

## Exploring Indian Youth's Use of AI Chatbots for Mental Health Support: A Qualitative Study

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### Abstract

Indian youth face many barriers to conventional mental health care, such as limited services, cost, stigma and geographic gaps. This situation has coincided with the rapid adoption of AI chatbots for mental health care. This study explored why digitally connected Indian youth choose chatbot-based mental health support, what sustains or ends such engagement, and how chatbot use fits broader help-seeking behaviour. This study used a qualitative research design with a semi-structured interview approach. 20 participants, aged 18-25 years, who had used AI mediated mental health support for at least once in the past six months were recruited using purposive sampling. Using Braun and Clarke's (2006) six-phase approach with COREQ-guided reporting, data were analyzed with reflexive thematic analysis. Analysis yielded seven themes: (1) safe, non-judgmental sanctuary; (2) practical accessibility; (3) reduced stigma and anonymity; (4) autonomy and self-directed care; (5) instrumental help; (6) enjoyment and curiosity; and (7) limitations and safety concerns. Participants described chatbots as low-threshold, immediately available supports and useful first steps toward help, yet they identified risks that limit suitability for complex or high-risk needs. The findings suggest chatbots are valuable supplements for mental health care in Indian contexts if they are culturally adapted, privacy-protected, and integrated into stepped care with clear escalation pathways to human services.

**Keywords:** AI chatbots, youth mental health, India, qualitative study, digital mental health care

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Across the globe and in India, youth are increasingly confronted with mental health issues such as anxiety, depression, and stress linked to academic pressures and the shift into adulthood, yet access to timely, appropriate, evidence-based care remains limited (Mehrotra and Vijayakumar, 2025). The mental health of adolescents and young adults is a significant public health issue worldwide, as depressive and anxiety disorders constitute a considerable part of the disease burden for this age group, and suicide ranks among the top causes of death for individuals aged 15–29 (WHO, 2022). In low- and middle-income countries like India, the treatment gap is particularly large (Arvind et al., 2020).

Given the size of India's adolescent and young adult population and the fact that they are mostly found in educational environments with high stress levels and limited access to proper mental health facilities, a continuous effort to provide scalable interventions has emerged as a public health priority (Mehrotra and Vijayakumar, 2025).

At the same time, Indian youth's rapid adoption of smartphones and the overall digitalisation of most aspects of daily life have opened up new avenues for technology-mediated mental health care (Sagar and Singh, 2022). From therapist-inspired scripted agents to large-language-model chatbots, conversational agents driven by rule-based or generative AI are becoming a new class of scalable, affordable tools that claim to provide mood monitoring, crisis recognition, psychoeducation, and brief cognitive-behavioral techniques (Fitzpatrick et al., 2017). While the majority of the evidence is still developing, a number of commercially accessible applications, such as Wysa, Woebot, ChatGPT, etc., have shown promising signs of viability, high engagement, and symptom reductions in some user groups (Farzan et al., 2025; Li et al., 2025).

Hence, many young people now report using AI chatbots as a first or supplemental

source of help because of these two trends: (1) unmet mental health needs among adolescents and (2) the widespread availability of conversational AI services (Sarkar et al., 2023; Siddals et al., 2024). Designing safe, socially acceptable, and culturally relevant digital mental health initiatives requires an understanding of why young people favor or select chatbots over more traditional avenues (Agarwal and Das, 2025). Digital platforms have grown quickly as low-threshold, scalable forms of mental health care that can reach young people where traditional services cannot, particularly conversational agents that run on smartphones (Abd-Alrazaq et al., 2020).

According to an expanding body of evidence, some chatbots can reduce perceived symptoms of anxiety and depression in short trials and show promising engagement metrics in routine use (Fitzpatrick et al., 2017; Inkster et al., 2018). Real-world Wysa evaluations show widespread engagement and possible benefit for some users (Iglesias et al., 2023), and early RCT results from Woebot showed short-term reductions in symptoms among university populations (Fitzpatrick et al., 2017). Specifically for CBT-informed chatbots, findings show reduction of symptoms of anxiety and depression over short periods, and users often report benefits such as immediate availability, anonymity, and psychoeducational content (Karkosz et al., 2024). Systematic reviews and meta-analyses have generally reported small-to-moderate effects for chatbots on symptoms, but they also highlight heterogeneity in study design, quality, and safety reporting (Abd-Alrazaq et al., 2020).

Qualitative and mixed-methods research from high-income populations and settings has started to explore the reasons why people are turning to AI for mental health support (Koulouri et al., 2022). Some of the reasons derived include the fact that chatbots serve as consistent, stigma-free companions, offer low-stakes environments for practicing coping

mechanisms, and allow regular rehearsal of cognitive techniques (Cruz-Gonzalez et al., 2025). Convenience, mood-tracking ability, immediacy (24/7 access), and perceived nonjudgment are also cited by users as reasons for using the service. Many users also claim it helps them as a first step in seeking counselling support (Eltahawy et al., 2024).

However, experts caution that chatbots cannot replace clinical judgment, and problems including poor contextual comprehension, suicidality risk management, and the limits of therapeutic scope still exist (Inkster et al., 2018; Li et al., 2023).

When it comes to India, the mental health ecosystem is different from many Western contexts, where the majority of chatbot research has been conducted. Stigma, collectivist family expectations, low mental health literacy, gender norm dynamics, and a severe lack of qualified practitioners, particularly outside of urban areas, are obstacles to Indian teenagers getting treatment (Arvind et al., 2020). According to the National Mental Health Survey 2015–2016, there is a significant treatment gap and a high prevalence of common mental disorders.

According to research in India, seeking formal care for mental health is significantly hampered by social implications and stigma such as parental reactions and fear of "bringing shame" (Gaiha et al., 2020). These sociocultural and institutional restrictions make young people more likely to favor private, low-threshold digital solutions (Shahwan et al., 2020).

Additionally, Indian customers would prefer culturally relevant material, linguistic flexibility, and interaction with local support resources. In their current stage of functioning, international commercial chatbots might not perform well in these parameters without modification (Gaiha et al., 2020). Early research on Wysa in Indian cohorts suggests acceptability, and recent Indian studies and pilot projects have started to assess locally

relevant digital treatments; nevertheless, the evidence base is still small and mostly quantitative (Anand & Srivastava, 2025).

At the same time, the rapid proliferation of digital penetration in India, along with digital mental health programs such as public and private platforms like MANAS, presents both opportunities and challenges for the implementation of chatbots (Chaudhry and Debi, 2024).

The current review highlights three main gaps: (1) a shortage of focused qualitative research that explores the reasons why digitally connected Indian youth initially choose chatbots (as opposed to other pathways) and what sustains or ends their engagement (2) inadequate knowledge about contextual and cultural moderators (family expectations, stigma, language, and academic pressure) that may influence user preferences in India and (3) limited research regarding youth perceptions of safety, privacy, and escalation pathways, that is, how young users determine when a chatbot is or is not enough and whether they will seek human care when necessary.

It's important to comprehend why young people choose chatbot-based support for multiple reasons. First, it guides the creation of treatments that are appropriate and successful in local settings. Second, it helps developers, policymakers, and clinicians in anticipating unintended consequences (privacy hazards, delayed care), as well as in developing safety-net procedures that direct high-risk users into person-delivered care. Third, in order to maximize reach while maintaining quality, qualitative insights offer the empirical foundation required to modify globally created digital tools for Indian languages, culture, and care pathways (Wadhwa, 2021).

Thus, the present study aims to understand, from the perspective of digitally

connected Indian youth, why they turn to AI chatbots for mental health care and support, what motivates initial uptake, what sustains or ends engagement, and how chatbot use fits into broader help-seeking and coping behaviours.

## **Methods**

### **Research Design**

The present study adopted a qualitative design to explore why Indian youth seek mental health support from AI-based chatbots. This approach enabled in-depth examination of participants' lived experiences, perceptions, and motivations (Creswell & Poth, 2016). Data were analysed using Reflexive Thematic Analysis (Braun & Clarke, 2006), and the COREQ checklist (Tong et al., 2007) guided rigor and reporting quality.

### **Participants**

The sample comprised 20 undergraduate students aged 18–25 years ( $M = 20.95$ ,  $SD = 3.52$ ; 10 males, 10 females) from universities in Karnataka, India. A homogeneous sample was purposively selected to explore shared experiences within a specific context. Purposive sampling was used, as the study's target sample was digitally connected youth who had used AI-based chatbots for mental health support at least once in the past six months. This ensured that participants had adequate experiential knowledge of the phenomenon under study. Of 24 individuals approached, 20 consented to participate, while four declined due to time constraints or lack of interest.

### ***Inclusion Criteria:***

a) Participants aged 18–25 years. b) Individuals who have used AI-based chatbots for mental health support in the past six months. c) Willingness and ability to provide informed consent and participate in a recorded interview.

**Exclusion Criteria:**

a) Individuals who have never interacted with AI-based chatbots for psychological or emotional concerns. b) Participants currently receiving formal psychotherapy or psychiatric treatment (to avoid potential confounding factors). c) Those unwilling to participate in an online audio-recorded interview.

**Data Collection**

Data were collected through semi-structured, in-depth face-to-face interviews conducted in English between July and August 2025, each lasting 45–60 minutes. The interview guide was developed from relevant literature, reviewed by two external experts (a counsellor and a clinical psychologist), and pilot-tested with two students to establish clarity, flow, and face validity, with minor refinements made thereafter. Sample questions included, *‘What kinds of issues typically lead you to use the chatbot? What kinds of issues typically lead you to use the chatbot? How would you describe your experience while interacting with the chatbot?’*

Each participant was interviewed once after obtaining informed consent, and interviews were audio-recorded and transcribed verbatim. Field notes captured contextual observations and reflections. Data collection and analysis occurred concurrently. Data saturation was reached after 17 interviews, with three additional interviews conducted to confirm thematic sufficiency. Saturation was thus determined based on analytic redundancy rather than a predetermined sample size.

**Ethical consideration**

Participants received an information sheet at least 24 hours before the interview outlining the study’s purpose, procedures, and voluntary nature. Written and verbal informed

consent were obtained. Confidentiality, the right to withdraw, and secure data handling were assured. All data were anonymised using pseudonyms, and the study adhered to the principles espoused by the Declaration of Helsinki (2024).

### **Researcher Reflexivity**

Both authors are psychology faculty, which informed topic selection and sensitivity to issues of stigma, access, and help-seeking among Indian youth. Continuous reflexive discussions, field notes, and peer debriefing with two external subject experts were used to question preconceptions, consider alternate interpretations, and ensure that themes remained grounded in participants' narratives rather than the researchers' prior beliefs.

### **Data Analysis**

Data analysis followed the six phases of Braun and Clarke's (2006) reflexive thematic analysis. Transcripts were repeatedly read, coded, and grouped into themes, which were reviewed, refined, named, and defined before reporting. Consistent with qualitative principles, the study aimed to generate contextual, in-depth understanding rather than statistical generalisation.

## **Results**

Using Braun and Clarke's (2006) framework, seven major themes emerged. A summary of findings and supporting verbatim is given in Table 2.

**Table 1**

*Participant Details*

<b>Variable</b>	<b>N (20)</b>	<b>%</b>
Gender		
Female	10	50
Male	10	50

Age		
18-25	20	10
		0
Educational status		
Undergraduate (Arts)	6	30
Undergraduate (Science)	8	40
Undergraduate (Commerce)	6	30
AI Chatbot used for mental health support		
ChatGPT	16	80
Wysa	2	10
Woebot	2	10
Frequency of Use		
Occasional (once a week or less)	5	25
Moderate (2-3 times per week)	7	35
Frequent (once per day or more)	8	40
Place of residence		
Semi-Urban	4	20
Urban	16	80

Note. Twenty participants were enrolled in this study. The Standard Deviation in age is 3.52 and the mean age of the participants was 20.95 years (18-25).

**Table 2**

*Themes and Sub-themes*

Themes	Sub-themes	Supporting Verbatim
Safe and Non-judgemental Sanctuary	Non-judgemental listener	<i>“I can tell it anything, even things I’ve never told my friends. It never looks down on me, so I speak more freely.” — P3</i>
	Always available companionship	<i>“At 2 a.m. when I panic, I just open the app. No appointments, no waiting...it’s truly so helpful.” — P7</i>

	Emotional validation and relief	<i>“Sometimes it feels like nobody understands me...and I feel like a fool. But I was amazed at how easily it (Chatbot) could understand me...it put into words the feelings even I couldn't express.” — P13</i>
	Experimentation and ‘first-step’ help	<i>“I didn’t know anything about therapy, the bot taught me what counselling feels like...it’s like a starter step.” — P10</i>
Practical accessibility	Low cost	<i>“My family won’t pay for counselling. The AI is free so I went for it.” — P16</i>
	Convenience and immediacy	<i>“I chat with chatGPT about my problems while on my way home from university, it fits into my day easily, it has become a routine now.” — P12</i>
	Geographic reach	<i>“In my city there’s no therapist that I have heard of. Woebot was basically the only counselling I could get.” — P9</i>
Reduced stigma and anonymity	Shield from cultural/familial judgement	<i>“If my parents knew I was seeing a counsellor they’d overreact...This way I get counselling without anyone finding out.” — P6</i>
	Anonymous disclosure	<i>“I first told the bot about my confusion with my gender identity; it felt safer than telling even my best friend.” — P17</i>
Autonomy, control and self-directed care	Pacing and self-direction	<i>“I decide when to stop or continue; I don’t feel pushed. That control makes me more comfortable.” — P1</i>
	Privacy over family/peers	<i>“I don’t have to explain anything to anyone. It’s private and that privacy is precious where I live.” — P2</i>
Instrumental help	Practical coping strategies	<i>“It gave me a breathing exercise and I could calm down in five minutes... I still use that.” — P14</i>
	Perspective and reframing	<i>“It helped me understand my father’s point of view...I had never thought about the problems he could have because of me but from that day on I started to view my father with a more forgiving</i>

		view... ” — P7
	Role-play and simulated conversations	“I practised what to say to my parents using the chatGPT’s roleplay and when the real talk happened I felt actually prepared.” — P5
Enjoyment and curiosity	Novelty and technological fascination	“It’s kind of fun to see what the bot says next...technology made something helpful also interesting...I have respect for it.” — P20
	Companionship and reduced loneliness	“Even though I know it’s not human, talking to it at night made me feel less alone.” — P11
	Peer suggestion	“My best friend told me about chatGPT counselling at first. Because of my anger problems I was really stressed about finding a therapist but I was too hesitant. Then she told me about this and I tried it once and found it really helpful.” — P15
Limitations and safety concerns	Issues of safety filters and guardrails	“Sometimes it suddenly gives a safety message and stops the conversation...it felt like being cut off when I needed to continue.” — P16
	Generic responses and perceived limited empathy	“Sometimes it replies with the same sentence no matter what I say...it’s so annoying.” — P19 “There are moments when the bot sounds robotic and I’m reminded that...it’s not real. It’s just a robot.” — P12 “It never waits for me to get deep into the problem. It’s always in a hurry to answer...that’s how it feels...like it is an answering machine.” — P10
	Memory discontinuity	“It forgets things I shared earlier; that makes me doubt whether it actually understands my situation.” — P10
	Overdependence	“I started checking the app for small worries...now I feel upset if I can’t access it.” — P9 “Sometimes I prefer talking to the bot over real people...I worry that it’s becoming a problem but I don’t know how to stop.” — P1

Personal Safety  
and confidentiality  
concerns

*“I have confessed some stuff to chatGPT...now I am afraid that somehow somebody in the future can hack into my account and get that info...thoughts come to my mind...that’s why I am being more careful with using AI for stuff.”*  
— P19

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## **Theme 1— Safe and Non-judgmental Sanctuary**

Participants perceived chatbots as safe, anonymous, non-judgmental, always-available spaces to share distress, often as a “first listener” or a preparatory step before seeking human help.

### ***Non-judgmental Listener***

Participants felt the bot was non-judgmental, reduced disclosure anxiety, and enabled them to openly share opinions and experiences they might hesitate to disclose to humans. They also valued its consistently empathetic tone, perceiving an absence of negative responses regardless of what they shared.

### ***Always-available Companionship***

The 24/7 availability and on-demand access made chatbots helpful for mental health support, especially during emergencies. Participants described seeking help at midnight, unlike with human therapists, and felt emotionally supported due to round-the-clock accessibility.

### ***Emotional Validation and Relief***

Participants reported emotional relief, clarity, and catharsis after interacting with the bot, gaining new perspectives on their issues. Some participants with prior therapy experience felt the AI chatbot produced better outcomes than traditional therapy.

### ***Experimentation & 'First-Step' Help***

Participants viewed chatbots as a low-risk trial for therapy, helping them familiarise with mental health support before seeking traditional professional care.

### **Theme 2—Practical Accessibility (cost, convenience, reach)**

Participants adopted chatbots due to low or no cost compared to traditional therapy. In essence, AI chatbots are capable to bypass infrastructural and socioeconomic constraints.

#### ***Low Cost / Low Barrier***

Many participants noted that the economic accessibility of the AI chatbot was a major reason why they turned to the bot for support.

#### ***Convenience & Immediacy***

Instant mobile access increased bot utilisation, eliminating scheduling constraints typical of traditional care. Participants accessed the chatbot anytime, integrating help-seeking seamlessly into daily digital routines without detaching from work or study, and often engaging with the bot alongside other daily activities.

#### ***Geographic Reach***

Chatbots provided support where professional services were unavailable, especially in semi-urban areas, as they were geographically accessible to anyone with an internet connection.

### **Theme 3—Reduced Stigma & Anonymity**

Indian youth often cite stigma towards mental health issues as one of the major barriers to seeking mental health support. AI chatbots are an affordable, accessible means to bypass the stigma issue.

#### ***Shield from Cultural/Familial Judgment***

Participants sought help with total privacy and no fear of disclosure, viewing anonymity as a shield from judgment and an enabler of authentic emotional expression.

### ***Anonymous Disclosure***

For participants, the anonymity of interacting with chatbots encouraged them to open up about taboo topics such as sexual trauma or gender identity.

### **Theme 4—Autonomy, control, and self-directed care**

Participants felt that they were in control of their own mental health journey while using the chatbots, as they didn't impose any control on the participant and were always at the service of the participant.

### ***Pacing & Self-Direction***

Participants appreciated the flexibility that the AI chatbots provided. They could decide when, how, and how much to share with the chatbot.

### ***Privacy Over Family/Peers***

Chatbots ensured discretion from familial and peer interference.

### **Theme 5—Instrumental Help: Guidance, Psychoeducation & Immediate Coping**

Participants reported that chatbots offered practical, skill-based interventions, helping regulate distress, reframe experiences, and clarify interpersonal problems. Chatbots suggested coping and emotional regulation tools, and were viewed by some as helpers or tools rather than 'therapists' or 'counsellors'.

### ***Practical Coping Strategies***

Chatbots provided tangible tips such as breathing exercises, mindfulness techniques, and grounding strategies, which were simple to comprehend and follow.

### ***Perspective and Reframing***

Chatbots helped the participants reinterpret events and reframe perspectives. This led the participants to better understand problems in their daily lives, such as relationship conflicts.

### ***Role-Play & Simulated Conversations***

Another significantly beneficial feature of the chatbots was their ability to offer role-play scenarios and provide simulated conversations. This helped the participants to practice imagined exchanges for closure and to build confidence to conduct the actual conversation later.

### **Theme 6—Enjoyment and Curiosity**

For participants, chatbots were not just useful tools but also intriguing companions that offered both emotional relief and intellectual interest. Participants stayed engaged because interacting with the chatbot felt both fascinating and comforting.

### ***Novelty & Technological Fascination***

Participants described how awed and enthralled they felt when the AI chatbot responded to their problems with ease and perceived efficacy. This increased participants' curiosity and led them to further experiment with the chatbot's mental health services.

### ***Companionship & Reduced Loneliness***

Participants explained that they derived comfort from the chatbot and that conversing with it made them feel less alone despite the fact that they were aware of the artificiality of the relationship.

### ***Peer Suggestion***

For some participants, they were encouraged by their friends to try out the chatbot for counselling and out of curiosity, they tried using the bot and gradually became regular users.

## **Theme 7–Limitations and Safety Concerns**

Positive experiences of the participants coexisted with frustration at the chatbot response and awareness of its technical and ethical boundaries. Despite overall satisfaction, participants voiced concerns regarding inconsistency, guardrails, and limited empathy, among many other issues. The sanctuary that chatbots provided was conditional.

### ***Issues of Safety Filters***

Participants felt frustration when automated safety messages interrupted their disclosure.

### ***Generic responses & perceived limited empathy***

When bots offered generic responses or were only superficially solution-focused, participants felt momentarily abandoned, feeling a sudden realisation that the chatbot after all, was a digital machine with artificial empathy.

### ***Memory discontinuity***

Participants felt that chatbots lacked reliability sometimes due to the bots ‘forgetting’ prior exchanges. This increased the perception that the bots lacked actual empathy.

### ***Overdependence***

Some participants also felt that their emotional and psychological dependence on the chatbots increased the more they interacted with them, ultimately reaching a point where they couldn’t handle simple conversations without seeking help from AI.

### ***Safety and confidentiality concerns***

Participants expressed concern over the apparent safety and confidentiality of confessing and disclosing to an AI chatbot.

## Discussion

This study examined how Indian youth engage with AI chatbots for mental health support and interpret their nature, value, and limits within sociocultural and institutional contexts. In this study, the term “counselling” is used descriptively, reflecting participants’ framing rather than implying formal psychotherapy. Hence, the findings are interpreted as reflecting perceived usefulness and experiential value rather than therapeutic effectiveness in a clinical sense.

Findings suggest that digitally connected Indian youth are drawn to chatbots due to structural barriers, sociocultural constraints, and affective needs. While consistent with global research (Cruz-Gonzalez et al., 2025; Karkosz et al., 2024), these findings are particularly salient in India, where counselling access is uneven, mental health literacy is limited, and collectivistic norms shape mental health perceptions (Sehgal et al., 2025).

### **Safe and Non-Judgmental Sanctuary in a Stigmatised Environment**

A central theme was the perception of AI chatbots as safe, non-judgmental spaces that encouraged disclosure without fear of evaluation, unlike interactions with family, educators, or counsellors. This reflects persistent mental health stigma in India, where distress is framed as weakness and disclosure discouraged (Maria, 2024). Chatbots enabled low-consequence vulnerability through emotional neutrality, as the absence of visible reactions reassured users and encouraged disclosure, consistent with existing research (Li et al., 2025). However, participants noted limits such as repetitive responses, poor memory, and lack of genuine empathy, aligning with prior research (APA, 2025; Torous and Blease, 2024; Zimmerman et al., 2024).

### **Practical Accessibility and Structural Unavailability of Care**

In India, counselling and therapeutic services remain scarce or inaccessible, especially within educational institutions where confidentiality and competence are often questioned, resulting in a substantial treatment gap (Singh et al., 2024; Weaver et al., 2023). Cost further restricts access, with private therapy remaining unaffordable for many (Arahanthabailu et al., 2024; Behera et al., 2023), while geographical barriers affect those in smaller towns or living away from home (Mathur et al., 2024). Within this context, chatbots were experienced as accessible, low-cost, and available without appointments. However, their use often reflected necessity rather than preference.

Despite 2025 Supreme Court guidelines mandating strengthened institutional mental health support, implementation gaps persist, highlighting a disconnect between policy intent and practice (Mehrotra and Vijayakumar, 2025).

### **Reduced Stigma and Anonymity**

Anonymity emerged as a key driver of chatbot engagement, reducing barriers to discussing taboo or morally sensitive issues such as sexuality, gender identity, substance use, and family conflict (Gaiha et al., 2020). In India, mental health concerns are often dismissed, resulting in stigma and hesitancy toward professional care (Wadhwa, 2021). Within this context, chatbots functioned as low-risk entry points for emotional validation and coping, aligning with research on preparatory or “rehearsal” spaces (Madrid-Cagigal et al., 2025). However, participants also raised concerns about data privacy, device sharing, and surveillance, complicating the assumption that digital mental health tools are inherently private or stigma-free in the Indian context (Lata and Kumar, 2025; Menon and Shilpa, 2023).

### **Autonomy, Control, and Self-Directed Care**

Participants shared that they engaged with chatbots mainly as a form of self-directed, multipurpose emotional support rather than as a structured therapeutic intervention. Chatbots were used flexibly for emotional reflection, advice-seeking, reassurance, distraction, and meaning-making, underscoring the need to conceptualise such use as user-driven care shaped by individual goals and interpretations (Chaudhry and Debi, 2024). These practices blur conventional distinctions between therapy, self-help, and everyday coping, particularly in contexts where formal counselling is perceived as stigmatised or inaccessible (Scholich et al., 2025).

A salient finding is that participants were not deliberately seeking “therapy chatbots.” Many preferred ChatGPT, a general-purpose large language model, over purpose-built mental health applications such as Wysa or Woebot. While limited dissemination and mental health literacy in India may contribute to this pattern, participants’ accounts suggest that their preference was driven primarily by conversational fluency, responsiveness, breadth of knowledge, constant availability, and a high degree of user control. In this sense, ChatGPT was repurposed from a productivity and conversational tool into a source of emotional support, rather than being engaged with as counselling in a clinical sense (Schäfer et al., 2025).

Instead of following predefined therapeutic protocols, participants actively shaped conversations, selected themes, elicited specific forms of feedback, and disengaged at will. This mode of interaction resembles an informal process of “prompt-engineering” one’s own

coping strategies, positioning chatbot use as self-guided emotional regulation rather than psychotherapy (Song et al., 2025).

Participants were able to control the pace and depth of the interaction by determining what to disclose, when to engage, and when to disengage, without the perceived burden of disappointing, offending, or being evaluated by another person, aligning with existing research (Torous and Blease, 2024). Studies also suggest a higher preference for tools that provide brief, modular interactions that can easily integrate into everyday life (Madrid-Cagigal et al., 2025).

Consistent with this, participants reported little interest in structured, goal-oriented, or diagnostically framed treatment. They expressed a preference for informal emotional connection, responsiveness, and companionship, with one participant describing therapy as “too detached and clinical” and therefore “not for me.” Such accounts point to scepticism toward traditional therapeutic relationships, particularly among young people experiencing stress, loneliness, or everyday distress who do not identify as mentally ill.

These patterns resonate with broader sociocultural shifts in digital contexts, where boundaries between information-seeking, emotional disclosure, companionship, and care are increasingly blurred (Smith et al., 2025). Despite constant connectivity (eg. social media), participants described emotional isolation and unmet relational needs. Conversational AI offered a form of interaction that was responsive, non-demanding, and free from reciprocal obligation, enabling it to be experienced as “someone” rather than a “service” (Chaturvedi et al., 2023; Park et al., 2023).

Notably, engagement often began through curiosity or productivity-related use and gradually evolved into emotionally meaningful interaction. This transition from tool to

companion appears central to participants' experiences of emotional relief, which emerged relationally through sustained conversation rather than through formal therapeutic techniques. Taken together, these findings suggest that some young people are renegotiating what "mental health care" means, prioritising relational presence and emotional attunement over diagnoses or institutionalised care, with the preference for ChatGPT reflecting a broader reconfiguration of help-seeking values shaped by digital culture.

An important interpretive consideration concerns the non-clinical profile of the sample, as participants did not report diagnosed mental disorders or engagement in formal psychotherapy. This positioning likely shaped their preference for autonomy, flexibility, and self-directed engagement, rendering chatbots sufficient and appropriate for everyday or transient distress. Such preferences cannot be assumed to generalise to individuals with clinical conditions, who typically require greater structure and professional guidance (Beck, 2020; Patel et al., 2018).

### **Instrumental Help, Cognitive Support, and Problem-Solving**

Participants used chatbots for problem-solving and decision-making related to academic stress, interpersonal conflict, and future planning. This aligns with research showing youth seek practical guidance alongside emotional validation, while remaining cautious about high-stakes decisions (Chin et al., 2025; Yamamoto, 2024; Zhai et al., 2024). Role-play, simulated dialogues, breathing exercises, psychoeducation and reframing were key advantages, supported by research on CBT-informed chatbots (Karkosz et al., 2024; Ho et al., 2018). However, content quality and cultural adaptation influence whether these lessen symptoms or only provide temporary relief (Algumaei et al., 2025).

### **Enjoyment, Curiosity, and Affective Engagement**

Enjoyment and curiosity motivated early chatbot engagement, with exploratory interactions driven by fascination with conversational AI, later evolving into emotional comfort during loneliness or boredom (Følstad and Brandtzaeg, 2020). This suggests use embedded in everyday digital routines rather than crisis-only contexts. However, enjoyment-based engagement raises concerns about overuse and emotional dependence (Ng and Zhang, 2025). Indian media reports note increasing adolescent reliance on AI companions and potential avoidance of human relationships (Maharashtra Times, 2025; Times of India, 2025). Participants' awareness of these risks indicates reflexive, rather than passive, engagement with chatbots (Vasconcelos et al., 2023).

### **Gender, Academic Discipline, and Differential Engagement**

Although the study did not explicitly analyse gendered patterns of chatbot use, the balanced representation of male and female participants is noteworthy given evidence that men, particularly in India, report higher stigma and lower help-seeking for mental health concerns (Feng et al., 2025). Chatbots may thus provide young men with a socially acceptable medium for emotional expression that bypasses norms of traditional masculinity that discourage vulnerability, though this warrants further research. Additionally, participation from arts, science, and commerce students indicates that engagement with mental health chatbots is not limited to technology-oriented disciplines and might be shaped more by accessibility, emotional safety, and perceived utility than by technological affinity alone (Maria, 2024).

### **Marginalisation, Equity, and AI-Mediated Empathy**

A limited yet salient insight emerged from one participant who identified as

LGBTQ+. This participant recounted a prior therapeutic encounter marked by the therapist's visible discomfort and perceived disgust, which led to an immediate breakdown of trust and premature disengagement from care. Such experiences align with literature on minority stress, provider bias, and insufficient affirmative training within Indian mental health services (Sanil, 2024). In contrast, the participant described turning to ChatGPT and Wysa, which were experienced as more emotionally validating and attentive to the nuances of identity, discrimination, and everyday distress (Ma et al., 2024).

Although this finding cannot be generalized, it raises critical questions concerning equity, accountability, and the evolving role of AI-based mental health support for marginalized populations. Notably, the participant's preference for chatbots did not arise from novelty or convenience alone but from a perceived absence of safe, affirming human care (Naik et al., 2025). In this context, chatbot use functioned as a compensatory response to exclusionary or harmful therapeutic encounters rather than as a rejection of professional mental health care per se.

This observation raises a broader ethical concern: if human-mediated mental health systems remain insufficiently inclusive, marginalized individuals may be increasingly diverted toward AI-based alternatives. While chatbots may provide immediate support, their use as primary sources of care risks obscuring systemic failures in professional training, institutional accountability, and regulation (Falade, 2025).

This risk could be amplified by economic incentives favoring scalable, low-cost AI over structural reforms in mental health education and service delivery. This may result in the marginalization of already vulnerable groups, whereby their mental health care is increasingly relegated to automated systems while human care remains inaccessible, unsafe,

or unwelcoming. Such a trajectory would represent not progress, but a displacement of responsibility from institutions and professionals to technology, raising serious questions about justice and accountability in mental health systems (Fournier-Tombs and McHardy, 2023).

At the same time, participants, including the LGBTQ+ participant, noted limitations of chatbots, particularly their weak grounding in Indian sociocultural contexts, including family dynamics, language nuances, and cultural norms (Gaiha et al., 2020; Grabb et al., 2024). Thus, while chatbots may offer provisional safety, they remain imperfect substitutes for culturally competent, affirmative human care.

### **Limitations, Safety Concerns, and Ethical Tensions**

Participants articulated several concerns regarding the limitations of AI-mediated mental health support. Recent case reports and media accounts documenting catastrophic outcomes following unsafe or chatbot interactions further highlight the necessity of robust guardrails and safety protocols (The Guardian, 2025). From a risk-management perspective, safety mechanisms are therefore essential rather than optional.

However, findings from the present study reveal a paradox: participants frequently experienced these same safeguards as disruptive or alienating. Automated safety messages, abrupt tonal shifts, or sudden redirection to external resources were described as interrupting emotional disclosure and undermining conversational continuity, particularly for users seeking emotional validation or low-intensity support. Rather than facilitating care, such interventions sometimes diminished trust and curtailed engagement, being perceived as impersonal or silencing (Ni and Yang, 2025).

This tension reflects the fact that safety features are experienced differently depending

on users' clinical positioning and perceived severity of distress. Participants in this study largely occupied a non-clinical or subclinical space, where distress was understood as situational or transient, making crisis-oriented guardrails disproportionate or invalidating in response.

The core issue, therefore, is not whether guardrails are necessary, but how, when, and for whom they are activated. Current chatbot systems rely on keyword detection and probabilistic risk models that struggle to distinguish metaphorical or exploratory expressions of distress from imminent risk, leading to both over-triggering and under-detection. This limitation reflects the broader absence of contextual depth, longitudinal judgment, and relational history in chatbots that human clinicians draw upon when assessing risk (Pichowicz et al., 2025).

Conceptually, these findings position AI-mediated mental health support as a risk-stratified intervention whose appropriateness depends on severity, vulnerability, and user intent (Meady et al., 2025). The discomfort participants expressed toward safety interruptions should not be interpreted as resistance to care but as evidence of a mismatch between their needs and the chatbot's risk assumptions. Addressing this mismatch requires not only technical refinement but also ethical clarity regarding the limits of AI responsibility and the necessity of human oversight.

A further limitation identified by this study concerns the fundamentally disembodied nature of chatbot-mediated interaction. Counselling and psychotherapy rely substantially on non-verbal cues such as facial expressions, posture, vocal tone, pauses, and affective incongruence, which are important for therapeutic alliance and risk assessment (Henry et al., 2012). Text-based chatbots operate without access to such multimodal information,

depending entirely on linguistic input and user self-disclosure. Although future systems may incorporate voice, video, or physiological data, such developments raise significant ethical concerns related to privacy, consent, surveillance, and algorithmic bias, especially in low- and middle-income contexts such as India (Fournier-Tombs and McHardy, 2023). This limitation complicates the use of the term “AI-based counselling”, further supporting that chatbot interactions are supplementary means for emotional support rather than counselling or therapy in a clinical sense.

These constraints complicate debates surrounding safety and guardrails. The question is not simply how to design better safeguards, but whether AI systems can ever reliably perform nuanced clinical risk assessment without embodied presence and professional accountability.

Hence, the findings of this study support the position that AI chatbots should not be relied upon for crisis management or high-risk mental health care. Their ethical deployment requires clear disclaimers, robust referral pathways, and public education about when human professional support is indispensable. The limitations identified here do not negate the value participants found in chatbot interactions, but they underscore the necessity of resisting the conflation of emotional support with clinical care.

### **Implications**

This study highlights key implications for AI mental health support in the Indian context. Localized language, culturally resonant metaphors, and contextual sensitivity enhance trust and engagement (Wang et al., 2022), suggesting that future chatbots should embed Indian cultural scripts and emotional idioms. Anonymity and data privacy remain crucial, necessitating encrypted interfaces and transparent notifications (Li et al., 2025;

Sehgal et al., 2025). Hybrid models that combine chatbots with professional support can bridge service gaps, with chatbots acting as first-line supports and facilitating referrals when risk signals emerge, in line with WHO guidelines (WHO, 2025). In Indian universities with low counsellor ratios, chatbots can supplement, not replace, human care (Arvind et al., 2020). Digital wellbeing literacy is essential to prevent overreliance (Torous & Blease, 2024). Finally, national-level policy support, ethical certification, and evidence-based design are needed to ensure transparency, accountability, and safety.

### **Limitations and Future Directions**

Although this study offers valuable insights, several limitations must be acknowledged. The findings have limited transferability, as participants were 20 English-speaking undergraduate students aged 18–25 with regular smartphone and internet access, representing a digitally connected and relatively privileged segment of Indian youth. As a result, the findings may not extend to rural, non-English-speaking, or economically disadvantaged populations affected by the digital divide. Future research should include these groups to examine how language, infrastructure, device access, and digital competence shape engagement with AI-based mental health tools. Comparative urban–rural and linguistic studies are particularly valuable in assessing whether AI chatbots mitigate or inadvertently reinforce existing mental health inequalities.

Next, the study did not examine participants' caste or religious identities. Given the strong influence of caste, religion, and sexuality on stigma, access, and distress in India, future research should adopt an intersectional lens. Qualitative studies with LGBTQ+ individuals, religious minorities, and caste-oppressed communities are needed to understand how AI-mediated mental health support is experienced across marginalized groups.

While the qualitative design enabled in-depth exploration of subjective experiences, it did not assess clinical outcomes such as changes in anxiety or depressive symptoms. Future quantitative or mixed-methods studies are needed to examine clinical effectiveness. Additionally, reliance on self-reported accounts may involve recall bias or idealisation; incorporating chatbot conversation logs or usage data could strengthen validity and contextualisation of participant narratives.

Furthermore, technological heterogeneity across chatbot platforms complicates interpretation, as participants used both general-purpose LLMs and mental health-specific bots with differing designs, memory, and safety features, which may affect satisfaction (Naik et al., 2025). Comparative studies among Indian youth could clarify which features sustain trust and engagement. Ethical and emotional implications of repeated exposure to algorithmic empathy also require longitudinal examination. Finally, this study assesses perceived usefulness rather than therapeutic effectiveness, and future research should clarify whether chatbot use constitutes counselling, self-help, or digital companionship.

### **Conclusion**

In conclusion, Indian youth's reliance on AI chatbots for mental health support reflects global trends such as seeking emotional safety, stigma reduction, access, and guidance, while being shaped by distinct cultural and institutional contexts. For most digitally connected Indian youth, chatbots represent a response to unmet need rather than a luxury. The findings reveal both the promise and paradox of AI companionship: chatbots fill critical gaps left by limited counselling resources, yet their availability and perceived empathy may blur boundaries and risk emotional dependence. The challenge lies not in replacing human care but in integrating AI ethically within support systems. Until counselling services in India

become more accessible, culturally responsive, and trusted, young people are likely to continue seeking alternative forms of emotional support. Hence, AI chatbots act as indicators of systemic gaps that reflect both the possibilities and the shortcomings of contemporary mental health care in India.

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