PREDICTING ATTITUDES TOWARD MENTAL HEALTH HELP-SEEKING BY PERCEIVED STIGMA AND THE USE OF CONVERSATIONAL ARTIFICIAL INTELLIGENCE FOR MOOD SUPPORT

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ABSTRACT

This study aimed to examine how perceived stigma (i.e. public, personal, self-stigma) and the use of conversational artificial intelligence (CAI) for mood support predicted attitudes toward mental health help-seeking. Participants were 137 Thai adults with experience using CAI for mood support. Data were collected via online questionnaires using a convenience sampling method. A hierarchical multiple regression was employed for data analysis. Results indicated that, after controlling for prior mental health service experiences, perceived public, personal, and self-stigma, as well as usage of CAI for mood support, significantly predicted attitudes toward mental health help-seeking (F (6, 130) = 16.16, $p < .001$) and accounted for 42.7 percent of its variance. Self-stigma was the strongest negative predictor of attitudes toward mental health help-seeking (β = -.509, $p < .001$), followed by public stigma (β = -.230, p = .005), personal stigma (β = .157, p = .041), and the use of CAI for mood support (β = -.137, p = .045). Additionally, whereas these factors significantly predicted the attitudes above and beyond mental health service experiences, the experience also significantly predicted the attitudes, with ongoing mental health service experience emerging as a significant predictor relative to no counseling experience (β = 0.552, p = .008). These findings can inform strategies for ways to promote positive attitudes toward mental health help-seeking.

Keywords: Help-Seeking Attitude, Mental Health, Perceived Stigma, Conversational Artificial Intelligence

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INTRODUCTION

The number of people experiencing mental health problems has been increasing worldwide. According to the study of Zhang et al. (2026), the total number of prevalent cases of mental disorders globally rose by 68.09% from 1990 to 2021) In Thailand, 4.4 million people experienced mental health problems recently, yet only 10.6% accessed professional psychological services (Institute for Population and Social Research of Mahidol University, 2025). This should be considered because delayed help-seeking and prolonged periods without appropriate treatment may lead to severe negative outcomes, including more persistent symptoms, poorer remission rates (Scott et al., 2022), increased self-harm or suicide, and maladaptive coping mechanisms like substance abuse (Kothgassner et al., 2020).

Research suggests that an individual's attitude toward mental health help-seeking is a crucial factor deterring their decision to seek professional help (Arin, 2011; El-Hachem et al., 2023; Elhai et al., 2008). Individuals have negative attitudes towards seeking professional psychological help, as they often perceive the need for psychological support as a sign of personal weakness or an inability to manage challenges independently (Radez et al., 2021). The most prominent factor contributing to this negative attitude is stigma, which serves as a significant psychological deterrent to help-seeking behavior (Syafitri et al., 2025; Topkaya, 2021; Velasco et al., 2020). Stigma toward seeking professional help has been strongly related to negative attitudes toward mental health help-seeking and reduced intention to seek help (Punyakanok, 2010; Tanomwong, 2022).

Help-seeking stigma can be divided into three types: public stigma, personal stigma and self-stigma (Corrigan, 2004; Vogel et al., 2007). Public stigma refers to the negative social perceptions such as viewing those who seek help as undesirable, worthless, or weak (Özdemir et al., 2023). Personal stigma represents perceived pressure from a person's immediate circle, such as friends and family (Vogel et al., 2009). Both public and personal stigma can lead to the internalization of self-stigma, where individuals develop negative perceptions of themselves for seeking help (Punyakanok, 2010). All three dimensions of stigma are negatively associated with attitudes toward seeking professional psychological help (Cheng et al., 2024; Punyakanok, 2010; Sairung, 2022). To avoid these stigma-related barriers, individuals are increasingly utilizing highly private and accessible alternatives for support like conversational artificial intelligence (CAI) (Kosyluk et al., 2024).

CAI refers to artificial intelligence technologies that simulate human-like conversation through text-based interaction such as ChatGPT, Gemini or Claude. In recent years, CAI has emerged as a widely accessible tool that offers immediate responses. Beyond traditional professional and educational tasks (Ajlouni et al., 2023; Rezai et al., 2024; Wang & Akhter, 2025) CAI is increasingly used as a vital resource for mood support, including personal life counseling, problem-sharing, and self-care (Akdogan et al., 2025; Alanzi et al., 2025; Kishimoto et al., 2025; Raile, 2024; Wester et al., 2025). Individuals experiencing high self-stigma are particularly drawn to CAI due to its privacy, demonstrating more favorable perceptions of AI-delivered services compared to human-delivered psychotherapy (Hoffman et al., 2024).

This preference for AI-delivered services is highly evident among adults (aged 18-40) due to their digital fluency, utilizing CAI significantly for accessing health information and seeking social companionship (Yaşar et al., 2025). Furthermore, data from the Institute for Population and Social Research, Mahidol University (2025) indicate that individuals aged 18-24 and 25-40 constituted two of the highest-risk groups for depression, anxiety, and suicidal behaviors in 2023)

Given its high accessibility, immediate availability and cost-effectiveness, CAI has emerged as an appealing alternative for individuals hesitant to seek formal help (Varghese et al., 2024). Current qualitative evidence suggests that CAI may function as a promising stepping stone towards receiving appropriate support by reducing stigma and fear of judgment, which are

primary barriers to help-seeking (AlMaskari et al., 2025; Wester et al., 2025). In addition, CAI facilitates individuals in openly sharing their problems (Wester et al., 2025). This aligns with quantitative findings indicating that CAI reduces the perceived threat of judgment, and its perceived anonymity effectively stimulates self-disclosure (Croes et al., 2024). However, the quantitative evidence of CAI on professional help-seeking attitudes remains unclear. Without empirical data examining CAI use alongside multidimensional stigma, it is undetermined whether CAI actually fosters positive help-seeking attitudes or inadvertently reinforces reliance on AI as a substitute for formal treatment.

Therefore, this research aimed to examine the relationships among perceived stigma (i.e., public, personal, and self-stigma), CAI use for mood support, and attitudes toward seeking professional psychological help. Furthermore, it investigated how these dimensions of stigma and CAI usage predict attitudes toward seeking professional psychological help among Thai adults. Data were collected from Thai adults experiencing using CAI for mood support. Findings should help fill in the research gap and inform strategies for promoting positive attitudes toward mental health help-seeking.

LITERATURE REVIEW

Perceived Stigma and Attitude toward Mental Health Help-seeking

Attitude toward mental health help-seeking reflects on personal evaluation of seeking professional support, shaped by beliefs about its potential benefits and risks. Positive evaluations, such as perceiving therapy as effective, are associated with stronger intentions, whereas concerns about stigma or negative outcomes tend to reduce such intentions. One of the strongest barriers to the attitudes is stigma. When social harmony and adherence to cultural norms are emphasized, mental health conditions and help-seeking behaviors may be perceived as inappropriate or unacceptable, thereby increasing vulnerability to stigmatization (Abdullah & Brown, 2011).

Public stigma is how individuals perceived that society devalues, rejects, and discriminates against help-seekers, viewing them as socially undesirable or inherently weak (Alluhaibi & Awadalla, 2022; Vogel et al., 2007). Personal stigma represents an individual's perception that their immediate social circle such as family members and close friends will view them negatively and react unfavorably if they seek professional help (Vogel et al., 2009). Self-stigma is the psychological process wherein individuals internalize the negative stereotypes prevalent in society and apply them to themselves (Vogel et al., 2006). The internalized stigma model conceptualized stigma as a cognitive process through which both public stigma (Lannin et al., 2015; Yu et al., 2021) and personal stigma (Cheng et al., 2024; Punyakanok, 2010) become self-stigma.

Both public and personal stigma often act as a precursor to self-stigma (Punyakanok, 2010). As individuals perceive negative societal attitudes and anticipate rejection from their close networks, they may gradually internalize these views, which directly generates negative attitudes toward mental health help-seeking (Vogel et al., 2007; Ludwikowski et al., 2009). While public and personal stigma represent the external threat of social rejection, self-stigma represents an internal threat to one’s identity, often serving as the most potent barrier to seeking professional care (Vogel et al., 2006; Andersen et al., 2022).

Conversational Artificial Intelligence (CAI) and Attitude toward Mental Health Help-seeking

To explain by label avoidance theory, some individuals might refrain from seeking traditional mental health services to prevent being associated with stigmatizing labels. Some might turn instead to Conversational Artificial Intelligence (CAI). As CAI systems are perceived as non-judgmental and anonymous, they provide a stigma-free alternative that encourages engagement among those who would otherwise avoid help-seeking due to concerns about social evaluation.

Apart from its accessibility, cost-effectiveness, and 24/7 availability (Varghese et al., 2024), CAI provides an opportunity for individuals to openly share personal concerns within a psychologically safe environment, which can reduce perceived barriers and foster the confidence needed to approach human therapists (Akdogan et al., 2025; Hadar-Shoval et al., 2023). By functioning as a safe and low-risk rehearsal space, CAI may help reduce stigma and enhance readiness for formal intervention (Lopes et al., 2024; Raile, 2024). Ultimately, CAI can serve as a bridge that complements traditional mental health services, addressing stigma-related barriers that often prevent high-risk populations from accessing professional care (Pandya et al., 2024; Wester et al., 2025).

Research has found that CAI promotes self-care and positively impacts overall well-being by providing non-judgmental support, emotional validation, and a sense of being heard (Raile, 2024; Wester et al., 2025). Furthermore, CAI has been shown to enhance emotion regulation in multiple aspects (Ajlouni et al., 2023; Kishimoto et al., 2025; Rezai et al., 2024; Wang et al., 2025). It enables users to articulate feelings, reappraise negative emotions, and focus on positive aspects, which collectively foster emotional awareness and mindfulness (Kishimoto et al., 2025; Rezai et al., 2024). Moreover, CAI provides practical strategies, such as virtual simulations and deep breathing exercises, which support users in managing stress more effectively (Ajlouni et al., 2023; Wang & Akhter, 2025). Additionally, there are several studies showing that using CAI significantly reduces psychological distress, including symptoms of anxiety and depression in various patient groups (Akdogan et al., 2025; Alanzi et al., 2025).

Furthermore, methodological gap remains in the measurement of CAI usage. Previous literature has often relied on simplistic dichotomous questions or self-reported usage logs, which may not fully capture the nature of the interaction. After reviewing several measurement tools, the Conversational AI Dependence Scale (CAIDS; Chen et al., 2025) was identified as highly relevant, as it includes a specific subscale for mood support. Notably, despite being part of a dependence scale, an examination of the items within this specific subscale reveals that they capture a neutral utilization of CAI for emotional coping, rather than measuring maladaptive dependency. Thus, this mood support subscale was selected for application in the present study.

Literature Gap

Although previous research indicated the benefit of the use of CAI for mood support, there has yet to be examining the association that CAI had with attitudes toward mental health seeking in relation to the three types of stigma and how each predicted the attitudes when examined simultaneously. These predictions would be controlled for prior mental health service experiences The current study, hence, was proposed to fulfill this literature gap.

1) **H1:** Perceived stigma (i.e., public, personal, and self-stigma) would be negatively associated with attitudes toward mental health help-seeking;

2) **H2:** The use of CAI for mood support would be positively associated with attitudes toward mental health help-seeking;

3) **H3:** Controlled for prior mental health service experiences, perceived stigma and the use of CAI for mood support would predict attitudes toward mental health help-seeking.

From the literature review, the conceptual framework can be drawn as shown in Figure 1.

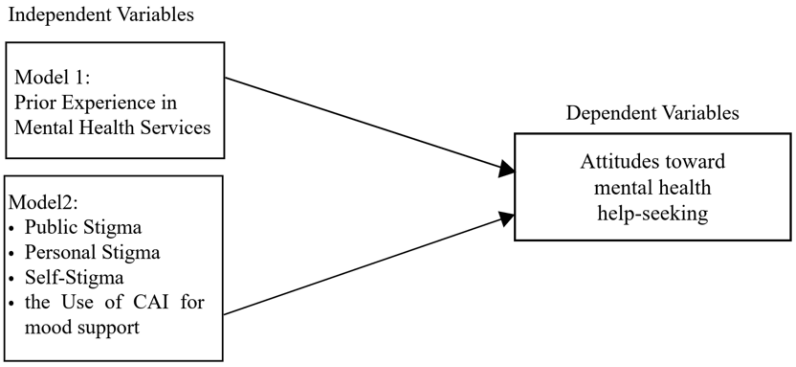

Figure 1 Conceptual Framework

RESEARCH METHODOLOGY

This study employed a quantitative, cross-sectional correlational research design to investigate the relationships that public stigma, personal stigma, self-stigma, the use of CAI for mood support had with attitudes toward seeking professional psychological help. Whether the three dimensions of stigma and CAI predicted attitudes toward mental health help-seeking were examined. The required sample size was estimated using G*Power 3.1.9.6 with medium effect size (f^2=0.15), α =0.05, power of 0.95) The estimation indicated a minimum of 129 participants. To account for potential incomplete responses, the target sample size was set at 135 participants.

Participants were recruited through convenience sampling. Eligible participants were Thai adults aged 18-40 years who had prior experience using CAI for mood support and voluntarily completed the online questionnaire.

The questionnaire consisted of four parts. Relevant information was as follows:

Demographical Information. The first part of the questionnaire covered demographics, including gender, age, frequency of CAI use for mood support, and prior experience with mental health services.

Stigma. The second part measured the three types of perceived stigma: 1) public stigma measured using the 12-item Thai version of the Stigma Scale for Receiving Psychological Help (SSRPH), with items rated on a 4-point Likert scale ranging from 0 (strongly disagree) to 3 (strongly agree) (α = .895), 2) personal stigma measured using the 12-item Thai version of the Perceptions of Stigmatization by Others for Seeking Help (PSOSH), rated on a 5-point Likert scale ranging from 1 (no reaction at all) to 5 (reacting strongly) (α = .944), and 3) self-stigma measured using the 12-item Thai version of the Self-Stigma of Seeking Help Scale (SSOSH), rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) (α = .893).

Attitudes toward mental health help-seeking. The third part assessed attitudes toward seeking professional psychological help using the 10-item Thai version of the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF) (Udomsri, 2024). Items were rated on a 4-point Likert scale ranging from 0 (strongly disagree) to 3 (strongly agree). In this study, the internal consistency of the scale was acceptable (α = .739).

Use of Conversational Artificial Intelligence for mood support. The fourth part measured the use of CAI for mood support using a 4-item mood support subscale of the Conversational AI Dependence Scale (CAIDS; Chen et al., 2025). While the overall CAIDS score was used to indicate AI dependence, it was composed of four subscales, which examined four dimensions of this dependence (i.e., uncontrollability, withdrawal symptoms, negative impacts, and usage of CAI for mood support). The four items in the last subscale, which examined the responders' tendencies to use CAI when experiencing negative feelings were used. The items were phased in relatively neutral terms, minimizing connotations of dependence. They were, for instance,

"When experiencing negative emotions (such as depression, anxiety, helplessness, guilt, etc.), I tend to use CAI for comfort." "When I feel irritable, I usually use CAI to seek relief.". Participants rated the backtranslated 6-point Likert scale ranging from 1 (completely disagree) to 6 (completely agree). The Index of Item Objective Congruence (IOC) score of the backtranslated scale was 0.95 and its internal consistency was high (α = .872).

Data were collected via a Qualtrics electronic questionnaire, circulated via the social media accounts (i.e., Facebook, Instagram, and LINE). Descriptive statistics were employed to summarize demographic characteristics, means, and standard deviations. Inferential statistics were utilized to assess underlying assumptions before conducting Pearson's correlation analyses to explore the relationships that study variables had with attitudes toward seeking professional psychological help. Subsequently, a hierarchical multiple regression analysis was conducted to determine how perceived stigma and CAI use for mood support predict these attitudes, after controlling for prior mental health service experience.

RESEARCH RESULTS

Demographic Characteristics

Data were collected via online survey. One-hundred sixty-two individuals participated in the survey in total. However, 18 respondents (11.1%) were excluded as they did not meet the inclusion criteria of experiencing using CAI for mood support. Additional 7 responses (4.32%) were removed during the data cleaning process due to their straight-lining responses. Consequently, the final sample size utilized for the statistical analysis comprised 137 participants, slightly exceeding the target sample size of 135 participants.

The majority of the participants were female (70.8%). Their mean age was 28.8 (*SD* = 6.15). 43.8% of participants had never experienced mental health services. The remaining had previously used (41.6%) and continued the usage (14.6%) until the time of the study participation, respectively. All of them had used CAI for mood support, in accordance with the inclusion criterion.

Descriptive Statistics

Table 1 Descriptive statistics for the studied variables (*N* = 137)

Variable	*Min*	*Max*	*Possible Range*	*M*	*SD*	*Skewness*	*Kurtosis*
1) Public	0.00	3.00	0 - 3	1.52	0.61	0.09	0.05
2) Personal	1.00	4.58	1 - 5	2.20	0.96	0.60	-0.72
3) Self	1.00	4.17	1 - 5	1.95	0.74	0.83	0.15
4) CAI	1.00	6.00	1 - 6	3.70	1.32	0.04	-0.92
5) Attitudes	0.60	3.00	0 - 3	1.90	0.43	-0.14	0.08

Prior to descriptive analysis, data distribution was assessed in terms of skewness and kurtosis. Based on Hasiloglu and Hasiloglu-Ciftciler (2023), skewness and kurtosis values within the range of -1.0 to +1.0 are considered acceptable indicators of normality for Likert-type data. In this study, skewness ranged from -0.14 to 0.83 and kurtosis ranged from -0.92 to 0.15, indicating that all variables fell within the acceptable range (Hasiloglu & Hasiloglu-Ciftciler, 2023). Therefore, the data can be regarded as sufficiently normal for parametric analysis,

including Pearson's correlation and multiple regression.According to Table 1, participants reported a moderate level of perceived public stigma (M = 1.52, SD = 0.61), as the score falls just around the midpoint of the 0-3 Likert scale. For the other two domains of stigma, which were both measured on a 1-5 scale, the results indicate relatively low levels of both perceived personal stigma (M = 2.20, SD = 0.96) and perceived self-stigma (M = 1.95, SD = 0.74). Lastly, participants demonstrated moderate levels of both the use of CAI for mood support (M = 3.70, SD = 1.32) and attitudes toward mental health help-seeking (M = 1.90, SD = 0.43).

Correlation Analysis

In order to test the research hypotheses, a correlation analysis was conducted to examine the relationships between study variables and attitudes toward mental health help-seeking. Pearson's product-moment correlation coefficient was utilized for the primary variables. The results of the correlation analysis are presented in Table 2.

Table 2 Correlation Analysis

Variable	1	2	3	4	5
1) Public Stigma	(0.90)				
2) Personal Stigma	.43***	(0.94)			
3) Self-Stigma	.45***	.40***	(0.89)		
4) Use of CAI for Mood Support	.18*	.13	.10	(0.87)	
5) Attitudes Toward Help-Seeking	-.40***	-.17*	-.58***	-.21**	(0.74)

Note: Cronbach's alphas in parentheses.
Significance based on one-tailed tests. *p < .05, ** p < .01, ***p < .001.

As shown in Table 2, attitudes toward mental health help-seeking were significantly and negatively associated with perceived public stigma (r = −.40, p < .001), personal stigma (r = −.17, p = .026), and self-stigma (r = −.58, p < .001). Therefore, H1 is supported. Additionally, the analysis indicated that attitudes toward mental health help-seeking were significantly associated with the use of CAI for mood support. However, the association was negative (r = −.21, p = .008). Consequently, H2, which predicted a positive association between the two variables, is not supported.

Multiple Regression Analysis

Prior to conducting multiple regression analyses, preliminary analyses were performed to ensure that there were no violations of the assumptions of multicollinearity. Collinearity statistics indicated no statistical evidence of problematic multicollinearity. Referring to Hair et al. (2019), VIF values needed to be below 5, and the tolerance needed to be beyond 0.10. As shown in the current study, the VIF and tolerance values fell within the expected range, suggesting that it was appropriate to proceed with multiple regression analysis.

Table 3 Hierarchical Multiple Regression Analysis Predicting Attitudes Toward Mental Health Help-Seeking

Predictor	Model 1		Model 2				
	B	SE	B	SE	β	Tolerance	VIF
Constant	1.795***	0.054	2.668***	0.124			
Mental Health Service Experiences							
1 - 0	0.161*	0.077	0.065	0.063	0.152	0.978	1.02
2 - 0	0.265*	0.108	0.236**	0.087	0.552	0.978	1.02
Public Stigma			-0.161**	0.056	-0.230	0.831	1.20
Personal Stigma			0.070*	0.034	0.157	0.868	1.15
Self-Stigma			-0.294***	0.046	-0.509	0.841	1.19
CAI for Mood Support			-0.044*	0.022	-0.137	0.981	1.02
R^2	.055*		.427***				
Adjusted R^2	.041		.401				
ΔR^2	.055*		.373***				
F for change in R^2	3.87*		21.10***				

Note: $N = 137$. Prior Experience in mental health services: 0= No Experiences, 1=With Only Prior Experiences, 2= With Prior and Current Experiences. Unstandardized regression coefficients (B) and standard errors (SE) are presented alongside standardized coefficients (β), Tolerance, and VIF for the final model.* $p < .05$, ** $p < .01$, *** $p < .001$

Hierarchical multiple regression analyses were conducted to predict attitudes toward mental health help-seeking. In Model 1, the control variable, prior experience in mental health services, was entered in the first block with "no experiences" (0) as a reference group. The result showed that prior experiences, both "prior experiences only" (1) and "prior and current experiences" (2), significantly predicted attitudes toward mental health help-seeking, explaining 5.5% of the variance in the attitudes (R^2= .055, Adjusted R^2= .041, $F(2, 134) = 3.87$, $p = .023$).

In Model 2, the predictor variables (perceived public stigma, personal stigma, self-stigma, and the use of CAI for mood support) were entered in the second block The addition of these variables significantly improved the model, explaining an additional 37.3% of the variance (ΔR^2= .373, F (4, 130) = 21.1, $p < .001$). These findings indicated that, controlling for prior experience in mental health services, the three types of stigma (i.e., perceived public stigma, personal stigma, self-stigma) and the use of CAI for mood support remained significant predictors of attitudes toward mental health help-seeking. Altogether, Model 2 explained 42.7% of the variance in attitudes toward mental health help-seeking (R^2 = .427, Adjusted R^2= .401, F (6, 130) = 16.16, $p < .001$). It was worth noting that, current experiences in mental health services significantly predicted the attitude. Those currently receiving services (2) showed significantly higher attitudes toward mental health seeking than those with no experiences in the services ($p = .008$).

The standardized regression equation of the prediction, with was as follows:

$$Z_{Attitudes} = 0.152\ Z_{Past\ Experience} + 0.552\ Z_{Current\ Service} - 0.230\ Z_{Public\ Stigma} + 0.157_{Personal\ Stigma} - 0.509\ Z_{Self\text{-}Stigma} - 0.137\ Z_{CAI\ Use}$$

Perceived self-stigma was the strongest negative predictor of attitudes toward mental health help-seeking. Specifically, for every one standardized unit increase in perceived self-stigma, the attitudes decrease by 0.509 standardized units. Likewise, increases in perceived public stigma and the use of CAI for mood support were associated with 0.230 and 0.137 standardized unit decreases in the attitudes, respectively. In contrast, perceived personal stigma showed a significant positive association (β = 0.157, $p = .041$). Regarding the control variables, current usage of mental health services positively and significantly predicted help-seeking attitudes (β = 0.552, p = .008), whereas past experience was not statistically significant in this prediction (β = 0.152, p = .304).

DISCUSSION AND CONCLUSION

The present study examined the relationships that perceived stigma (i.e., public stigma, personal stigma, and self-stigma) and CAI use for mood support had with attitudes toward mental health help-seeking among Thai adults with prior experience using CAI for mood support. Additionally, how these variables predicted the attitudes was investigated.

Findings revealed that all dimensions of perceived stigma were significantly and negatively correlated with attitudes toward mental health help-seeking. Consistent with previous research, self-stigma demonstrated the strongest negative association with help-seeking attitudes compared to external forms of stigma (El-Hachem et al., 2023; Mackenzie et al., 2019; Özdemir et al., 2023).

The second correlation analysis demonstrated a significant negative association that the use of CAI for mood support had with attitudes toward mental health help-seeking. This finding did not support Hypothesis 2 and initial qualitative studies which suggested that CAI might reduce stigma and encourage readiness to engage with formal mental health support (Lopes et al., 2024; Raile, 2024). The inconsistent finding in the current study, obtained through a quantitative study, might have resulted from the different research methodology. Additionally, the finding might be attributable to the label avoidance theory (Kosyluk et al., 2024), which suggests that individuals may avoid formal mental health services to prevent being associated with stigmatizing labels. With its increased accessibility, CAI might have become an affordable, private, and less stigmatizing alternative to traditional mental health services. Hence, the usage of CAI became negatively associated with attitudes toward mental health help-seeking.

In the hierarchical multiple regression analysis, after controlling for prior mental health service experience, the predictor variables collectively explained a significant proportion of the variance in attitudes toward mental health help-seeking ($R^2 = .427$, $F(6, 130) = 16.16$, $p < .001$). The findings indicated that the predictor variables significantly predicted attitudes independently of participants' prior experience.

As hypothesized, the three stigmas (i.e., self-stigma, personal stigma, and public stigma) as well as CAI significantly predicted help-seeking attitudes. When compared, self-stigma stood out as the strongest predictor ($\beta = -0.509$, $p < .001$). This dynamic can be explained by the internalization model of stigma (Cheng et al., 2024; Mackenzie et al., 2019; Yu et al., 2021).

Public stigma involves negative societal perceptions of help-seekers as undesirable, worthless, or weak (Özdemir et al., 2023), whereas personal stigma reflects perceived pressure from one's immediate circle (Vogel et al., 2009). According to the internalization model, both public and personal stigma operate as external social pressures or threats. Individuals subsequently internalize these external negative beliefs to form self-stigma with a negative attitude directed toward themselves. As self-stigma absorbs much of the negative variance from this internalization process, it emerges as the primary and most potent barrier to positive help-seeking attitudes.

Beyond the internalization process, the detrimental effect of public stigma can be further understood through social identity theory (Klik et al., 2019). This theory explains stigma in terms of group membership and identity processes, emphasizing how individuals derive their sense of self from belonging to social groups and internalizing the group's specific norms, values, and perceptions. Consequently, when individuals perceive that the broader society holds stigmatizing views toward mental health services, they may adopt negative help-seeking attitudes to align with these group norms and protect their social standing.

Contradictory to the hypothesis, personal self-stigma was found to positive predict attitude toward mental health seeking. This finding was consistent with past report that show small positive direct effect of personal stigma (Punyakanok, 2010). One of the possible explanations could be drawn in terms of the associations among the three types of stigma. Although

preliminary analyses did not suggest multicollinearity, these stigmas were found to be significantly moderated intercorrelated. These associations might have impacted their unique contributions to the prediction of mental health seeking attitude and rendered the unique contribution of each type of stigma unclear. The findings, hence, warrants further investigation in future research.

Regarding the role of CAI, the use of CAI for mood support emerged as a significant negative predictor of mental health help-seeking attitudes. This finding was consistent with the correlational analysis and might be explained in a similar manner. Specifically, individuals might perceive CAI as a more private, accessible, and less stigmatizing alternative to traditional psychological support, which inadvertently deters their readiness to engage with formal mental health services.

With the significant roles of self- and public stigma in negatively predicting attitudes toward mental health seeking, interventions designed to promote these attitudes, particularly among Thai adults, should address these stigmas, particularly the reduction of self-stigma which was the most significant predictor. This can be achieved by using media campaigns to provide psychoeducation to the public about mental health (Whipple et al., 2025). Additionally, organizing activities where people can connect with those who have actual mental health experiences can help build empathy and better understanding (Crockett et al., 2025; Mendon et al., 2024) and hence reduce public self-stigma, which could impact the self-stigma, based on the internalization model of stigma (Yu et al., 2021). Furthermore, with CAI being shown to negatively predict mental health seeking attitudes, caution should be instilled in its usage. Promoting accurate understanding of limitations and appropriate scope of CAI support, alongside the benefits of formal help-seeking, would be a promising public health strategy.

Not unlike other research investigations, the current study entailed limitations. The cross-sectional and self-report design precludes causal conclusions and relevant response bias. Furthermore, regarding the measurement of CAI usage, the current study relied on a subscale specifically focused on mood support. This finding may not be generalizable to the broader context of CAI usage. In addition, the current participants included only Thai adults who had used CAI for mood support, limiting the generalizability of the current findings to non-users and other demographic populations. Future research should address these current limitations by employing a longitudinal design to investigate associations between predictor variables and the attitudes over time. Moreover, incorporating objective assessments, such as actual help-seeking behaviors or clinical service utilization rates, would strengthen the evidence base beyond self-report measures. Developing and applying a CAI measurement tool explicitly designed to capture general utilization would be a valuable direction for future research to overcome the measurement limitation. To better understand the complex interactions identified in this study, future investigations should employ research designs and statistical procedures that allow for the examination of intercorrelations among different types of stigma. Lastly, data collection could extend to different age groups and non-CAI users to enhance understanding across different populations.

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