

TOPICAL WEBINAR FOR APA MEMBERS

An Educational Resource from Upheal

AI in Mental Health: Part 1 – Therapeutic vs. Harmful AI Use by Patients

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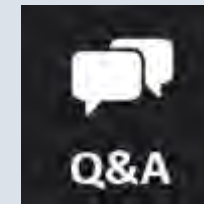
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Leila Anderson

PRESENTER

Leila Anderson, LMFT-S

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Leila Anderson is a systemic therapist, supervisor, and Sr. Clinical AI Product Manager at Upheal whose practice is at the intersection of clinical rigor, ethics, and emerging mental health technology. She brings over a decade of experience across residential, correctional, psychiatric, and community-based settings, with specializations in complex trauma, shame, and high-acuity clinical presentations. Her therapeutic approach integrates IFS, EMDR, and DBT, with particular emphasis on self-of-the-therapist work and ethical decision-making. Leila serves on the TAMFT board of directors and speaks regularly at state and national conferences.

Today's Agenda

- **The Clinical Reality** — how patients are already using AI + what the research shows
- **Assessing for AI Use** — screening, intake questions, what to gather
- **Addressing AI Use** — discussing risks and safer use with patients
- **Understanding the Risks** — contraindications and clinical cautions
- **Ethics, Law & Consent** — obligations, documentation, the evolving legal landscape

SETTING THE STAGE

The Clinical Reality

Adults Are Already Using AI for Support

- **Nearly half (48.7%)** of adults with a mental health condition who use AI describe using it for support or well-being.

“Therapeutic purposes” here reflects how participants described their own use — not an endorsement of AI as therapy.

- **What that use looks like:**

- *Journaling and emotional processing*
- *Venting between therapy sessions; seeking coping ideas at 2am*
- *Processing interpersonal conflicts and exploring symptoms*

Source: Rousmaniere et al. (2025). Large language models as mental health resources. Practice Innovations. doi:10.1037/pri0000292

Adolescents Are Not an Exception

- **1 in 8 adolescents** use generative AI for emotional support.
- **~26 million** US adolescents and young adults were in this first nationally representative sample.
- If you work with adolescents, AI use is almost certainly already part of their emotional landscape — even if they haven't told you.

Source: McBain et al. (2025). Use of generative AI for mental health advice among US adolescents. JAMA Network Open, 8(11), e2542281.

The Profession's Own Data: 2025–2026

- **More than 1 in 3 psychologists** report patients bringing AI into their care (APA, 2026).
- **More than half of psychologists** have experimented with AI tools in the past year (APA Practitioner Pulse, 2025).
- **APA's 2025 health advisory:** generative AI chatbots and wellness apps lack the evidence and regulation to ensure user safety — they are not a substitute for professional care.

Sources: APA (2026) Chatbots & Mental Health Survey; APA (2025) Practitioner Pulse Survey; APA (2025) Health Advisory.

The Profession Is Catching Up: APA 2025

In June 2025, APA released Ethical Guidance for AI in the Professional Practice of Health Service Psychology — establishing new obligations for clinicians.

- **Informed consent** — patients should be informed when AI is discussed or integrated in their care.
- **Transparency** — be clear about the nature, limitations, and risks of any AI tool.
- **Bias awareness** — account for how AI can mislead, including:
 - *Validation bias — telling users what they want to hear*
 - *Inaccurate or fabricated information*
 - *Cultural bias and uneven performance across populations*

Source: American Psychological Association (2025, June). [apa.org](https://www.apa.org)

PART 1 · CLINICAL ASSESSMENT

Assessing for AI Use

The Screening Gap: Why Patients Don't Tell You

- **They don't think it's relevant** — patients classify AI as a productivity tool, not a therapeutic one, even when using it emotionally.
- **Shame or anticipated judgment** — “Will my therapist think I’m replacing them?” creates real disclosure barriers.
- **Habit, not decision** — many reach for AI automatically in distress; it doesn't feel worth reporting.
- **We haven't asked** — most intake forms create no pathway for disclosure.

Intake Screening: Sample Questions

Frame these alongside other coping and support questions — standard clinical inquiry, not surveillance.

■ Opener

- *“Some people use AI tools like ChatGPT for support between sessions. Have you ever done this, or thought about it?”*

■ Embedded

- *“When you’re having a hard time emotionally, what do you do to cope? Do any apps or online tools factor into that?”*

What to Gather: Clinical Information

- **Platform & tool** — which AI (ChatGPT, Claude, Gemini); general-purpose vs. purpose-built for support.
- **Frequency & pattern** — how often; timing (bedtime, crisis, between sessions); duration.
- **Purpose & function** — venting, coping guidance, psychoeducation, reassurance-seeking.
- **Content & themes** — what topics; overlap with treatment; what the patient can't say in session.

Special Consideration: Trauma Populations

Independent, patient-directed AI use carries distinct clinical risks for trauma patients.

- **Avoidance reinforcement** — comfort without contact with distressing material.
- **Inadvertent re-exposure** — unstructured narrative without titration or the safety of a therapeutic frame.
- **Co-regulation without integration** — soothing arousal without the processing that produces recovery.
- **Parasocial bond formation** — intense attachment to AI that complicates the therapeutic relationship.

PART 2 · CLINICAL RESPONSE

Addressing AI Use in Clinical Practice

Not All AI Engagement Is Equal

- **Harmful** — OCD reassurance loops; crisis venting without escalation; avoidance of in-session work; parasocial dependency.
- **Assess further** — unstructured venting; self-diagnosis; high-frequency or compulsive use; secrecy or shame.
- **Potentially supportive** — journaling to bring to session; noticing patterns; practicing skills already learned; organizing thoughts before session.

The Relational Decoy

When a patient takes distress to AI at 11pm instead of bringing it to session Tuesday, material heading for the therapeutic relationship gets absorbed elsewhere – and this can have unintended consequences.

- **Lower-risk use** — orienting, noticing, preparing; the material still comes to session.
- **Higher-risk use** — processing or resolving affect, seeking validation, or re-narrating trauma alone.

Case Examples: Supporting Treatment Goals

If a patient is already using AI, these are lower-risk ways their use can align with — rather than undermine — treatment goals.

- **Reflecting on stuck points or thinking errors** — a patient examines a thought identified in session, then brings it back to discuss with you.
- **Noticing between sessions** — a patient tracks moments connected to their goals, to review together.
- **Preparing for session** — a patient organizes thoughts or feelings they want to raise.

Patient Handout: Between-Session AI Guidance

■ Helpful uses

- *Journal feelings or situations to bring to therapy*
- *Explore homework questions; practice coping or self-compassion skills*
- *Write out thoughts before a hard conversation*

■ Use caution or avoid

- *As crisis support — call your therapist or a crisis line instead*
- *Big decisions, reassurance-seeking, or resolving distress meant for session (or for a conversation with a friend or partner).*

PART 3 · SAFER PATIENT USE

Helping Patients Use AI More Safely

Safer Use for Patients Already Using AI

This is about harm reduction for patients who are already using AI — not prescribing AI as part of treatment.

- Many general-purpose tools let a user set a short, persistent instruction (a “system prompt”) in custom settings or memory.
- Its most useful role is adding safety guardrails — crisis redirection and limits on advice.
- Patients don’t need to code; plain language works. You can point to these options — you don’t prescribe them.

Example Safety Guardrails a Patient Can Add

- **Crisis redirection** — “If I mention self-harm or suicide, stop and give me crisis resources (988) and tell me to contact my therapist.”
- **Stay in scope** — “Do not give medical, diagnostic, or medication advice. Encourage me to talk to my provider.”
- **Reduce over-reliance** — “Keep replies brief. Don’t try to replace therapy; help me bring things to my next session.”

Harm-reduction options for patients already using AI — not a recommendation to use it.

PART 4 · CLINICAL RISK

Contraindications & Risk Assessment

Contraindications: Five Clinical Presentations

- **Active psychosis / paranoid ideation** — AI persona and ‘memory’ can be absorbed into delusional frameworks.
- **Dissociative presentations** — unstructured AI can blur states and time; needs real-time therapist presence.
- **OCD & reassurance-seeking** — an always-available reassurance machine can function as a compulsion.
- **Crisis-level presentations** — active SI, recent self-harm, or acute risk require human clinical presence.
- **Significant attachment disruption** — parasocial bonds can compete with the therapeutic relationship.

Clinical Decision Tree: Is Patient AI Use Higher Risk?

- **Start** — a patient is using, or considering using, AI between sessions.
- **Higher-risk — counsel against independent AI use if any are present:**
 - *Active psychosis or paranoid ideation*
 - *Dissociative presentation*
 - *OCD with a reassurance-seeking pattern*
 - *Active crisis or safety risk*
- **If none apply** — risk is lower; still assess attachment and AI literacy, and keep the conversation open.

PART 5 · PROFESSIONAL ETHICS

Ethics & Informed Consent

Discussing Patient AI Use: Professional Considerations (APA 2025)

- **Be transparent about what AI is and isn't** — if AI comes up in care, patients should understand it's not human and has real limits.
- **Discuss risks and limitations** — AI can be biased, inaccurate, or harmful for specific populations.
- **Where AI use is part of care, document it** — informed consent is a starting point — but consent alone does not resolve legal or liability concerns.
- **Revisit over time** — how a patient uses AI can change; keep the conversation open.

Informed Consent Addendum: What to Include

- **Tool & context** — name the tool(s) and why AI is being discussed in care.
- **Nature of AI** — responses come from a language model, not human clinical judgment.
- **Data privacy** — how the platform handles the patient's data.
- **Limitations & safety** — AI can be inaccurate or biased; what to do in a crisis during use.
- **Right to decline** — consent can be declined or withdrawn anytime, without affecting care.
- **Not a substitute for compliance** — consent does not replace applicable laws, regulations, or professional standards.

The Legal Landscape: State Laws Are Evolving

- **Laws vary by state and change fast** — 36+ states introduced 70+ AI-chatbot bills in early 2026.
- **Restrictions are expanding** — several states have enacted or are weighing limits on AI in mental health services (e.g., Illinois, Nevada, Texas).
- **Disclosure is becoming the norm** — some states now require disclosing when AI is used in diagnosis or treatment.
- **Know your obligations first** — understand applicable law and consult your board or counsel before incorporating any AI-related activity into care.

Practical Next Steps

- **Add AI screening questions to intake** — make it easy for patients to disclose.
- **Learn how your patients are already using AI** — ask, listen, and document.
- **Review applicable laws and professional guidance** — know your state's rules and the APA standards.
- **Consult legal counsel and/or your malpractice carrier** — before any AI-related change to care.
- **Evaluate any AI tool** — for privacy, security, evidence base, and compliance before considering clinical use.

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