

Personality, Attachment, and Help-Seeking as Predictors of Attitudes Toward AI in Psychotherapy

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E d i t o r	R e v i e w e r s
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1. Round 1

1.1. Reviewer 1

Reviewer:

The recruitment and inclusion paragraph states that eligible participants had “familiarity or prior experience with artificial intelligence technologies as well as mental health service platforms,” yet the demographic results report that one participant was unfamiliar with AI and a substantial proportion had not used mental health services. These elements appear inconsistent with the stated eligibility requirements and need to be reconciled. If familiarity, actual prior use, and experience with mental health platforms were distinct criteria, the operational definitions should be reported explicitly. The authors should specify how familiarity was assessed, what minimum level qualified a participant, whether “mental health service platforms” referred to actual service use or merely awareness, and whether any respondents who failed these criteria were retained. Without this clarification, readers cannot determine whether the analyzed sample fully corresponds to the population defined by the inclusion criteria.

The manuscript states, “Participants were excluded if they self-reported having active or acute psychiatric disorders that could interfere with completing the questionnaires,” while the Results indicate that 79 participants reported a history of psychiatric disorders and 30 reported psychiatric medication use. This is not necessarily contradictory because a past psychiatric history differs from an active acute disorder, but the manuscript does not explain the screening procedure sufficiently to allow

that distinction to be evaluated. The authors should specify the exact screening questions, the time frame used to define “active” or “acute,” whether medication use itself was exclusionary or only medication associated with cognitive impairment, and who determined eligibility when a participant endorsed psychiatric history. It would also be useful to report whether any potential respondents were excluded before completing the study, rather than stating only that no participants among the final 274 met exclusion criteria.

The ethical reporting in the paragraph beginning, “All questionnaires in this study were self-report instruments and were distributed online via social media platforms,” is incomplete for a study collecting potentially sensitive information about psychiatric history, medication use, personality pathology, attachment, and mental health help-seeking. Informed consent is mentioned, but the manuscript should provide the name of the approving institutional ethics committee, approval/reference number, date of approval, confidentiality procedures, data-storage safeguards, whether IP addresses or other identifying metadata were collected, and whether participation was anonymous. The authors should also clarify whether participants received any compensation and whether a debriefing or mental-health support resource was provided, especially because questionnaires included clinically sensitive content.

The measurement description for the outcome variable requires substantial clarification. The manuscript states that the “Attitudes toward the Use of Artificial Intelligence in Treatment Questionnaire” contains 39 items across “distrust and accountability, procedural awareness, personal interaction, efficiency, and being informed,” and further notes that it is applicable to laboratory procedures and radiology. This raises an important construct-validity question: it is not sufficiently clear whether the instrument was originally designed specifically for psychotherapy or more broadly for medical AI. The authors should provide the original source, adaptation procedure for the psychotherapy context, Persian translation/back-translation procedure, evidence for content and construct validity in the target population, scoring direction of each subscale, possible total score range, and interpretation of higher scores. If the scale was adapted from a general healthcare AI instrument, the manuscript should explicitly explain and psychometrically justify that adaptation rather than treating it as a directly established psychotherapy measure.

The manuscript reports reliability information from previous studies, for example, “Bayrami et al. reported a Cronbach’s alpha of 0.795,” and states that the attachment measure has coefficients “equal to or greater than 0.80,” but it does not report internal consistency estimates obtained from the current sample. Reliability is sample-dependent and should not be inferred solely from prior publications. The authors should report Cronbach’s α and preferably McDonald’s ω for the total AI-attitude score, each PID-5-BF domain, each attachment dimension, and the professional help-seeking scale using the present $N = 274$. Given that path coefficients can be attenuated by measurement error, current-sample reliability is essential for evaluating the credibility of the structural results. If any scale has marginal reliability, the authors should discuss its implications for estimated associations.

The correlation matrix needs both statistical and presentation revision. The manuscript states that “ $p < 0.05$ is indicated by one asterisk (*)” and “ $p < 0.01$... by two asterisks (**),” but the presented matrix does not consistently display these significance markers, while the narrative later assigns significance to individual correlations. The authors should provide a fully annotated correlation matrix with exact or thresholded p-values and preferably 95% confidence intervals for key associations. In addition, because the strongest observed correlations are substantial—for example, negative affectivity with anxious attachment and negative affectivity with disinhibition—the authors should discuss conceptual overlap among predictor constructs even if VIF values are acceptable. The issue is not only statistical multicollinearity but also whether overlapping constructs complicate interpretation of unique path coefficients.

Table 8 contains evident labeling errors that must be corrected before the results can be evaluated reliably. Specifically, the row with $\beta = -0.10$ and $t = -1.52$ is labeled “Avoidant Attachment $\rightarrow$ Attitude Toward Help-Seeking,” although the surrounding text identifies this coefficient as the path from avoidant attachment to AI use. Similarly, the row with $\beta = 0.03$ and $t = 0.42$ is labeled “Anxious Attachment $\rightarrow$ Attitude Toward Help-Seeking,” whereas the narrative identifies it as the direct path from anxious attachment to AI use. These duplicated outcome labels create uncertainty about whether the numerical estimates themselves were transcribed correctly. The authors should cross-check every table entry against the original LISREL output and regenerate the table directly from verified model estimates rather than correcting labels manually in isolation.

Authors revised and uploaded the document.

1.2. Reviewer 2

Reviewer:

There is a major conceptual and scoring inconsistency between the description of the Adult Attachment Scale and the variables analyzed in the Results. The Methods state that the Collins and Read RAAS assesses “Dependence, Closeness, and Anxiety,” whereas the descriptive statistics and path model refer to “Secure Attachment,” “Avoidant Attachment,” and “Anxious Attachment.” These are not automatically equivalent variables, and the manuscript does not explain how the original RAAS subscales were transformed or classified into the three reported attachment styles. The authors must provide the exact scoring algorithm, item composition, any reverse scoring, cut-off or classification rule if categorical styles were derived, and psychometric justification for treating the resulting variables as continuous path predictors. Unless this issue is resolved, the construct validity of all attachment-related correlations, direct paths, and indirect effects remains uncertain.

The description of the Professional Psychological Help-Seeking Attitude Scale requires correction and fuller documentation. The manuscript notes that five items are reverse-scored and that higher total scores indicate more positive attitudes, but it does not report the validated Persian version, psychometric properties in the current population, or whether the original factor structure was retained. More importantly, the citation attached to this measurement section should be checked carefully against the reference list because the currently associated reference appears not to correspond clearly to the Fischer and Farina instrument. The authors should cite the original instrument development paper and, if applicable, a validated Persian adaptation. A measurement section must allow readers to trace the exact version used and determine whether its interpretation is appropriate for Iranian university students.

The data-analysis paragraph states only that “path analysis modeling was conducted using SPSS and LISREL version 8.8 software,” which is not sufficient for reproducibility. The authors should report the estimator used in LISREL, the covariance or correlation matrix analyzed, treatment of missing data, treatment of incomplete questionnaires, whether variables were entered as observed composite scores, whether standardized or unstandardized coefficients were the primary estimates, and how indirect effects were tested. In particular, mediation analysis should ideally use bootstrap confidence intervals because the sampling distribution of an indirect effect is often non-normal. The manuscript presently relies largely on t-values for indirect effects; the authors should report bootstrap resampling details and 95% confidence intervals, or provide a methodological justification for the approach used.

The assumptions section treats skewness and kurtosis values below |2| as sufficient evidence that “the distribution of the variables is normal.” This conclusion is too categorical. Acceptable univariate skewness and kurtosis do not establish multivariate normality, which is more directly relevant to maximum-likelihood path analysis. The authors should report the estimator-specific normality requirements and, where relevant, assess multivariate normality using an appropriate statistic such as Mardia’s coefficient or employ robust standard errors/corrected test statistics. Similarly, residual plots from an ordinary regression analysis should not be presented as comprehensive evidence that all assumptions of the entire path model have been satisfied. The assumptions section should be revised to distinguish univariate normality, multivariate normality, linearity, homoscedasticity, independence, influential observations, and multicollinearity.

Authors revised and uploaded the document.

2. Revised

Editor’s decision after revisions: Accepted.

Editor in Chief’s decision: Accepted.