INDIAN STREAMS RESEARCH JOURNAL
ISSN NO : 2230-7850
IMPACT FACTOR : 5.1651 (UIF)
VOLUME - 16 | ISSUE - 9 | OCTOBER – 2026

COMBINING HUMAN AND ARTIFICIAL INTELLIGENCE IN PSYCHOLOGICAL CARE: BENEFITS, RISKS, AND THE CASE FOR HYBRID THERAPY

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ABSTRACT



As artificial intelligence (AI) tools enter mental health care, the debate is often framed as a choice between human therapists and machines. A growing body of evidence and clinical experience suggests a different answer: combining the two. This paper examines hybrid psychological care, in which human professionals and AI-based tools work together, and weighs its benefits against its risks. The paper reviews established models of combined care, including stepped care, blended treatment, and computer-assisted therapy; the potential benefits of hybrid models, such as wider access, lower cost, between-session support, and reduced pressure on scarce professionals; and the risks, including privacy and data protection, safety in crisis situations, bias and inequality, effects on the therapeutic relationship, and unresolved questions of accountability. Ethical guidance from the World Health Organization and recent scholarship on AI ethics in mental health is considered. The paper argues that the evidence supports AI as a support for therapists rather than a replacement for them, proposes a framework for responsible integration, and presents a proposed cohort study, with suggested table templates, for comparing human-only, AI-only, and combined care. It concludes that hybrid care, carefully governed, offers the most realistic path to expanding psychological support without sacrificing what makes therapy effective.

KEYWORDS: *Hybrid Therapy, Blended Care, Artificial Intelligence, Psychotherapy, Ethics, Privacy, Therapeutic Relationship, Stepped Care, Digital Mental Health.*

INTRODUCTION

Every discussion of artificial intelligence in mental health eventually arrives at the same question: will machines replace therapists? The question is understandable. AI-driven conversational agents can now hold fluent conversations, deliver structured therapeutic content, and reach millions of users at almost no cost, while human therapy remains expensive and scarce (Stade et al., 2024; Torous et al., 2021). Yet the framing of replacement assumes that human therapy and AI-driven support do the same job, and the evidence reviewed in the companion paper to this one suggests they do not. Human therapy rests on a genuine working relationship and deep clinical judgment; AI tools offer availability, structure, and scale. If the two have different strengths, the practical question is not which one should win, but how they can be combined so that each covers the other's weaknesses.

In practice, combination is already happening without any formal design. A person in weekly therapy may use a chatbot at night when distress peaks; another may begin with an app and seek a

therapist only when the app is no longer enough; a third may alternate between the two without telling either provider about the other. Health systems did not plan these patterns, and research has barely begun to measure them. Understanding when combining helps, when it does nothing, and when it might harm is therefore an empirical question, not a theoretical one, and it is the question the proposed study in this paper is designed to address.

The idea of combining human and technological care is not new. Stepped care models have long proposed that less intensive treatments, including self-help, should be offered first, with more intensive professional care reserved for those who need it (Bower & Gilbody, 2005). Blended treatment, in which face-to-face sessions are combined with internet-based modules, has been tested for more than a decade (Erbe et al., 2017). Computer-assisted cognitive therapy showed as early as 2005 that technology could carry part of the therapeutic work without loss of benefit (Wright et al., 2005). What is new is the capability of modern AI, and the speed at which patients are adopting it on their own. This paper examines the case for hybrid psychological care: the models through which human and AI support can be combined, the benefits such combination promises, the risks and ethical problems it raises, and the conditions under which AI should be understood as supporting therapists rather than replacing them.

AIMS AND OBJECTIVES

The main aim of the study is to examine the combination of human and artificial intelligence support in psychological care, with attention to its benefits, risks, ethical challenges, and implications for the role of the therapist. The specific objectives are:

- To examine the existing models through which human therapy and technology-based support are combined, including stepped care, blended care, and computer-assisted therapy.
- To analyse the potential benefits of hybrid care for patients, therapists, and health systems.
- To identify the risks of hybrid care, including privacy, safety, bias, and over-reliance on automated support.
- To study the ethical questions raised by AI in psychological care, including consent, data protection, accountability, and effects on the therapeutic relationship.
- To examine whether current evidence supports AI as a support for therapists or as a replacement for them.
- To propose a framework for the responsible integration of AI-based tools into psychological care.
- To propose a research design, with suggested tables, for a comparative study of adults receiving human-only, AI-only, and combined support.
- To suggest measures for protecting patients and preserving the quality of care as AI tools become more common.

REVIEW OF LITERATURE

The most established model of combined care is stepped care. Bower and Gilbody (2005) argued that psychological services should be organized so that the least intensive effective treatment is offered first, with self-help and low-intensity interventions at the base and specialist therapy reserved for those whose needs remain unmet. The model assumes that simpler treatments do not compromise outcomes for many patients and that organizing care in steps uses scarce professional time more efficiently. Stepped care provides the clearest conceptual home for AI-based tools: a well-designed automated intervention is, in effect, a highly scalable form of low-intensity support at the base of the system.

The human side of the combination rests on one of the strongest evidence bases in health care. Cuijpers and colleagues (2023), in a comprehensive meta-analysis of 409 randomized trials with 52,702 patients, found cognitive behavior therapy effective for depression across delivery formats, and the

wider literature supports the major therapies across common conditions (Wampold & Imel, 2015). Any combined model must therefore preserve what makes the human component work, above all the therapeutic alliance, whose association with outcome has been confirmed across hundreds of studies (Fluckiger et al., 2018; Martin et al., 2000). The goal of combination is to extend this proven core, not to dilute it.

A second model is blended care, in which face-to-face sessions and digital modules are combined within a single course of treatment. Erbe and colleagues (2017) systematically reviewed studies of blended treatment for mental disorders in adults and found that blending was applied mostly to depression and anxiety, that treatments combining internet-based modules with personal sessions generally showed promising results, and that such combinations have the potential to reduce the amount of therapist time required per patient, although the number and quality of studies remained limited. Earlier evidence in the same direction came from Wright and colleagues (2005), who tested computer-assisted cognitive therapy for depression and found that patients improved comparably while therapist time was substantially reduced, suggesting that a well-designed program can carry part of the structured work of therapy.

A third stream of literature provides frameworks for designing and evaluating such combinations. Mohr and colleagues (2014) proposed the Behavioral Intervention Technology model, which links the clinical aims of an intervention to behavioral strategies and to the technological elements that deliver them, offering a common language for deciding which parts of treatment technology should carry and which parts should remain human. Torous and colleagues (2021), reviewing the wider field of digital psychiatry, concluded that apps, chatbots, and related tools can augment traditional care but that implementation, engagement, and evidence quality remain the central challenges. D'Alfonso (2020) similarly described AI in mental health as a set of tools that extend clinical capacity rather than substitute for clinical relationships.

Research on the therapeutic relationship in digital settings is directly relevant to hybrid care. Henson and colleagues (2019) found that users of mental health apps report alliance-like experiences, but that the digital alliance differs in kind from the human one. This finding supports a division of labor in which AI tools provide structure, reminders, and between-session contact, while the human relationship carries the deeper therapeutic work. The ethical literature raises the sharpest concerns. Rubeis (2022) analysed the ethics of AI and big data in mental health care, highlighting threats to autonomy, problems of informed consent, privacy risks from sensitive data, and bias in algorithmic systems. The World Health Organization (2021) set out six guiding principles for AI in health: protecting human autonomy; promoting well-being, safety, and the public interest; ensuring transparency and explainability; fostering responsibility and accountability; ensuring inclusiveness and equity; and promoting responsive and sustainable systems. Finally, Stade and colleagues (2024) warned that large language models, while promising for behavioral health, can produce false or unsafe responses and require careful evaluation before clinical use. Safety research on consumer voice assistants has shown how badly unprepared general-purpose systems can be for crisis disclosures (Miner et al., 2016).

RESEARCH METHODOLOGY

The present paper, entitled "Combining Human and Artificial Intelligence in Psychological Care: Benefits, Risks, and the Case for Hybrid Therapy," follows a descriptive and analytical research approach. It reviews published evidence and ethical guidance on the combination of human-delivered and AI-based psychological support. Secondary sources include peer-reviewed journals in psychology, psychiatry, and digital health, systematic reviews, randomized trials, conceptual frameworks, and reports of the World Health Organization, published between 2005 and 2024.

Building on this review, the paper proposes a primary study. The proposed study would follow a cohort of approximately 100 adults who are already receiving psychological support in one of three

forms: human therapy only, AI-based support only, or a combination of both. No participant would be assigned to a condition; the study observes the care people have already chosen. Respondents would complete short validated questionnaires at the start of the study and again after several weeks: the PHQ-9 for depression and the GAD-7 for anxiety (Kroenke et al., 2001; Spitzer et al., 2006), the short revised Working Alliance Inventory for the working relationship (Hatcher & Gillaspy, 2006), and the CSQ-8 for satisfaction (Attkisson & Zwick, 1982). In addition, respondents would be asked which benefits and which concerns they associate with AI-based support. Data would be analysed using percentages, averages, tables, and comparisons across the three groups. Because data collection has not yet been carried out, the tables below are proposed templates, to be completed with the data of the study.

SUGGESTED TABLES (4–5)

The following five tables are designed for a proposed sample of 100 respondents. They examine the demographic profile of respondents, the form of care currently used, the perceived benefits of combined care, the concerns respondents hold about AI-based support, and change in symptoms and satisfaction across the three forms of care. Each table is a proposed template: the figures are left blank and are to be completed with the primary data of the study.

Table 1: Demographic Profile of Respondents (Proposed)

Demographic Category	Respondents	Percentage
Age 18-25 years	-	-
Age 26-35 years	-	-
Age 36-45 years	-	-
Age 46 years and above	-	-
Male	-	-
Female	-	-
Other / prefer not to say	-	-
Total	100	100%

Explanation: The table will present the age and gender distribution of the proposed sample, allowing the three care groups to be compared for background differences before outcomes are examined.
Source: Proposed table template prepared by the researcher; to be completed with primary data collected for the study.

Table 2: Form of Psychological Care Currently Used (Proposed)

Form of Care	Respondents	Percentage
Human therapy only	-	-
AI-based support only	-	-
Combined human and AI-based care	-	-
Total	100	100%

Explanation: The table will show how respondents are distributed across human-only, AI-only, and combined care. The size of the combined group is itself informative, since little is currently known about how many people already use both forms of support together.
Source: Proposed table template prepared by the researcher; to be completed with primary data collected for the study.

Table 3: Perceived Benefits of Combined Care (Proposed)

Perceived Benefit	Respondents	Percentage
Support available between therapy sessions	-	-
Lower overall cost of care	-	-
Easier to start talking about problems	-	-
Reduced waiting time for support	-	-
Better continuity of care	-	-
Total respondents	100	100%

Explanation: The table will record which benefits of combining human and AI-based support respondents endorse. Respondents may select more than one benefit, so percentages need not sum to one hundred. It is designed to test whether the benefits proposed in the literature, such as availability, cost, and continuity, are the ones users themselves value.

Source: Proposed table template prepared by the researcher; to be completed with primary data collected for the study.

Table 4: Concerns About AI-Based Support (Proposed)

Concern	Respondents	Percentage
Privacy of personal information	-	-
Receiving wrong or unsuitable advice	-	-
Lack of genuine understanding or empathy	-	-
Handling of crisis situations	-	-
Becoming too dependent on the tool	-	-
Total respondents	100	100%

Explanation: The table will record which concerns about AI-based support respondents endorse, again allowing multiple selections. It is intended to measure how far the risks discussed in the ethical literature, such as privacy, safety, and the absence of genuine understanding, are felt by the people who use these tools.

Source: Proposed table template prepared by the researcher; to be completed with primary data collected for the study.

Table 5: Symptom Change and Satisfaction by Form of Care (Proposed)

Form of Care	Mean PHQ-9 Change	Mean GAD-7 Change	Mean CSQ-8 Score
Human therapy only	-	-	-
AI-based support only	-	-	-
Combined human and AI-based care	-	-	-

Explanation: The table will compare mean change in depression and anxiety scores from start to follow-up, together with mean satisfaction, across the three forms of care. It is designed to answer the study's central question: whether combining human and AI-based support is associated with outcomes as good as, or better than, either form alone.

Source: Proposed table template prepared by the researcher; PHQ-9 (Kroenke et al., 2001), GAD-7 (Spitzer et al., 2006), and CSQ-8 (Attkisson & Zwick, 1982) are validated measures.

OVERALL INTERPRETATION

The five proposed tables give the study a fixed structure before any data are collected. The first two establish who the respondents are and which form of care they use. The third and fourth examine the perceived benefits and concerns attached to AI-based support, connecting the ethical debate in the literature to the lived experience of users. The fifth compares outcomes and satisfaction across human-

only, AI-only, and combined care. Because the study has not yet collected data, the tables contain no figures. Their purpose at this stage is to commit the analysis in advance, so that the eventual findings, whatever they show, can be interpreted against a design fixed beforehand.

RESULTS

As the proposed primary study is still in the design stage, this section reports the main results of the published research reviewed above, which together define the present state of knowledge on combining human and AI-based care.

First, combination works where it has been tried. Computer-assisted cognitive therapy produced improvement comparable to standard therapy while substantially reducing therapist time (Wright et al., 2005), and blended treatments combining internet modules with personal sessions have shown promising results, mostly for depression and anxiety (Erbe et al., 2017). Second, AI-based conversational agents used on their own show early evidence of short-term benefit for mild to moderate symptoms: significant reductions in depression were found in the Woebot randomized trial (Fitzpatrick et al., 2017), and reductions in both depression and anxiety in the trial of Tess (Fulmer et al., 2018), while real-world analysis of Wysa found greater improvement among more frequent users (Inkster et al., 2018). Third, the evidence base remains thin: the meta-analysis of Abd-alrazaq and colleagues (2020) rated the chatbot evidence as weak and conflicting, and almost no studies have examined combined human and AI care as a distinct form of treatment. Fourth, on the relationship side, users form alliance-like bonds with digital tools, but these differ from the human alliance that reliably predicts outcomes in traditional therapy (Fluckiger et al., 2018; Henson et al., 2019; Martin et al., 2000). Fifth, the ethical literature and institutional guidance agree that privacy, safety, transparency, accountability, and equity are unresolved and require governance before widespread deployment (Rubeis, 2022; World Health Organization, 2021).

METHODS

The paper adopts a narrative review method. Sources were identified from major peer-reviewed journals in psychology, psychiatry, and digital health, including The British Journal of Psychiatry, the Journal of Medical Internet Research and its sister journals, World Psychiatry, the American Journal of Psychiatry, Current Opinion in Psychology, BJPsych Open, and Internet Interventions, together with guidance from the World Health Organization. Priority was given to systematic reviews, randomized trials, and widely used conceptual frameworks. Material was selected for relevance to four questions: how human and technology-based care have been combined in practice, what benefits such combinations produce, what risks and ethical problems they raise, and what role AI should play relative to human professionals. The proposed primary study described in the Research Methodology section follows a cohort design, observing adults already receiving human-only, AI-only, or combined support, without assigning participants to conditions, and measuring change over time with standardized instruments.

STATEMENT OF THE PROBLEM

Mental health systems face two simultaneous pressures. The first is unmet need: large numbers of people with common mental health problems receive no support because human therapy is scarce, expensive, and difficult to access. The second is rapid, unregulated adoption: millions of people already use AI-based tools for emotional support, mostly outside any clinical framework, with unclear evidence, unclear privacy protection, and no clear accountability when something goes wrong. Neither pure human therapy, which cannot scale, nor pure AI care, which cannot yet be trusted with complex or high-risk needs, offers an adequate answer on its own. A combined model is attractive in principle, but its benefits are assumed more often than demonstrated, and its risks, from privacy failures to the erosion of the therapeutic relationship, are real. There is a need for research that examines human-only, AI-

only, and combined care together, measuring outcomes, satisfaction, perceived benefits, and user concerns in the same study. The present paper responds to this problem by reviewing the evidence for hybrid care and proposing a design for such a study.

SCOPE AND LIMITATIONS

Scope of the Study

The review covers peer-reviewed research and institutional guidance on the combination of human-delivered and AI-based psychological support published between 2005 and 2024, with emphasis on depression and anxiety in adult populations. It covers models of combined care, benefits, risks, and ethical questions, and it proposes a comparative study of human-only, AI-only, and combined support. Its findings are intended to be useful for students, researchers, clinicians, service planners, and developers involved in bringing AI-based tools into psychological care.

Limitations

The study has certain limitations. First, almost no research has examined fully hybrid human plus AI care as a distinct treatment, so parts of the argument rest on adjacent evidence from blended care, computer-assisted therapy, and standalone chatbot trials. Second, the underlying evidence for AI tools is young, short-term, and often produced by developers themselves. Third, the technology is changing faster than the research cycle, and findings about current tools may not apply to the next generation based on large language models (Stade et al., 2024). Fourth, the proposed study is observational: without random assignment, differences between groups may partly reflect the characteristics of the people who choose each form of care. Finally, the paper is a narrative review rather than a systematic one, and aims to organize the evidence rather than to pool effect sizes.

DISCUSSION

The evidence assembled here points to a consistent conclusion: the strengths of human therapy and of AI-based support are largely complementary. Human professionals contribute genuine understanding, clinical judgment, the ability to manage complexity and risk, and a working relationship that is itself therapeutic (Fluckiger et al., 2018; Wampold & Imel, 2015). AI tools contribute availability at any hour, low cost, consistency, scalability, and a nonjudgmental point of first contact (Torous et al., 2021; Vaidyam et al., 2019). In a combined model, each covers the other's weakness: the machine provides continuity between sessions and reaches people who would otherwise receive nothing, while the professional provides the relationship, the diagnosis, and the safety net.

This is why the most defensible reading of current evidence is that AI should support therapists rather than replace them. Replacement claims outrun the evidence on every dimension that matters most: no AI system has shown durable outcomes for severe or complex conditions, none can conduct a competent risk assessment, none carries professional accountability, and none can form the mutual, genuinely understanding relationship that predicts improvement in human therapy (Henson et al., 2019; Miner et al., 2016). Support, by contrast, is already demonstrable: structured agents reduce symptoms in the short term, blended and computer-assisted formats reduce therapist time without clear loss of benefit, and stepped care offers a ready-made framework for placing automated support at the base of the system (Bower & Gilbody, 2005; Erbe et al., 2017; Fitzpatrick et al., 2017; Wright et al., 2005).

Combination also changes the therapist's role rather than abolishing it. In a hybrid model the professional becomes something closer to a conductor of care: assessing needs, choosing which tasks technology should carry, monitoring progress through data the tools collect, stepping in when risk or complexity appears, and holding responsibility for the whole. This role requires new skills, including the ability to evaluate the quality and safety of digital products, and new boundaries, such as clarity about what the tool may say to the patient between sessions. Professional training has barely begun to

prepare therapists for this role, which is one more reason the shift should be guided rather than left to the market.

The risks of hybrid care deserve equal weight, because they are the risks most likely to be ignored in the rush to adopt. Privacy is the first: conversations about mental health are among the most sensitive data a person can produce, and the privacy practices of commercial mental health apps have repeatedly been found inadequate. Safety is the second: an automated tool that misses a crisis disclosure, or responds to it inappropriately, can cause real harm, and general-purpose systems have already been shown to fail such tests (Miner et al., 2016). Bias and equity form the third: systems trained on unrepresentative data may work less well for exactly the underserved groups they are meant to reach (Rubeis, 2022; World Health Organization, 2021). The fourth is quieter but no less serious: if AI support is used to cut costs by thinning out human care, hybrid models could degrade rather than improve treatment for those who need it most. These risks do not argue against combination; they argue for governance, transparency, and evidence as conditions of combination.

RECOMMENDATIONS

On the basis of the review, several recommendations can be made. Health systems should adopt AI-based tools within a stepped care framework, positioning them as low-intensity first-line support with explicit routes to human professionals, not as substitutes for professional care. Therapists should be encouraged to use AI tools for between-session support, psychoeducation, and monitoring, and should be trained to discuss the tools their patients are already using. Developers should design for the hybrid model from the start: crisis detection with clear referral pathways, transparent limits, data protection by default, and independent evaluation before effectiveness claims are made. Regulators and professional bodies should establish standards for privacy, bias testing, safety reporting, and accountability in line with the World Health Organization's (2021) principles, and should clarify who is responsible when automated advice causes harm. Researchers should study combined care directly, as a distinct treatment model, rather than continuing to study human and AI care in separate literatures. Finally, patients should be told plainly what an AI tool is and is not, so that its support supplements rather than displaces the human help they may need.

CONCLUSION

The future of psychological care is unlikely to be a contest between human therapists and artificial intelligence, because the two do different things well. Human therapy supplies understanding, judgment, relationship, and accountability; AI supplies availability, structure, and reach. The evidence reviewed here, from stepped care and blended treatment to the first trials of conversational agents, supports combining them: hybrid care can widen access, lower cost, and support patients between sessions, while preserving the human core of effective therapy. The same evidence shows that combination without governance would be careless: privacy, safety, bias, and accountability must be settled by design and by regulation, not left to goodwill. AI should be developed, evaluated, and deployed as a support for therapists, not a replacement for them. The proposed comparative study of human-only, AI-only, and combined care is intended as one step toward the evidence on which such decisions should rest.

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