

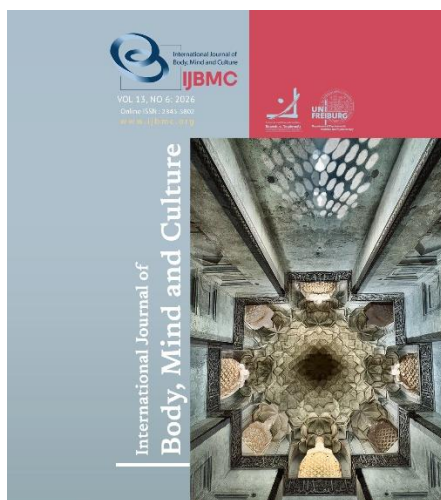
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The Forgotten Body in Digital Mental Health: Why Culture, Embodiment, and Human Connection Must Shape the Future of AI-Assisted Care

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ABSTRACT

Artificial intelligence is rapidly reshaping digital mental health care through chatbots, predictive analytics, mobile applications, digital phenotyping, and large language model-based support systems. These tools promise scalability, personalization, and improved access in contexts where mental health services remain scarce or fragmented. Yet the dominant imagination of AI-assisted care often treats distress as information to be classified, monitored, and responded to, while overlooking the embodied, cultural, relational, and moral conditions through which suffering is experienced and healing becomes possible. This editorial argues that the future of AI-assisted mental health care must not be organized around technical efficiency alone. Instead, it must be grounded in three neglected dimensions: the body as a site of affective and psychological life, culture as the interpretive frame of distress and recovery, and human connection as a core therapeutic mechanism rather than an optional supplement. Drawing on recent evidence from digital mental health, cultural adaptation, therapeutic alliance, embodied cognition, and AI ethics, this article proposes a human-centered and culturally responsive agenda for AI-assisted care. AI can support mental health systems, but it should not redefine care as frictionless automation. The next generation of digital mental health must be clinically safe, culturally situated, embodied, relational, transparent, and accountable.

Keywords: AI-Assisted Care, Digital Mental Health, Embodiment, Culture, Therapeutic Alliance, Human Connection, Ethical AI.

Introduction

Digital mental health has entered a decisive moment. What began as web-based psychoeducation, mobile self-help tools, and guided digital interventions has rapidly expanded into AI-assisted triage, conversational agents, passive sensing, digital phenotyping, and large language model-based support. The argument for these technologies is compelling: mental health systems are under-resourced, many people face long waiting lists, stigma continues to prevent help-seeking, and digital tools can provide immediate, low-cost, and scalable forms of support. In this context, artificial intelligence appears to offer what conventional systems often cannot: availability, personalization, speed, and reach.

Yet the central danger is not that AI will enter mental health care. It already has. The danger is that AI-assisted care may inherit and intensify a narrow model of the person. Too often, digital mental health systems treat distress as a sequence of linguistic inputs, symptom scores, behavioral signals, and risk categories. Such systems may be useful, but they can also flatten the lived complexity of mental suffering. A person in distress is not simply a data profile, a cognitive pattern, or a risk score. A person suffers in a body, within a culture, through relationships, across histories, and under social conditions that may either wound or sustain them.

This editorial argues that the future of AI-assisted mental health care must be shaped by culture, embodiment, and human connection. These are not decorative concerns to be added after the technical system has been built. They are foundational to what mental health care is. If AI is to support care rather than merely simulate it, digital mental health must move beyond automation-centered design toward a clinically grounded, culturally responsive, embodied, and relational model of care.

The Promise and the Blind Spot of AI-Assisted Mental Health

AI-assisted mental health technologies are often justified by reference to access. This justification is legitimate. Many people who need care never receive it, and digital tools can reduce some barriers related to cost, geography, stigma, and availability. Evidence from internet- and mobile-based interventions shows that such approaches can have meaningful effects for depression and related conditions, although outcomes

vary by severity, guidance, engagement, and implementation context (Terhorst et al., 2024). Recent work has also emphasized that human support, digital navigators, integration into services, and implementation science are essential for moving digital mental health from experimental promise to real-world value.

However, access without depth may become a weak substitute for care. A system that is always available is not necessarily clinically wise. A chatbot that responds fluently is not necessarily relationally attuned. A predictive model that detects risk is not necessarily capable of understanding the meaning of despair in a person's life. AI systems may improve screening, psychoeducation, documentation, monitoring, and stepped-care decision-making, but these functions should not be confused with the full practice of mental health care.

The current enthusiasm around AI risks reinforcing an informational model of mental suffering. In this model, distress is something to be detected, labeled, and managed through increasingly precise computational systems. But mental suffering is also embodied tension, shame, grief, cultural dislocation, social exclusion, loneliness, trauma, spiritual conflict, and relational rupture. These dimensions are not always visible in text, symptom checklists, or passive digital traces. If digital mental health forgets the body, culture, and human relationship, it may become more efficient while becoming less therapeutic.

The Forgotten Body

The body is often absent from AI-assisted mental health discourse, except as a source of biometric data. Wearables, sleep trackers, heart-rate variability, movement patterns, and physiological sensors are increasingly positioned as tools for detecting emotional states or predicting relapse. These developments may be valuable, especially when used with consent, transparency, and clinical interpretation. Yet measuring the body is not the same as understanding embodiment.

Embodiment refers to the fact that psychological life is lived through the body. Anxiety may be experienced as tightness in the chest, trauma as dissociation or hypervigilance, depression as heaviness and fatigue, grief as bodily collapse, and shame as posture, gaze, silence, or withdrawal. Psychotherapy has always involved more than words. Tone, pacing, breathing,

gesture, movement, eye contact, silence, and bodily presence shape the therapeutic encounter. Research on embodied cognition and interpersonal synchrony suggests that psychotherapy is not only a verbal exchange but also an embodied and relational process (Mende & Schmidt, 2021). Recent work on embodied cognition in clinical psychotherapies similarly challenges reductionist models that treat therapy as a purely cognitive or brain-based intervention (Fugate et al., 2024).

AI systems are strongest where experience can be represented in structured or semi-structured data. The body resists such simplification. A client's hesitation before answering, the way they look away, the rhythm of their breathing, or the embodied meaning of feeling unsafe in a room may be clinically significant but difficult to capture through text-based interaction. Even when multimodal AI becomes more advanced, the ethical question remains: should every embodied signal be captured, analyzed, and converted into prediction? The body is not merely an instrument panel for mental states. It is part of the person's dignity, vulnerability, privacy, and agency.

An embodied approach to AI-assisted care would therefore ask different questions. Not only: Can the system detect distress? But also: Does the system help the person return to their body safely? Does it support grounding, agency, rest, movement, breath, and relational regulation? Does it recognize when digital interaction is insufficient and embodied human care is needed? Does it avoid intensifying dissociation, compulsive self-monitoring, or anxiety about bodily signals? The future of digital mental health should not be a flight from the body into the screen. It should help people reconnect with embodied life.

Culture Is Not a Translation Layer

Culture is another dimension frequently reduced in digital mental health. Too often, cultural adaptation is treated as translation, localization, or interface adjustment. These steps matter, but they are insufficient. Culture shapes how distress is named, where help is sought, what counts as healing, how stigma operates, how family and community are involved, and how authority, privacy, spirituality, gender, and emotion are understood.

A culturally unresponsive AI system may appear neutral while reproducing hidden assumptions about

autonomy, emotional expression, individualism, diagnosis, and treatment. For example, a system trained primarily on Western clinical language may misinterpret idioms of distress from other cultural contexts. It may encourage forms of self-disclosure that are unsafe or inappropriate in some social settings. It may frame recovery as individual self-management while ignoring family obligations, collective identity, migration stress, racism, poverty, or political violence. It may also pathologize culturally meaningful experiences or fail to detect culturally specific expressions of risk.

Recent literature on cultural and contextual adaptation of digital health interventions emphasizes that culture and context must shape design methods, intervention content, delivery models, and implementation strategies rather than being treated as superficial modifications (Naderbagi et al., 2024). This is especially urgent in AI-assisted care because AI systems learn from data, and data are never culturally innocent. They reflect whose experiences have been recorded, whose language is dominant, whose categories are legitimized, and whose suffering remains invisible.

Culture must therefore be built into AI-assisted mental health from the beginning. This requires participatory design with communities, culturally diverse datasets, transparent documentation of model limitations, adaptation for local idioms of distress, and evaluation across cultural groups. It also requires humility. No AI system should claim universal psychological understanding. Mental health care is always situated. AI tools should be designed to ask, learn, and defer when cultural meaning exceeds computational confidence.

Human Connection Is Not a Luxury Feature

The third neglected dimension is human connection. In many digital mental health models, human support is treated as a scalability problem. The ideal system is imagined as one that can deliver more care with fewer humans. This assumption deserves serious challenge. Human connection is not merely an expensive add-on to mental health care; it is one of its active ingredients.

The therapeutic alliance has long been understood as central to psychotherapy, involving agreement on goals, collaboration on tasks, and the development of a therapeutic bond (Bordin, 1979). Recent work on digital therapeutic alliance suggests that alliance-like processes may exist in digital and AI-mediated settings, including

engagement, empathy, goal alignment, and perceived support (Malouin-Lachance et al., 2025). Yet a digital therapeutic alliance should not be mistaken for a full substitute for human therapeutic relationship. AI may simulate responsiveness, but simulation and relationship are not identical.

Human connection matters because mental suffering often involves isolation, shame, mistrust, fear, and the breakdown of relational safety. Healing may require being recognized by another person, not only receiving technically appropriate suggestions. It may require rupture and repair, shared silence, moral witness, humor, grief, and the felt presence of someone who can be accountable. AI systems can be supportive, but they cannot bear responsibility in the way clinicians, peers, families, and communities can.

This distinction is especially important for high-risk situations. AI tools may fail to understand context, may respond with inappropriate reassurance, may miss escalating risk, or may reinforce harmful patterns if safeguards are weak. Ethical guidance from the World Health Organization and professional organizations such as the American Psychological Association emphasizes transparency, human oversight, safety, accountability, privacy, and equity in the use of AI for health and psychology (Association, 2024; Organization, 2024). These principles are not bureaucratic obstacles. They are essential protections against the illusion that fluent digital interaction equals safe clinical care.

A relational approach to AI-assisted mental health would position AI as part of a care ecology. AI could support clinicians by reducing administrative burden, monitoring between sessions with consent, helping patients practice skills, identifying when additional support may be needed, and improving access to psychoeducation. But the goal should be human-supported care, not human-erased care.

Toward a Culturally Responsive, Embodied, and Relational Model of AI-Assisted Care

The next generation of AI-assisted mental health should be guided by a broader model of care. Such a model would include at least six principles.

First, AI should augment rather than replace human care. The most defensible role for AI in mental health is supportive: triage assistance, psychoeducation, between-session reinforcement, administrative support, measurement-based care, and carefully bounded self-

help. High-risk, complex, severe, or culturally ambiguous situations require human oversight and clear escalation pathways.

Second, digital mental health must be culturally designed, not merely translated. Communities should participate in defining the problem, shaping the intervention, evaluating harms, and determining what acceptable care looks like. Cultural adaptation should include language, metaphors, values, family structures, explanatory models, stigma, spirituality, and local health system realities.

Third, AI-assisted care should treat embodiment as clinically meaningful. Digital tools should support body awareness, grounding, sleep, movement, breathing, sensory regulation, and safe reconnection with bodily experience. They should also recognize the limits of screen-based intervention and avoid converting intimate bodily signals into excessive surveillance.

Fourth, therapeutic alliance should remain central. Even when AI tools are used, care pathways should preserve goal alignment, trust, accountability, and human availability. Digital systems should be evaluated not only by symptom reduction but also by engagement, perceived safety, relational quality, dropout, adverse events, and user experience.

Fifth, evaluation must move beyond average effects. Digital interventions may work differently across severity levels, cultural groups, socioeconomic contexts, and forms of distress. Evidence from internet- and mobile-based interventions suggests the need for more precise understanding of who benefits, under what conditions, and with what level of guidance (Terhorst et al., 2024). AI-assisted care must therefore be evaluated through equity-sensitive and context-sensitive research designs.

Sixth, ethical governance should be continuous. AI models change, user behavior changes, and risks emerge over time. Governance should include clinical validation, bias assessment, privacy protection, adverse-event monitoring, transparent communication of limitations, and mechanisms for human review. In mental health, safety cannot be assumed from technical performance alone.

Practical Implications

For clinicians, the task is not to reject AI but to use it critically. Clinicians should ask whether a tool strengthens or weakens the therapeutic relationship,

whether it fits the patient's culture and context, whether it has evidence for the intended population, and whether risks are clearly managed.

For developers, the challenge is to design for lived experience rather than abstract users. This means working with patients, clinicians, caregivers, and communities from the earliest stages of development. It also means resisting the temptation to market emotional fluency as clinical competence.

For researchers, the priority is to study mechanisms, harms, equity, and implementation. Symptom outcomes matter, but they are not enough. Research should examine how AI-assisted tools affect help-seeking, self-understanding, bodily awareness, dependency, stigma, therapeutic alliance, and access to human care.

For policymakers and health systems, regulation should distinguish between wellness tools, clinical decision support, therapy-adjacent systems, and autonomous mental health agents. The greater the clinical claim and the higher the risk, the stronger the requirement for evidence, oversight, and accountability.

Conclusion

AI-assisted mental health care will shape the future of psychological support. The question is not whether these technologies will be used, but what vision of the human person they will carry into care. If digital mental health is built around efficiency alone, it may expand access while narrowing the meaning of healing. It may respond quickly while listening poorly. It may personalize content while ignoring culture. It may measure the body while forgetting embodiment. It may simulate empathy while weakening human connection.

The future of AI-assisted care must be different. It must recognize that people suffer and heal as embodied, cultural, relational beings. AI can be a valuable tool within mental health systems, but it should remain a tool in the service of care, not a replacement for care itself. The forgotten body must be remembered. Culture must be treated as constitutive, not peripheral. Human connection must be protected as a therapeutic necessity. Only then can digital mental health become not merely more intelligent, but more humane.

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