (p. 32), by World Health Organization, 2025 (https://iris.who.int/server/api/core/bitstreams/31714489-1345-4439-8b37-6cbdc52e15ca/content). CC BY-NC-SA 3.0 IGO.

The current scale of this global crisis seems to be beyond human resources and capacity. Recent data underscores the severity of this capacity problem. According to the 2025 Practitioner Pulse Survey by the American Psychological Association (2025), 46% of psychologists report having no openings for new patients. The burden on the workforce is further evidenced by high rates of burnout, particularly among early-career psychologists, with 51% reporting that they feel burned out (American Psychological Association, 2025).

Therefore, the urgent need for new and scalable ways to expand mental healthcare has driven the search for innovative solutions. In this context, Artificial Intelligence (AI) has recently become a major force in healthcare. Thanks to advances in deep learning, big data, and compute, AI now shows remarkable abilities in many areas, including diagnosis and personalized treatment in the mental healthcare services.

In the first chapter, this study focuses on the definition and history of AI in general. After briefly reviewing the advances in the field of AI within the context of healthcare services, the study focuses on a very few perception and attitude studies available, covering mental health practitioners' stance towards the AI globally and locally in Türkiye. The second chapter outlines the methodology and analytical procedures employed in this study. The third section presents the findings, which are reported as themes and sub-themes supported by direct quotations from interviews. In the fourth and final section, the results are discussed in the context of the existing literature, and the study's limitations and recommendations for future research are presented.

1.1.The Definition and History of AI

The term "Artificial Intelligence" (AI) was first introduced by John McCarthy in a 1955 proposal (McCarthy et al., 1955). Years later, McCarthy (2007) articulated a definition that has become foundational in the field: "the science and engineering of making intelligent machines, especially intelligent computer programs" (p. 2). While there is no single, universally accepted definition, AI is broadly understood as the capacity of machines to simulate the intellectual processes of intelligent beings (Copeland, 2024). More recent, business-oriented definitions describe AI as the application of "advanced analysis and logic-based techniques to interpret events, support and automate decisions, and take actions" (Gartner, n.d.). In simple terms, AI enables machines to perform complex tasks that have traditionally required human intelligence.

AI's foundational concepts emerged in the 1950s with Alan Turing's work, which introduced the Turing test as a measure of machine intelligence (Buchanan, 2005). Shortly after, the field of AI was formally established during the 1956 Dartmouth Conference, marking the beginning of modern computer science. While early years showed optimism about general problem-solving capabilities, the limited computational power of the era led to the first "AI winter" in the 1970s (Haenlein & Kaplan, 2019).

The 1980s witnessed a renewed interest in AI with the introduction of neural networks designed to replicate human decision-making processes. These developments were particularly significant in demonstrating AI's potential for practical applications (Buchanan, 2005). However, limitations in these systems led to a second "AI winter" in the 1990s, as the technology failed to meet high expectations (Haenlein & Kaplan, 2019).

The current era of AI, beginning in the early 2000s, has been transformed by three key developments: the availability of big data, significant increases in computational power, and advancements in deep learning algorithms (Haenlein & Kaplan, 2019). With the improvements in compute power and big data, unprecedented achievements emerged in natural language processing and pattern recognition (Buchanan, 2005).

1.2. Recent Rise of the AI

The field of AI has experienced extraordinary advancement in recent years. In many sectors AI is no longer just a tool as it is actually shaping industries (Haenlein & Kaplan, 2019) In today's world, AI is transforming how organizations, companies, governments and individuals operate. A recent report shows that 79% of organizations now regularly use generative AI, up from 33% in 2023 (McKinsey & Company, 2025). The same report notes that organizations are reporting use-case level cost and revenue benefits from AI. Specifically, revenue increases are most commonly seen in marketing and sales, strategy and corporate finance, and product or service development, and cost reductions are predominantly reported in software engineering, manufacturing, and IT (McKinsey & Company, 2025).

This trend is also mirrored in another report, which observed that industry leads in AI development, producing almost 90% of major models released globally (Stanford HAI, 2025). Across different domains, such as finance, manufacturing, logistics, and service sectors, AI is powering significant improvements (Rashid & Kausik, 2024). These advances show how AI has become essential to many companies. In short, while AI once belonged to the researchers in scientific fields only, today it's a strategic asset for companies and organizations of all sizes. AI has evolved from a technical innovation into the fuel for productivity and economic growth. It is considered one of the most disruptive technologies of our time, reshaping how people work and make decisions across nearly every domain (Păvăloaia & Necula, 2023). This

transformation involves augmenting human capabilities by automating routine tasks, which allows employees to focus on higher-value responsibilities (World Economic Forum, 2025).

A critical moment took place in November 2022 with the public release of ChatGPT by OpenAI, marking a significant breakthrough in Large Language Models (LLMs). This development demonstrated critical abilities of the AI in human-like text generation and complex task completion (Kung et al., 2023). The impact was immediate: professionals in many fields began to experiment with LLMs for a great variety of tasks. These advancements have led to significant developments in applications across multiple industries including healthcare (McKinsey & Company, 2025). Figure 1.2. lists AI agent use percentages (%) by industry (including healthcare) and business function as of 2025.

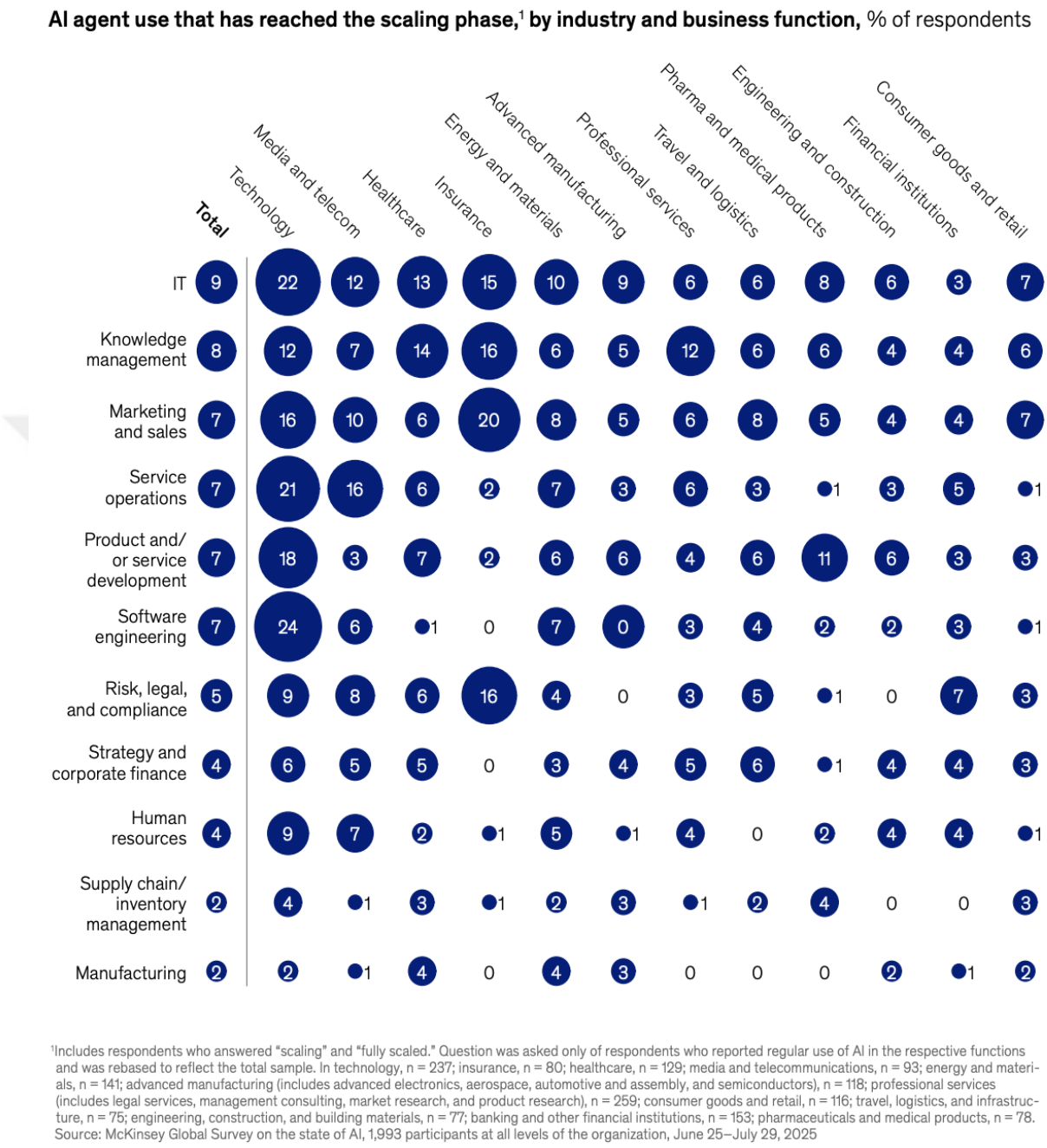


Figure 1.2. AI agent use percentages (%) by industry and business function as of 2025

Note. From *The state of AI in 2025: Agents, innovation, and transformation* (p. 6), by McKinsey & Company, QuantumBlack AI by McKinsey, 2025 (https://www.mckinsey.com/capabilities/quantumblack/our-insights/the-state-of-ai#/). Copyright 2025 by McKinsey & Company.

As AI tools matured, their use expanded into specialized sectors including healthcare. In medicine, for instance, AI systems are achieving remarkable performance. In medical imaging,

an AI system exceeded human radiologists in detecting breast cancer from mammograms (McKinney et al., 2020). In dermatology, deep-learning models have shown accuracy comparable to expert dermatologists in identifying skin cancers (Salinas et al., 2024). Another breakthrough came in drug discovery where AlphaFold, built by DeepMind, revolutionized protein structure prediction. That achievement has been described as one of the most important scientific advances of recent years, and was recognized with a Nobel Prize (Callaway, 2024).

These stories show more than a success. They actually mark a paradigm shift. AI is no longer a nice-to-have technology; it is integrated into very critical processes across multiple industries and fields. For the field of mental healthcare, this means the question is no longer *if* AI will play a role, but *how* it should be integrated into the mental healthcare.

1.3. History of AI Applications in Mental Healthcare

The integration of AI in mental healthcare traces back to the 1960s with the development of ELIZA, one of the first natural language processing programs designed to simulate a psychotherapist (Fiske et al., 2019). Though quite basic, ELIZA laid the conceptual groundwork for AI-assisted mental health support of the future. The field saw limited progress until the 1990s, when systems showed promise in psychiatric diagnosis, followed by an increase of innovation in 2000s (Fiske et al., 2019).

The evolution of AI applications in mental healthcare can be categorized into several key domains: The first category involves diagnostic support systems, which have demonstrated increased accuracy in identifying mental health conditions through pattern recognition in clinical data (Torous et al., 2020). These systems have shown promise in early detection of conditions such as depression, anxiety, and potential suicide risk through analysis of speech patterns, facial expressions, and social media activity (D'Alfonso, 2020).

The second major category is therapeutic support tools, which include AI-powered chatbots and virtual agents designed to provide basic mental health support and psychoeducation. These applications have shown effectiveness in delivering cognitive behavioral therapy (CBT) interventions, especially for mild and moderate conditions, demonstrating significant improvements in symptoms like anxiety and depression (Feng et al., 2025; Li et al., 2025). Studies have demonstrated that AI-assisted chatbots can significantly

improve access to mental health support, particularly in underserved populations or regions with limited access to mental health professionals (Hegde & Prasad, 2025; Han & Zhao, 2025).

Treatment monitoring and outcome prediction represent the third significant domain. AI systems have been developed to track patient progress, analyze therapeutic responses, and predict treatment outcomes (Thieme et al., 2020). These systems can process multiple data sources such as smartphone and wearable sensor data to provide mental health professionals with useful insights about treatment effectiveness (Dinh-Le et al., 2019; Moshe et al., 2021).

In 2024, the research landscape shifted dramatically. According to Hua et al. (2025), LLM-based chatbot studies constituted 45% of new research in 2024. As Generative AI became accessible, a phenomenon of "shadow therapy" emerged. A 2025 study found that approximately 13% of adolescents and young adults in the United States reported using general-purpose AI (like ChatGPT) for mental health support, often without the knowledge of their parents or clinicians (Feng et al., 2025). This unregulated use exposed significant risks. Research from Stanford University in 2025 highlighted that while LLMs excelled at empathy, they often failed in safety-critical scenarios (Moore et al., 2025; Scholich et al., 2025).

In 2025, the field moved to a more pragmatic phase characterized by Agentic AI, which emerged as the dominant technological paradigm. Unlike a chatbot that passively waits for a prompt, an AI agent can reason, plan, and execute tasks across workflows. In mental healthcare, a personalized AI-enabled chatbot for self-referrals exemplifies this shift. A study in Nature Medicine (2024) demonstrated that a self-referral chatbot called Limbic Access helped 45,000 patients access therapy and significantly increased self-referrals among minority groups and non-binary individuals (Habicht et al., 2024).

In addition, the evidence base for AI in mental health matured significantly in 2025. A major systematic review by Feng et al. (2025**)** analyzed 14 randomized controlled trials involving 1,974 young people. According to the findings, AI-driven conversational agents demonstrated a moderate-to-large effect size in reducing depressive symptoms. However, the effects were nonsignificant for anxiety disorders (Feng et al., 2025). Furthermore, researchers have begun using Generative AI to train clinicians, with studies showing that AI simulators can significantly improve mental health professionals' self-efficacy in suicide risk assessment (Elyoseph et al., 2025). Nevertheless, while 45% of new studies in 2024 utilized LLMs, only 16% of those studies had progressed to clinical efficacy testing. This indicates that the

clinical validation of Generative AI is still lagging behind its technical development (Hua et al., 2025).

Finally, in the last years, the model where mental healthcare providers are supported by AI agents that handle documentation, triage, and between-session monitoring has emerged as the dominant paradigm. The study argues that like every other discipline, these disruptive advancements signal a fundamental transformation in mental healthcare, placing AI as an integral component of the services. Therefore, it is very important to understand how and where AI will be integrated, underlining that the successful integration of these powerful tools depends critically on the attitudes and acceptance of the professionals who will actually use them.

1.4. AI Adoption Rates in Mental Health: Global and Local Perspectives

The adoption of AI-enabled technologies among mental health clinicians is still in its early stages. A physician survey conducted by the American Medical Association (2024) indicated that 66% of physicians use AI tools in their clinical practice. Although this statistic applies to the whole healthcare, it shows a shift toward digital transformation in healthcare practice in general. According to a more recent study though, the vast majority of practitioners surveyed (psychotherapists, psychiatrists, and clinical psychologists) reported that they have not used AI-enabled technologies in their clinical practice, and this low usage aligns with the finding that nearly half of the surveyed practitioners had never even heard of AI-enabled technologies in their field (Cecil et al., 2025). Furthermore, practitioners' willingness to engage with these tools is notably higher for clinician-centered tools, compared to more patient-centered applications (Cecil et al., 2025). This suggests that current adoption intentions are more focused on administrative and therapist-support purposes. In addition, 43% of mental health professionals in Australia use AI applications for research, report writing, or documentation rather than direct therapeutic decision-making (Cross et al., 2024).

The most recent findings indicate a dramatic acceleration in AI use trends in the field of psychology. According to the 2025 Practitioner Pulse Survey by the American Psychological Association (2025), the percentage of psychologists who reported never using AI tools to assist with their practice fell from 71% in 2024 to 44% in 2025. Furthermore, regular interaction with the technology has intensified; approximately 29% of psychologists now report using AI tools

at least monthly, a figure that has more than doubled from the 11% reported in 2024 (American Psychological Association, 2025).

In addition, United Kingdom's National Health Service (NHS) provides one of the most concrete examples of AI integration into clinical workflows. Conversational AI systems have been introduced across NHS Talking Therapies services as a self-referral and triage mechanism, and consequently, approximately 40% of NHS Talking Therapies services use such systems, improving access among underserved populations (Habicht et al., 2024). This example shows that widespread use of AI is possible when a country has the right foundations in place such as strong digital infrastructure and clear rules for how systems should be managed.

In the meantime, the adoption of AI in Türkiye's mental health sector is still in a very early stage. The Turkish Ministry of Health has institutionalized AI coordination under the "Yapay Zekâ ve Yenilikçi Teknolojiler Daire Başkanlığı" (The Directorate of Artificial Intelligence and Innovative Technologies). This Directorate oversees projects and pilots related to AI development in healthcare. The Ministry of Health also actively utilizes AI in general healthcare services and clinical decision support. The most prominent public-facing AI application is called "Neyim Var?," a system designed to guide patients to the appropriate medical experts based on their symptoms. This system reduces the burden on the healthcare system by reducing incorrect outpatient referrals (T.C. Sağlık Bakanlığı, n.d.; Usul, 2021). In the clinical domain, AI is particularly leveraged in medical imaging. For instance, the analysis of mammography images by AI has achieved a success rate of nearly 90% in the early detection of cancer (Yıldız, 2025).

Regarding official statistics, a major milestone was reached in October 2025 when the Turkish Statistical Institute (TÜİK) published its first official report on AI usage. The data revealed that 19.2% of individuals in Türkiye used generative AI tools in 2025, with the highest adoption rates observed among the 16–24 age group (39.4%) (Türkiye İstatistik Kurumu, 2025). While these statistics offer a general baseline, specific adoption rates for mental health professionals remain unindexed in official reports. However, related initiatives such as the Turkish National Intelligence Scale (TUZÖ) project, coordinated by the Health Institutes of Türkiye (TÜSEB), indicate a move toward integrating advanced psychometric tools into the healthcare system (TÜYZE, 2025).

Currently, there seems to be no specific AI projects conducted by the Ministry of Health specifically on mental health. However, a related initiative is the Turkish National Intelligence Scale (TÜZÖ) project, coordinated by the Health Institutes of Türkiye (TÜSEB), to develop a domestic intelligence test for integration into the healthcare system (TÜYZE, 2025). In addition, the Psychiatry Unit at Sakarya Education and Research Hospital recently launched an education program covering the AI applications in clinical contexts (Sakarya Eğitim ve Araştırma Hastanesi, 2024). These developments might suggest that Türkiye is moving through a pre-adoption phase, building digital literacy that will enable broader implementation in the upcoming years. However, there are no official data or research available regarding the actual adoption rates as of 2025, and there are very limited number of studies showing that there is indeed increased awareness and scholarly discussions on the subject (Akkan & Ülker, 2023; Gültekin & Şahin, 2024).

1.5. AI Adoption Attitudes in Mental Healthcare: Global and Local Perspectives

The rapid advancement of AI technologies in mental healthcare has triggered research interest in understanding practitioners' attitudes toward the AI adoption. A global survey of 791 psychiatrists revealed a cautious attitude with 48.7% believing AI would have minimal impact on psychiatry over the next 25 years (Doraiswamy et al., 2020).

Recent research also indicates different levels of acceptance among mental health professionals, with cognitive behavioral therapists demonstrating more positive attitudes compared to other therapeutic orientations (Sebri et al., 2021). Common concerns include AI's narrow ability to understand emotions, maintain therapeutic alliance, and handle complex psychological cases. Several factors influence professionals' acceptance of AI technologies, including their professional background, technological literacy, ethical considerations, and concerns about their own job security (Hassan et al., 2024). Systematic review of the recent qualitative studies indicated that clinicians are open-minded about incorporating AI in mental healthcare but are also quite cautious, emphasizing that successful adoption requires careful consideration of potential negative impacts on the therapeutic relationship and patient well-being (Rogan et al., 2024).

The current literature indicates significant gaps in understanding professional attitudes toward AI adoption in mental healthcare in Türkiye. Internationally, there exists a body of

primary qualitative research examining the perceptions, experiences, and views of mental healthcare professionals (and other healthcare workers) regarding the use of AI and digital technologies (Rogan et al., 2024; Tun et al., 2025). When it comes to Türkiye though, a recent study underlined that National Mental Health Action Plan (2021–2023) acknowledged "chronic shortages of mental health professionals and the need for technology-driven solutions" (Ballı et al., 2024, pp. 317-318). Turkish experts also emphasized that AI tools must be tailored to the Turkish language and also the country's cultural context for effective use (Ballı et al., 2024, p. 325).

The research investigating the attitudes of mental health professionals in Türkiye towards AI is scarce. The key research of this new field is the qualitative study by Gültekin and Şahin (2024), which interviewed 13 mental health professionals with expertise in AI. This study found an anxious optimism among the expert group, who identified advantages like widespread availability of mental health services and reduced workload (Gültekin & Şahin, 2024). This finding is strongly supported by an earlier study from Canpolat (2021), which surveyed psychological counselors and academic staff. Canpolat (2021) found that while counselors believed AI could be used for educational guidance, they firmly concluded that AI cannot replace the human psychological counselor in the field. This establishes a crucial thematic consensus across studies: professionals view AI as a potential "assistant" rather than a "replacement" (Canpolat 2021; Gültekin & Şahin, 2024). Gültekin and Şahin (2024) also noted that even the expert participants in their study doubted that AI would transform mental health services radically. The same skepticism is also shown by quantitative data from Başar and Erkül (2024), who surveyed 275 Turkish medical doctors, including psychiatrists. Their findings identified the key drivers for adoption as rational, not emotional: Trust, Perceived Usefulness, and Perceived Ease of Use were the strongest positive predictors, while technological anxiety was found to be an insignificant factor. This quantitative emphasis on "Trust" aligns with the primary gap identified by Gültekin and Şahin (2024), who critically noted that even their AI-savvy participants expressed "limited views on ethical and legal issues." This ethical and professional anxiety is mirrored in the emerging academic discourse, where Turkish academics and clinicians are publishing conceptual essays exploring the theoretical challenges of integrating AI into practice (Ayhan, 2023; Ediboğlu, 2023). A primary concern reflected in the literature is whether foundational clinical concepts, such as transference, are compatible with

non-human agents (Ayhan, 2023). This studies all suggest a need for more Türkiye-specific research, stating that teams should be formed in the country to conduct studies on AI in psychotherapy (Ayhan, 2023). Given the nature and scope of the existing literature in Türkiye, new qualitative research, particularly covering psychotherapists with different levels of AI expertise, seems to be necessary to move the field from understanding what experts think to what the profession thinks about AI adoption.

1.6. Rationale for the Theoretical Approach and Technology Acceptance Model

This research explores how psychotherapists understand, evaluate, and approach the use of AI in psychotherapy. The field of AI in mental health is still emerging, but prior studies have already produced well-established theoretical models explaining technology acceptance in healthcare. Because the goal of this study is to examine how known determinants of acceptance are observed in therapists' attitudes, a deductive (theoretical) thematic analysis was chosen over an inductive one. Deductive approach allowed the study to start with clearly defined constructs from a theoretical framework rather than generating categories from scratch. This provided conceptual clarity and a consistent lens for mapping the qualitative data. Braun and Clarke (2006, 2019) emphasize that a theoretical or deductive thematic analysis is appropriate when the researcher wants to extend existing theory rather than generate new concepts. Similarly, Nowell et al. (2017) argue that deductive approaches enhance transparency and reliability because codings are theoretically anchored and auditable.

Because this study focuses on AI in psychotherapy, a rapidly evolving field, using a deductive approach helps not only maintaining consistency and transparency but also ensuring that codings remain stable and meaningful over the course of time. It also enables meaningful comparison with prior research. This approach fits the study's research questions, which are actually explanatory questions, which focus on why and how clinicians accept or resist AI, making a theory-driven analysis the most appropriate strategy.

For the deductive approach, several theoretical models could have been used. For example, the Unified Theory of Acceptance and Use of Technology combines ideas like performance and effort expectancies, social influence, and support conditions (Venkatesh et al., 2012). However, literature suggests that Unified the Unified Theory of Acceptance and Use of

Technology is more recommended for larger surveys and especially for organizations. (Cecil et al., 2025; Rosli et al., 2022; Venkatesh et al., 2012). However, this study with a sample of 18 participants needs a richer framework to make sure all contextual depth is captured. In parallel, ethical frameworks for AI in healthcare, including guidance from the UNESCO (2021) and WHO (2021), mostly focus on transparency and accountability. Even though transparency and accountability are vital for understanding therapists' concerns about confidentiality and professional boundaries but they do not fully address behavioral dynamics of the technology use. Finally, Technological Acceptance Model (TAM) covers all of important points that the research questions are seeking answers for extending from the beliefs to the emotions and behavioral intentions. Therefore, TAM was selected as the theoretical framework for this study, as a well-known and established framework for understanding how and why psychotherapists accept or reject AI technologies.

1.6.1. Evolution of TAM to TAM3

TAM began as a simple explanation that people adopt technology mainly when they believe it is useful and easy to use, which shapes their intention and actual use (Davis, 1989). A decade later, TAM2 kept those main ideas but added where "usefulness" beliefs come from: social influence and cognitive evaluations tied to the job with experience and voluntariness functioning as moderators (Venkatesh & Davis, 2000). Afterwards, TAM3 expanded TAM2 and developed a detailed account of what drives "ease of use," adding anchors such as computer self-efficacy, anxiety, perception of external control, and enjoyment (Venkatesh & Bala, 2008). TAM3 also introduced a detailed framework for "ease of use," covering users' confidence with computers (self-efficacy), anxiety, perceived external control, playfulness, and how these evolve with experience (Venkatesh & Bala, 2008). In short, TAM3's strength is its completeness as it unites the simplicity of the original constructs with richer psychological mechanisms as shown in Figure 1.3. (Venkatesh & Bala, 2008; Marangunić & Granić, 2014).

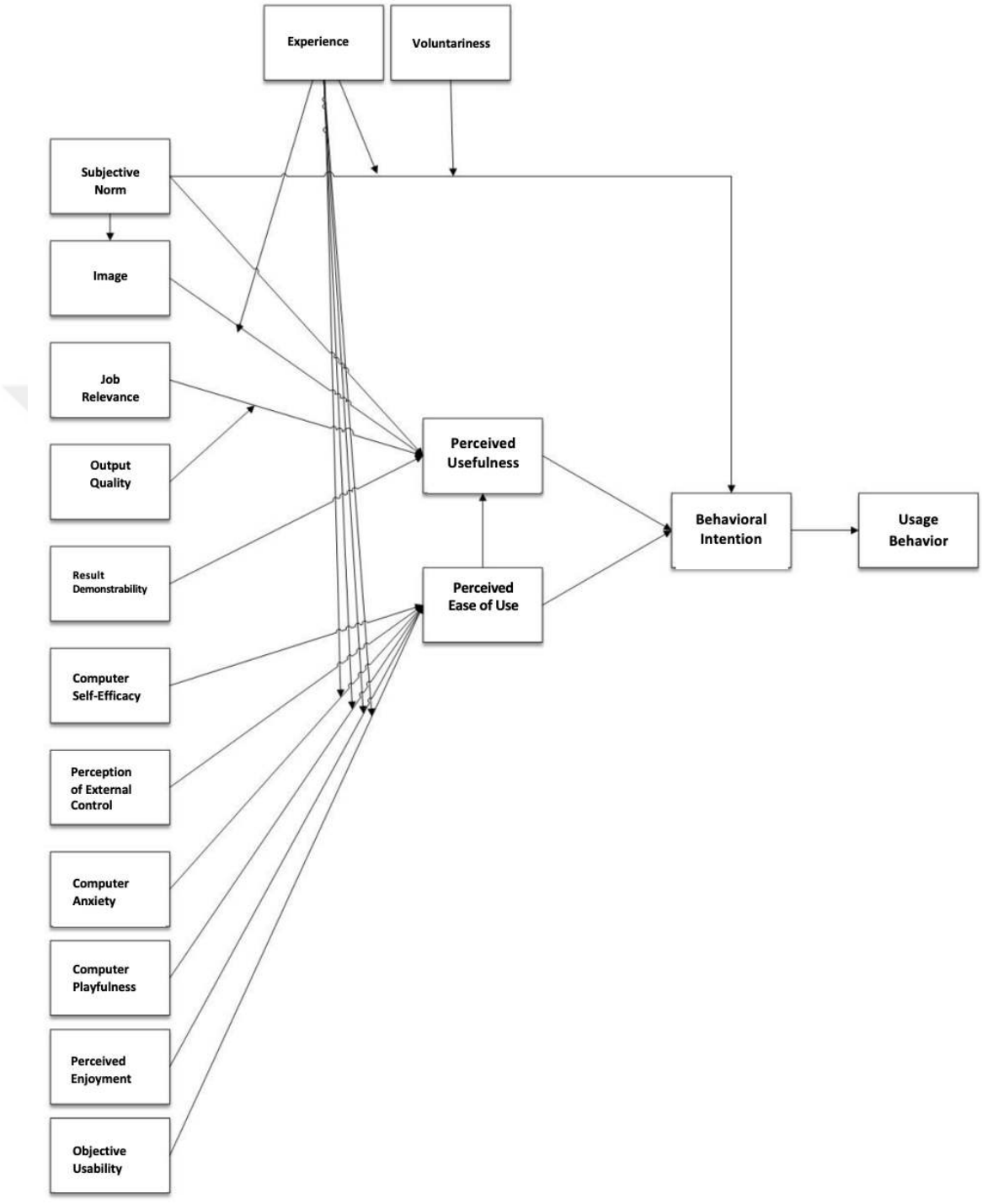


Figure 1.3. Technology Acceptance Model 3 (TAM3)

Note. Adapted from "Technology Acceptance Model: A review," by D. Marikyan and S. Papagiannidis, in S. Papagiannidis (Ed.), *TheoryHub Book* (p. 8), 2024 (https://open.ncl.ac.uk/). CC BY-NC-SA 3.0 IGO.

TAM has been one of the most widely studied frameworks for explaining why people adopt or reject new technologies with meta-analyses and reviews (Holden & Karsh, 2010; King & He, 2006; Marangunić & Granić, 2014). Reviews and meta-analyses have shown that the model consistently explains especially the effects of perceived usefulness and ease of use on technology adoption (King & He, 2006; Yousafzai et al., 2007). In healthcare, TAM has proven particularly helpful in explaining clinicians' acceptance of electronic systems and decision-support tools (Holden & Karsh, 2010). More recent studies confirm that TAM3 continues to be relevant for studying modern digital tools, including AI applications, because it integrates both personal and social factors influencing acceptance (Marikyan & Papagiannidis, 2024). Overall, TAM3 provides a powerful way to understand psychotherapists' beliefs, motivations, and barriers regarding the use of AI in therapy. TAM3 has been widely validated in healthcare contexts too, demonstrating strong explanatory power (Holden & Karsh, 2010).

Moreover, TAM's rigor really stands out during major crises or sudden changes in the world. For instance, according to Rosli et al. (2022), during the COVID-19 pandemic, when schools and universities were quickly and mandatorily shifted to online learning, TAM immediately became the main framework for researchers. One systematic review published during that time examined 104 different publications that used TAM just to understand how higher education handled the rapid technological change (Rosli et al., 2022). The rapid integration of AI applications in mental healthcare might be an equivalent technological shock like the sudden obligation to switch to online learning. Consequently, this study argues that TAM3 serves as the most effective theoretical framework to meet the research needs during the sudden changes of the AI revolution.

1.6.2. TAM3: Structure and determinants

TAM3 is the most comprehensive version of the Technology Acceptance Model family. The model integrates insights from TAM (Davis, 1989), TAM2 (Venkatesh & Davis, 2000), and complementary work in cognitive psychology on self-efficacy, perceived behavioral control, anxiety, enjoyment, and objective usability (Venkatesh, 2000; Venkatesh & Bala, 2008).

Like the earlier versions, TAM3 proposes that people's "Behavioral Intention" to use a technology predicts their actual use, and two beliefs form the foundation of this process: 1) Perceived Usefulness (PU): the belief that using the technology will improve job performance or effectiveness, and 2) Perceived Ease of Use (PEOU): the belief that use of the technology will be easy, or will require minimal effort (Marikyan & Papagiannidis, 2024, Venkatesh & Bala, 2008). Both beliefs influence the user's "Behavioral Intention" to adopt the technology.

TAM3 expands the explanation of what actually shapes "Perceived Usefulness" and "Perceived Ease of Use" as it claims that factors affecting usefulness are mostly cognitive and task-related, while those affecting ease of use are emotional and experiential (Venkatesh & Bala, 2008). Determinants of "Perceived Usefulness" and "Perceived Ease of Use" are listed in Table 1.1.

Table 1.1 Determinants of Perceived Usefulness and Perceived Ease of Use

Determinants of Perceived Usefulness (PU)

Category	Construct	Definition	Relationship to PU
Social Influence	**Subjective Norm (SN)**	The pressure users feel when people important to them think they should or shouldn't use the technology.	Affects PU and intention especially in early adoption.
	Image (IMG)	The belief that using the technology enhances or harms their professional image.	Affects PU by linking technology use to prestige.
Cognitive	**Job Relevance (REL)**	The extent to which the technology is directly related to job tasks.	Increases PU as relevance amplifies perceived usefulness.
	Output Quality (OUT)	The perceived accuracy or reliability of results.	Increases PU especially when job relevance is also high.
	Result Demonstrability (RES)	The degree to which benefits of using the system can be observed.	Increases PU supporting justification of use.

Determinants of Perceived Ease of Use (PEOU)

Category	Construct	Definition	Relationship to PEOU
Anchoring Factors	**Computer Self-Efficacy (CSE)**	Confidence in ability to perform tasks using computers.	Increases PEOU.
	Perceived External Control (PEC)	Belief that adequate support, ethical safeguards and resources are available.	Increases PEOU.
	Computer Anxiety (CANX)	Fear or discomfort about using computers or new technology.	Decreases PEOU.
	Computer Playfulness (CPLAY)	Joy and curiosity in using computers or new technology.	Increases PEOU.
Adjustment Factors	**Perceived Enjoyment (ENJ)**	The extent to which using the technology is enjoyable.	Increases PEOU after initial experience.
	Objective Usability (OU)	Actual effort required to complete tasks with the new technology	Increases PEOU as users gain real experience.

Note: Adapted from "Technology Acceptance Model: A review," by D. Marikyan and S. Papagiannidis, in S. Papagiannidis (Ed.), *TheoryHub Book*, 2024 (https://open.ncl.ac.uk/); and from "Technology acceptance model 3 and a research agenda on interventions," by V. Venkatesh and H. Bala, 2008, *Decision Sciences, 39*(2), 273-315 (https://doi.org/10.1111/j.1540-5915.2008.00192.x). Copyright 2008 by the Decision Sciences Institute.

To explain why people find a system easy to use, TAM3 introduced the anchoring and adjustment framework as shown in Table 1.1. Anchoring factors are general feelings and beliefs that shape initial expectations, and adjustment factors emerge after hands-on experience.

1.6.3. Moderating factors: experience and voluntariness

TAM3 shows that experience and voluntariness can change how people decide to use technology. As people become more experienced with a technology, they start to see more clearly how its ease of use helps them work more effectively (Venkatesh & Bala, 2008).

However, over the course of time, the role of ease of use becomes less relevant. Once users are comfortable with a technology, what matters the most is whether it actually helps them do their job better (Venkatesh & Davis, 2000).

Experience also lowers anxiety about a technology. When people become familiar with a technological tool, their anxiety usually decreases (Venkatesh & Bala, 2008). Voluntariness also plays a role in how social influence affects technology use. When using a technological tool is required, such as by an employer or an institution, people are more likely to be influenced by others' opinions or pressure. But when using the system is optional, they tend to rely more on their own judgment (Venkatesh & Bala, 2008).

1.7. Purpose and Significance of the Study

1.7.1. Purpose of the study and research questions

The purpose of this study is to explore psychotherapists' attitudes toward the adoption of AI in psychotherapy practice in Türkiye, addressing a gap in Türkiye's current literature regarding practitioners' perspectives on AI integration in mental healthcare. While existing research focused on practitioners with established AI expertise only (Gültekin & Şahin, 2024), this qualitative study aims to provide a more comprehensive understanding by including psychotherapists with varying levels of AI expertise. Gültekin & Şahin (2024) interviewed 13 participants who were specifically selected for their specific knowledge and expertise of AI applications in psychology. This study, on the other hand, includes psychotherapists with varying levels of AI exposure, from those with minimal knowledge to those with advanced experience. This broader sampling approach provides insights into how different levels of AI familiarity influence attitudes toward AI adoption. Additionally, this study uses the Technology Acceptance Model (TAM3) as a theoretical framework, which enabled a structured analysis of the factors influencing AI adoption. Consistent with recent evidence, the successful integration of AI in mental health services depends on clinicians' willingness and intention to use these tools, which are shaped by critical factors such as beliefs about usefulness of the technology, social influence, ethical concerns, and ease of use of the technology (Cecil et al., 2025; Higgins et al., 2023; Kleine et al., 2023).

Finally, this study aims at addressing ***four research questions (RQs)*** below:

RQ1: What are psychotherapists' general attitudes and perceptions toward AI adoption in psychotherapy?

This question relates directly to TAM3's core beliefs: "Perceived Usefulness" and "Perceived Ease of Use." When therapists evaluate an AI system, they are expected to ask: "Will this help me in my practice?", "How hard will it be to use?" and "How will this be useful for my job performance?" These questions map exactly into "Perceived Usefulness" and "Perceived Ease of Use" and help structure how we analyze therapists' attitudes toward AI.

RQ2: What factors influence psychotherapists' willingness or resistance to integrate AI tools in their practice?

TAM3 introduces social and emotional variables that influence behavioral intention: Subjective Norm (SN) represents social and professional pressure from supervisors, peers, or institutions (Venkatesh & Davis, 2000). Meanwhile, Computer Self-Efficacy (CSE) and Computer Anxiety (CANX) reflect level of personal confidence and emotional comfort with technology (Compeau & Higgins, 1995). These constructs would help explain why some therapists feel open to experimentation while others remain cautious.

RQ3: How do psychotherapists perceive the potential benefits of AI in therapeutic settings?

This question again relates strongly to "Perceived Usefulness." TAM3 allows this belief to be interpreted through measurable cognitive factors such as Job Relevance, Output Quality, and Result Demonstrability (Venkatesh & Bala, 2008).

RQ4: What concerns do psychotherapists have regarding AI adoption in psychotherapy?

Concerns usually correspond to "Perceived External Control," which refers to users' perceptions of whether technical resources, training, ethical safeguards and institutional support are available to help them use AI effectively (Venkatesh et al., 2003).

In summary, TAM3 fits this study because it is comprehensive enough to capture psychotherapists' perceptions and attitudes while structured enough to guide a thematic analysis.

1.7.2. Significance of the study

This study carries significance both for academic and practical applications in clinical and technological contexts. From a theoretical standpoint, it fills an important gap in the literature by offering a qualitative, theory-driven understanding of psychotherapists' attitudes toward AI in mental healthcare practice. Existing qualitative research in Türkiye has been primarily limited to AI-savvy professionals (Gültekin & Şahin, 2024). By applying TAM3 within a thematic framework, this study aims at providing a structured yet deeply human evaluation of how psychotherapists perceive, evaluate, and emotionally respond to AI adoption.

The study's contribution is also methodological. It demonstrates how TAM3 can be used as a guiding framework for qualitative research in fast-moving technological fields. Using a deductive structure within a thematic analysis allows both mapping of perceptions and maintaining data richness. This way, the study aims at contributing to bridging the gap between psychological research and technology studies.

Another layer of significance lies in the researcher's unique position as a clinical psychology master's student and a professional in a global technology company. This dual role offers a rare bridge between two domains that are often disconnected: mental healthcare and advanced technology industry. The researcher's background enables both technological fluency and clinical knowledge, enriching interpretation of participants' narratives. This interdisciplinary and cross-sectoral perspective enhances the credibility and practical impact of the study. The results of this study offer the potential to translate psychological insights into realistic recommendations for AI developers and policymakers.

From a practical viewpoint, the study offers valuable guidance for designing and implementing AI systems that align with therapists' ethical standards and professional realities. Understanding therapists' concerns can guide the creation of human-centered AI systems that support rather than replace clinicians (Babu & Joseph, 2024). Findings may also be useful for curricula in psychology programs at the universities by integrating AI literacy into clinical psychology and psychiatry education. Such efforts could increase practitioners' confidence and reduce anxiety related to technological change (Compeau & Higgins, 1995; Venkatesh & Bala, 2008).

In the Turkish context, this research is particularly timely. Türkiye's National Mental Health Action Plan identified ongoing shortages of mental health professionals and emphasized

the need for technology driven solutions to improve service access (T.C. Sağlık Bakanlığı, 2021). However, academic work addressing AI adoption in mental healthcare remains scarce. By exploring Turkish therapists' perspectives, this study contributes early evidence to an emerging national discourse on AI integration in healthcare.

Finally, this research might contribute to public policy and industry collaboration. The findings can inform policymakers developing national AI guidelines and frameworks, ensuring that new technologies complement healthcare services (World Health Organization, 2021). Insights may also assist technology companies in designing evidence-based and privacy-aware tools customized to mental health settings.

In summary, this study is significant because it connects disciplines and sectors that are usually disconnected, expanding theoretical, methodological and relational boundaries. It not only improves academic understanding of a fast-emerging subject, but also has the potential to offer practical tips for technological innovation in the growing intersection of psychotherapy and AI.

2. METHOD

2.1. Participants and Sampling

The study used a two-phase non-probability sampling strategy to recruit 18 psychotherapists, consisting of psychologists and psychiatrists. The recruitment process began with convenience sampling, where participants are selected based on their ease of access to the researcher. This approach is frequently used in qualitative studies to quickly and efficiently gather initial data from an accessible pool of respondents (Etikan et al., 2016). Following the initial phase, the researcher utilized snowball sampling to broaden the participant pool beyond immediate professional network. This technique involved asking early participants to refer colleagues whom they would think that will be interested in participating in the study. Snowball sampling is particularly well-suited for accessing specialized populations, such as clinical practitioners as it uses trust and connections within established professional communities (Naderifar et al., 2017).

The final sample size of 18 participants is supported by established norms in qualitative research. This number aligns with recommendations suggesting that a sample of this size is often adequate to reach data saturation; the point where new interviews are unlikely to introduce new themes (Guest et al., 2006). Moreover, this sample size is similar to those used in other qualitative studies that explored technology adoption among mental healthcare professionals (Thieme et al., 2023).

Participants came from various therapeutic orientations, including cognitive-behavioral therapy, psychodynamic therapy, integrative therapy, existentialist therapy and schema therapy. The sample included practitioners across different career stages from early to senior professional phases. Additionally, the study included practitioners with varying levels of AI familiarity, from low-level to high-level of familiarity, to understand how technological competence might influence attitudes toward the adoption. Demographic information of participants can be found in Table 2.1.

Table 2.1. Demographics of Participants

Participant	Age	Gender	Profession	Orientation	Experience	AI Familiarity
P1	30	Male	Psychologist	Psychodynamic	5 years	High
P2	46	Male	Psychologist	CBT	25 years	Moderate
P3	36	Male	Psychiatrist	EMDR & CBT	12 years	High
P4	28	Male	Psychologist	EMDR & CBT	5 years	High
P5	60	Male	Psychiatrist	Integrative	36 years	Moderate
P6	51	Female	Psychiatrist	CBT & Psychodynamic	22 years	Low
P7	47	Female	Psychologist	Psychodynamic	25 years	High
P8	35	Male	Psychiatrist	Integrative	10 years	High
P9	48	Male	Psychiatrist	Psychodynamic	20 years	Moderate
P10	35	Male	Psychologist	Psychodynamic	9 years	High
P11	39	Female	Psychologist	Schema, Gestalt	13 years	Moderate
P12	40	Female	Psychologist	Schema, CBT	16 years	Moderate
P13	59	Female	Psychologist	Psychodynamic	15 years	Low
P14	39	Female	Psychologist	CBT & Psychodynamic	15 years	Moderate
P15	43	Female	Psychologist	Psychodynamic & Integrative	22 years	Moderate
P16	35	Male	Psychologist	Psychodynamic, Existentialist	5 years	Moderate
P17	36	Female	Psychologist	Psychodynamic	12 years	Low
P18	41	Male	Psychiatrist	CBT	17 years	High

The study sample consisted of 18 psychotherapists, comprising 8 females (44.4%) and 10 males (55.6%). The participants' ages ranged from 28 to 60 years (M = 41.56, SD = 8.87). Regarding professional background, the group included 12 psychologists (66.7%) and 6 psychiatrists (33.3%). Their professional experience in psychotherapy varied between 5 and 36 years, with a mean experience of 16.06 years (SD = 8.65).

Several exclusion criteria were applied. Psychotherapists with less than one year of clinical experience were excluded. Psychotherapists who express complete unwillingness to consider any form of technology integration in their practice were also excluded.

The inclusion and exclusion criteria were carefully designed to align with TAM3's core constructs. By including psychotherapists with varying levels of AI awareness and technology experience, the study can examine how perceived usefulness varies across different technology exposure levels. This diversity enables investigation of how psychotherapists at different stages evaluate the potential benefits of AI in their clinical work as well as their concerns. The inclusion of participants with minimal technology experience allows for exploration of how perceived ease of use relates to existing technology competency. This range helps understand a greater variety of potential barriers and facilitators to AI adoption across different levels.

2.2. Ethical Considerations

This research was conducted following the ethical approval from Başkent University's Ethics Committee (see Appendix 4) and in accordance with the ethical guidelines of "Türk Psikologlar Derneği" (TPD), Turkish Psychological Association (TPD, 2004).

All participants provided written informed consent (see Appendix 1) prior to participation, with clear information about the study's purpose and procedures, including the right to withdraw at any time without consequences. Particular attention was given to participant confidentiality. Interviews were conducted in private settings, and all data was anonymized during transcription. Audio recordings were stored securely and deleted after transcription verification.

2.3. Data Collection

Participants were reached through non-probability sampling (both convenience and snowball sampling) since the target of the research was a specific professional group, who are the mental health professionals actively doing psychotherapy more than 1 year. The interviewees were first given the informed consent form and demographic information form before starting with the interview questions. Individual interviews took place over the online video platform Google Meet with an audio recording device on. After receiving their written informed consent of the audio recording, each interview started with the verbal confirmation of the audio recording consent of the participant.

2.4. Measures

2.4.1. Demographic information form

The demographic information form collected participants' professional qualifications in mental healthcare along with their years of clinical practice as well as their psychotherapy experience. The questionnaire also documented participants' primary therapeutic orientation (such as cognitive-behavioral, psychodynamic, existentialist, schema or integrative approaches) and their current practice setting (private practice, institutional, academic, or online therapy). Additionally, participants were asked about their previous experience with technology in clinical practice, including any exposure to AI applications. Basic demographic information such as age, gender and educational background were also collected (see Appendix 2). All demographic information was collected in accordance with ethical guidelines and data protection regulations with participants' identities protected.

2.4.2. Semi-structured interview questions

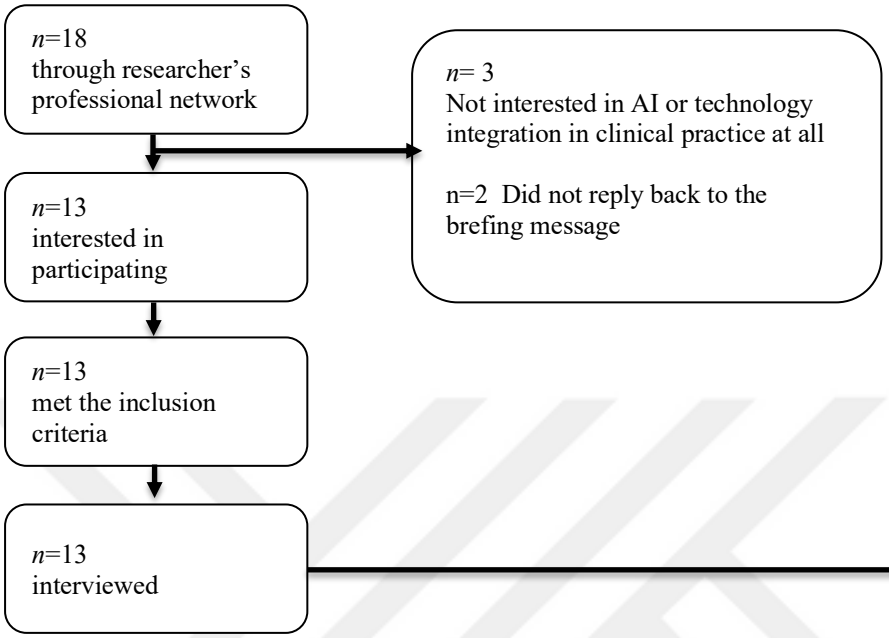
The interview questions were developed based on the TAM3 framework (Davis, 1989; Marikyan & Papagiannidis, 2024; Venkatesh & Davis, 2000) and informed by recent literature on AI adoption in healthcare (Hoose & Králiková, 2024; Kleine et al., 2023; Ni & Jia, 2025; Spytska, 2025; Tun et al., 2025). The questions were structured around TAM3's core constructs. The interview questions were piloted with two psychotherapists before beginning the main study, and minor adjustments were made based on pilot experiences and thesis advisor's feedback. All interviews were conducted online via video platform Google Meet in Turkish. The mean duration of the interviews was 39.22 minutes (SD = 12.41), varying according to the participant's pace and the depth of their answers. The interview questions can be seen in Appendix 3.

2.5. Procedure

Following the ethical approval, a short briefing text, including the study's goal and content as well as the researcher's contact details, was prepared and shared with potential participants. The researcher initially reached out to the participant candidates via email or WhatsApp messages depending on the available communication channel. Afterwards, individuals who expressed interest in participating were contacted by phone for a brief conversation to double

check whether they meet the inclusion criteria. Those who met the criteria were scheduled for online interviews. Before the interview, participants were given an informed consent form and a demographic information form. They returned the forms filled in and signed before the interviews. The interviews were audio-recorded to allow for transcription. Although the data collection process was originally planned to last one month, it extended to approximately five months due to busy agenda of the participants and also required rescheduling due to summer period. The overall data collection process is illustrated in Figure 2.1.

Phase 1: Convenience Sampling Phase



Phase 2: Snowball Sampling

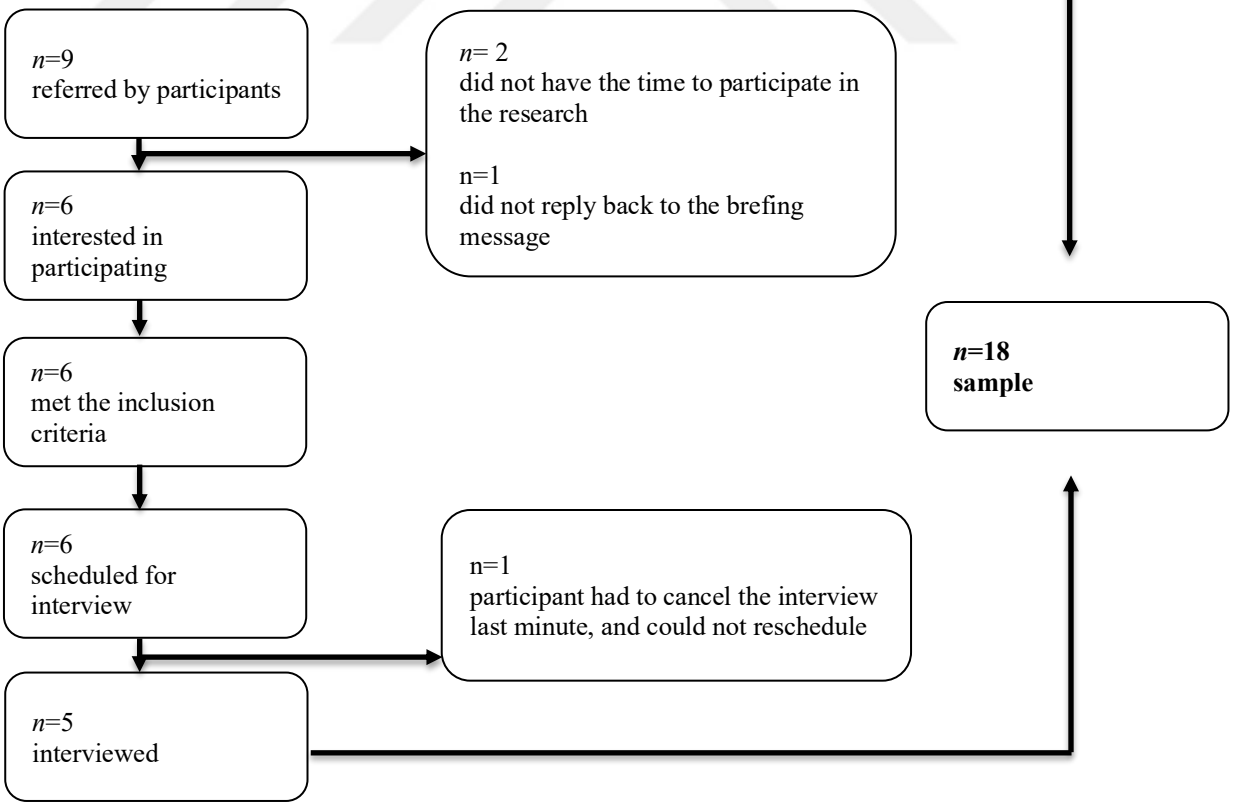


Figure 2.1. Data collection process

2.6. Qualitative Research and Thematic Analysis

Qualitative research plays a vital role in the science of psychology. It allows researchers to explore the human experience, which cannot be fully understood through statistics, by interpreting the subjective meanings individuals assign to a specific issue (Creswell, 2013). This approach is particularly valuable for investigating complex psychological concepts. Unlike quantitative methods that focus on measurement and statistical analysis, qualitative research examines the meanings, perceptions, and experiences of individuals (Braun & Clarke, 2013).

Therefore, for this study, a qualitative approach was chosen to gain a deep understanding of psychotherapists' perspectives on AI adoption. The goal was not to measure attitudes but to explore how and why these attitudes are formed. The research questions are exploratory, seeking to understand the "how" and "why" behind attitudes, rather than just "how many" people hold a certain view. A qualitative approach is uniquely suited for the research questions. In addition, Braun and Clarke (2013) emphasize that the qualitative research process starts with a commitment to understand the world from the participants' point of view. Consistent with this perspective, the primary objective was to understand what mental health professionals think and feel about AI adoption in mental healthcare.

Furthermore, thematic analysis serves as the foundational method for identifying, analyzing, and reporting patterns, or "themes," within the data (Braun & Clarke, 2006). The goal of this method is to organize and describe the dataset to interpret various aspects of the research topic. A key advantage of thematic analysis is its theoretical freedom; it is not tied to a specific pre-existing framework, allowing it to be adapted for the needs of different studies (Nowell et al., 2017). Therefore, the research utilized this freedom and flexibility to integrate its thematic analysis with a theoretical framework.

To ensure a structured and thorough analysis, this study followed the six-phase process outlined by Braun and Clarke (2006). This process served not as a linear set of rules, but as a guide, allowing the researcher to move back and forth between phases. The qualitative data analysis software *Delve*[1] was used to manage transcripts, coding, and theme development, maintaining an audit trail of the process. This six-phase process is summarized in Table 2.2.

[1] https://delvetool.com/

Table 2.2. The Six Phases of Thematic Analysis

Phase	Explanation
Phase 1: Familiarizing with the data	Transcribing the data, gaining familiarity by reading it repeatedly, and noting down initial ideas.
Phase 2: Generating Initial Codes	Taking notes on emerging and noteworthy parts of the data and performing coding.
Phase 3: Searching for Themes	Bringing related codes together to be combined into potential themes.
Phase 4: Reviewing Themes	Checking the coherence of themes; creating a thematic map.
Phase 5: Defining and Naming Themes	Clearly defining each theme, naming it appropriately according to its content.
Phase 6: Producing the Report	Selecting the most relevant and meaningful quotes for the identified themes, interpreting the results by linking them to the research questions and literature, and reporting them in an academic language.

Note. Adapted from "Using Thematic Analysis in Psychology," by V. Braun and V. Clarke, 2006, *Qualitative Research in Psychology, 3*(2), 77-101 (https://doi.org/10.1191/1478088706qp063oa). Copyright 2006 by Informa UK Ltd.

2.7. Adopting a Theoretical Thematic Analysis

Braun and Clarke (2006) described two primary approaches to thematic analysis: an inductive (bottom-up) approach and a deductive (top-down or theoretical) approach. An inductive analysis is data-driven. Themes are developed directly from the content of the data collected. In contrast, a theoretical (deductive) thematic analysis is driven by the study's specific research questions and is shaped by an existing theory.

This research adopted a theoretical thematic analysis. TAM3 provides a well-established theoretical lens for this purpose. By making the analysis within the TAM3 framework, the research becomes comparable to the existing literature on technology acceptance.

2.7.1. Phase 1: Familiarizing with the data

As seen in Table 2.2., the first step was to deep dive into the interview data (Braun & Clarke, 2006). All 18 audio recordings were transcribed word-for-word. Then, the researcher read each transcript over and over again, sometimes stepping away for a day or two to come back with fresh eyes. The goal was to get a real feel for what each person was saying and to become completely familiar with their perspective. While reading multiple times, the researcher took notes of initial ideas and thoughts, specifically noting where participants' narratives seemed to align with TAM3 concepts, such as mentions of professional reputation (“Image”) or technological fear (“Computer Anxiety”).

2.7.2. Phase 2: Generating initial codes

In this phase, the researcher started to organize the data, going through all the transcripts and applying "codes," which are basically short labels for interesting quotes or ideas that related to the research questions (Braun & Clarke, 2006). Coding was conducted with a deductive goal; segments were tagged not just descriptively, but with an eye toward TAM3 framework. For example, if a participant talked about “saving time,” it was coded as "efficiency gain," which links directly to “Perceived Usefulness.” Similarly, concerns about complex AI interfaces were coded with reference to “Perceived Ease of Use.” The qualitative analysis software *Delve* helped manage these codes efficiently.

2.7.3. Phase 3: Searching for themes

With all the codes in place, the researcher started to look for bigger patterns. This meant grouping similar codes together to form potential themes (Braun & Clarke, 2006). It was also during this phase that the researcher saw that some of these broad themes had more specific

ideas within them. These would later become the “subthemes,” which are “essentially themes-within-a-theme” (Braun & Clarke, 2006, p. 92). This process also involved mapping these data clusters onto the TAM3 framework. For instance, codes such as "worry about client data protection" and "fear of breaking confidentiality" were grouped under a potential subtheme of “Ethics and Data Privacy,” which aligns with TAM3’s “Perceptions of External Control” construct.

2.7.4. Phase 4: Reviewing the themes

This phase was all about cleaning up and refining. The researcher reviewed the work on two levels: first, read through all the coded data for each theme and subtheme to make sure they made sense as a group, and second, checked if the themes were telling an accurate story about the data as a whole. This process was quite dynamic and included many changes before the finalization. This phase also involved ensuring that the deductive use of TAM3 did not force data into categories where it did not fit. After doing some back-and-forth, in the end the researcher ended up combining some themes, splitting others, and removing a few subthemes.

2.7.5. Phase 5: Defining and naming the final themes

The researcher wrote a definition for each final theme, explaining exactly what it was about. The subthemes helped add more detail to these definitions. The researcher then gave each theme and subtheme a clear name that would immediately tell the reader what it meant. Theme names were crafted to be clear and, where appropriate, reflective of TAM3 terminology to facilitate academic comparison. For instance, a theme about how therapists perceived AI as a helpful tool in different areas was named “The Spectrum of AI's Perceived Role.”

2.7.6. Phase 6: Producing the report

The final step was to write a "Results" report. This involved choosing relevant quotes from the interviews to bring each theme and subtheme to life. The researcher also wrote a discussion section which connected the findings back to the research questions, relevant literature and the TAM3 framework. Both the results and discussion sections analyzed where the data supported standard TAM3 relationships, and also where they went beyond it.

2.8. Ensuring Trustworthiness

Trustworthiness in qualitative research is demonstrated by showing that the analysis was correct, consistent, and exhaustive. Therefore, the following strategies were employed to ensure trustworthiness as suggested by the literature (Nowell et al., 2017, pp 3-4).

2.8.1. Credibility

Credibility refers to confidence in the truth of the findings. To ensure the interpretations accurately reflected the participants' intended meanings, member checking was conducted. Preliminary results were shared with two participants, who were asked if the themes resonated with their perspectives. Their feedback was used to finalize the analysis. Also, a peer debriefing was utilized as suggested by the literature (Nowell et al., 2017). Apart from the thesis advisors feedbacks, a peer (PhD) from another university, who is experienced with qualitative research, provided an external check on the process.

2.8.2. Dependability and confirmability

Dependability and confirmability both relate to the consistency of the process. An audit trail was maintained throughout the research process as suggested in the literature (Nowell et al., 2017). The use of Delve software was instrumental in creating this trail as the software kept a record of all codes and their application to the data. Peer debriefing from an experienced qualitative researcher was also used to receive second opinion of the coding and review processes.

2.8.3. Transferability

Using a well-known theoretical framework like the TAM3 has strengthened transferability of the study. By connecting the specific findings of this study to the established concepts within TAM3, the results went beyond the experiences of 18 individuals. This "theoretical engagement" provides a common language and structure, allowing researchers and practitioners

to compare these findings with other studies (Stalmeijer et al., 2024, p.2). In other words, TAM3 framework acts as a bridge.

2.8.4. Reflexivity

In qualitative research, the researcher is not a distant observer but an active participant in creating meaning (Braun & Clarke, 2006; Creswell, 2013). This study was shaped by the researcher's unique position. The researcher had a rewarding but also challenging positionality, with one foot in the world of clinical psychology as a master's student and the other as a professional in a global technology company.

From the very beginning, this dual perspective was both an asset and also a potential bias producer. When preparing the interview questions, the clinical "hat" ensured the questions were based on the realities of psychotherapy, for instance, focusing on main concerns like the "therapeutic alliance." The researcher believes that this insider knowledge helped build rapport quickly. Participants seemed to relax, knowing they were speaking with someone who understood their world, which allowed for conversations that felt less like formal interviews. The technology "hat," meanwhile, provided a pragmatic angle, basing the questions on a realistic understanding of AI. On the other hand, even though the researcher found it easier to switch quickly from clinical context to the technological one during the conversations, a significant number of the participants had hard time juggling with two different angles. The unique positionality of the researcher might have caused confusion in the participants.

In addition, this dual role also presented other challenges. The most significant was the dynamic in the researcher-participant relationship. Some participants, knowing the researcher's tech affiliation, might have felt inclined to offer more positive responses or at least seem more enthusiastic about the subject than they truly felt. The researcher's own potential bias toward seeing the benefits of technology could also lead to overlooking some concerns. This became evident in the initial drafting of the interview guide. For instance, a question was originally phrased by the researcher as, "What are the benefits of using AI in mental healthcare?" ("Psikoterapide yapay zeka kullanımının faydaları nelerdir?") The wording presupposed that benefits do exist. Recognizing this bias, thesis advisor gave feedback to the researcher and the question was revised to a more neutral form: "Are there any benefits of AI in mental healthcare?" ("Psikoterapide yapay zeka kullanımının potansiyel faydaları var mıdır?"). This

adjustment was a critical step in ensuring the questions are neutral before starting the actual interviews.

Beyond these conceptual challenges, there were significant practical constraints. The researcher conducted this study while managing a demanding full-time professional role. This reality meant that the research process was often fragmented. What was originally planned as a period of continuous immersion in the data became a series of sprints separated by breaks. This disconnection occasionally delayed the analysis and finalization process. Each time the researcher returned to the data after a period away, it required a significant effort to re-establish the familiarity.

The researcher also kept notes throughout the entire research process, which might be called a “reflexive journal” (Nowell et al., 2017). This was a space for self-examination. Before each interview, assumptions were noted. After each session, moments of surprise or discomfort were also noted. During data analysis, and especially after periods of disconnection, the notes served as a helpful tool for re-engagement with the data. With the help of the notes, the researcher from time to time asked: "Is this theme emerging from the data, or is it coming from my own perspective?" This self-awareness was essential for ensuring that the final analysis captured the perspectives of the therapists rather than the researcher’s.

3. RESULTS

This chapter presents the findings from the theoretical thematic analysis of 18 semi-structured interviews conducted with psychotherapists in Türkiye. The analysis, guided by the TAM3 framework, identified three main themes and nine associated subthemes, which are listed in Table 3.1. and also visualized in Figure 3.1. Themes and subthemes are explained further in the subsequent sections, supported by quotations from the participants. Participant quotations are added in their original Turkish statements followed by an English translation, prepared by the researcher.

The themes address the four research questions which are introduced in the Introduction Chapter. Theme 1 responds primarily to RQ1 and RQ3 by examining how therapists conceptualize AI's role and usefulness across clinical, administrative and systemic levels. Theme 2 addresses RQ2 by exploring the personal, emotional, and theoretical factors that shape therapists' readiness or resistance toward AI. Theme 3 directly relates to RQ4, capturing the ethical and institutional preconditions for AI adoption within psychotherapy practice. Together, these themes provide a comprehensive response to all four research questions, offering a multidimensional understanding of AI acceptance in psychotherapy.

Table 3.1 Mapping of Themes and Subthemes to TAM3 Constructs

Theme / Subtheme	Relevant TAM3 Constructs	Explanation
1. The Spectrum of AI's Perceived Role		Therapists assessed AI's overall usefulness for improving their work.
1.1 AI as an Assistant	REL; OUT; RES; ENJ; OU	AI viewed as highly useful for administrative, educational tasks
1.2 AI as a Public Health Tool	REL; OUT; RES; SN; IMG; OU	AI perceived as effective for screening, triage, and early detection, supporting social and institutional goals.
1.3 AI as a Therapist or Co-Therapist	REL; OUT; RES; CANX; IMG	Participants debated AI's therapeutic role; some valued efficiency, others feared loss of control.

Theme / Subtheme	Relevant TAM3 Constructs	Explanation
2. Therapist's Digital Readiness and Orientation		Readiness was shaped by self-confidence, theoretical stance, emotions, and digital experience.
2.1 Tech-Savviness	CSE; CANX; CPLAY; ENJ; OU	Higher computer self-efficacy reduced anxiety and improved enjoyment.
2.2 Influence of Therapeutic Orientation	REL; OUT; SN; IMG; CANX	Orientation influenced how relevant and credible AI seemed; structured approaches showed higher acceptance, relation-based ones expressed more caution.
2.3 Emotional Dimension: From Fear to Enjoyment	ENJ; CANX; CPLAY	Emotional reactions ranged from fascination to fear.
2.4 Practical Experience of AI	ENJ; CSE; REL; OU	Direct experimentation increased confidence and enjoyment.
3. Common Concerns and Preconditions for Adoption		Adoption depended on ethical safeguards and maintenance of professional autonomy.
3.1 Importance of Ethics and Data Privacy	PEC; SN; IMG; OUT; RES; OU	Ethical safety, data privacy, and output quality were prerequisites for acceptance.
3.2 Dependency and Autonomy	CANX; CSE; PEC; REL; OU	Therapists emphasized balancing confidence and control, resisting over-dependence on AI systems.

Note. This table maps each theme and subtheme identified to corresponding constructs of the TAM3 (Venkatesh & Bala, 2008). Abbreviations: PU = Perceived Usefulness; PEOU = Perceived Ease of Use; REL = Job Relevance; OUT = Output Quality; RES = Result Demonstrability; ENJ = Perceived Enjoyment; OU = Objective Usability; CSE = Computer Self-Efficacy; CANX = Computer Anxiety; CPLAY = Computer Playfulness; PEC = Perceived External Control; SN = Subjective Norm; IMG = Image.

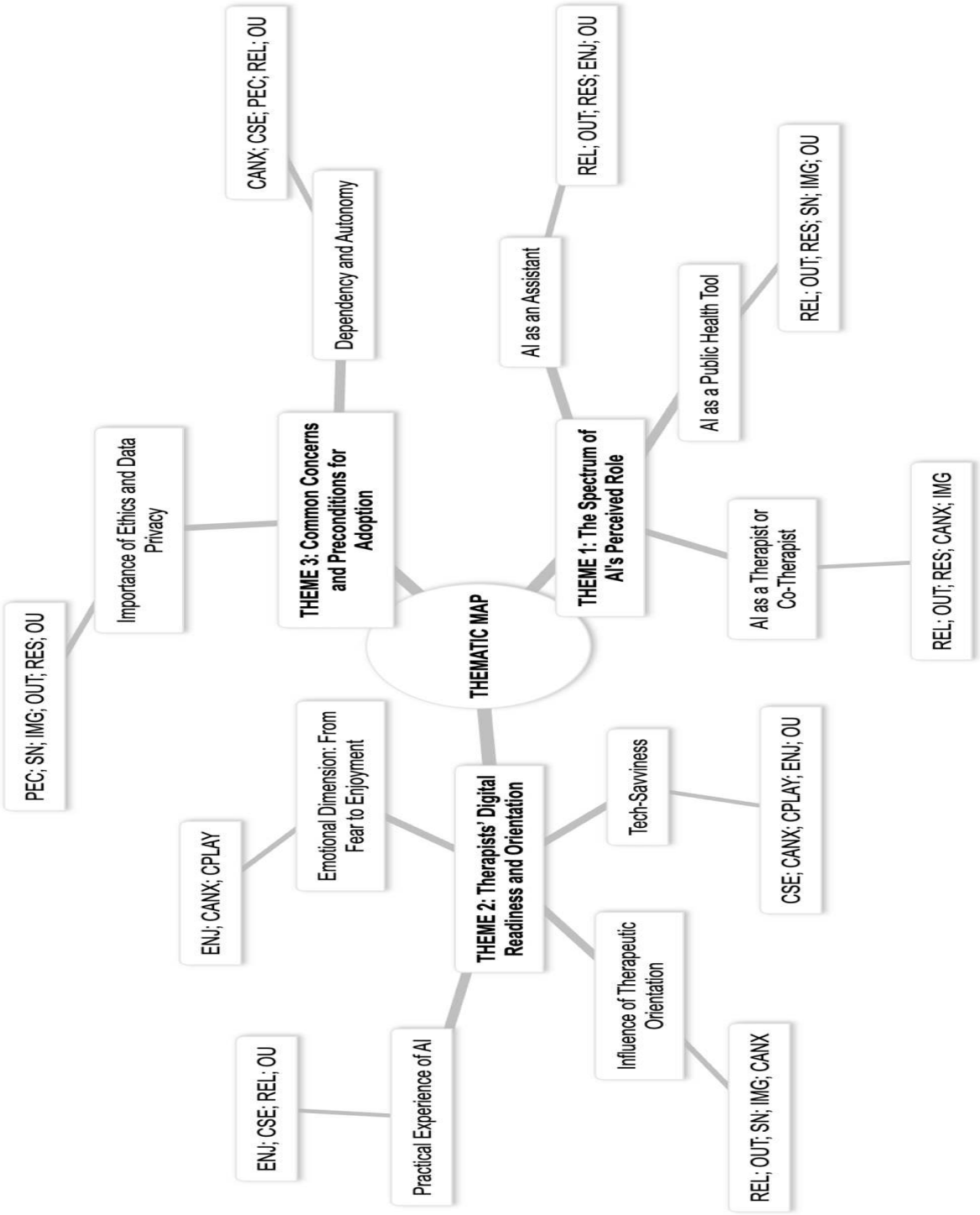


Figure 3.1. Thematic map of the themes and subthemes in relation to Technological Acceptance Model 3 constructs.

Note. This figure shows the relations among themes and subthemes as well as the associated Technological Acceptance Model 3 constructs derived from the theoretical mapping in Table 3.1.

3.1. Theme 1: The Spectrum of AI's Perceived Role

The first theme captures participants' perceptions of the various roles AI might play in mental healthcare. These roles ranged widely, from an administrative tool to a sophisticated clinical co-pilot, and even a fully autonomous therapist. This theme aligns closely with the “Perceived Usefulness” construct of TAM3, as participants discussed AI's potential to improve their job performance and, in some cases, to perform the job itself.

3.1.1. Subtheme 1: AI as an assistant

This was the most widely accepted and positively viewed role of AI for many participants. Based on their experiences with AI outside their profession, therapists saw value in delegating non-clinical tasks to AI such as research, scheduling, note-taking and summarizing. They also appreciated the value of AI in scholarly tasks such as literature searches, translations, and report preparation. Participants viewed these functions as having high “Perceived Usefulness” and “Job Relevance” because they believe AI would help them save time, increase their speed, and improve their effectiveness in non-clinical work.

Beyond these instrumental functions, several participants also described using AI as an assistant in supervision and reflection. For example, P4, shared that entering session summaries into an AI allowed them to receive “technical feedback” quickly, finding this “very helpful”. Similarly, P5 and P13 imagined using AI as a reflective partner for especially theoretical knowledge sharing. These participants expand the assistant role beyond administrative tasks into the domain of intellectual reflection.

Within the TAM3 framework, these experiences align with “Perceived Usefulness” and "Output Quality,” as AI was perceived to enhance therapists’ effectiveness with satisfactory output quality both practically and cognitively. The curiosity and satisfaction therapists reported when experimenting with AI for self-learning suggest "Perceived Enjoyment.” Some participants expressed "Perceived Enjoyment" in using these tools, particularly when they significantly eased their workload. Furthermore, positive experiences regarding AI's "Objective Usability" often reinforced the perception of its high usefulness for these assistant roles.

P1: Takvime destek olan bir şeyi ben kullanırdım... Eğer benim programım orada tanımlı ise... yapay zeka biliyorsa mesela, şu şu saatleri önerebilirsiniz derse, ben bunu severim. (I would use something that supports a calendar... For example, if my schedule is defined there... and if AI knows, for instance, if it says "you can propose these specific hours to your client," I would love that.)

P2: Yani mesela çeşitli makaleleri özetlemesini istediğimde veya böyle hızlıca mesela bazen şu konuda acaba nasıl bir şey var deyip bana öyle getirsin istiyorum. Bazen bir sürü makale var böyle makaleleri atıp, mesela şunların bir hepsini toplasan bir özet yapsan dediğim oluyor veya işte kendi sunumlarım oluyor, sunumlarımı daha güzel görsel hale getirir misin diye yapay zekayı yüklediğim sunumlarım oluyor. Bu şekilde kullanıyorum. (I mean, for example, when I want it to summarize various articles, or sometimes when I quickly wonder 'what's available on this topic' and want it to bring me that. Sometimes I have a lot of articles, and I throw them in and say, for example, 'can you gather all of these and make a summary,' or I have my own presentations, and I upload my presentations to AI to ask, 'can you make my presentations more visually appealing.' This is how I use it.)

P3: Yani hayal ettiğiniz her şeyi yapabilecek bir asistan, bir yardımcı gibi. (Like an assistant, a helper, that can do anything you can imagine.)

P5: Kuramsal bilgi alışverişinde bulunmakta en çok işime yarar, iyi anlamadığım bir şeyi daha iyi anlayabilmek için şunları şunları yükleyip buradan ne anladık diye sormak gibi. (It would be most useful for exchanging theoretical knowledge, like uploading various things to better understand something that I don't grasp well, and asking AI, 'What do we understand from this?)

P7: Bir yardımcı gibi yani bir asistan gibi çalışıyor. Bayağı her şeyi bilen bir asistan gibi çalışıyor. (Like a helper, I mean, it works like an assistant. It works like an assistant who knows quite a lot.)

P9: Çok az revizyon gerektirebilecek biçimde çok iyi bir asistan aslında, ama bir şey araştırma amaçlı ya da somut bir bilgiyi kullanma amaçlı olarak teyit edilmesi gereken bir asistan. (It's actually a very good assistant that requires very little revision, but it's an assistant that needs to be verified when used for research or for concrete information.)

P12: Yani işte bir takvim, bir randevu oluşturma pratiği. Yani işin daha teknik kısımlarında yapay zeka evet... (Meaning, as a calendar, practice of creating an appointment. Yes, AI in the more technical parts of the job...)

P13: Seans özetleri ve onların toparlanması ve aslında düzenlenmesi gibi bir şey benim çok işime yarar. Hala defter kalem çalışıyorum. (Something like session summaries and their collection and organization would be very useful for me. I still work with a notebook and pen.)

P14: Kendi araştırmalarım için özellikle şu konuda çok seviyorum kendisini. Yabancı bir dilde yazı yazmakla ilgili bana çok yardımcı oluyor. Kelime üretmek, bağlaçları bulmak yani ifade etmeyi kolaylaştırıyor bazen kendimi başka bir dilde. (For my own research, I especially love it as it helps me a lot with writing in a foreign language. Generating words, finding conjunctions, it makes it easier to express myself in another language.)

P15: Yapay zekayı daha çok herhangi bir konuyla ilgili bir araştırma yaparken kullanıyorum. (So I use AI mostly when doing research on any given topic.)

P16: "Marabalık" kısmını belki yapay zekaya devrederek işi kolaylaştırabilir veya o kişinin işine daha da konsantre bir şekilde sürdürmesine belki yardımcı olabilir. Nasıl ki insanlar geliri arttıkça bazı işleri delege etmeye başlar. Ev temizliği, belki yemek yapma veya benzeri şeyler, benzeri hizmet satın almak gibi, dışarıdan outsource etmek gibi, böyle bir etkisi olabilir (yapay zekanın). (Perhaps by delegating the "drudgery" parts to AI, it could make the job easier, or it could perhaps help that person continue their work in a more concentrated way. Just as people start to delegate some jobs as their income

increases. Like house cleaning, maybe cooking, or similar things, like buying similar services, like outsourcing, (AI) could have an effect like this.)

P18: Şimdi (yapay zeka) daha çok ciddi bir yardımcı, işleri çok hızlandıran ve daha istediğim gibi yapmak için bana destek olan bir aparat..." (...now it's more of a serious assistant, something that speeds up work, and an apparatus that supports me in doing things the way I want.)

In TAM3 terms, strong perception of usefulness is founded through “Job Relevance,” "Result Demonstrability" and "Output Quality” for the AI to play the assistant role. Participants found that AI produced tangible results that often required minimal or no revision. The experience of AI generating high-quality drafts and summaries allowed therapists to clearly and quickly observe the direct, positive outcomes of the technology, which significantly increased their behavioral intention to adopt it. By focusing on non-clinical, supportive functions, AI was perceived as directly aligning with the administrative and scholarly needs of the profession. Finally, the information generated by the AI were also seen to be of good quality. Whether it was academic literature reviews, or good quality translations, or visually improved presentations, the high quality of the output supported participants' effectiveness as a psychotherapist. Therefore, these positive experiences, marked by high “Job Relevance”, "Output Quality”, and "Result Demonstrability,” not only increased the participants' intention to adopt AI but also served to build their self-efficacy with the technology over time.

3.1.2. Subtheme 2: AI as a public health tool

Moving beyond the individual therapy, this subtheme highlights how therapists imagine AI contributing to mental healthcare at a larger level. Participants evaluated AI as a public health tool rather than a medium which is only available for individual use. Several participants with a broader perspective imagined AI's significant impact occurring outside the therapy room. They saw its potential as a large-scale public health tool for early detection, public screenings, public risk assessments, and more efficient allocation of mental health resources. This aligns with the “Perceived Usefulness” construct, where the technology benefits the entire healthcare system

this time. Several participants saw high “Perceived Usefulness” and “Job Relevance” in public screening, effective triaging and risk evaluations as they also find AI’s "Objective Usability" and "Result Demonstrability" quite high.

P2: Dolayısıyla yapay zeka bunları bizim için eleyebilir ve önümüze daha saf bir grubu bırakabilir. Yani 3 bin kişiyle görüşmektense 500 kişiye inmiş, 500 kişiyle yapılmış derinlemesine bir görüşme bence çok daha etkili. (Therefore, AI can filter these for us and leave a purer group before us. Instead of interviewing 3,000 people, I think an in-depth interview conducted with 500 people, narrowed down to 500, is much more effective.)

P4: Resim analizi üzerine bir yapay zeka modeli geliştirdik. Aslında çocukların çizimleri üzerine bize bir ön değerlendirme veriyor... Aslında tarama kısmında birazcık daha riskli vakaları tespitte işimize yarıyor diyebiliriz. (We developed an AI model for picture analysis. It actually gives us a preliminary assessment based on children's drawings... We can say that it helps us in the screening phase to identify higher risks.)

P7: Demografik bilgileri almak gibi olabilir. Ön görüşme yapmak gibi olabilir. Ve o ön görüşmede yapılacak yönlendirmeleri yapmak gibi olabilir. (It could be like collecting demographic information. It could be like conducting a preliminary interview. And it could be like making the referrals that would be done in that preliminary interview.)

P8: Mesela özellikle otistik bireylerin cinsellikle ilgili yaşadığı bazı zorluklar. Yapay zeka çok daha anonim bir varlık olduğu için daha rahat olduğunu hissetmiştim…Yurt dışında yaşayan buradan göçmüş gitmiş yalnızlık çeken hastalarda yapay zeka tek başına mesela bir sohbet aracı olan hastalarım var ve bu açıdan faydalı mesela. (For example, some difficulties that autistic individuals experience with sexuality. I felt they were more comfortable because AI is a much more anonymous entity... For patients living abroad who have migrated from here. For patients suffering from loneliness, for example, I have patients for whom it is a conversation tool, and it is useful in this respect.)

P9: Aslında monitörizasyon ve belki triaj açısından da çok önemli olabilir... kişinin teknolojik dijital ayak izlerinden... bir depresyona girmek üzere ya da girmiş olup olmayabileceğinin saptanması, intihar riskinin öngörülebilmesi ve dolayısıyla doğrudan psikoterapi değilse de psikoterapi ihtiyacının öncelikli olan kişilerin daha hızlıca saptanması ile ilgili de önemli bir yeri olmak üzere. (In fact, it could be very important for monitoring and perhaps triage... detecting from a person's digital footprints... whether they are about to enter or have entered depression, predicting suicide risk, and thus, even if not directly psychotherapy, quickly identifying people who should be prioritized for psychotherapy.)

P10: Zaten şu an şey yapıyor, sosyal destek hizmeti sunuyor aslında. (In fact, it's already providing a social support service.)

P14: Mesela otizm spektrumunda olan yetişkin danışanlarıma çok faydalı olabileceğini düşünüyorum. Çünkü bazen onların hakikaten bir terapistin onunla geçirdiği vakitten çok daha fazla anlık durumlarda, anlık olaylarda destek ve desteğe ihtiyacı oluyor...Olmayan bir sosyal desteğin muadili olarak var olmasının işlevsel olabileceğini düşünüyorum. (For example, I think it could be very useful for my adult clients on the autism spectrum. Because sometimes they truly need support in instant situations, instant events, much more than the time a therapist spends with them… I think it could be functional as an equivalent to social support that isn't there.)

P18: Riskli profillerinin belirlenmesi olabilir. Yani bu riski. İntihar riski de diyebilirsiniz… Danışanlar çok da bir bilgi sahibi olmadan terapist seçiyorlar. Dolayısıyla belki yapay zeka araçlarıyla kişiler kendilerine uygun psikoterapi türlerini tanıyabilirler. Kendi yaşadıkları zorlukla ilgili en etkili türünün ne olduğunu bilebilirler ve bu şekilde doğru uzmanı bulabilirler." (It could be the identification of high-risk profiles. This risk. You could say suicide risk... Clients choose therapists without much information. Therefore, perhaps with AI tools, people can identify the psychotherapy types suitable for them. They can know the most effective type for the difficulty they are experiencing and find the right expert this way.)

These reflections show that several therapists perceive AI's contribution at a structural level. By delegating initial screening and triage to AI, they see this technology as capable of extending access to care. This broader view reframes "Perceived Usefulness" not only as individual efficiency but also as a systemic one. In TAM3 terms, this subtheme demonstrates an expanded sense of "Perceived Usefulness" that goes beyond individual practice and aligns with high "Job Relevance" and high "Output Quality" in the broader healthcare ecosystem.

Several therapists in this study also envisioned AI as a bridge toward vulnerable populations. A small group of participants described AI as a provider of psychoeducation, screening, or companionship to groups who often struggle to access therapy, including LGBTQI+ individuals, migrants, and neurodivergent people. For example, P12 emphasized AI's potential for inclusive representation in psychoeducational materials, describing how AI tools helped visualize "older queer" identities otherwise absent in mainstream resources. P14, working with adults on the autism spectrum, saw AI as a continuous aid that could sustain support between sessions, providing structure and guidance at moments when therapist is unavailable. Similarly, P4, drawing on their work with migrant populations, highlighted AI's value as an unbiased aid, suggesting that AI supervision could minimize human bias.

Together, these reflections position AI's "Perceived Usefulness" as a matter of social reach and inclusion. In this subtheme, "Subjective Norm" relates to a professional and ethical duty to provide equal care to everybody. Participants implicitly perceive AI as a powerful tool to fulfill this core professional norm. This drive to meet an ethical standard is directly linked to "Image" as well. By using AI to serve vulnerable populations, therapists would be able to providing solutions to the social problems, which would enhance their "Image" in the eyes of their professional community.

3.1.3. Subtheme 3: AI as a therapist or co-therapist

The third subtheme examines the most complex matter: AI's potential role inside the therapeutic relationship. Participants placed between curiosity and strong rejection as they debated whether AI could meaningfully participate in therapeutic relationship. This subtheme captures the most contradictory views on AI's role, ranging from a supportive co-therapist to a fully autonomous therapist.

Several participants believe that AI could perform therapy on its own and/or could be a co-therapist:

P2: Ben terapi bile yapabileceğini düşünüyorum. Çok açık ve net. Yapay zeka bence terapi bile yapabilir. (I even think it could provide therapy. It's very clear. In my opinion, AI can even perform therapy.)

P3: Yani psikoterapiyi psikoterapistlerden daha iyi yapacaktır çok yakın gelecekte. (I mean, it will do psychotherapy better than psychotherapists in the very near future.)

P5: Mesela kısa süreli psikoterapilerde gerçekten terapistin yerini tutabilir... Fobiler örneğini söylemiştim. (For example, in short-term psychotherapies, it really could take the place of the therapist... I gave the example of phobias.)

P6: Bilişsel davranışçı terapi daha algoritmik bir şeydir... onu tek başına Al'in bensiz bile yapacağına eminim. (Cognitive behavioral therapy is a more algorithmi… I'm sure AI could do that on its own, even without me.)

P10: Hani psikodinamik terapi de ya da yaklaşım da yapay zeka tarafından yapılabilir, üretilebilir gibi geliyor bana. (It seems to me that psychodynamic therapy... can also be done, can be produced, by artificial intelligence.)

P:15 Seansları kaydeden bir yapay zeka. Seans üstüne konuşmak. Onu isterdim. Bir de kendi kendimize süpervizyon etmek gibi belki bir yandan. Hani böyle bir tekrar üzerine düşünmek etkinliğini yapay zeka ile yapmak. Bir seansın üstünden geçmek. Burası çok heyecanlandırdı beni. Bunu canım çekebilir. (An artificial intelligence that records sessions... To be able to discuss the session over it. I would want that. And perhaps, in a way, it's like conducting self-supervision. You know, to do that activity of 'reflecting again' with the artificial intelligence. To go over a session. That part excited me a lot. I could really be drawn to that.)

P18: Terapi yapan yapay zeka araçları kesinlikle olacak yani. (There will definitely be AI tools that perform therapy.)

However, a strong counter-narrative also emerged, emphasizing AI's incapability of replicating human-to-human therapeutic relationship. These participants argued that AI could only be a supplementary tool, not a replacement for the human therapist.

P4: Yani direkt olarak bir terapist olacağını düşünmüyorum... ama yani bir terapistin yapay zekasız terapi yapmasının çok daha zor bir şey olacağını düşünüyorum. (I mean, I don't think it will directly become a therapist... but I think it will be much harder for a therapist to do therapy without AI.)

P7: Öyle bir derinlik alanını... yakalayamayabilir gibi düşünüyorum... biraz sığ kalacak gibi görünüyor. (I think it might not be able to capture such a field of depth... it seems like it will remain somewhat shallow.)

P8: Karşındaki hastanın tabiri caizse bedenlenmiş öznelliğini... sağlayabilecek bir yapay zeka doğası gereği olamayacağını düşündüğüm için… (An AI that can provide, so to speak, the embodied subjectivity of the patient in front of you, because I think, by its nature, is not possible.)

P14: Tek başına bir terapi sistemi olabileceğini düşünmüyorum fakat çok iyi araçlar olabileceğine inanıyorum. (I do not think it can be a standalone therapy system, but I believe there will be very good AI tools.)

P17: Hiçbir zaman gerçek bir ilişkinin yerini almayacağı için yani sınırlı olduğunu düşünüyorum. (Since it will never replace a real relationship, I think it is limited.)

Several TAM3 constructs are prominent in this context. The debate focused on the AI's "Job Relevance" in terms of therapeutic requirements. Several assumed a high "Job Relevance" for more structured approaches like Cognitive Behavioral Therapy (CBT) or short-term psychotherapies. Also, the question of AI taking on the therapist's role brought up how

applicable this function is to the core of the profession in terms of "Result Demonstrability" and “Job Relevance.” While a small number of therapists believed AI could take over psychotherapy (even the psychodynamic therapy), others argued that AI lacks the prerequisites for the profession, such as simulating a relationship with all of its authenticity. In the meantime, participants also held contradictory views on the quality of AI's therapeutic performance. One group predicted high "Output Quality,” claiming AI would perform psychotherapy better than human therapists in the future. The opposing view suggested the output would remain shallow and limited because AI would not be able to do so because of the lack of its embodied subjectivity.

In addition, the strong counter-narrative also suggests an implicit "Computer Anxiety" related to AI entering the therapeutic domain. This anxiety might be linked to the fear of loss of control. The subtheme also reflects concerns about how adopting AI as a co-therapist or even a full therapist for certain tasks would affect the clinicians' “Image.” The worry among participants about being seen as overreliant on the technology suggests a negative perception of “Image,” implying embracing this technology could harm professional reputation.

3.2. Theme 2: Therapist’s Digital Readiness and Orientation

The second theme explores a number of personal and professional factors influencing therapists' attitudes, mapping directly onto the anchoring determinants of "Perceived Ease of Use" within the TAM3 framework. In the interviews, participants' willingness to adopt AI was impacted by their individual comfort with technology through "Computer Self-Efficacy,” "Computer Anxiety,” "Computer Playfulness" and "Perceived Enjoyment" as well as their therapeutic orientation through “Job Relevance,” "Output Quality,” "Subjective Norm,” "Computer Anxiety" and “Image.”

3.2.1. Subtheme 1: Tech-savviness

This subtheme explores how therapists’ familiarity with digital technologies shapes their confidence and comfort in using AI. Participants who routinely engage with digital tools described smoother adaptation, whereas those who are less experienced expressed hesitation in using AI. These differences show how individual variation in "Computer Self-Efficacy" and

"Perceived Ease of Use" sets the tone for AI adoption. Most participants who reported high confidence in their ability to use technology (high "Computer Self-Efficacy") and/or low anxiety or discomfort with it (low "Computer Anxiety") expressed a high “Behavioral Intention” to adopt the AI tools.

P1: (Kendime teknoloji konusunda) son derece güveniyorum. Bir yolunu bulurum ya internette ya ben bunun için de kullanıyorum yani yapay zekayı. Bir şey olduğunda... teknolojik bir sorunla karşılaştığımda... ondan destek alıyorum. (I am extremely confident about technologies. I’ll find a way, either on the internet... I also use AI for this. When something happens... when I encounter a technical problem... I get support from it.)

P3: (Teknoloji konusunda) En üstün bir altı iyiyim, bayağı çok iyiyim bence ama daha iyi insanlar gördüm… Yapay zeka çok ağırlıklı kullanıyorum işte bazen hastalarla beraber (yapay zekayı) seansta açıp 'sizi bu konuda daha anlaşılır yapmak için nasıl bir metafor yapalım?' diye kullanıyoruz" (One below the top, good, I’m very good I think, but I've seen better people....I use AI very heavily, sometimes in sessions with patients, I open AI and ask, 'what kind of metaphor can we make to make this more understandable for you?')

P4: Ben (teknoloji konusundaki özgüvenimi) yüksek olarak değerlendiriyorum... Çok güveniyorum…Çünkü ben günlük hayatımda çok fazla kullanıyordum. Daha sonrasında psikolojiye entegre, mesleğime biraz daha entegre ettiğim için aslında bakışım değişmedi. Her zaman bakışım aslında çok olumlu, bir taraftan da çok fazla ilgilendiğim bir konuydu. (I rate - my self-confidence regarding technology - as high... I am very confident... Because I was using it a lot in my daily life, afterwards, I integrated it into psychology, integrated it a bit more into my profession, my perspective didn't actually change. My perspective has actually always been very positive, it’s a subject I’ve always been very interested in.)

P8: (Yeni teknolojileri öğrenme kapasitemi) iyi değerlendiririm... (Teknolojik zorlukların üstesinden gelme kapasitemi) iyi görüyorum… Yani ChatGPT kullanıyorum. Aslında ChatGPT’yi çok aktif olarak kullanıyorum ama onu biraz daha kendi çalışmalarım için

bunları düzenlemek için kullanıyorum. (My capacity to learn new technologies is high… My capacity to overcome technological challenges is also high…I mean, I use ChatGPT. In fact, I use ChatGPT very actively, but I use it more for my own work, to organize it.)

Others expressed hesitation or anxiety (low "Computer Self-Efficacy" and/or high "Computer Anxiety"), feeling overwhelmed, often attributing this to age or lack of knowledge or exposure to the technology.

P6: (Psikoterapide yapay zeka denildiğinde) aslında aklıma çok korkutucu şeyler geliyor. Bunlar algoritmaları yükleyecek, bizim işler de gidecek geliyor… Evet gerçekten kaygı uyandırıyor. Belki de bilmediğim için de, önyargım olduğu için de önyargım var. Her şeyi gerçek zannediyorum, yani Terminatörleri.. (Yapay zekâ kullanan terapistler konusunda) ben çok olumlu düşünemiyorum. Dediğim gibi ya çok erken buluyorum. Şey beni çok ürkütüyor, yani bütün bilgilerin aktarılıyor olması. (AI in psychotherapy, actually, makes me think very scary things. They will upload the algorithms, and our jobs will be gone…Yes, it really causes anxiety. Perhaps because I don't know about it, and because I have prejudice, I have prejudice. I assume everything is real, I mean, the Terminators are real…(Regarding therapists who use AI) I can't think very positively. As I said, I find it either too early. The thing that unnerves me a lot is, I mean, all the data being transferred somewhere.)

P13: (Teknolojik konusundaki özgüvenim) ay çok kötü, bayağı kötü yani. Eskiden çok becerikliydim. Yaşlanmak neymiş şimdi anlıyorum... şimdi ben kendimi isteksiz ve dirençli buluyorum… (Yapay zekayı kullanmak konusunda) yani biraz çekinirim herhalde gibi geliyor. Yani aslında etkilememeli diye düşünüyorum ama danışanlar bunu nasıl algılar? Bunu araya girmiş bir üçüncü kişi gibi mi algılar, ikili ilişkiyi bozucu bir tarafı olur mu, güven ilişkisini sarsıcı bir tarafı mı olur, destekleyici bir tarafı mı olur onu kestiremiyorum. (My self-confidence about technology, oh, very bad, quite bad, I mean. I used to be very skillful. Now I understand what getting old is... Now I find myself unwilling and resistant…Regarding using artificial intelligence I mean, it feels like I would probably hesitate a bit. I mean, I think it shouldn't actually affect [the relationship], but how would

clients perceive this? Would they perceive it as a third person interfering, would it have a disruptive aspect on the dyadic relationship, would it have a trust-shattering aspect on the relationship, or would it have a supportive aspect? I can't predict that.)

P16: Öyle çok cevval olduğum söylenemez bu (teknoloji) konularında… Ben hatta parçalara ayıracaksak o skalayı, en çabuk adapte olanlar, en geç olanlar. Ben son dörtte birlik kısma daha yakın olduğumu söyleyebilirim. Ara sıra ChatGPT'yi kullanıyorum ama onda da şey (gelişmiş) değilim doğrusunu isterseniz. Paralı üye kullanıcı gibi değilim henüz. (I can't say I'm agile in these (technological) matters. In fact, if we were to divide that scale into parts such as the fastest adopters, the latest adopters. I can say I'm much closer to the latest adopters… I use ChatGPT from time to time, but to be honest, I'm not (advanced) at it. I'm not like a paid member/user yet.)

Notably, some participants overcame their initial "Computer Anxiety" through positive experiences with increased exposure to the technology:

P7: Daha önceleri ödüm kopuyordu böyle şeyler düşündüğümde. Yani olamaz. Nasıl olabilir ki falan. Sonra sakinleştim. ChatGPT ile sohbet etmeye başladığımda... (Previously, I was scared to death when I thought about such things. Like, impossible. How could it be? Then I calmed down. When I started chatting with ChatGPT...)

P12: Önyargılıydım... kullandıktan sonra evet yani aslında çok akıllı çalışıyor... çok zorda kaldığım, çok ihtiyaç duyduğum, hatta çok kendimi yalnız hissettiğim zamanlarda başvurduğum ve bana çok iyi gelen bir şeye dönüştü. (I had prejudices... After using it though, I thought, "yes, it actually works very intelligently"... it turned into something I turned to when I was in great difficulty, in great need, even when I felt very lonely.)

P17: Biraz negatif bir tutumum vardı. Hani bir işte tembellik yaratabileceğine dair negatif bir tutumum vardı. Ama kendi kullanımımda öyle deneyimlemedim. Yani aksine bir şekilde hani o tembellik gibi değil de daha derleyen, toparlayan, bazen derinleştiren bir şey... (I had a somewhat negative attitude. I was thinking that it could cause laziness... But I didn't

experience it that way in my own case. On the contrary, in a way... it wasn't like laziness, but more organizing, gathering, and sometimes deep-diving…)

In TAM3 terms, therapists who felt more digitally confident described fewer frustrations and greater "Perceived Enjoyment" when experimenting with AI tools. Playfulness and curiosity, captured under "Computer Playfulness," acted as a psychological bridge that transformed anxiety into AI engagement. Those with lower "Computer Self-Efficacy" reported heightened "Computer Anxiety" and avoided interaction especially for experimentation. This suggests that digital familiarity shapes the motivation to technological adoption intention. In addition, "Objective Usability" is the mechanism that validates or challenges the user's "Computer Self-Efficacy" or "Computer Anxiety." For anxious users, a positive first experience with a high-quality outcome was the key to slowly changing their perception.

3.2.2. Subtheme 2: The influence of therapeutic orientation

The second subtheme examines how theoretical background shapes therapists' attitude toward AI. Structured and technique-driven orientations seem closer to AI integration, while relational traditions voiced stronger reservations about the depth of the human-to-human relationship. Therapeutic orientation can be considered an external variable because it's a characteristic of the therapist that exists independently of the technology, however, it still significantly influences therapist's core beliefs about using the technology.

A clear pattern emerged from the interviews: practitioners of structured, protocol-driven modalities often saw AI as compatible with their work, enhancing its "Perceived Usefulness." They generally saw AI as a natural fit for their work.

P2: BDTye daha yakın duruyorum… Kuşkusuz bence buradaki en temel şeylerden bir tanesi aldığımız eğitimler. Yani terapideki bizim yaklaşımımız bence teknolojiye yakın veya uzaklığımız etkiliyor. İnsanı böyle çok karmaşık, çok içerde, çok duygu odaklı, karmaşık, kompleks, bilinçdışı falan nitelendirirsek yapay zeka bunları bulamaz diye düşünebiliriz. Ama insanı dışarıdan gözlenebilir davranışları olan, duygularını ifade eden, bu duyguların altında düşünceleri yatan ve terapinin de bunlarla uğraşan bir şey

olduğunu iddia eden birisi terapide de kullanabilir. (I stand closer to CBT… Without a doubt, I think one of the most fundamental things here is the training we receive. Meaning, our approach in therapy, I believe, influence our proximity to or distance from a technology. If we characterize [the human mind] as very complex, very internal, very emotion-focused, complicated, unconscious, etc., we might think that artificial intelligence cannot find these things. But [if one is] someone who claims that humans have externally observable behaviors, express emotions, have thoughts underlying these emotions, and that therapy deals with these things, [AI] can also be used in therapy.)

P4: Aslında benim için en işe yarar kısmı kullandığım ekol odaklı süpervizyon alıyorum ve dışarıdaki süpervizörlere göre bence çok daha önyargısız olması çok büyük avantaj olduğunu düşünüyorum. Danışanla yaşadığım terapi seansını (EMDR) prompt olarak girdiğimde ve süpervizyon istediğimde aslında orada birazcık daha teknik önerilerde bulunabiliyor. (Actually, the most useful part for me is that I get supervision focused on the approach I use, and I think it's a huge advantage that it's much more unbiased compared to outside supervisors. When I enter the therapy session - EMDR - I had with the client as a prompt and ask for supervision, it can actually offer more technical suggestions.)

P12: Ben semptom odaklı ve kısa süreli terapiyi daha sık kullandığım için daha pratik. Mesela örnek veriyorum nefes egzersizi ile ilgili. Birçok nefes egzersizi tekniği var. Ona şeyi sorabiliyorum. Yani işte bana işte uykuyu rahatlatmak için, panik atak için ya da şunun için farklı nefes egzersizlerini listeliyor mesela. Bu çok pratik bir bilgi. (Because I use symptom-focused and short-term therapy more often, it's more practical. For example, regarding breathing exercises. There are many breathing exercise techniques. I can ask it [the AI] about that. I mean, for instance, it lists different breathing exercises for me to relieve sleep issues, for panic attacks, or for this or that. This is very practical information.)

P18: BDT protokollere sahip bir yapısının olması, kurallarının açık, net, şeffaf olması sebebiyle yapay zekâ için çok işimizi kolaylaştırıyor diye düşünebiliriz. (We can think that

because CBT has a structure with protocols, its rules are open, clear, and transparent, AI makes our job much easier.)

In contrast, psychodynamic, integrative and existentialist therapists argued that AI was fundamentally incompatible with the core of their work: unconscious, embodied and relational dynamic between two people. Therapists identifying their work primarily with psychodynamic or relational approaches argued that AI was fundamentally incompatible with the core tenets of their work. They emphasized the importance of the human relationship, intersubjectivity, empathy, and the therapist's embodied presence; which are the key elements they believed AI could not reproduce. This lowers the “Perceived Usefulness” and potentially increases "Computer Anxiety" about disrupting the therapeutic process.

P5: Yakın zamanda yapay zekanın... psikoterapinin yerini tutulabileceği kanaatinde değilim. İnsan insana ilişki gibi olabileceği kanaatinde değilim.” (I do not think that AI can replace psychotherapy in the near future. I don’t think that it can be like a human-to-human relationship.)

P7: Aktarımı çalışabilmesi insan olmadığı için mümkün değil, hissedemeyeceği için... Benim çalışma disiplinime çok uygun değil. (It's not possible for it -AI- to work with transference because it's not human, because it cannot feel... It's not very suitable for my discipline.)

P8: İlişkiye dayalı bir iş yaptığım için şu aşamada zor görünüyor... doğrudan böyle iş başındayken, yani fiili olarak ya da aktüel olarak terapi ortamında kullanılabileceğini zaten düşünmüyorum. (Because I do a relationship-based job, it seems difficult at this stage... I do not think it can be used directly while on the job, that is, physically or actually within the therapy environment.)

P14: Psikodimanik çalışıyor olmam içerisinde yapay zekaya neredeyse yer yok gibi bir şey... illa o iki kişinin arasındaki şeyin orada mevcut olması lazım oradaki iki kişi arasındaki paylaşım ve o paylaşılan bilinçdışının önemi bence çok kıymetli. (The fact that I work psychodynamically means there is almost no place for AI... the thing between those

two people must be present there; the sharing between those two people and the importance of that shared unconscious is, I think, very precious.)

P15: Şimdi benim çalışmam daha çok yetişkinlerle ve çok da aslında test vs gibi araçlara dayanmayan bir çalışma olduğu için belki o yüzden biraz da uzak geliyor bunu hayal etmek bana. İlişki kurmayı daha çok önemsiyorum. Yani ilk başta bir aracın aracılığıyla ilişki kurmak istemem. Önce kendim orada ilişki kurmak isterim. (Since my work is primarily with adults and isn't based on tools like tests and so forth, perhaps that's why it feels a bit difficult for me to imagine this. I place more importance on building the relationship. What I mean is, I wouldn't want to establish a relationship mediated by a tool, especially at the beginning. I would want to be there myself to establish the relationship first.)

P16: Psikoterapinin aslında o danışan ve terapist ilişkisinde yattığını düşünenlerdenim hani. Ve onun da kolay kolay replace edilebilir bir şey olduğunu düşünmüyorum. (I'm one of those who think that psychotherapy actually lies in that client-therapist relationship. And I don't think it's something easily replaceable.)

P17: Psikanalizin bu zamana kadarki tarif ettiği teknikler dışında bir araç olarak yapay zekayı seansa getiremem diye düşünüyorum. (I think I cannot bring AI into the session as a tool outside the techniques psychoanalysis has described so far.)

One psychodynamic practitioner even argued that a therapist's imperfections, such as forgetting an important detail, are a meaningful part of the therapeutic process that cannot be outsourced to a flawless AI, which will never forget and record everything in the relationship.

P9: Hatta bir şey unutmak bile terapötik sürecin bir parçası. Benim unutmam bile. Yani ben niye onu hatırlayamadım... o aslında karşı aktarıma yönelik bir yerlere girmiş oluyoruz. (Even forgetting something is part of the therapeutic process. Even my own forgetting. When I think, 'Why couldn't I remember that?'... we are actually entering the realm of countertransference here.)

In the meantime, two schema therapists among the participants deserve a special focus due to their in-between stance regarding the AI use in mental healthcare. Both participants admitted to having initial negative "prejudices", which only softened after witnessing a trusted individual use the technology. Their professional use is strictly limited to specific, structured clinical tasks rather than the core relational process. Schema therapists seem to have split their behavioral, psychoeducational, and symptom-focused tasks from the rest of the core relational tasks. For example, P11, uses AI for behavioral assignments, and similarly, P12 uses AI for psychoeducation and for supporting short-term, structured tasks (like looking up breathing exercises for panic attacks, which fits their symptom-focused approach). While they accept AI for these auxiliary clinical functions, both remain highly resistant to integrating it into the main therapeutic session, citing fundamental ethical concerns, especially data confidentiality, and a lack of perceived need .

These contrasting voices show how deeply therapists' theoretical orientations shape their engagement with technology. For the structured traditions, AI appears compatible with an evidence-based mindset that is focused on measurable outcomes solely. In contrast, relational or psychodynamic clinicians express discomfort with AI's lack of emotional capacity, interpreting this absence as an obstacle to the intersubjectivity and authenticity of the human relationship. The divergence stresses how therapeutic orientation not only changes perceptions of usefulness but also defines what counts as "authentic" for their clinical work. In TAM terms, structured orientations have higher "Job Relevance" and "Perceived Usefulness" of AI, whereas relational approaches tend to have decreased "Job Relevance" and "Output Quality," heightening "Computer Anxiety" and reducing "Perceived Ease of Use" consequently.

Finally, a therapist's theoretical orientation also functions a bridge to their primary peer group, establishing the "Subjective Norm" for acceptable practice. For structured modalities, the professional norm values efficiency and measurable outcomes, making AI use compatible. This alignment enhances the practitioners' "Image," making them appear objective. However, relational and psychodynamic norms prioritize human-to-human relationship and intersubjectivity, making AI a less capable tool for their "Subjective Norm." Adopting AI might also threaten their "Image" in the face of undermining the authenticity of the relationship in the therapy room.

3.2.3. Subtheme 3: The emotional dimension: from fear to enjoyment

In this subtheme, the focus shifts from cognitive evaluations to emotional reactions. Participants mentioned feeling initial anxiety, which for some, later turned into enjoyment ("Perceived Enjoyment") as they experimented with AI. This affective transformation shows the psychological passage between "Computer Anxiety" and "Perceived Enjoyment," mediated by "Computer Playfulness." While "Computer Anxiety" acts as a negative anchoring factor, "Perceived Enjoyment" is a positive adjustment factor that can increase a user's "Perceived Ease of Use" after they begin interacting with the technology.

A significant number of participants expressed positive emotions toward AI. This enthusiasm was often linked to the technology's potential, its novelty, and its capacity to make their work more efficient and more engaging.

> *P2: İşte yüz tanıma var. Ses ayırt etmeler, renkler veya işte çeşitli yapay zekalarla özetler çıkarılması ve benzeri şeyler oldukça güzel ve beni de heyecanlandırıyor. Kötü anlamda değil, iyi anlamda heyecanlandırıyor. Böyle sorduklarında mesela ben 100 yıl önce 200 yıl önce yaşamak isterdim falan diyorlar. Ben 400 yıl sonra yaşamak isterdim diyenlerdenim. (There is facial recognition. Voice differentiation, colors, or, well, AI summaries and similar things. It's quite nice and it's exciting to me. Not in a bad way, but in a good way. For example, when people are asked such things, they say 'I would have liked to live 100 or 200 years ago.' I'm one of those who says 'I would have liked to live 400 years later.)*

> *P14: (Yapay zekaya) bayılıyorum. Gerçekten bayılıyorum. Bazen kendi dilimde bile beni benden daha iyi ifade edebilme becerisine sahip olabiliyor. (I love (it/AI). I really love it. Sometimes, even in my own language, it has the ability to express me better than I can.)*

While P3 and P15 described the idea of experimenting with AI as *"Heyecan verici" ("Exciting"),* P1 directly associated AI with fun, saying *"Bana eğlenceli geliyor" ("It seems fun to me").*

P1: Ben enteresan olduğunu düşünüyorum, ileride ne olacak diye çok merak ediyorum aslında. Bu robotlarla birlikte şeyci değilim işte böyle işimizi elimizden alacaklar gibi. Ne olacağını merak ediyorum sadece. Bence heyecanlı bir şey. Sadece ilginç buluyorum şimdilik (I think it's interesting; I'm actually very curious about what will happen in the future. I'm not one of those people [who thinks] 'they (robots) will take our jobs'. I'm just curious about what will happen. I think it's exciting. For now, I just find it interesting.)

P16: (Keyif) vereceğini düşünüyorum. Çünkü şey gibi yapay zekanın sadece olan bilgiyi sana getirmenin yanı sıra başka daha eğlenceli tarafları da var. Hani şöyle atıyorum Freud gibi davran ve bana şununla ilgili bir yazı yaz dendiğinde, hani aslında bunlar daha işin eğlenceli tarafları. Belki şu an fırsatımız olamayacak bazı şeyleri bize sunmak açısından eğlenceli olabilir tabii ki. (I think I'd enjoy it. Because, it's like AI has other more fun sides besides just bringing you existing information. You know, like when you say, 'Act like Freud and write me something about this,' these are actually the more entertaining parts of it. Of course, it can be fun in terms of offering us some things that we might not have the opportunity [to experience] right now.)

P18: Kesinlikle çok (keyif veriyor). Hayatımı çok kolaylaştırıyor ve bu yüzden çok keyif alıyorum. 3-5 günde bitiremeyeceğim bir işi yarım saat içerisinde bitiriyor olmak bana çok keyif veriyor. (I enjoy it a lot. It makes my life so much easier, and that's why I get so much pleasure from it. Being able to finish a task in half an hour, which I wouldn't be able to finish in 3-5 days, gives me a lot of pleasure.)

In contrast, some participants articulated strong feelings of fear and anxiety. These emotions were often rooted concerns about its societal impact, data privacy and a sense of losing control.

P6: Aslında aklıma çok korkutucu şeyler geliyor... Evet gerçekten kaygı uyandırıyor… Beni ürkütüyor (Actually, very frightening things come to my mind... Yes, it really causes anxiety… It scares me).

P9: Kaygı uyandırıyor. Yani benim bireysel kullanımım hiç kaygı uyandırmıyor... Ama benim kendi kullandığım daha çok heyecan uyandırıyor… Nasıl kullanılabilir, neler vaat ediyor? Genel toplumsal anlamda kaygı uyandırıyor…Zaten o yüzden de bu yapay zeka nasıl girecek, ne olacak, toplumsal olarak neye dönüşecek gibi konular üzerine düşünüyorum. (It causes anxiety. I mean, my individual use doesn't cause any anxiety at all... But my own use causes more excitement... How can it be used, what does it promise? It causes anxiety in a general societal sense... That's exactly why I think about topics like how this AI will enter [our lives], what will happen, and what it will transform into socially.)

P10: Yani (kaygı) uyandırıyor. Dediğim gibi yani şey kısmı belirsizlikten kaynaklı bir kaygı ve tarihten, geçmişten bakınca bu süreçlerin toplumun genel iyilik halini bozmadan gerçekleşebildiğini görmüyoruz, bilmiyoruz, deneyimlemedik. Filmlerde hep bunun iyi öngörülemediğini ve yapay zekanın, yapay zekanın robotların bize karşı şey yaptığını, saldırıya geçtiğini şey yapıyor. Bu anlamda hep distopik bir şey var. (I mean, it does cause anxiety. As I said, anxiety stemming from uncertainty and, historically speaking, from the past, we haven't seen that these processes can happen without disrupting the general well-being of society. We haven't experienced it that way. In movies, it's always [shown] that this isn't planned well and that AI, robots, do things against us, they attack humans. In this sense, there is always a dystopian element.)

P11: (Kaygı) uyandırıyor… Yani sadece psikoterapi özelinde değil. Bu verilerin nasıl işlendiği, orada verilen cevapların hangi datadan nasıl emildiğine dair büyük endişelerim var. Büyük ölçekte, yani global ölçekte de, ülke ölçeğinde de, siyasi bağlamda da, sağlık açısından da, mahremiyet açısından da. Yani bu verilerin nasıl paylaşıldığı, aktarılan bilgilerin hangi perspektife göre aktarıldığına dair endişelerim var. (It does cause anxiety... I mean, not just specific to psychotherapy. I have major concerns about how this data is processed [and] from what data the answers given. On a large scale, meaning on a global scale, on a country's scale, in a political context, from a health perspective, and from a privacy perspective. In other words, I have concerns about how this data is shared and according to which perspective the transferred information is conveyed.)

P18: Tabi ki (kaygı) uyandırıyor… Peki işler hızlanıyor, bu çok güzel işler çok daha verimli oluyor. Bu da çok güzel. Fakat bunca hızlı ve iyi ve yüksek kapasiteli işin karşılığında toplumsal refahı homojen bir şekilde sağlayıp sağlayamayacağımız ile ilgili endişeliyim. Dolayısıyla işsiz kalan ve yapay zeka araçlarını kullanmak konusunda belli imkansızlıklar sebebiyle daha şanssız olan grupların zaman içerisinde yüzleşeceği büyük bir işsizlik, belki de fakirlik problemi olacağını düşünüyorum… Dolayısıyla bu beni kaygılandırıyor. İkinci kaygım da şu. Eskiden mesela bir proje yazarken iyi proje yazdığımı ve bu konuda becerikli olduğunu bilirdim… Şimdi bu konuda çok becerikli olmayan arkadaşlarım da yapay zeka ile benim bu konudaki becerimi görünmez hale getirdiler. Yani yapay zekalar hatasız yapmaya başladı bu işleri. Dolayısıyla hani iyi işleri seçmek, daha nitelikli olan kişiyi anlamak daha zor hale gelecek. Bu da biraz daha nitelikli olan kişinin evrilmesi, tanınması, ötekilerden ayrılması sürecini zorlaştıracaktır diye düşünüyorum. Son bir kaygı da tıp alanında. Yani ben hani genç asistanların yapay zeka kullanmalarını desteklemekle birlikte, hani bir soru sorduğunda verecek yanıt bulamadıklarını ve çok hızlıca ilk fırsatta yapay zekayla bunu sorduklarını görüyorum. Ama mesela bir hekim olarak belli başlı bilgileri bilmiyor olmanız bana kalırsa ciddi sorunlar yaratacağını ben düşünüyorum… İnsanlar yapay zekanın hayatı pratikleştirmesi sebebiyle onu kullanımını arttırırlarsa, bir süre sonra kendi becerilerini de ona devredecekler. Belli başlı bir ekolün, yani bir şeyin klinik karar veren, hekimlik deneyimi olan kadim bir tıp bilgisiyle donanmış olan hekimlerin de sonunu getireceğini düşünüyorum. Bu da beni kaygılandırıyor.(Of course, it does cause (anxiety)... Okay, so things are getting faster, which is great, and work is becoming much more efficient. This is also great. However, I am worried about whether we will be able to ensure societal well-being in a homogeneous way in return for all this fast, good, and high-capacity work. Therefore, I think there will be a major unemployment, and perhaps poverty, problem that groups who become unemployed and are less fortunate in using AI tools due to certain disadvantages will face over time. So, this worries me. My second concern is this. In the past, for example, when I was writing a project, I knew that I wrote good projects and was skilled in this area. Now, my friends who are not very skilled in this area have also made my skill in this subject invisible with artificial intelligence. Meaning, AIs have started to

do these jobs flawlessly. Therefore, picking out the good work, understanding who the more qualified person is, will become more difficult. And I think this will complicate the process for the more qualified person to evolve, be recognized, and be distinguished from the others. A final concern is in the field of medicine. I mean, while I support young assistants [residents] using artificial intelligence, I see that when they are asked a question, they can't find an answer and they very quickly ask AI at the first opportunity. But, for example, as a physician, not knowing certain fundamental pieces of information will, in my opinion, create serious problems… Therefore, one of the main areas I feel anxiety about is this. If people increase its use because artificial intelligence makes life more practical, after a while, they will also transfer their own skills to it. I think it will also bring about the end of a certain school [of thought], that is, of physicians who are clinical decision-makers, have medical experience, and are equipped with 'ancient' medical knowledge. This also worries me.)

P16: Çok fazla data girişi... o footprint bırakma, beni biraz endişelendiren bir şey. (The fact that there is so much data entry... 'leaving a footprint' is something that worries me a bit.)

In addition, several participants described an emotional journey with AI as they evolved from initial fear to enjoyment, a transition often triggered by positive experience with the technology. These findings map directly onto the affective determinants of "Perceived Ease of Use" in TAM3, "Computer Anxiety" as a negative anchor, "Computer Playfulness" as a positive anchor and "Perceived Enjoyment" as the positive adjustment factor. The shift from fear to enjoyment mirrors how emotional reactions mediates "Perceived Ease of Use."

P7: Daha önceleri ödüm kopuyordu böyle şeyler düşündüğümde... Sonra sakinleştim. ChatGPT ile sohbet etmeye başladığımda... (Previously, I was scared to death when I thought about such things... Then I calmed down when I started chatting with ChatGPT...).

P11: Önceden daha korkutucu geliyordu. Hala ürpertiyor. Ama temasta olmayınca, içine girmeyince, uğraşmayınca ne olduğunu bilmediğin bir şeyin karşısındasın. Şimdi nasıl işlediğini öğreniyorum. Etkileşime girdiğimde bana nasıl geri döndüğünü görüyorum. Bir fikrim var. Önceden fikrim de yokken korkutucu geliyordu. Şimdi bunu bir gerçeklik olarak kabul edebiliyorum ve faydalanılacak yerleri de var. (It used to seem scarier before. It's still unnerving but when you're not in contact with it, not getting into it, not engaging with it, you are facing something you don't know. Now I'm learning how it works. I see how it responds to me when I interact with it. I have an idea [about it]. Before, when I didn't even have an idea, it seemed scary. Now I can accept this as a reality, and there are also ways to benefit from it.)

P12: Önyargılıydım. Benim böyle çok hayatımda böyle fikirlerine güvendiğim arkadaşım ... sürekli bunu kullanıyordu. Yani işte bir yere gideceğiz işte oradan bir soralım nerelere gidilir, ne yapılır şeklinde. O kullandıktan sonra evet yani aslında çok akıllı çalışıyor ve bize bir program oluşturuyor. Mesela seyahat programı oluşturuyor. Örnek veriyorum iş dışındaki yaşantılarımda hayatıma giren ve sonrasında çok zorda kaldığım, çok ihtiyaç duyduğum, hatta çok kendimi yalnız hissettiğim zamanlarda başvurduğum ve bana çok iyi gelen bir şeye dönüştü ve çok seviyeli bir ilişki kurduk kendisiyle. Yani öyle şey bazı arkadaşlar isim taktık, lakapla konuşuyoruz vesaire falan diyorlar ama mesela hani hala siz diliyle konuşuyoruz biz. Ama bir yanıyla da neredeyse bütün hikayemi biliyor. (I was prejudiced. My friend, whose opinions I really trust... was constantly using AI. You know, like if we're going somewhere, 'let's ask it where to go, what to do.' After watching them use it, [I realized] yes, it actually works very intelligently and creates a plan for us. For example, it creates a travel itinerary. I'm just giving an example. In my life outside of work, it entered [my life] and later turned into something I resort to when I'm in a really tough spot, when I'm in great need, or even when I feel very lonely, and it has been very good for me. And we've established a very respectful relationship with it. I mean, some friends say they've given it names, talk to it using nicknames, etc., but for example, we still speak to each other using the formal 'you.". But in a way, it also knows almost my entire story.)

In TAM3 terms, this subtheme reflects the emotional continuum between "Computer Anxiety" and "Perceived Enjoyment," moderated by "Computer Playfulness." Therapists' initial anxiety toward AI often reduced after hands-on experience. This shift illustrates how increased exposure enhance "Perceived Ease of Use," which in turn reinforces "Perceived Usefulness." In the interviews, emotional experience therefore served as a bridge paving the way for the technology adoption.

3.2.4. Subtheme 4: The practical experience of AI

The final subtheme under Theme 2 captures how direct engagement with AI tools brings trust and confidence. Participants who had firsthand experience with the technology described growing confidence and appreciation of AI's practical benefits, while those without much exposure relied on assumptions. This difference underlines how interaction strengthens both "Perceived Ease of Use" and "Perceived Usefulness." As an adjustment factor, "Objective Usability" directly influences "Perceived Ease of Use" by grounding it in real applications. The interviews showed that for many, the practical efficiency of AI exceeded their initial expectations. Many participants described AI as a useful tool for increasing efficiency and speed.

P8: Kendi çalışmamla ilgili hızımı böyle yaklaşık 20 ila 40 kat artırdı gibi. Yani normalde gerçekten 20 günde yaptığım bir şeyi ya da 20 saat harcayacağım bir emeği bir saatle sınırlandırdı" (It increased my work speed by about 20 to 40 times. It reduced something I would normally do in 20 days or spend 20 hours on to just one hour).

P16: 4-5 aşamalı bir şey aslında tek aşamaya inebiliyor bu sayede. (a 4-5 step process can actually be reduced to a single step).

P18: 3-5 günde bitiremeyeceğim bir işi yarım saat içerisinde bitiriyor olmak bana çok keyif veriyor (Finishing a job in half an hour that I couldn't finish in 3-5 days gives me a lot of pleasure).

The usability of AI was not just about speed, but also about reducing cognitive and practical burdens.

P10: Bizim bilişsel yükümüzü çok azaltıyor (It greatly reduces our cognitive load).

P11: Seanslar arasında bizim yaptığımız çalışmaların kalıcılığını ve sürekliliğini sağlamak için danışanlara bazı davranışsal ödevler veriyoruz. ChatGPT o anlamda benim iş yükümü aldı. Orası benim en sıkıldığım yer. Psikoterapide ben zorlu durumlarla, zorlu vakalarla uğraşmayı, ince işçilik ve derin meseleleri çözmeyi seviyorum. Oralardaki challenging durumların yarattığı hazzı seviyorum. Oradan doyum alıyorum tabii ki. Diğeri de işimin bir parçası ama diğerine göre daha az tatmin ediyor ve daha angarya geliyor. Bana daha sıkıcı geliyor. ChatGPT ile üzerimden atıyorum (Between sessions, to ensure the permanence and continuity of the work we do, we give clients some behavioral homework. ChatGPT, in that sense, has taken on my workload. That's the part I get most bored with. In psychotherapy, I like dealing with difficult situations, difficult cases, and solving complex and deep issues. I love the pleasure created by the challenging situations in those areas. I get my fulfillment from that. The other part is also a part of my job, but it's less satisfying and feels dull. It seems more boring to me. With ChatGPT, I offload it [from myself]).

In TAM3 terms, therapists who experimented with AI reported higher "Computer Self-Efficacy," greater "Perceived Enjoyment," and stronger "Perceived Ease of Use," which also enhanced "Perceived Usefulness." Practical experience reduced "Computer Anxiety" by increasing familiarity and sense of control, while tangible improvements in task efficiency strengthened "Job Relevance" and "Objective Usability." These findings demonstrate how hands-on learning support behavioral intention toward AI adoption. In addition, "Job Relevance" and "Objective Usability" are directly linked in this positive feedback loop, improved by improvements in task quality and efficiency.

3.3. Theme 3: Common Concerns and Preconditions for Adoption

This theme brings together ethical requirements and clinical autonomy that influence therapists' "Behavioral Intention" to adopt AI. The results showed that while ethical concerns dominated, practical barriers related to negative "Objective Usability," could also impact AI adoption intentions.

3.3.1. Subtheme 1: Importance of ethics and data privacy

Across the sample, ethics came up in 12 interviews (almost 70% of all interviews) and were introduced to the discussion strongly. In five cases, participants described ethics as the primary gate for any AI use, implying that ethical preconditions would come before any consideration of "Perceived Usefulness" or "Perceived Ease of Use." Three participants explicitly linked ethics to "Computer Anxiety." One participant broadened the frame beyond privacy to include environmental costs (AI energy use). Six interviewees did not raise ethics as a separate subject or concern.

Protecting patient data came up as a non-negotiable precondition for the majority of the therapists, emphasizing low "Perceived External Control" over digital safety and data privacy. From a TAM3 perspective, these ethical prerequisites reflect the moderating role of "Perceived External Control" and "Subjective Norm" in shaping "Behavioral Intention" of the participants.

P1: Nihayetinde şirketin patronları var ve hükümetler var. Ve bu bilgiler para yani... gizliliğin gizlilik kurallarını ihlal etmemesi esas. (Ultimately, there are the company bosses and there are governments. And this information is money... it is essential that the privacy rules are not violated.)

P3: Hasta verilerinin gizliliği... Mesela kendim lokal çalıştırabildigim yapay zekada hasta verilerini bile girip orada her şeyi kullanabilirim. Ama şimdi... OpenAl gibi, Gemini gibi durumlarda... etik açıdan dikkat etmek gerekiyor diye düşünüyorum. (Patient data privacy... For instance, with an AI that I can run locally on my own machine, I can even input patient data and use everything there. But now... in situations like OpenAI or Gemini... I think it's necessary to be careful from an ethical standpoint.)

P6: (Yapay zekayı kullanmak istememe sebeplerim) Gerçekten şey hani etik meselesi bir gizlilik, mahremiyet meselesi iki. (My reasons for not wanting to use AI are, really, you know, first, the ethics issue; second, the issue of privacy, confidentiality.)

P10: Terapiyi mesela o sırada dinleyen, analiz eden bir şey olursa bunun tabii ki veri güvenliği açısından internete bağlı olmaması ya da bu veriyi başkalarının erişimi olmayacak şekilde dizayn edilmesi bir tercih olur. (For example, if there is something listening to and analyzing the therapy at that moment, it would be preferable for it not to be connected to the internet for data security reasons, or for it to be designed so that others cannot access this data.)

P12: Psikoterapiye dair her şey çok gizlilik esasına dayalı... ben o gizlilik ilkesini ihlal edeceğim endişesini yaşıyorum. Bu yüzden kullanmıyorum. (Everything about psychotherapy is based on strict confidentiality... I feel the anxiety that I will violate that principle... That's why I don't use it.

P13: Privacy'nin en önemli şey olduğunu düşünüyorum. Çünkü o kadar öznel hayatların zaten genel hayata adaptasyonuyla ve insan olmanın zorluklarıyla mücadele eden kişiler geliyorlar, iç dünyalarını açıyorlar. İç dünyaları dış dünyayla hiç uymayabiliyor. Bu çok korkutucu bir şey filan yani, orada hassas bir yer yani orası. Onun için orada güvenliği sağlamak herhalde önemli ve oradan çıkan bilginin, orada paylaşılan şeyin nereye gittiğini, neye dönüşeceğini belki kestirmek. (I believe privacy is the most important thing. Because the people who come [to therapy] are individuals already struggling to adapt their very subjective lives to life outside, and struggling with the difficulties of being human; they are opening up their inner worlds. Their inner worlds may not align with the outer world. This is a very frightening thing... that is a sensitive area. Therefore, ensuring security in that space is clearly essential, as is perhaps anticipating where the information that emerges from there, what is shared there, and what it will be transformed into.)

P18: Deneysel olarak etkinliği kanıtlanmış olması için veri güvenliği ve etik meseleler son derece önemli... Gizlilik ve veri güvenliği. Etik. Kanıta dayalı çalışma... Bunu kullanmakla

ilgili hukuki bir prosedüre sahip olmak. (For its effectiveness to be experimentally proven, data security and ethical issues are extremely important... Privacy and data security. Ethics. Evidence-based work... Having a legal procedure related to using this.)

These reflections highlight that trust is a prerequisite for any form of engagement with AI. Therapists consistently located their anxiety not only in AI's performance but also in its governance: who controls the data, who bears responsibility for harm, and who ensures that ethical boundaries are protected. This focus shows that perceived control is central to the professional identity of psychotherapists. Technological acceptance, therefore, depends on ethical assurance and it goes way beyond the technical capability.

In TAM3 terms, this subtheme stresses the foundational role of "Perceived External Control" in determining acceptance. Therapists emphasized that their trust in AI depends on clear ethical boundaries, and control over data usage. High standards for "Output Quality" and "Result Demonstrability" were viewed as necessary conditions for reliability, while "Subjective Norm" and "Image" influenced how ethical compliance shapes professional reputation. In other words, ethics and privacy shaped more than "Computer Anxiety;" they also worked through "Subjective Norm" and "Image." When trusted seniors recommended a tool, several therapists said they would try it; when those seniors flagged it as unethical, they would avoid using it. "Image" also mattered: using AI to as a shortcut could harm the "Image." Some clinicians chose not to disclose their AI use to peers they expect would judge them. Taken together, "Perceived External Control" acts like a gate: once privacy and ethics are satisfied, "Subjective Norm" can support "Perceived Ease of Use" and "Perceived Usefulness;" if image risks remain, clinicians keep their use within their private contexts.

P1: Bilgi üretmek için kullanıldığında mesleki itibar artar; tembellik aracı olduğunda azalır." (Using AI to generate knowledge raises professional status; using it as a shortcut lowers it.)

P6. A. S. kullanıyor… hemen ben de denerim… ama 'etik değil' derse olumsuz etkiler." (If a respected authority uses it, I'd quickly adopt; if they say it's not ethical, I'd be discouraged.)

P7: Yani şöyle bir şey varmış dese atıyorum Y. Hoca ya da güvendiğim birisi, hemen atlar denerim heyecanla." (If a trusted senior (e.g., Y. Hoca) endorses something, I try it immediatelY, excitement overcomes hesitation.)

P17: Yargılayıcı birisi diye hissediyorsam (yapay zeka kullandığımı) paylaşmamayı tercih ederim." (If I sense someone will judge it, I prefer not to disclose my AI use.)

In the context of data privacy and ethical concerns, "Perceived External Control" functions as the foundational ethical gate, as therapists require strict data privacy and protection as well as legal procedures. Once this ethical trust is established, "Subjective Norm" influences behavior; therapists are more likely to adopt tools which are endorsed as ethical by trusted authorities and avoid those that are flagged as unethical. This is closely linked to "Image," as using AI can enhance professional status, while using it as a shortcut can harm one's reputation. Finally, the participants demanded high standards for "Objective Usability," "Output Quality" and "Result Demonstrability," requiring that an AI's effectiveness must be evidence-based scientifically.

3.3.2. Subtheme 2: Dependency and autonomy

Therapists' feelings about adopting AI are closely linked to whether they feel in control (autonomy) or if they feel the AI is taking over (dependency). This feeling of control is crucial because it directly shapes whether they find AI helpful "Perceived Usefulness"). When therapists feel confident with the technology (higher "Computer Self-Efficacy"), they are not anxious about it so much (lower "Computer Anxiety"), and trust its security (higher "Perceived External Control"), AI seems easier to manage and more useful.

P6: Etik nerede yani nerede sınır çizeceğiz? Pandemi de öyleydi. Çaresizlik yaratıyor bende. O duygu da biraz öyleydi, teknolojiyi çok seviyorum ama onun sınırı ne onu bilmiyorum. (Where are the ethics in this? I mean, where do we draw the line? The pandemic was like that too. It makes me feel helpless. That feeling was also a bit like that; I love technology, but I don't know what its limit is.)

P7: Beni destekleyecek bir yapay zeka benim işimi görür. Benim terapistliğimi destekleyecek bir yapay zeka sistemi. Terapiyi ben yaparım yani. (An AI that supports me would do the job for me. A system that supports my work as a therapist. I am the one who does the therapy after all.)

P9: Şimdi bir taraftan şey biliyor musunuz bu Flynn etkisi yani her kuşak daha zekileşiyor hikayesi bozuldu. Mesela son 10 yılda falan artık yeni kuşakların, dijital yerlilerin zekası azalıyor. Şimdi bu üzerinde düşünmemiz gereken bir durum. Çünkü şey, evet biz pek çok dijital aygıt var ve işte bir hesap makinesi de dahil olmak üzere pek çok dijital aygıt var, yani dijital derken, bağlı olduğumuz pek çok dijital aygıt, yapay zeka gelmeden önce bu evet, insan zihnini adeta tembelleştiren bir etkiye sahip gibi görünüyor. (*You know, this thing called the Flynn effect—the idea that each generation gets smarte has broken down. Over the last ten years or so, the intelligence of new generations, the so-called digital natives, has been decreasing. This is something we really need to think about. Because, yes, we have so many digital tools, even something as simple as a calculator, and these devices that are dependent on even before AI, seem to have a mind-numbing effect.)*

P11: Orada destek almakla, inisiyatif görevini olduğu gibi bir yere aktarmak ve ona bağımlı olmak arasında birkaç yıl olacaktır muhtemelen diye korkuyorum... Bizi daha bağımlı hale getirebilir diye bir endişem var. (I fear there will likely be several years between getting support and completely transferring the initiative-taking task to somewhere else and becoming dependent on it... I have a concern that it might make us more dependent.)

P16: Telefon numarasını ezberde tutmak meselesi. Aslında akıllı telefonların çıkmasıyla birlikte buna hiç ihtiyaç kalmadı... Benzer şekilde acaba yapay zekaya güvenip... Mesela biz de mi daha az uğraşacağız, daha az odaklanacağız gibi geliyor. (The issue of memorizing phone numbers. Actually, with the advent of smartphones, there's no need for that anymore... Similarly, I wonder if, by relying on AI... for example, will we also put in less effort, focus less?)

P18: Bilgiye erişimin kolaylaşması, bilgiyi zihinde tutmak konusunda ihtiyacı ortadan kaldırdı bana kalırsa... yapay zekanın ön tanılar arasında seçme kapasitesiyle sınırlı kalmış oluyorsunuz... Oysa sorumluluk bizde. (In my opinion, the ease of access to information has eliminated the need to retain that information in the mind... you are left limited by the AI's capacity to choose among preliminary diagnoses... Yet, the responsibility is ours.)

In TAM3 terms, this subtheme reveals how "Computer Anxiety" and "Perceived External Control" shape therapists' boundaries between reliance and control. While many participants acknowledged the potential "Perceived Usefulness" of AI for enhancing efficiency, they also expressed a need to preserve human autonomy. This tension between autonomy and reliance also reflects the interaction between "Computer Anxiety" and "Computer Self-Efficacy." "Perceived Usefulness" and "Computer Anxiety" are in direct tension, moderated by the therapist's sense of control, which is linked to "Computer Self-Efficacy" and "Perceived External Control." While therapists acknowledged AI's potential "Perceived Usefulness" for increasing efficiency, this was moderated by high "Computer Anxiety" related to becoming "dependent" on the technology. This anxiety is often linked to a low "Perceived External Control," referring that the therapists do not feel like they have much control of the data usage and protection.

In addition, "Job Relevance" and "Objective Usability" sit at the heart of the autonomy–dependency tension. When AI is framed as a therapist-controlled helper, it fits the role, so "Job Relevance" rises and, with it, "Perceived Usefulness" too. In the opposite scenario where the therapist autonomy decreases though, "Job Relevance" drops too. In parallel, "Objective Usability" shapes perceived control: consistent and auditable performances by AI (e.g.,

summaries, translations literature reviews) strengthen "Objective Usability," lifting "Perceived Ease of Use" and balancing "Computer Anxiety." Poor performance weakens "Objective Usability," increases anxiety about over-dependence.

Taken together, the three core themes form a holistic picture of how psychotherapists perceive and emotionally experience AI within the TAM3 framework. Across all themes, therapists' narratives demonstrated how TAM3 constructs interact dynamically rather than in isolation. "Perceived Usefulness" emerged as the central determinant, reinforced by "Job Relevance," "Output Quality," and "Result Demonstrability" whenever AI was perceived as efficient, relevant, and credible. Emotional and cognitive mechanisms such as "Computer Self-Efficacy," "Computer Anxiety," "Perceived Enjoyment," and "Computer Playfulness" moderated engagement with the AI by transforming fear into curiosity and confidence through hands-on experience. External factors, including "Subjective Norm," "Image," and "Perceived External Control," defined the ethical and professional boundaries within which technology acceptance could take place. Together, these findings show that technology adoption in psychotherapy is not a linear process of usefulness alone but rather multidimensional among complex determinants. This finding is also in line with the TAM3 literature (Venkatesh & Bala, 2008).

Finally, the three themes also address the study's four research questions. Findings from theme 1 respond to RQ1 and RQ3, revealing how therapists' general attitudes toward AI are shaped around "Perceived Usefulness." Theme 2 answers RQ2 by showing the personal and theoretical factors influencing willingness or resistance. Moreover, theme 3 responds to RQ4, demonstrating that ethical considerations and autonomy form the boundaries of trust which are necessary for technology adoption. These results suggest a dynamic technology acceptance process. Cognitive, affective, and social factors appear to interact to influence psychotherapists' attitudes toward AI in their clinical work.

4. DISCUSSION

4.1. Restatement of Purpose and Methodology

The primary purpose of this study was to explore the attitudes of psychotherapists in Türkiye towards the adoption of AI in their clinical practice. Using the TAM3 framework, the research analyzed the factors influencing psychotherapists' potential acceptance or resistance regarding the AI use in their profession. The qualitative methodology, a theoretical thematic analysis, was selected to address a critical gap in the existing literature, which usually consists of quantitative surveys or studies focusing exclusively on practitioners with high level of AI expertise. By engaging 18 psychotherapists with varying professional backgrounds and different levels of AI expertise, this research resulted in rich interpretive data. Three core themes, nine subthemes, associated TAM3 constructs, relevant participants and their key insights are mapped into Table 4.1.

Table 4.1 Participant–Theme Mapping Matrix

Theme / Subtheme	Core Constructs (TAM3)	Participants (P#)	Key Insights Expressed by Participants
Theme 1: The Spectrum of AI's Perceived Role			
1.1 AI as an Assistant	REL; OUT; RES; ENJ; OU	P1, P2, P3, P4, P5, P7, P9, P12, P13, P14, P15, P16, P18	Scheduling/calendar; session summaries & documentation; research/translation & writing; educational material creation; supervision and reflection**;** time-saving administrative automation
1.2 AI as a Public Health Tool	REL; OUT; RES; SN; IMG; OU	P2, P4, P7, P8, P9, P10, P14, P18	Population screening and early-risk identification; monitoring/early warning; triage and referral; inclusive psychoeducation and community outreach; between-session social support for vulnerable groups.

Theme / Subtheme	Core Constructs (TAM3)	Participants (P#)	Key Insights Expressed by Participants
1.3 AI as a Therapist or Co-Therapist	REL; OUT; RES; CANX; IMG	P2, P3, P5, P6, P10, P18; P4, P7, P8, P14, P17	Two positions: (1) For structured, protocolized work (e.g., brief/CBT-like tasks), AI could deliver elements of therapy autonomously; (2) AI should remain a human-supervised co-therapist that offers prompts, metaphors, plan/homework support.
Theme 2: Therapists' Digital Readiness and Orientation			
2.1 Tech-Savviness	CSE; CANX; CPLAY; ENJ; OU	P1, P3, P4, P6, P7, P8, P12, P13, P16, P17	Tech confidence made trying AI easier, curiosity helped people get started, small early successes increased confidence, limited experience led to hesitation, concerns about client perceptions and data security persisted, several shifted from initial worry to cautious use after experience.
2.2 Influence of Therapeutic Orientation	REL; OUT; SN; CANX; IMG	P2, P4, P12, P18, P5, P7, P8, P9, P14, P16, P17	Two positions: (1) Structured/protocolized orientations (e.g., CBT, EMDR, brief/symptom-focused work) see AI as a natural fit—useful for standardized tasks, skills coaching, psychoeducation, supervision/technical guidance, and workflow support; (2) Relational/analytic orientations (psychodynamic, integrative, existential, humanistic) insist AI should stay at the margins and align with norms that prioritize the human-to-human relationship.
2.3 Emotional Dimension: From Fear to Enjoyment	ENJ; CANX; CPLAY	P1, P2, P3, P5, P6, P7, P9, P10, P11, P12, P14, P15, P16, P17, P18	Initial worry shifting to curiosity and enjoyment after firsthand use, time-savings increasing positive feelings, privacy/data-footprint worries, fears of loss of control, anxieties about inequality/job loss and dystopian scenarios,

Theme / Subtheme	Core Constructs (TAM3)	Participants (P#)	Key Insights Expressed by Participants
			contrast between personal excitement and broader social worry.
2.4 Practical Experience of AI	ENJ; CSE; REL; OU	P8, P10, P11, P16, P18	Significant speed-ups, multi-step tasks collapsed into one step, reduced cognitive load, offloading routine/homework tasks between sessions, confidence and trust growing with firsthand use, enjoyment increasing after visible results.
Theme 3: Common Concerns and Preconditions for Adoption			
3.1 Importance of Ethics and Data Privacy	PEC; SN; IMG; OUT; RES; OU	P1, P3, P6, P7, P10, P12, P17, P18	Ethics/privacy as a precondition before any use, confidentiality and data control non-negotiable, demand for evidence and auditability of outputs, concerns about professional image.
3.2 Dependency and Autonomy	CANX; CSE; PEC; REL; OU	P6, P7, P9, P11, P16, P18	Balancing trust and control; against over-reliance on AI systems in clinical decision-making, preference for AI as a therapist-controlled helper.

Note. This table maps each participant's main contributions to the emergent themes and subthemes identified through theoretical thematic analysis. Abbreviations: PU = Perceived Usefulness; PEOU = Perceived Ease of Use; REL = Job Relevance; OUT = Output Quality; RES = Result Demonstrability; ENJ = Perceived Enjoyment; OU = Objective Usability; CSE = Computer Self-Efficacy; CANX = Computer Anxiety; CPLAY = Computer Playfulness; PEC = Perceived External Control; SN = Subjective Norm; IMG = Image.

4.2. Discussion by Themes and Subthemes

Across the interviews, therapists expressed mixed perceptions and attitudes towards the AI use in psychotherapy. Rather than fixed positions for or against AI, participants showed

complex attitudes shaped by the purpose of AI use in therapeutic settings. To begin with, several participants declared that they did not know any actual AI-supported apps or tools that are used in clinical practice, a finding in line with the literature (Cecil et al., 2025). Therefore, their perceptions and arguments evolved around potential and imagined roles that AI could play in their profession. Furthermore, the majority of practitioners appear to rely on their own social resources or self-paced learning rather than formal professional training for their current AI knowledge, leading to a lack of detailed technical understanding. Such lack of exposure suggests that current attitudes may represent a theoretical interest in learning rather than a practical readiness for use. Learning intentions consistently appear higher than use intentions, arguably due to the critical nature of clinical decisions. Crucially, this knowledge gap appears to stem from a deficit in professional education and institutional guidance. Most participants said that professional organizations and institutions are not knowledgeable about the AI applications or related ethical issues in the clinical field. This lack of formal instruction is significant, as insufficient training is identified as a contributor to technology-related medical errors, Specifically, when these systems are difficult to use, causing strain and issues like poor concentration which is linked to medical errors in the literature (Gaube et al., 2021).

The analysis of the interviews implies multiple factors shaping the attitudes of the Turkish psychotherapists towards AI, which can be characterized as “cautious acceptance” for most of the participants. This “cautious acceptance” is highly conditional, depending on ethical considerations and professional role boundaries. In this context, core TAM3 do operate through a high degree of interdependence, where professional values and ethical considerations function as moderators. The central finding is the acceptance of AI as an assistant for administrative tasks. This central finding is strongly supported by recent quantitative data from the 2025 Practitioner Pulse Survey by the American Psychological Association (2025). The report confirms that administrative and supportive functions currently dominate the landscape of AI adoption in the field. While regular monthly use remains at 29%, task-specific adoption is higher. Specifically, among psychologists who use AI, 52% report using it for writing assistance and 33% for content generation. Furthermore, 42% of psychologists identify improved efficiencies as the primary benefit of AI tools. (American Psychological Association, 2025).

On the contrary, most participants reject AI as a replacement for relational work, which is considered as the very core of the therapeutical process. This finding is consistent with prior local Turkish research by Gültekin and Şahin (2024), which similarly positioned AI in an assistant role.

In this context, human-computer interaction (HCI) might provide a useful lens for discussing these findings. HCI refers to the field studying how humans design, use, and experience digital systems, with an emphasis on usability, functionality, and human values (Dix, 2017). Within HCI, user-centered systems stress that technology interfaces should be grounded in users' needs and characteristics (Gulliksen et al., 2003). From this perspective, well-designed systems demand minimal effort from the user, which resonates with TAM3's construct of perceived ease of use. Participants in the current study commented on how AI tools are easy and efficient to use (referring to LLMs mostly), and how easy it would probably be to integrate the AI tools into their clinical practice. This pattern directly reflects HCI principles that user-centered design enhances usability, so that when systems are tuned to users' needs and abilities, perceived effort decreases and acceptance becomes more likely (Dix, 2017; Gulliksen et al., 2003; Venkatesh & Bala, 2008). In other words, therapists' reactions to AI in this study mirrored classic HCI concerns: technology was welcomed when it was designed to support user needs.

The first theme "AI's perceived roles" illustrates how psychotherapists evaluate the role of AI could play in psychotherapy as ranging from a supportive assistant to a potential co-therapist. The findings of the interviews regarding the perceived role of the AI are in line with the recent literature:

> *"Clinical LLMs could take a wide variety of forms, spanning everything from brief interventions or circumscribed tools to augment therapy, to chatbots designed to provide psychotherapy in an autonomous manner. These applications could be patient-facing (e.g., providing psychoeducation to the patient), therapist-facing (e.g., offering options for interventions from which the therapist could select), trainee-facing (e.g., offering feedback on qualities of the trainee's performance), or supervisor/consultant facing (e.g., summarizing supervisees' therapy sessions in a high-level manner)."*(Stade et al, 2024, p.2)

Similarly, the role of "AI as an Assistant" was the most commonly accepted with participants enthusiastically supporting the use of AI for scheduling, summarizing notes, research, and translation. This maps perfectly to the cognitive determinants of "Perceived Usefulness" within TAM3: the tasks have high "Job Relevance," the outputs are seen as high quality ("Output Quality"), and the benefits are clear ("Result Demonstrability") (Venkatesh & Bala, 2008). This high acceptance can also be considered as a classic example of successful HCI, which is focused on how people interact with technology, stating that successful adoption relies on not only user-friendly interfaces but also on efficient workflows that align with user tasks (Innerview, 2024; Langote et al., 2024). High usability leads directly to a high "Perceived Ease of Use" because it reduces the user's mental effort, making the tool feel intuitive. This reinforces the established link between "Perceived Ease of Use" and "Perceived Usefulness" in healthcare technology (Rahimi et al., 2018). In addition, participants also view AI positively in administrative and psychoeducational roles organizing notes, preparing homework, or summarizing literature because these tasks do not interfere with the therapist's core professional identity. These perceptions echo previous findings that clinicians adopt new tools more readily when the tools reduce their administrative workload (Ni & Jia, 2025; Spytska, 2025).

On the contrary, the role of "AI as a Therapist" was met with skepticism and resistance by a significant portion of the participants. Most psychotherapists considered this potential role for AI impossible to achieve, at least in the near future, citing the technology's incapacity to form an authentic relationship. This indicates a critical failure of "Perceived Usefulness" and "Job Relevance" for the core task of psychotherapy. This resistance can also be understood as a rejection of AI anthropomorphism, which is the attribution of human-like feelings and agency to non-human entities (Airenti, 2015). Anthropomorphism is a fundamental response in human-AI interaction (Nass & Moon, 2000). As users interact with the AI, they sometimes treat it as a human-like agent, which can affect their trust and perceived effectiveness. For instance, certain participants said they used polite language (formal you) with the AI, some give names to the AI, or some imagined the AI "understood" their needs. The tendency to humanize the system can make the interaction more engaging. By personifying the AI (for example, thanking the chatbot or joking with it), users may increase the system's "perceived usefulness" and emotional appeal, as according to literature, anthropomorphic attributes often serve a functional role in user experience (Blut et al., 2021). In TAM3 terms, such behaviors may be seen as increasing

“computer playfulness” (and “perceived enjoyment”) and reducing “computer anxiety,” thereby enhancing behavioral intentions (Venkatesh & Bala, 2008).

Even though in some contexts, designers use anthropomorphism, such as an 'empathetic' tone, to increase user trust (Adam et al., 2021), the participants in this study seemed to acknowledge a constant gap between what is real and authentic and what is simulated even with the highest output quality. Instead of building trust, the human-like quality in this study seems to highlight a lack of authenticity, which is almost impossible to fill in at last by the current state of the technology. It aligns with ethical concerns that anthropomorphism by design in tech world constitutes a deception, because it fosters the false belief in users that the AI agent possesses human mental and emotional capabilities (Sharkey & Sharkey, 2021). This is considered deceptive because current AI are merely machines that are not alive, sentient, or capable of feelings, yet their human-like presentation creates the illusion that the AI is sentient, emotional, and caring or that it understands you or loves you. The primary concern is that this emotional deception promotes a misplaced trust in the AI, especially when applied to vulnerable users like younger children or older people with cognitive limitations (Sharkey & Sharkey, 2021). Furthermore, for a psychotherapist, whose entire practice is built on maintaining and interpreting clear boundaries, this can be considered an existential threat to the work. Therefore, when AI is anthropomorphized into a "therapist," it is no longer perceived as a tool (which would have high "Perceived Usefulness") but as a deficient and inauthentic agent (which would have low "Perceived Usefulness"). This perceived inauthenticity significantly lowers the "Output Quality" and "Job Relevance" of the interaction as well.

Similar concerns emerge internationally: Clinicians report skepticism that AI can replace human empathy and spontaneity, even if they acknowledge its capacity for increased efficiency (Blease et al., 2020; Rogan et al., 2024). Recent studies on generative AI chatbots show that clinicians worry about harmful outputs, blurred boundaries, and unclear accountability if something goes wrong (Hipgrave et al., 2025; Rubin et al., 2024). Participants in this study also underlined that they do not feel comfortable with unclear accountability of who controls data. In this sense, high “Perceived Usefulness” coexists with perceived threats to relational safety. The Turkish context also echoes this pattern: In the literature, mental health professionals describe psychotherapy as fundamentally relational and affective and they see AI primarily as a useful tool for assessment and psychoeducation, and reject its use as an autonomous therapist

(Gültekin & Şahin, 2024). Therefore, therapists draw a clear boundary: most of the participants are willing to adopt AI tools that improve their work, but they resist delegating core relational functions to machines.

Similarly, therapists' behavioral intention is moderated by ethical and relational boundaries. When the imagined AI function moved closer to the clinical core, interpretation, empathy, or transference, therapists' behavioral intention to use the AI technologies weakened. The findings show that even with high perceived usefulness, adoption will not occur if AI threatens therapeutic authenticity or professional autonomy. Thus, the subthemes of AI as an Assistant and AI as a therapist/co-therapist illustrated high behavioral intention for supportive, low-risk tasks; low behavioral intention for relational functions.

In the meantime, the subtheme "AI as a Public Health Tool" seems to be the acceptable middle ground. Therapists were open to AI for screening, triage, and early risk detection because, in this context, the AI is positioned as a technical instrument, not a relational partner. This role leverages the high "Perceived Usefulness" of the "assistant" (efficiency, scale) without triggering the anthropomorphism of the therapist role. For the "AI as Public Health Tool" subtheme, some participants expressed a sense of professional duty and social benefit. This aligns with subjective norm and image constructs; which are the social influence mechanisms that increase behavioral intention when AI use is viewed as socially desirable.

The second theme of the study, "Therapist's Digital Readiness and Orientation," explores the personal and professional factors that shape adoption. According to the research, the participants generally fell into two digital adoption types: enthusiastic adopters and cautious & slow adopters. Enthusiastic adopters, though a small group, described themselves as confident and curious, using AI tools in both clinical and personal contexts heavily. Their theoretical orientations tended to be more structured or technique-based frameworks, such as EMDR and CBT, which may encourage openness to technological experimentation (Bursnall et al., 2022; Kaptan et al., 2024; Nævdal et al., 2025; Thew et al., 2022) Participants who were "Enthusiastic Adopters" demonstrated high "Computer Self-Efficacy" and high "Computer Playfulness," leading to "Perceived Enjoyment" and reinforcing their high "Perceived Ease of Use" and "Perceived Usefulness." In TAM3 terms, enthusiastic adopters in this sample can be understood as highly ready profile: They reported high "Perceived Ease of Use," "Perceived Enjoyment," "Computer Playfulness" and "Computer Self-Efficacy," combined with low

“Computer Anxiety.” They experienced experimentation with AI as enjoyable and useful. TAM3 predicts that such a configuration of beliefs strengthens “Perceived Usefulness” and, in turn, “Behavioral Intention” to adopt the technology (Venkatesh, 2000; Venkatesh & Bala, 2008). Empirical work with therapists delivering internet-delivered CBT supports this link: higher self-efficacy with digital tools, more positive ease-of-use beliefs and more prior experience are associated with greater acceptance and intention to use internet-delivered CBT in routine care (Nævdal et al., 2025). Seen together, these findings suggest that digital savviness among clinicians might be seen as a direct driver of higher “Behavioral Intention.”

In contrast, the cautious & slow adopters, the majority of participants, expressed conditional interest in AI. They underlined empathy, intersubjectivity and transference–countertransference dynamics, and questioned whether an always-available, always-recording, technically “flawless” tool could be a good relational fit. This group was primarily rooted in psychodynamic, humanistic, existential, and integrative traditions. Their stance echoes prior work showing that therapists from relational orientations tend to be more ambivalent about online psychotherapy, often highlighting worries about the therapeutic relationship and embodied presence (Békés & Aafjes-van Doorn, 2020; Jesser et al., 2022). In TAM3 language, this corresponds to moderate “Perceived Ease of Use,” lower “Computer Self-Efficacy” and “Perceived Enjoyment,” and higher “Computer Anxiety,” a profile that is expected to have reduced “Perceived Usefulness” and “Behaviroal Intention.” This is also in line with earlier findings that therapists in relational approaches often express greater caution about digital formats (Jesser et al., 2022).

The finding that therapeutic orientation impacts acceptance can also be re-interpreted as a fundamental HCI matter. HCI is, at its core, about ensuring that technology functionality corresponds to users' task requirements, a concept formally known as Task-Technology Fit (Goodhue & Thompson, 1995). This distinction is critical because the model suggests, “*irrespective of the attitude that individuals hold about technology, they are not likely to adopt it, if there is a mismatch between the technology's functionality and task requirements*” (Goodhue & Thompson, 1995, p. 7). For therapists from structured modalities like CBT or EMDR, an AI tool aligns with their protocol-driven workflow. In contrast, for a psychodynamic, existentialist or integrative therapist, the workflow might be non-linear and interpretive (Blease et al., 2021). In the context of Task-Technology Fit, this workflow is characterized by high task

non-routineness, and consequently, a structured AI tool would create a critical mismatch between the technology's functionality and task requirements (Goodhue & Thompson, 1995). Attempting to force this fit would be expected to result in much lower “Perceived Ease of Use” and “Perceived Usefulness.”

Another significant subtheme captured the wide spectrum of affective responses psychotherapists exhibited towards AI, ranging from deep fears to genuine fascination. Crucially, the interviews revealed that these emotional responses are not static but rather dynamic evolving through interaction. Many participants described a distinct emotional path: an initial phase of "Computer Anxiety,” often rooted in fear of the unknown or ethical concerns and "Perceived Enjoyment" after a period of risk-free experimentation for their personal use. This pattern mirrors findings from the rapid transition to telepsychotherapy during the COVID-19 pandemic, where Békés et al. (2021) observed that while concerns about therapeutic quality initially predicted negative attitudes, anxieties softened as clinicians gained practice and witnessed positive client outcomes. In fact, even one of the participants of this study, who had the most fearful and distant attitude to the AI use in mental healthcare, said that even though they are not in favor of the AI use in their profession now, they cannot be complete sure about the future because they were also completely against the virtual therapy before the COVID-19 pandemic, and now they are still seeing clients online as their worries softened over time. Therefore, both literature and this study’s findings reveal that once the most skeptical therapists had some positive experiences with AI, their “Perceived Ease of Use” and “Perceived Usefulness” starts improving. This progression provides empirical support for TAM3’s structural model, where experience functions as a critical moderator. As Venkatesh and Bala (2008) claimed, hands-on experience demystifies the technology, lowering “Computer Anxiety” while simultaneously increasing "Perceived Ease of Use;” this reduction in emotional friction subsequently paves the way for higher "Perceived Usefulness" and stronger "Behavioral Intention.” However, the depth and complexity of these emotional shifts suggest that TAM3’s current affective constructs (Computer Anxiety, Computer Playfulness, and Perceived Enjoyment) might be insufficient to fully capture the intensity of psychotherapists' reactions. The transition from "fear of replacement" to "enjoyment of efficiency" involves professional identity work that goes beyond simple "playfulness," or “enjoyment.” Therefore, future research of technology acceptance models in mental health might benefit from a more comprehensive

affective framework, one that integrates deeper emotional dimensions rather than limiting the emotional experience to anxiety and enjoyment alone.

The third theme, "Common Concerns and Preconditions for Adoption," brings together the ethical and autonomy-related issues identified by participants. This study showed that these concerns are not just factors but critical prerequisites for adoption. Psychotherapists' perceptions of the use of AI in their professional work were heavily influenced by ethical considerations. Throughout the interviews, therapists consistently viewed ethics as an essential part of their professional identities. Confidentiality, data privacy, and data protection were the main topics of their conversations, suggesting that these ideas are crucial for integrating technology into mental health treatment. Concerns raised in the literature are also reflected in this study. Researchers like D'Alfonso (2020) and Fiske et al. (2019) stress that using AI in mental health raises serious ethical issues, emphasizing the need for algorithmic transparency as well as clear privacy and data security guidelines. This finding is further supported by the most recent Practitioner Pulse Survey, which indicates that as familiarity and adoption of AI grow, so do professional anxieties (American Psychological Association, 2025). The report notes that despite the rising use of these tools, concerns regarding their ethical implications have intensified. The most significant concerns cited by psychologists are potential data breaches (67%), unanticipated social harms (64%), and biased inputs and outputs (63%) (American Psychological Association, 2025).

In the context of TAM3, this means "Perceived External Control" functions as a gatekeeper for the entire model. The data from this study suggests a modification to the standard TAM3 model: If "Perceived External Control" is perceived as low (i.e., safeguards are absent), "Behavioral Intention" to adopt becomes zero, regardless of how high the "Perceived Usefulness" or "Perceived Ease of Use" might be. Trust in healthcare AI is the foundation upon which all other factors are built (Steerling et al., 2023).

Moreover, in this study, ethical considerations served as a guide rather than an obstacle against the technological developments. While expressing interest in AI's potential and not denying the technology use completely out of their concerns, participants made sure to frame their investigation within clear ethical boundaries. Participants often expressed that their professional networks or associations lag behind technological novelties. Therefore, individual practitioners have to carry the ethical responsibility alone in the absence of formal guidelines.

These results highlight the necessity of well-defined policy frameworks that divide ethical responsibility among practitioners, professional associations, and AI developers. Participants also showed a humanistic understanding of technology: rather than viewing ethics as an obstacle to technological developments, they positioned it as the foundation for meaningful integration. Caring about ethics, in this sense, is not simply protective but also can be transformative for technology. In this way, therapists in the study showed their capacity to engage with the technology critically yet constructively at the same time.

As part of the last subtheme, “Dependency vs Autonomy,” participants' anxiety about becoming 'dependent' or 'losing skills' can be understood as a response to the anthropomorphic dilemma. AI systems are often intentionally designed with friendly, human-like interfaces to foster a sense of connection, and this can lead to 'misplaced trustworthiness' and 'emotional overreliance' (Laestadius et al., 2022). This encourages users to compromise their privacy by disclosing sensitive information as if they were friends (Akbulut et al., 2024). The therapists' fear of "dependency" is a professional-level articulation of this exact risk. They are afraid that the AI's human-like interface will drive both themselves and their patients into this trap, leading to a loss of critical human judgment and, ultimately, a loss of autonomy. This connects the autonomy concern directly to the ethical concern: the anthropomorphic design of the AI amplifies the ethical risk of privacy violations by encouraging over-disclosure (Akbulut et al., 2024). In response to the fear of losing their professional autonomy, participants generally characterized AI's role as a reflective or educational collaborator. They discussed the usefulness of AI in the context of generating psychoeducational materials, summarizing recent literature, and organizing supervision notes, emphasizing functions that enhance learning. This distinction is essential: AI was appreciated for its instrumental role in helping the therapist's cognitive and organizational functions, rather than for its ability to interpret emotional content. Such perspectives align with Spytska’s (2025) notion of intelligent assistance, in which AI tools contribute to professional self-monitoring without stepping into the interpersonal domain of therapy. By assigning technical tasks to AI while maintaining interpretive and relational control, the participants sought to preserve their clinical autonomy.

If low 'Perceived External Control' and the 'anthropomorphic dilemma' are the problems, then 'human-centered' HCI might emerge as the solution. Trust in healthcare AI should be based on specific HCI principles like 'transparency,' 'explainability,' and 'visibility' (Amann et al.,

2020). In TAM terms, by designing AI tools that are transparent and explainable , developers can build "Perceived External Control" (trust), reduce "Computer Anxiety" to counter the dangers of anthropomorphism. This approach would reassert the AI's controllable "assistant" status.

4.3. Discussion by Special Focus Areas

Several special focus areas emerged from the interviews, standing alongside the formal themes and subthemes identified in the study. The special focus areas can be discussed as extensions of AI's perceived roles by the psychotherapists.

4.3.1. AI for vulnerable populations

A meaningful point that emerged within this theme was the idea that AI might help people who have difficulty reaching therapy elsewhere. Several participants spoke about possible contributions of AI involvement in therapeutic processes for vulnerable groups such as neurodivergent clients, migrants, and LGBTQI+ individuals. They felt that AI could lower some of the barriers these groups face, such as stigma, language barrier, or the lack of affordable services. For example, one participant thought AI could provide small forms of daily or between-session support for adults on autism spectrum, helping them manage routines or emotional regulation when the therapist is not available. Another participant, who works with LGBTQI+ communities, used AI to create inclusive educational materials and described how this visibility itself can be therapeutic. Finally, some other participant who has worked with migrants and refugees, said AI-based supervision felt "less judgmental," compared to human supervision, suggesting that AI might help reduce human bias in certain contradictory contexts.

These reflections show that therapists in this study see AI not only as a private productivity tool but also as a possible way to widen access to mental healthcare. In TAM3 terms, "Perceived Usefulness" extends beyond individual efficiency to include social usefulness. This perspective adds an important layer to technology acceptance research: Adoption is strengthened when the technology is seen as both clinically helpful and also socially fair.

Finally, recent studies and real-world applications increasingly demonstrate the tangible value of AI interventions for vulnerable populations, with specialized applications ranging from the therapeutic use of social robotics, such as LuxAI's QTrobot in autism therapy (LuxAI, n.d.), to targeted support chatbots like REALbot for LGBTQI+ youth (Escobar-Viera et al., 2023) and the International Rescue Committee's (IRC) AI-powered platform for survivors of human trafficking (IRC, 2025). Research also support that AI's most significant impact may be in reaching vulnerable populations, such as the elderly or adolescents, who often face barriers like stigma or high costs (Luxton, 2020).

4.3.2. AI as a supervisor

Another significant finding was the idea that AI could function as a supervisory tool. Two participants reported that they had already used AI for supervision-related purposes. One therapist described entering their notes into an AI program as prompts and receiving feedback on a protocol-based intervention which they found both useful and unbiased. Another participant explained that discussing de-identified cases with AI helped them reflect on their own decision-making. AI was perceived as a supplementary reflective partner, capable of offering quick and alternative viewpoints when supervisors are not available. Within the TAM3 framework, these experiences align with “Perceived Usefulness” and "Output Quality,” as AI helps therapists refine their understanding and technique.

This finding broadens the meaning of AI as an assistant from efficiency to professional growth. According to the interviews, by providing immediate feedback, AI encouraged therapists to examine their interventions and reasoning more critically. Similarly, in educational settings, AI may serve as a supervisory tool, allowing trainees to rehearse their clinical thinking and organize their insights before meeting with a human supervisor. Such preparation can make supervision sessions with human professionals more productive. The availability of an always-accessible, non-evaluative tool might reduce performance anxiety for the trainees. Recent studies have begun to demonstrate the practical value of AI as a supervisory aid in psychotherapy training. For example, AI has been used to provide structured feedback to novice counselors (Chaszczewicz et al., 2024), and to support clinical supervision in university counseling clinics by summarizing sessions and highlighting intervention patterns (Sheperis &

Sharvit, 2025). In addition, AI's potential help with novice psychotherapists who cannot afford or reach a human supervisor should be considered carefully.

4.4. Methodological Reflections and Limitations

This study used a theoretical thematic analysis based on the TAM3 model to investigate how psychotherapists view the use of AI in mental healthcare. The research combined a theoretical framework with a qualitative approach to capture the structure and meaning of professional attitudes. According to Braun and Clarke (2019), thematic analysis offers a flexible but robust way to identify patterns in meaning within a dataset while keeping an interpretive depth. The deductive nature of the analysis einabled connecting coding categories directly to the TAM3 constructs, which ensured both clarity and consistency in the research.

4.4.1. Reflexivity

Reflexivity was an important part of the research. The researcher's background as a master's student in clinical psychology and a professional in a global technology company influenced how the topic was chosen, handled and evaluated. This dual background provided the researcher with a view from both sides at the intersection of psychotherapy and technology.

This dual position had its own pros and cons. The familiarity with clinical psychology enabled deeper understanding of participants' clinical language, ethical concerns, and professional views. This helped to build rapport during interviews, as the researcher could easily follow discussions about therapeutic processes. Similarly, the professional experience in the technology sector facilitated a better understanding of AI concepts and TAM3 constructs. This hybrid position became a methodological strength, allowing the researcher to bridge two different cultures which usually speak separate languages.

However, the same dual role also presented a significant risk of bias. Pre-existing assumptions from both fields could have influenced the researcher's decisions at several stages, starting from preparing interview questions to interpreting themes. The technology background risked a subtle pro-technology bias that might minimize participants' concerns. Conversely, the clinical orientation risked over-identification with participants' professional anxieties.

4.4.2. Sampling and contextual limitations

The study's findings are shaped by its sampling strategy and contextual boundaries. Participants were recruited through convenience and snowball sampling. The snowball method may have introduced some bias into the sample. Participants often referred colleagues within their own social or professional circles, who likely shared similar digital literacy levels and practice environments. Consequently, the final sample was primarily composed of urban, digitally competent psychotherapists with reliable access to digital networks. Psychotherapists in rural settings may face different challenges, like limited internet access or limited interest in AI technologies due to infrastructural insufficiencies, which was not fully captured in this study.

Finally, the study is contextually bound to Türkiye. Participants' perceptions were shaped by the national healthcare system, local professional norms, and the specific local culture surrounding technology. The findings should therefore be interpreted within this context and not directly transferred to other countries. Furthermore, the data collection period coincided with the rapid evolution of generative AI tools around the globe, which might have excessively influenced participants' curiosity and caution towards the subject. As the technology and its regulation evolve (and also become more normalized), longitudinal studies might be necessary to see potential changes in attitudes and perceptions.

4.4.3. Limitations of the theoretical framework

Another limitation concerns the theoretical framework itself. TAM3 was chosen for its validated structure and strong explanatory power in studies of technology adoption (Venkatesh & Bala, 2008). The model provided conceptual clarity and facilitated the coding. However, pre-defined theoretical frameworks also imposed boundaries. TAM3 was originally developed for organizational and efficiency-driven settings, not for clinical contexts where relational and ethical factors are central. While TAM3 constructs such as "Perceived Usefulness" and "Perceived Ease of Use" proved relevant, they might not fully capture the deeply interpersonal dimensions of psychotherapy. As Holden and Karsh (2010) note, models like TAM are powerful in predicting adoption behavior but less successful in explaining the complex, professional, and relational dynamics regarding the resistance among healthcare providers.

It is also important to recognize how the researcher's dual position may have influenced this theoretical choice. Coming from a technology background, the researcher may have been predisposed to structured approaches to understanding adoption. This orientation might have emphasized "how professionals will use AI" over "how AI changes the relational aspect of therapy". Consequently, certain relational themes might not have been fully represented because they did not fit completely within TAM3's categories.

While TAM3 offers a good understanding of cognitive and emotional determinants of technology acceptance, the findings of this study also suggest that personality traits may serve as moderators of these determinants. A number of participants in the study explicitly related their comfort or discomfort with AI with their personality characteristics rather than with the AI itself. For example, one therapist stated that they felt anxious toward AI simply because they "tend to be anxious about almost everything," while others described their technological confidence as part of a broader personal tendency to "being open and curious about new things." Such statements might imply that TAM3 constructs of "Computer Anxiety," "Computer Playfulness," and "Perceived Enjoyment" may be influenced not only by positives experience but also by personality traits.

This observation resonates with the Five-Factor Model of personality, summarized as OCEAN (Openness, Conscientiousness, Extraversion, Agreeableness, and Neuroticism), which has been linked to technology-related behaviors in the literature (Correa et al., 2010; Devaraj et al., 2008). For instance, according to Korukonda (2005), high Neuroticism is associated with greater technology anxiety and avoidance, and according to (Devaraj et al., 2008) high Openness predicts exploration and curiosity towards new tools and high Conscientiousness supports deliberate, structured learning behaviors. These personality patterns also appeared indirectly among the participants: Therapists high in self-described general anxiety demonstrated lower "Perceived Ease of Use," whereas those who emphasized curiosity or flexibility reported higher "Perceived Enjoyment" and "Computer Playfulness."

These patterns suggest that personality traits might have a function in the TAM3 hierarchy, shaping the emotional and cognitive factors predicting the "Behavioral Intention." In simple terms, personality traits shape people's feelings and thoughts about AI first, and those feelings and thoughts then influence whether they intend to use it. Integrating measures of OCEAN traits into future TAM3-based models could therefore refine the theory's explanatory

depth, enabling the model to distinguish between trait-related and other dynamics. This proposal aligns with TAM literature stating that not taking into account individual differences such as personality traits and demographic variables in technology acceptance studies would be a theoretical problem (Marangunić & Granić, 2014, p. 85).

In clinical contexts, this integration may be especially helpful. Understanding how therapists' own personality configurations shape their engagement with AI could help in developing targeted training programs. Thus, expanding TAM3 to include personality moderators may not enhance its theoretical completeness.

In summary, these reflections highlight both the strengths and boundaries of the study. The integration of a theoretically grounded model (TAM3) with a qualitative approach offered structure and depth but inevitably filtered findings through certain conceptual and positional lenses. By openly acknowledging positionality, contextual constraints, and theoretical limits, the study aims to support readers in interpreting the findings more effectively.

4.5. Further Implications and Future Research

The findings of this research offer critical insights into how AI can be integrated into psychotherapy. Based on the themes derived from the interviews, this section first outlines the implications grounded in participants' narratives and also presents the study's specific recommendations.

4.5.1. Implications for clinical practice

The findings of this study offer critical insights for the day-to-day practice of psychotherapy. The data suggests that for Turkish psychotherapists, the integration of AI is not a binary choice of "acceptance" or "rejection," but a complex relationship of professional boundaries. Rather than a dichotomous stance, these attitudes are characterized by a simultaneous complexity where enthusiasm and anxiety coexist.

The most immediate implication for clinical practice is the validation of the "AI as an Assistant" model. Participants explicitly distinguished between AI's high usefulness in administrative tasks (scheduling, translation, summarization) and its unsuitability for relational work. This implies that clinicians can safely begin integrating AI into their workflows by

targeting "low-stakes" administrative burdens. By offloading these tasks, therapists can potentially reduce burnout and cognitive load without compromising the "human-to-human" core of the therapeutic alliance.

The theme "Dependency and Autonomy" highlighted a significant fear among therapists regarding the loss of professional skills or cognitive laziness. They specifically noted that while AI can offer preliminary diagnoses, the ultimate responsibility lies with the clinician. This implies that clinical practice must adopt a strict "Human-in-the-Loop" workflow. AI outputs, whether they are session summaries, case formulations, or diagnostic screenings, must be treated strictly as drafts that require verification. Clinical protocols should explicitly state that AI cannot be the sole decision-maker in any therapeutic intervention.

Although participants expressed high concern about "data privacy" and "ethical boundaries" , they also noted that clients might use these tools independently. The finding that AI can be viewed as a potential "social support" or "triage" tool by some participants implies that clients may increasingly bring AI-generated insights into the therapy room. Psychotherapists must therefore be prepared to discuss AI not just as a tool they use, but as an entity their clients interact with (or forming relationships with).

Finally, following up on these implications and greater context discussed in the Introduction, this study outlines several recommendations for clinical practice. First, given the rapid rise of AI chatbots, clients may engage in "shadow use," utilizing AI for therapeutic purposes without the therapist's knowledge (Moëll & Aronsson, 2025). Recent legal cases highlight the critical necessity of addressing this trend, specifically regarding client protection and AI-induced harm, by exposing the devastating consequences because highly anthropomorphic AI might lead to psychological exploitation (Anadolu Agency, 2025; Montgomery, 2024). To manage this, therapists should integrate a "Digital Anamnesis" into their standard intake assessment. Just as clinicians inquire about substance use or medical history, they should proactively ask if clients use chatbots to track moods or have received advice from AI tools regarding their issues, allowing the therapist to assess potentially maladaptive attachments.

Alongside these inquiries, building trust requires transparency regarding the clinician's own use of technology. Since ethical concerns remain a strong barrier to adoption, psychotherapists should add a specific "AI and Technology Policy" to their informed consent

forms. This policy should transparently explain which specific AI tools are utilized in the practice, explicitly clarifying that clinical decision-making is always performed by the human therapist, while explaining the measures taken to ensure client privacy is safely handled.

4.5.2. Implications for professional training

The findings indicate an AI literacy gap with many psychotherapists remaining uncertain about AI's capabilities, or at least indicating that their circles and professional associations do not have adequate information regarding the AI. Lack of information or trainings might lead to both fascination and fear. This highlights a need to build AI literacy, the ability to critically understand, evaluate, and use these systems (Long & Magerko, 2020). University psychology programs and professional associations should integrate AI literacy into their training curricula. AI education would help empower future psychotherapists to be active shapers of technology, not just passive consumers. This is particularly important because majority of the participants, regardless of their exposure and expertise levels, showed an openness to using AI as a supplement to their clinical work. Under such a model, the clinicians use AI for tasks like summarizing notes, supervision, or creating psychoeducational content. Recent literature also sees this scenario as an imminent possibility as explained in Table 4.2.

Table 4.2 Imminent Applications of Large Language Models in Psychotherapy

Task	Target Audience	Example Input to LLM	Example LLM Output
Aid in administrative tasks	Clinician	Psychotherapy session recording	"... Met with patient for cognitive behavioral therapy for depression. Reviewed homework; patient completed three thought records over the past week. Introduced 'thinking biases' worksheet; assisted patient in identifying patterns of problematic thinking applicable to her automatic negative thoughts from the past week..."
Offer feedback on therapy homework worksheets	Patient	Digital CBT worksheet; Patient writes, "I've always felt this way," as evidence in support of the negative automatic thought: "I'm unlovable" on the worksheet	"Remember, 'evidence' means facts that support the belief. Sometimes it's helpful to think about facts so strong they would stand up in a court of law. What is the evidence that you are unlovable?"
Produce adherence and competence ratings for elements of therapy	Researcher	Psychotherapy session recording	"*...Therapist helped patient identify negative automatic thoughts* Adherence rating (0-1): 1 Competence rating (0-6): 5..."
Identify trainee psychotherapist's areas of success and areas for improvement	Psychotherapy trainee	Psychotherapy session recording	"...In the following exchange, the therapist successfully used Socratic questioning to ask open-ended, non-leading questions: *[Patient: I should have known that it wasn't safe to get in that car. Therapist: Hm, help me understand... how could you have known that it wasn't safe?]...*"
Suggest an improved therapeutic response, offer education about therapeutic exchanges	Peer counselor or lay mental health worker	Message-based exchange between patient and peer counselor; peer counselor has drafted a response: "You'll be fine"	"This could be improved by offering validation of the client's feelings. For instance, you might say, 'it sounds like you're going through a difficult time, and it's understandable to feel overwhelmed.' Would you like to rewrite before sending?"

Note. From "Large language models could change the future of behavioral healthcare: A proposal for responsible development and evaluation," by E. C. Stade et al., 2024, *npj Mental Health Research, 3*, p. 5 (https://doi.org/10.1038/s44184-024-00056-z). CC BY 4.0.

These tasks require a good level of competence in terms of AI literacy. To build this competence safely, in addition to integrating AI literacy in the formal education programs, the study recommends creation of AI "sandboxes." In computer science, a "sandbox" is "an isolated testing environment that enables users to run programs or open files without affecting the application, system or platform on which they run" (TechTarget, n.d.). Applied to the psychotherapy context, these would be secure, isolated environments where clinicians can experiment with AI tools using synthetic data, which is defined as "artificial data generated by a model trained or built to replicate real data" (Hernandez et al., 2022, p. 30). This would allow them to build familiarity with the technology without a major risk to client confidentiality. This allows the clinicians to analyze the AI's biases and errors in a safe setting before considering it for real clinical decision-making. For example, a supervision group could use a synthetic case study to test how an LLM formulates a diagnosis. This type of testing builds AI literacy and

confidence simultaneously, allowing therapists to understand the tool's limitations through direct engagement.

According to this study, individual motivation seems to be exceeding institutional preparedness but therapists would need institutional support to make sure of the ethical safeguards systematically. Therefore, clinics and hospitals must invest in secure digital infrastructure and form interdisciplinary ethics committees to guide this implementation. Organizations should establish AI committees composed of clinicians, IT specialists, and legal experts. These committees could oversee AI integrations. In addition, interdisciplinary mentorship is essential for the AI adoption process at the institutional level. Pairing psychotherapists with data scientists or engineers can bridge the gap that often prevents or slows down an efficient collaboration. The creation of new roles within mental health institutions, professionals who are fluent in both clinical and technical languages, would facilitate effective communication between fields.

4.5.3. Implications for technology design and policy

The interviews show a clear starting point for design and policy: Data privacy must come first. Therapists would not try a new tool unless they believe that client material stays protected and confidential. Privacy-by-design methods can help at this point. Privacy-by-design means building privacy into the system from the beginning. In other words, reducing how much data are collected, limiting who can see them, and adding safeguards at every step (Cavoukian, 2011). Privacy-by-design methods are briefly summarized in Table 4.3.

Table 4.3 Privacy-by-design methods (a simple guide)

Method (plain term)	What it means in simple words	Why it helps in psychotherapy settings
Data minimization	Only collect what is truly needed; avoid extras	Fewer sensitive details stored; risk is lower (WHO, 2021).
Local/sovereign hosting	Keep data and computation under the institution's legal control (e.g., hospital servers)	Clearer accountability and alignment with local rules (WHO, 2021).
Federated learning	Train models without moving raw patient data off-site	Enables collaborative learning with less data sharing (Kaissis et al., 2020).
Differential privacy	Add carefully calibrated noise so shared statistics can't identify individuals	Supports analysis with stronger anonymity (Kaissis et al., 2020).
Pseudonymization / de-identification	Remove direct identifiers from the data	Lowers the chance a client can be re-identified (WHO, 2021).
Encryption & access control	Encrypt data; restrict access by role; use multi-factor login	Limits who can read data even if systems are breached (WHO, 2021).

Note. Adapted from *Ethics and governance of artificial intelligence for health*, by World Health Organization, 2021 (https://www.who.int/publications/i/item/9789240029200), and from "Secure, privacy-preserving and federated machine learning in medical imaging," by G. A. Kaissis, M. R. Makowski, D. Rückert, and R. F. Braren, 2020, *Nature Machine Intelligence, 2*(6), 305–311.

These privacy-by-design approaches do not remove the risks completely, but might reduce them to the clinically acceptable levels. In addition, design should be in line with the therapist's workflow. For example, a therapist-facing co-pilot running on local infrastructure might help. Co-pilot's explanations should be practical and transparent so that clinicians can check and justify outputs (Tonekaboni et al., 2019). Early pilots would be safest if they focus on low-risk tasks such as anonymous summaries, literature reviews, or creating psychoeducation materials. When clinicians see useful and credible outputs, their confidence would grow, which is consistent with acceptance research (Venkatesh & Davis, 2000; Venkatesh & Bala, 2008).

Finally, AI technology must be supported by a robust regulatory framework. Mental health NGOs, associations, boards and the relevant government agencies should collaborate to define standards of AI tools in mental health all together. These policies should be guided by the World Health Organization's trustworthy AI principles (WHO, 2021).

4.5.4. Future research directions

This study suggests several paths for future research. First, longitudinal studies are needed to explore how therapists' attitudes regarding AI change over time. Future research might follow therapists over time to understand how their beliefs and behavior change based on their real-life experiences. Post-adoption research shows that positive experiences decrease anxiety and encourage continued use (Bhattacherjee & Premkumar, 2004). Monitoring a group over months or years could show whether concerns change over time.

Second, cross-cultural studies in other countries can determine which findings apply broadly. Health systems, training practices, regulations, and public perceptions vary in the different countries and they are very much to likely influence technology acceptance (Greenhalgh et al., 2017). Comparative studies could also look at subgroups, such as whether therapists from different therapeutic backgrounds, gender or generations respond differently.

Third, the study's sandbox proposal could serve as an effective setting for experimental research on clinician–AI interactions. Research should test technical choices in controlled environments that protect privacy and use synthetic data instead of real patient data. Federated structures (models training without moving raw data) and locally governed structures (data and compute stay under an institution's control) can minimize privacy risks in experimental research (Rieke et al., 2020).

Finally, mixed-methods research can also provide valuable insights. Qualitative studies can show how therapists think about AI, but they do not quantify how common these views are or how strongly different factors are correlated. Incorporating quantitative measures would allow researchers to assess the size and direction of these effects for larger samples.

4.6. Conclusion

This research examined how psychotherapists in Türkiye discuss integrating AI into their clinical practice. The study was conducted using the TAM3 model, which identified that therapists are not merely adopting AI, nor are they necessarily resisting it; instead they are in the process of a thoughtful transition. They cautiously approach AI through an ethical lens that reflects the humanist roots of their professional discipline.

It is apparent that for psychotherapists, the use of technology is both an ethical and relational decision, rather than simply a technical one. The study further developed the TAM3 model to demonstrate that such constructs as "perceived usefulness," are very closely related with moral values. This is illustrated by a central tension between two views on the role of AI: While there is an opinion that AI should primarily be used to assist with administrative tasks, such as documentation, and numerous participants rejected any tool that may potentially reduce empathy, authenticity, or the therapeutic alliance, a smaller group believed that AI could be capable of acting as an autonomous therapist. This clear divide demonstrates that for this profession "utility" is not only a function of a technical evaluation but is based on the perceived capability for relational standards of care.

Overall, this study contributes to the understanding of AI acceptance by suggesting that it also serves as a reflection of psychotherapist's identity. The inclusion of AI into psychotherapy sheds light on the profession's core values: empathy and the importance of the human relationship. This study also illustrates that for AI to be successfully integrated into the practice of psychotherapy, technological advancements and ethics must develop together. To support AI in the field of psychotherapy, AI must be embedded in a culture of supervision and ethical accountability. All three parties, public institutions, universities, and technology companies, share an obligation to ensure that AI supports the empathy, creativity, and humanity that form the very heart of mental health practice.

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APPENDICES

Appendix 1: Informed Consent Form

Araştırmanın Adı: Psikoterapistlerin Ruh Sağlığı Alanında Yapay Zeka Kullanımına Yönelik Tutumlarının İncelenmesi: Teorik Bir Tematik Analiz

Araştırmacı: Başak Yeşil

Tez Danışmanı: Doç. Dr. Burçin Akın Sarı

Araştırmanın Amacı: Bu araştırma, Başkent Üniversitesi Sosyal Bilimler Enstitüsü Klinik Psikoloji Tezli Yüksek Lisans Programı kapsamında yürütülen bir yüksek lisans tezi çalışmasıdır. Araştırmanın amacı, psikoterapistlerin ruh sağlığı alanında yapay zeka kullanımına yönelik tutumlarını, beklentilerini ve kaygılarını derinlemesine anlamaktır.

Araştırma Süreci: Araştırma kapsamında sizinle çevrimiçi Google Meet platformu üzerinden yaklaşık 60-90 dakika sürecek bir görüşme yapılacaktır. Görüşme sırasında size yapay zeka teknolojilerinin psikoterapi alanındaki kullanımına ilişkin açık uçlu sorular sorulacaktır. Görüşme, veri analizi için ses kaydına alınacaktır.

Gizlilik ve Veri Güvenliği: Görüşme kayıtları ve kişisel bilgileriniz kesinlikle gizli tutulacaktır. Veriler sadece bilimsel amaçlarla kullanılacak ve üçüncü kişilerle paylaşılmayacaktır. Araştırma raporunda veya yayınlarda isminiz veya kimliğinizi belirten herhangi bir bilgi kullanılmayacaktır. Ses kayıtları yazıya döküldükten sonra silinecektir. Veriler şifreli bilgisayarlarda güvenli bir şekilde saklanacaktır.

Gönüllü Katılım: Bu araştırmaya katılım tamamen gönüllülük esasına dayanmaktadır. Görüşme sırasında herhangi bir nedenden ötürü kendinizi rahatsız hissederseniz görüşmeyi yarıda bırakabilirsiniz. Görüşme sonrasında verilerinizin kullanılmasını istemezseniz, araştırmacıya bildirerek verilerinizin silinmesini talep edebilirsiniz.

İletişim Bilgileri

Araştırma hakkında daha fazla bilgi almak veya sorularınız için aşağıdaki iletişim bilgilerini kullanabilirsiniz:

Araştırmacı: Başak Yeşil

E-posta:

Tel:

Tez Danışmanı: Doç. Dr. Burçin Akın Sarı

E-posta:

Tel:

Onay:

o Yukarıdaki bilgileri okudum ve anladım. Araştırmaya gönüllü olarak katılmayı kabul ediyorum. Bu formun bir kopyasının bana verilmesini kabul ediyorum.

o Bu araştırmaya katılmayı kabul etmiyorum.

Katılımcının:

Adı-Soyadı:

Tarih:

İmza:

Araştırmacının:

Adı-Soyadı: Başak Yeşil

Tarih:

İmza:

Appendix 2: Demographic Information Form

Kişisel Bilgiler

1. Yaş: ____
2. Cinsiyet:
    - Kadın
    - Erkek
    - Diğer
    - Belirtmek istemiyorum

Eğitim Bilgileri

3. En son tamamladığınız eğitim düzeyi:
    - Lisans
    - Yüksek Lisans
    - Doktora
    - Tıpta Uzmanlık
4. Lisans eğitiminizi tamamladığınız bölüm:
    - Psikoloji
    - Tıp
    - PDR
    - Diğer (Lütfen belirtiniz: _____)
5. Lisans mezuniyet yılınız: _____
6. Lisansüstü eğitiminizi tamamladığınız alan:
    - Klinik Psikoloji
    - Psikiyatri

- Diğer (Lütfen belirtiniz: _____)

7. Lisansüstü mezuniyet yılınız: _____

Mesleki Deneyim

8. Mesleğiniz (Birden fazla seçenek işaretleyebilirsiniz):
   - Klinik Psikolog
   - Psikiyatrist
   - Psikoterapist
   - Diğer (Lütfen belirtiniz: _____)
9. Mesleki deneyim süreniz: ____ yıl
10. Süpervizyon altında psikoterapi uygulama süreniz: ____ yıl
11. Aktif olarak psikoterapi yapıyor musunuz?
    - Evet
    - Hayır
12. Haftada ortalama kaç saat psikoterapi yapıyorsunuz? ____ saat
13. Ağırlıklı olarak hangi gruplarla çalışıyorsunuz? (Birden fazla seçenek işaretleyebilirsiniz)

Bireysel:

- Çocuk
- Yetişkin

Çift

Aile

Grup

14. Ağırlıklı olarak hangi kategorideki bozukluklarla çalışıyorsunuz? (Birden fazla seçenek işaretleyebilirsiniz)

- Kaygı Bozuklukları
- Obsesif-Kompulsif ve İlişkili Bozukluklar
- Travma ve Stresör İlişkili Bozukluklar
- Depresif Bozukluklar
- Kişilik Bozuklukları
- Beslenme ve Yeme Bozuklukları
- Somatoform Bozukluklar
- Diğer (Lütfen belirtiniz: _____)

Terapi Yaklaşımı

15. Öncelikli olarak kullandığınız terapi yaklaşımı/yaklaşımları (Birden fazla seçenek işaretleyebilirsiniz):
    - Bilişsel Davranışçı Terapi
    - Psikodinamik/Psikoanalitik Terapi
    - Şema Terapi
    - Bütüncül (Integrative) Terapi
    - Diğer (Lütfen belirtiniz: _____)
16. Aldığınız terapi eğitimleri ve sertifikalar: _____

Çalışma Ortamı

17. Çalışma ortamınız (Birden fazla seçenek işaretleyebilirsiniz):
    - Özel muayenehane
    - Hastane
    - Üniversite
    - Online

- Diğer (Lütfen belirtiniz: _____)

Teknoloji Kullanımı

18. Teknoloji kullanım düzeyinizi nasıl değerlendirirsiniz?
    - Başlangıç düzeyi
    - Orta düzey
    - İleri düzey
19. Klinik uygulamalarınızda hangi teknolojik araçları kullanıyorsunuz? (Birden fazla seçenek işaretleyebilirsiniz)
    - Online terapi platformları
    - Büyük Dil Modelleri (ChatGPT ve Gemini gibi)
    - Elektronik kayıt sistemleri
    - Değerlendirme/test uygulamaları
    - Psikoeğitim araçları
    - Mobil uygulamalar
    - Diğer (Lütfen belirtiniz: _____)
20. Yapay zeka destekli herhangi bir klinik uygulama/araç kullanıyor musunuz?
    - Evet (Lütfen belirtiniz: _____)
    - Hayır
    - Emin değilim.

Appendix 3: Semi-Structured Interview Questions

Warm-up Questions

1. Mevcut klinik uygulamalarınızda teknoloji nasıl bir rol oynuyor?
    - Ne tür teknolojiler kullanıyorsunuz?
2. "Psikoterapide yapay zeka" denildiğinde aklınıza neler geliyor?
    - Yapay zeka araçlarıyla ilgili deneyimleriniz neler?
    - Bu konudaki ilk düşünceleriniz neler?

Perceived Usefulness (PU)

Social Influence Processes

3. Subjective Norm:
    - Meslektaşlarınızın yapay zeka kullanımı hakkındaki görüşleri nelerdir?
    - Sizin için önemli olan kişilerin (süpervizörler, meslektaşlar) yapay zeka kullanımı konusundaki tavsiyeleri kararlarınızı nasıl etkiler?
    - Meslek örgütlerinizin yapay zeka konusundaki tutumları nelerdir?
4. Image:
    - Yapay zeka kullanımının mesleki statünüzü nasıl etkileyebileceğini düşünüyorsunuz?
    - Yapay zeka kullanan terapistler hakkındaki mesleki algı nasıl?

Cognitive Instrumental Processes

5. Job Relevance:

    Yapay zeka hangi klinik görevlerinizle en çok ilişkili olabilir?

    - Hangi terapi süreçlerinde yapay zeka desteği alabileceğinizi düşünüyorsunuz?

    Yapay zeka araçları terapötik ilişkilerinizi nasıl etkileyebilir?

    - Olası olumlu etkilerini detaylandırabilir misiniz?

- Peki ya olası olumsuz etkileri?
- Yapay zeka terapötik ittifakı nasıl etkileyebilir?

6. Output Quality:

   Psikoterapide yapay zeka kullanımının potansiyel faydaları var mıdır?

   - Spesifik örnekler verebilir misiniz?
   - Bu faydalar tedavi sonuçlarını nasıl etkileyebilir?

   Yapay zeka bir terapist olarak etkinliğinizi arttırır mı?

   - Yapay zeka mevcut uygulamalarınızı hangi yönlerden tamamlayabilir?
   - Yapay zeka günlük iş akışınızı nasıl etkileyebilir?
   - Yapay zekanın klinik kararlarınıza nasıl bir etkisi olabilir?
7. Result Demonstrability:
   - Yapay zekanın terapiye katkısı nasıl ölçülebilir?
   - Yapay zekanın faydasını danışanlarınıza nasıl açıklayabilirsiniz?

Perceived Ease of Use (PEOU)

Anchoring Factors

8. Computer Self-Efficacy:
   - Yeni teknolojileri öğrenme konusundaki genel kapasitenizi nasıl değerlendirirsiniz?
   - Teknolojik zorlukların üstesinden gelme konusunda kendinize ne kadar güveniyorsunuz?
9. Perception of External Control:
   - Yapay zeka kullanımı için gerekli teknik altyapıya sahip olduğunuzu düşünüyor musunuz?
   - Teknik sorunlarla karşılaştığınızda yardım alabileceğiniz kaynaklar mevcut mu?
10. Computer Anxiety:
    - Yapay zeka kullanımı düşüncesi sizde kaygı uyandırıyor mu?

11. Computer Playfulness:
    - Yapay zekanın hangi özellikleri size ilgi çekici geliyor?

Adjustment Factors

11. Perceived Enjoyment:
    - Yapay zeka araçlarını kullanmanın size keyif vereceğini düşünüyor musunuz?
12. Objective Usability:
    - Yapay zeka sistemlerinin kullanımını öğrenmek için ne kadar eğitim gerektiğini düşünüyorsunuz?
    - Günlük profesyonel rutininize yapay zekayı entegre etmek ne kadar çaba gerektirir?

Experience & Voluntariness

Experience

13. Past Experience:
    - Daha önce herhangi bir yapay zeka aracı kullandınız mı?
    - Varsa, bu deneyimleriniz yapay zekaya yaklaşımınızı nasıl etkiledi?

Voluntariness

14. Preference of use:
    - Yapay zeka kullanımının sizin isteğinize bağlı olması sizin için önemli mi?
    - Yapay zeka araçlarını mesleki pratiğinize dahil etmeye gönüllü müsünüz?

Behavioral Intention

15. Yapay zeka araçları kullanıma sunulduğunda bunları uygulamalarınıza dahil etme olasılığınız nedir?
    - Bu olasılığı etkileyen faktörler neler?
    - Sizi tereddüte düşüren şeyler neler?

16. Yapay zekayı uygulamalarınıza entegre etme kararınızı hangi faktörler etkiler?
    - Kullanım için olmazsa olmaz gereksinimleriniz neler olur?

External Variables

17. Terapi yaklaşımınız yapay zeka kullanımına yönelik görüşlerinizi nasıl etkiliyor?
    - Terapi yaklaşımınız hangi açılardan yapay zeka ile uyumlu veya çelişkili?
18. Danışanlarınızın terapide yapay zeka kullanımına nasıl tepki vereceklerini düşünüyorsunuz?
    - Tepkilerini etkileyebilecek faktörler neler olabilir?
    - Endişelerini nasıl ele alırsınız?

Closing Questions

19. Psikoterapide yapay zekanın gelecekteki rolüne ilişkin beklentileriniz neler?
    - Bu rolün zaman içinde nasıl değişeceğini düşünüyorsunuz?
    - Ne gibi fırsatlar veya zorluklar öngörüyorsunuz?
20. Psikoterapide yapay zeka konusunda paylaşmak istediğiniz başka şeyler var mı?
    - Başka endişe veya umutlarınız var mı?
    - Daha fazla dikkat edilmesi gereken alanlar olduğunu düşünüyor musunuz?

Appendix 4: Ethics Committee Approval

Evrak Tarih ve Sayısı: 26.02.2025-436478

1993

T.C.

BAŞKENT ÜNİVERSİTESİ REKTÖRLÜĞÜ

Akademik Değerlendirme Koordinatörlüğü

26.02.2025

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Konu : Başak Yeşil'in Etik Onayı

SOSYAL BİLİMLER ENSTİTÜSÜ MÜDÜRLÜĞÜNE

İlgi : 17.01.2025 tarih ve 420704 sayılı yazınız.

Enstitünüz Psikoloji Ana Bilim Dalı Klinik Psikoloji (Tezli) Yüksek Lisans Programı öğrencisi Başak Yeşil'in, Doç. Dr. Burçin Akın Sarı danışmanlığında yürüteceği, "Exploration of Psychotherapists' Attitudes Towards the Adoption of Artificial Intelligence in Mental Healthcare: A Theoretical Thematic Analysis" başlıklı tez çalışması değerlendirilmiş ve bilgilerinize ekte sunulmuştur.

Prof. Dr. Sadegül AKBABA ALTUN
Kurul Başkanı

Ek: Değerlendirme Formu

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Konu : Tez Çalışması

10 Şubat 2025

İlgili Makama

Üniversitemiz Sosyal Bilimler Enstitüsü Psikoloji Ana Bilim Dalı Klinik Psikoloji (Tezli) Yüksek Lisans Programı öğrencisi Başak Yeşil'in, Doç. Dr. Burçin Akın Sarı danışmanlığında yürüteceği, "Exploration of Psychotherapists' Attitudes Towards the Adoption of Artificial Intelligence in Mental Healthcare: A Theoretical Thematic Analysis" başlıklı tez çalışması değerlendirilmiş ve yapılmasında bir sakınca olmadığı tespit edilmiştir.

Bilgilerinize saygılarımızla sunarız.

Başkent Üniversitesi Sosyal ve Beşeri Bilimler ve Sanat Alan Araştırma Kurulu

Ad, Soyad	Değerlendirme	İmza
Prof. Dr. Gözen Güner Aktaş	Olumlu/~~Olumsuz~~	
Prof. Dr. Sadegül Akbaba Altun	Olumlu/~~Olumsuz~~	
Prof. Dr. Fatih Çetin	Olumlu/~~Olumsuz~~	
Prof. Dr. Hasan Tahsin Fendoğlu	Olumlu/Olumsuz	
Prof. Dr. Filiz Kalelioğlu	Olumlu/~~Olumsuz~~	
Prof. Dr. Hidayet Hale Künüçen	Olumlu/~~Olumsuz~~	
Prof. Dr. Özcan Yağcı	Olumlu/~~Olumsuz~~	