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Helper, not healer: Therapists on chatbots for older adults

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ABSTRACT

Conversational agents are increasingly offered as a way to extend mental health support, yet little is known about how practitioners who work remotely with older clients judge their place in care. This study surveyed 435 therapists and counsellors from six world regions who provide remote services and had worked with at least one client aged 65 or older in the previous year. Respondents rated eight chatbot functions, three service arrangements, and short scales measuring perceived benefit, perceived risk, implementation readiness, and willingness to recommend. Practical support was widely accepted: 82.5% endorsed appointment and routine reminders and 76.3% endorsed help with session preparation, whereas only 5.3% endorsed unsupervised treatment of complex distress and 1.4% independent crisis management. Acceptability also depended on how the service was organized. The same basic chatbot was rated far more favorably as an optional adjunct linked to a designated human contact than as a channel replacing routine appointments (Friedman $\chi^2(2) = 696.49$, Kendall's $W = .801$). In an exploratory regression, benefit, risk, and readiness were each independently associated with willingness to recommend, and the model explained 68.9% of its variance. Therapists appear to separate useful assistance from therapeutic responsibility, and their support depends on preserved human contact. Research with older users is needed to test whether these professional expectations hold in practice.

INTRODUCTION

Remote psychotherapy and counselling have become an ordinary part of mental health provision, and with them has come a steady stream of conversational software that promises to fill the gaps between appointments. Chatbots can send reminders, rehearse exercises, answer routine questions, and stay available at hours when no clinician is. For older adults, these features are often presented as a particular opportunity. Many older people live alone, some face mobility limits or long waits for services, and loneliness in later life carries well-documented health consequences (Holt-Lunstad et al., 2015). The same features, however, raise familiar doubts. A system that is always available may also be one that misreads distress, encourages reliance, or quietly takes the place of human contact that a person needs.

Most of what is known about mental health chatbots comes from studies of younger users, from reviews of system features, or from trials of specific products (Abd-Alrazaq et al., 2019; Fitzpatrick et al.,

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2017; Vaidyam et al., 2019). Far less attention has gone to the professionals who would decide whether such tools enter the care of older clients. Therapists are not neutral conduits in this process. They recommend or discourage tools, integrate or ignore them in treatment plans, and carry responsibility when something goes wrong. Their judgments therefore shape the conditions under which older adults encounter chatbots at all.

This article reports a cross-sectional survey of 435 therapists who provide remote services and work with clients aged 65 or older. The study did not ask whether chatbots are good or bad for older people in general. It asked a narrower set of questions. Which specific functions do therapists regard as acceptable? Does acceptability change when the same chatbot is placed inside different service arrangements? And how do perceived benefit, perceived risk, and the readiness of the surrounding service relate to a therapist's willingness to recommend a chatbot as an addition to human care? The questionnaire was built to keep these elements apart, so that a respondent could value a function while doubting the service that would deliver it, and could support routine assistance without accepting autonomous clinical decisions.

Older adults are defined here, for questionnaire purposes, as people aged 65 years or above. That boundary describes the client population respondents were asked to consider; it is not offered as a general definition of old age. Respondents were asked to think about adults living in the community and not to assume that advanced age implies cognitive impairment or dependence. A chatbot was defined as a text- or voice-based conversational system capable of responding to a user's input. The study did not assume that all such systems share the same design or capabilities, and it did not evaluate any commercial product.

BACKGROUND

Chatbots in Mental Health Support

Interest in conversational agents for mental health has grown quickly, but the evidence base remains uneven. In an early review of the psychiatric field, Vaidyam et al. (2019) found preliminary signs of benefit alongside small samples, short follow-up periods, and inconsistent outcome measures. A scoping review of chatbot features by Abd-Alrazaq et al. (2019) showed that most systems relied on rule-based responses and were delivered as standalone applications, which places clear limits on how far they can adapt to an individual user. Trial evidence exists, though it rarely concerns later life. Fitzpatrick et al. (2017), for example, reported reductions in depressive symptoms among young adults who used a fully automated agent delivering cognitive behavioral content over two weeks. Reviewing the wider field of digital psychiatry, Torous et al. (2021) described chatbots as promising but still at an early stage, with questions of engagement, safety, and evidence quality unresolved.

Discussions of chatbot counselling also turn on access. Nosrati et al. (2020) consider chatbots in relation to the difficulties of digital life, where the appeal of a constantly available interlocutor sits beside concerns about what that availability does to people. Their account directs attention to availability and continuity of support, which are central to the functions examined here. It does not establish effectiveness among older adults, and the present study does not treat it as doing so.

What Professionals Expect

Clinicians tend to draw a line between tasks that support care and tasks that constitute it. In a global survey of psychiatrists, Doraiswamy et al. (2020) found that most respondents expected artificial intelligence to take over documentation and similar administrative work, while very few believed it could provide empathic care. Sweeney et al. (2021) reported a comparable pattern among mental health professionals asked about chatbots specifically: respondents saw a role in information provision and self-management, but they doubted that such systems could grasp complex needs or respond adequately in an emergency. These findings suggest that professional acceptance is not a single attitude. It is a set of judgments that varies with the responsibility a task carries.

Concern about displacement also runs through public and professional responses to automation.

Sabbar and Habib Zadeh Khiyaban (2023) traced how online discourse about AI-driven job loss combines emotional and rhetorical reactions, with fears of replacement often expressed alongside recognition of practical gains. For therapists, displacement has a double meaning. It can refer to their own role, but it can also refer to the client, whose human contacts may be thinned out if a chatbot becomes the cheaper default. The present questionnaire addressed the second meaning directly by including displacement of human contact among its risk items and by asking about a scenario in which routine appointments were withdrawn.

Older Adults, Technology, and Loneliness

Older adults are a heterogeneous group with respect to technology. Czaja et al. (2006) found that technology use in later life was shaped by computer self-efficacy, computer anxiety, and cognitive abilities rather than by age alone. Interface design, prior familiarity, and available support all matter. This variation is one reason why professional endorsement cannot stand in for evidence about whether a particular person can or wants to use a chatbot. A related perspective from virtual education suggests that access to digital technologies alone is insufficient for meaningful engagement; opportunities for active participation and social interaction are also important in the design of technology-supported environments (Dastyar et al., 2023).

Loneliness complicates the picture further. It is associated with increased mortality risk (Holt-Lunstad et al., 2015), and companion chatbots are sometimes promoted as a partial response. Users of such systems do report forms of social support from them (Ta et al., 2020). One reason may be that conversational systems optimized for approval can occupy the role that confirming others normally hold in a person's life, acting as a kind of synthetic significant other. Yet a conversational exchange that feels supportive is not the same thing as a reciprocal relationship, and it is unclear whether chatbot use tends to supplement contact with family, friends, and professionals or to substitute for it. Therapists working with older clients are likely to be alert to this ambiguity, and it is reasonable to expect more divided views on chatbot conversation during loneliness than on practical tasks such as reminders.

Benefit, Risk, and Readiness

Technology acceptance research has long treated perceived usefulness as a central influence on intended use (Davis, 1989), and later models added the conditions surrounding use, such as organizational and technical support (Venkatesh et al., 2003). In clinical settings, a third consideration is perceived risk. A therapist may judge that a chatbot would help many clients while also judging that it could mislead some of them, compromise privacy, or miss deterioration. Benefit and risk are therefore not opposite ends of one scale; they can both be high at once.

Implementation readiness adds the surrounding service to the assessment. A chatbot that is acceptable in principle may be unacceptable in a setting without trained staff, accessible interfaces, clear governance, or a usable route to a human. In this study, readiness refers to a respondent's assessment of those conditions, not to personal confidence in artificial intelligence. Separating the three constructs makes it possible to ask whether willingness to recommend depends on each of them independently.

Three research questions guided the study. The first asked how acceptability varies across specific chatbot functions, from routine reminders to independent crisis management. The second asked whether the acceptability of the same basic chatbot changes across service arrangements that differ in human involvement. The third asked how perceived benefit, perceived risk, and implementation readiness are associated with willingness to recommend after accounting for professional characteristics and region.

METHOD

Design

The study used a cross-sectional online survey. The primary outcome was willingness to recommend a

chatbot as an addition to human care. The questionnaire measured perceived usefulness separately from implementation readiness and perceived risk, so that endorsement of a practical function could coexist with concern about the service in which it was delivered. It also separated support for routine activities from acceptance of autonomous clinical decision making. Function ratings referred to specified activities, while scenario ratings referred to service arrangements. The study did not cover institutional care, the diagnosis of neurocognitive disorders, or the evaluation of a particular commercial product.

Participants and Recruitment

The target population comprised adults who currently provided psychotherapy or counselling remotely, had at least two years of professional practice, and had worked with at least one client aged 65 or older during the previous year. Eligibility was established through screening questions about practice setting, professional designation, jurisdiction, and recent experience with older clients. Invitations were distributed through professional associations, remote-therapy networks, and practitioner communities in several world regions. They described the study without presenting chatbot adoption as a desirable professional position.

The sample was a nonprobability volunteer sample. Because the number of eligible practitioners who received an invitation was not known, a response rate could not be calculated. The target sample was 435 respondents, and no a priori power calculation was conducted. The analytic file contained 435 complete records from six broad regions (Table 1). Region was treated as a broad contextual variable rather than as a proxy for country, language, or regulatory setting. Recruitment across several regions does not make the sample globally representative.

Respondents also reported whether they had used a chatbot for any professional activity, their years of practice, and the proportion of their caseload made up of clients aged 65 or older. Prior professional use refers to use of a chatbot in the respondent's own work, not to delivery of chatbot treatment to older clients.

Table 1. *Regional Composition of the Sample*

Region	n	%
Europe	112	25.7
Asia	105	24.1
North America	96	22.1
Latin America and the Caribbean	58	13.3
Africa	41	9.4
Oceania	23	5.3
Total	435	100.0

Measures

Four short scales developed for this study used response options from 1 (strongly disagree) to 5 (strongly agree). Perceived benefit comprised five statements about availability between appointments, reinforcement of agreed activities, assistance with routines, preparation for human contact, and access to understandable information. Perceived risk comprised five statements concerning misleading responses, privacy, excessive reliance, missed deterioration, and displacement of human contact. Implementation readiness comprised four statements about staff preparation, accessible interfaces, service governance, and a usable route to human support. Willingness to recommend was the mean of three statements addressing an optional adjunct, a monitored trial of use, and inclusion in a jointly agreed care plan. No item was reverse scored, and higher scores indicated stronger agreement. Benefit and risk were kept as separate scales. All records contained complete item responses. Internal consistency was summarized with Cronbach's (1951) alpha; the scales are new and are not presented as validated instruments.

Eight function items used a separate acceptability scale from 1 (wholly unacceptable) to 5 (highly acceptable). A rating of 4 or 5 was counted as endorsement; a rating of 3 was treated as neutral rather than as rejection. The functions were appointment and routine reminders, preparation for therapy sessions, reinforcement of agreed coping exercises, information about community activities, conversation during periods of loneliness, general

psychoeducation, unsupervised treatment of complex distress, and independent crisis management. Each item was analyzed separately because the functions differ in their consequences and in the responsibility they place on the system. A summed acceptability score would have hidden that difference.

Three scenarios described the same basic chatbot offering routine check-ins, agreed exercises, and information, using common wording. In Scenario A, the chatbot was part of an optional service with accessible instructions, a designated human contact, consent-based information sharing, and an explicit escalation route. In Scenario B, it was an optional standalone service with accessible instructions and generic signposting but no designated professional contact. In Scenario C, it became the primary channel of support, routine human appointments were withdrawn, and only generic signposting remained. Respondents rated the acceptability of each arrangement from 1 to 5. Because the scenarios changed several features at once, contrasts between them estimate attitudes toward whole arrangements rather than the isolated effect of human oversight.

Analysis

Descriptive analysis reported means, standard deviations, and endorsement counts, with 435 as the denominator throughout. Wilson (1927) 95% intervals were calculated for function endorsement. These intervals express uncertainty under a model of independent records and do not account for volunteer recruitment or uneven international coverage. Repeated scenario ratings were compared with a Friedman (1937) test, and Kendall's W summarized the degree of separation among scenarios. Pairwise Wilcoxon signed-rank tests excluded zero differences and used a Holm (1979) adjustment across the three contrasts. Mean paired differences were reported with percentile intervals from 3,000 bootstrap samples drawn at the level of whole records, so that each respondent's three ratings stayed together.

An exploratory ordinary least squares model related willingness to recommend to benefit, risk, readiness, prior professional chatbot use, years of practice (per five years), older-client caseload (per ten percentage points), and five region indicators, with Europe as the reference category. Standard errors used the HC3 heteroskedasticity-consistent estimator (Long & Ervin, 2000), with t-based 95% intervals on 423 residual degrees of freedom. The three-item willingness mean was treated as approximately continuous, so coefficients represent differences in scale points rather than odds or probabilities. Variance inflation factors were used to check predictor overlap. As a further check, intervals were recalculated from 1,500 bootstrap samples drawn within the six regional strata at their original sizes. The model was not intended to rank regions or to support causal claims.

Ethical Considerations

Participation was voluntary and based on informed consent. The questionnaire collected no identifying client histories, and respondents were asked not to report confidential case details. Records were stored securely and handled under a data-management plan appropriate to the jurisdictions involved.

RESULTS

Sample and Measurement

Of the 435 respondents, 190 (43.7%) reported prior professional chatbot use. Mean practice experience was 12.07 years (SD = 6.80), and clients aged 65 or older made up an average of 40.77% of respondents' caseloads (SD = 19.94 percentage points). The sample therefore varied considerably in both experience and the share of older clients served.

Mean benefit and mean risk were both relatively high, readiness was lower, and willingness sat just below the scale midpoint (Table 2). Respondents, in other words, tended to see real advantages and real hazards at the same time, and they were less confident that services were prepared. Benefit and risk were essentially uncorrelated (r = .001). Willingness correlated with readiness at r = .543, with benefit at r = .475, and with risk at r = −.382.

Internal consistency was highest for perceived

benefit. The three-item willingness scale reached only α = .64, which calls for caution in interpreting fine differences between respondents on that measure. Its items also address related but distinct decisions: adjunct use, a monitored trial, and inclusion in a care plan. Reliability coefficients say nothing about construct validity or comparability across countries, and regional stratification cannot compensate for the absence of formal language testing. The regional categories should not be read as culturally homogeneous groups.

Table 2. *Descriptive Statistics and Internal Consistency of the Composite Measures*

Measure	Items	M	SD	α
Perceived benefit	5	3.73	0.71	.83
Perceived risk	5	3.78	0.64	.77
Implementation readiness	4	3.39	0.76	.75
Willingness to recommend	3	2.85	0.68	.64

Acceptability by Function

Practical assistance attracted the strongest support (Table 3). Appointment and routine reminders were endorsed by 359 respondents (82.5%), and preparation for therapy sessions by 332 (76.3%). Reinforcement of coping exercises already agreed with a therapist was endorsed by 63.7%, and information about community activities and general psychoeducation fell in a similar range. What these functions share is a supporting role: they help clients keep appointments, arrive prepared, follow through on agreed work, and find information. Endorsement of a function is a judgment about its acceptability, not evidence that a given system delivers accurate reminders, suitable exercises, or useful local information.

Conversation during periods of loneliness produced a more divided response. It was endorsed by 52.0% of respondents, with a mean of 3.51, leaving considerable room for neutral ratings and reservations. This result cannot be read as a measured effect on loneliness. A user might value a conversational exchange without it replacing reciprocal relationships, and the survey cannot show how chatbot use affects contact with family, friends, or professionals. The inference is limited to the relative standing of this function among those listed.

The sharpest drop occurred for functions that would place clinical responsibility on the system. Unsupervised treatment of complex distress was endorsed by 23 respondents (5.3%), and independent crisis management by six (1.4%). These figures express professional judgments about acceptability rather than clinical assessments of any particular system. Figure 1 shows the full pattern with Wilson intervals. Because the items were analyzed descriptively, their ordering was not tested through a formal set of pairwise comparisons.

Acceptability by Service Arrangement

When the same chatbot was integrated into an optional service with a designated human contact, its mean acceptability was 4.05 (SD = 0.81). As an optional standalone service it averaged 3.32, and as the primary channel replacing routine appointments it averaged 1.93 (Table 4). Endorsement fell from 75.9% to 42.5% and then to 2.5%. The Friedman test indicated a very large difference across arrangements, $\chi^2(2) = 696.49$, $p < .001$, Kendall's $W = .801$.

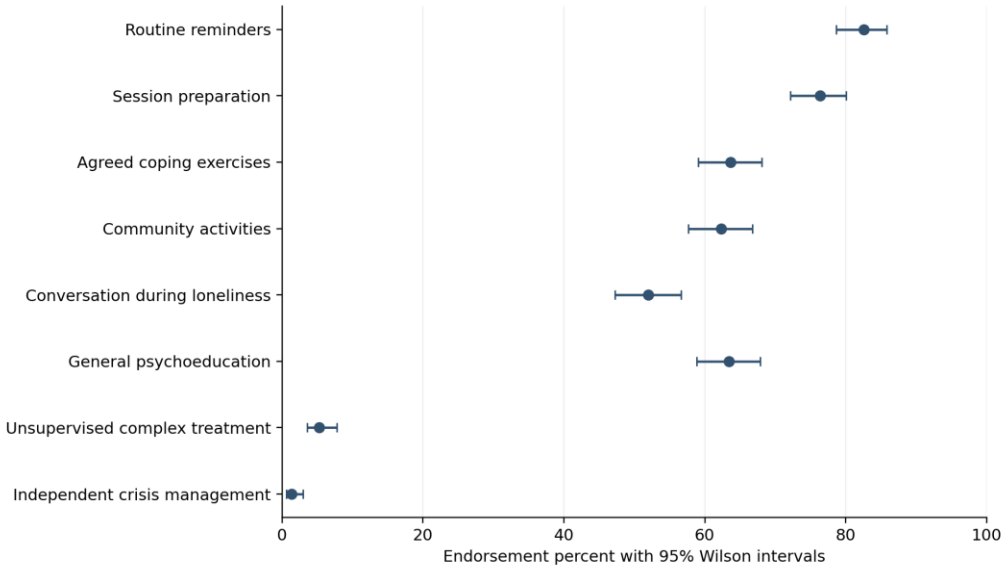
All three pairwise contrasts remained significant at $p < .001$ after Holm adjustment (Table 5). Moving from the integrated to the standalone arrangement lowered acceptability by 0.72 scale points on average, and moving from the integrated arrangement to the primary channel lowered it by 2.11 points. Because each interval was built from paired records, it preserves the link between a respondent's three ratings. Figure 2 shows how the distribution of ratings shifted across arrangements. The scenarios bundled several features, so the contrasts cannot show whether the designated human contact, optional use, accessibility, or continued appointments accounts for any particular difference.

Table 3. *Acceptability of Specified Chatbot Functions*

Function	M	SD	Endorsed n	%
Appointment and routine reminders	4.21	0.77	359	82.5
Preparation for therapy sessions	4.05	0.80	332	76.3
Reinforcement of agreed coping exercises	3.80	0.86	277	63.7
Finding community activities	3.73	0.86	271	62.3
Conversation during periods of loneliness	3.51	0.86	226	52.0
General psychoeducation	3.76	0.88	276	63.4
Unsupervised treatment of complex distress	2.14	0.86	23	5.3
Independent crisis management	1.72	0.75	6	1.4

Note. Endorsement is a rating of 4 or 5 on a scale from 1 (wholly unacceptable) to 5 (highly acceptable). N = 435.

Figure 1. *Endorsement of Specified Chatbot Functions*



Note. Endorsement is a rating of 4 or 5. Error bars show 95% Wilson intervals

Table 4. *Acceptability Ratings for Three Service Arrangements*

Arrangement	M	SD	Mdn	Endorsed n
A. Integrated optional adjunct	4.05	0.81	4	330
B. Optional standalone service	3.32	0.89	3	185
C. Primary channel replacing appointments	1.93	0.77	2	11

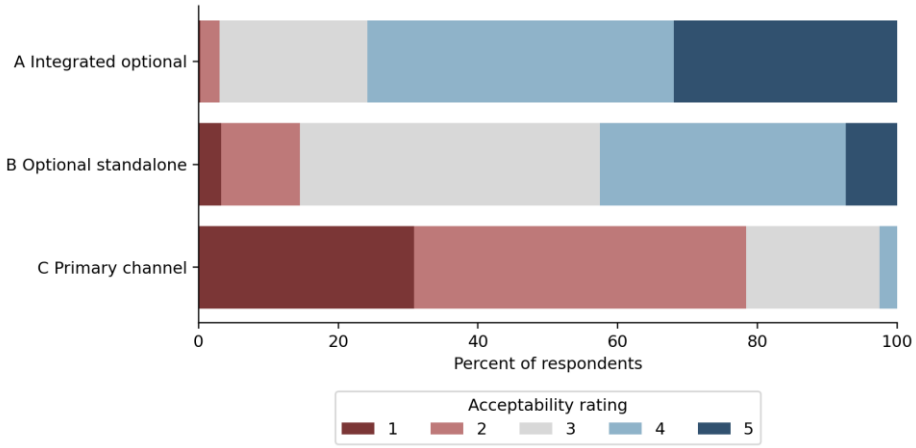
Note. Ratings range from 1 (wholly unacceptable) to 5 (highly acceptable). Endorsement is a rating of 4 or 5. N = 435.

Table 5. *Paired Contrasts Between Service Arrangements*

Contrast	Mean difference	95% bootstrap CI	Holm-adjusted p
A – B	0.72	[0.64, 0.81]	< .001
A – C	2.11	[2.03, 2.20]	< .001
B – C	1.39	[1.30, 1.47]	< .001

Note. Confidence intervals are percentile intervals from 3,000 bootstrap samples of whole records. p values are from Wilcoxon signed-rank tests with Holm adjustment.

Figure 2. *Distribution of Acceptability Ratings Across Service Arrangements*



Note. Ratings range from 1 (wholly unacceptable) to 5 (highly acceptable). The arrangements differ in several service characteristics at once.

Correlates of Willingness to Recommend

The adjusted model explained 68.9% of the variance in willingness to recommend (Table 6). Holding the other variables constant, a one-point increase in perceived benefit was associated with a 0.46-point increase in willingness, and a one-point increase in readiness with a 0.47-point increase. Perceived risk had a coefficient of −0.39. The intervals for all three excluded zero. These are associations among questionnaire measures; they do not show that changing one attitude would change recommendation behavior.

Prior professional chatbot use was associated with 0.17 additional points of willingness after adjustment. Experience had a small negative coefficient (−0.05 per five years of practice), and older-client caseload a small positive one (0.04 per ten percentage points). Effects of this size do not justify describing experienced therapists as resistant to innovation, or therapists with many older clients as enthusiasts for artificial intelligence. None of the adjusted regional contrasts excluded zero, although the absence of a clear difference does not demonstrate that regions are equivalent.

The largest variance inflation factor was 1.50, indicating little overlap among predictors. Region-stratified bootstrap intervals for benefit, risk, and readiness were [0.41, 0.51], [−0.45, −0.33], and [0.42, 0.52], respectively, close to the HC3 intervals and with the same signs. This agreement speaks to numerical stability under resampling. It does not address the modest reliability of the willingness scale, shared method variance, omitted influences, or recruitment bias.

Table 6. *Exploratory Regression of Willingness to Recommend*

Predictor	B	HC3 SE	95% CI	p
Intercept	0.89	0.17	[0.56, 1.22]	< .001
Perceived benefit (per scale point)	0.46	0.03	[0.41, 0.51]	< .001
Perceived risk (per scale point)	−0.39	0.03	[−0.45, −0.33]	< .001
Implementation readiness (per scale point)	0.47	0.03	[0.41, 0.52]	< .001
Prior professional use (yes)	0.17	0.04	[0.10, 0.25]	< .001
Experience (per five years)	−0.05	0.01	[−0.08, −0.02]	.001
Older-client caseload (per ten percentage points)	0.04	0.01	[0.02, 0.05]	< .001
Asia vs. Europe	0.05	0.06	[−0.07, 0.16]	.438
North America vs. Europe	0.04	0.05	[−0.07, 0.14]	.488
Latin America and the Caribbean vs. Europe	0.09	0.06	[−0.03, 0.22]	.152
Africa vs. Europe	0.07	0.07	[−0.06, 0.20]	.305
Oceania vs. Europe	−0.02	0.09	[−0.20, 0.15]	.801

Note. N = 435. R^2 = .689. Confidence intervals are t-based with 423 residual degrees of freedom. Europe is the reference region.

DISCUSSION

The clearest finding of this study is that therapists do not hold a single view of chatbots for older clients. They hold several, and the views depend on what the chatbot is asked to do and on the service around it. Reminders and session preparation were accepted by large majorities. Unsupervised treatment and independent crisis management were rejected almost unanimously. Between these poles sat functions such as psychoeducation, reinforcement of agreed exercises, and conversation during loneliness, where opinion was more mixed. The pattern supports a distinction between assistance and responsibility. A chatbot that helps a client follow through on human care is, for most respondents, a reasonable addition. A chatbot that takes over the judgments a clinician would normally make is not.

This distinction is consistent with earlier surveys of clinicians, in which administrative and informational tasks were seen as suitable for automation while empathic and high-risk work was not (Doraiswamy et al., 2020; Sweeney et al., 2021). The present study extends that pattern to practitioners working remotely with older adults, and it adds a second dimension. The scenario ratings show that the same set of functions can be welcomed or rejected depending on how the service is arranged. Respondents broadly accepted a chatbot that sat beside a named human contact with a clear escalation route. Their support fell when that contact disappeared and collapsed when the chatbot replaced routine appointments. For most of these therapists, then, what made a chatbot acceptable was largely the human contact kept around it. A recent review of AI in professional work reaches a comparable conclusion, holding that responsible use of AI requires sustained human involvement and treating the erosion of human oversight as a central concern (Dariush & Piriyaei, 2026).

The mixed response to conversation during loneliness deserves attention. Loneliness is a serious concern in later life (Holt-Lunstad et al., 2015), and users of companion systems do describe feeling supported (Ta et al., 2020). Yet respondents were noticeably less sure about this function than about practical ones. One plausible reading is that therapists see loneliness as a problem of relationships, and they are uncertain whether conversation with software adds to a person's relationships or quietly substitutes for them. The inclusion of displacement of human contact among the risk items, and the very low acceptance of Scenario C, point in the same direction. Concern about displacement here seems to be less about therapists' own jobs, the theme that dominates much

public discussion of automation, and more about what happens to the client's social world.

The regression results add to this picture. Benefit and risk were almost entirely uncorrelated, which means that a therapist's view of what a chatbot could do well told us nothing about how worried that therapist was about what it could do badly. Both were independently associated with willingness to recommend, and readiness had an association as large as benefit. This fits the broad logic of technology acceptance models, in which perceived usefulness matters alongside the conditions that make use feasible (Davis, 1989; Venkatesh et al., 2003). It also suggests that efforts to encourage adoption by stressing benefits alone are likely to miss much of what drives professional hesitancy. A therapist who sees clear advantages may still decline to recommend a chatbot if the service lacks trained staff, accessible interfaces, governance, or a reliable path back to a human. Research on AI adoption elsewhere points the same way: clear gains in efficiency coexist with persistent barriers to adoption, including data governance problems and organizational resistance (Habib Zadeh Khiyaban & Sabbar, 2026).

The smaller coefficients should be read with restraint. Prior professional use was associated with somewhat higher willingness, which may reflect familiarity, self-selection into use, or both; the cross-sectional design cannot separate these. Longer experience and a larger older-client caseload had small and opposite associations. Neither supports a story about resistant veterans or enthusiastic specialists. The absence of clear regional differences after adjustment is also not evidence that therapists in different parts of the world think alike, particularly given broad regional categories and untested language equivalence. A related emphasis on contextual sensitivity appears in environmental education research, which argues that digital innovations should be integrated with culturally grounded practices rather than treated as context-independent replacements for established approaches (Dariush et al., 2025).

For practice and service design, the results suggest a cautious but workable path. Chatbots for older clients are most likely to gain professional support when they are limited to supporting functions, offered as an option rather than a requirement, linked to a named human contact, and backed by a clear escalation route. Services that present chatbots as a way to reduce human appointments should expect strong professional opposition. Readiness is not a background condition; it was as strongly associated with willingness as perceived benefit. Investments in staff preparation, accessible design, and governance may therefore matter as much to adoption as improvements in the software itself. A similar conclusion has been drawn for AI more broadly: responsible deployment depends on combining explainable tools with ethical governance (Habib Zadeh Khiyaban & Sabbar, 2022).

The study speaks to professional attitudes, not to the experience of older adults. Therapists' judgments are an indirect and partial source of information about the people they serve. They can identify what professionals expect and fear, but they cannot show whether an older person can use a given interface, wants the service, benefits from it, or is harmed by it. Accessibility in later life cannot be inferred from professional endorsement. The functions that therapists favor are reasonable candidates for study with older users, and that is the most that the present data can claim for them.

LIMITATIONS

Several limitations qualify these findings. The sample was a volunteer, nonprobability sample, no response rate could be calculated, and no a priori power analysis was conducted. Therapists with strong views about artificial intelligence, favorable or unfavorable, may have been more likely to take part. Eligibility rested on screening questions, and because licensing standards differ across jurisdictions, these questions could not establish a common international standard of professional status. The scales were developed for this study and have not been validated, and the willingness scale had modest internal consistency. Item equivalence across languages was not formally tested, and the six regional categories are too broad to capture differences between countries or regulatory settings. The scenarios changed several features together, so they cannot isolate the effect of any single feature

such as human oversight. The regression is exploratory and correlational, all measures came from a single questionnaire, and relevant influences may have been omitted. Finally, the study did not measure outcomes for older adults, including preferences, clinical benefit, adverse events, sustained social contact, or successful transfer to human support.

Future Research

The most pressing next step is research with older adults themselves. Studies should examine preferences and actual use across differences in sensory ability, literacy, language, support arrangements, and familiarity with technology, and should measure outcomes rather than attitudes. Experimental vignettes that vary one service feature at a time could clarify which elements of human involvement matter most to professionals. Longer and better-validated measures of willingness, along with formal testing of translated items, would strengthen cross-national comparison. Studies that follow services as they introduce chatbots could also show whether professional expectations about reminders, preparation, and escalation hold up in routine practice.

CONCLUSION

Therapists who work remotely with older clients appear willing to accept chatbots in a supporting role and unwilling to hand them clinical responsibility. They endorsed reminders and session preparation, divided over conversation during loneliness, and almost uniformly rejected unsupervised treatment and crisis management. Their acceptance also depended heavily on service design: a chatbot linked to a named human contact was broadly acceptable, while one that replaced appointments was not. Perceived benefit, perceived risk, and the readiness of the service each contributed to willingness to recommend. Taken together, these findings describe a professional stance that is open to useful assistance but firmly attached to human care. Whether that stance serves older adults well is a question that only research with older adults can answer.

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