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NOT EVERYONE NEEDS PSYCHOTHERAPY, AND COUNSELING PSYCHOLOGY OFFERS A PROPORTIONATE, NON-PATHOLOGISING FORM OF HELP

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Summary. Public and professional discourse increasingly treats psychotherapy as the default response to psychological distress, while counselling is often represented as a preliminary, less rigorous, or less profound form of help. This article challenges that hierarchy without constructing an artificial opposition between the two practices. A critical integrative review of literature published from 2022 to July 2026 was used to examine recent evidence on professional identity, expansion of mental-health concepts, stepped and low-intensity care, shared decision making, autonomy support, client-defined outcomes, non-response, and adverse experiences in psychotherapy. The synthesis suggests that counselling-oriented and psychotherapy-oriented work overlap substantially in methods and relationship processes, but can still be distinguished by their primary centre of gravity. Counselling-oriented work commonly prioritises contextual understanding, decision support, resource mobilisation, developmental adaptation, and transfer of competence, whereas psychotherapy-oriented work more often prioritises sustained modification of persistent symptoms, pervasive patterns, and recurrent relational or intrapsychic difficulties. On this basis, the article proposes the Proportionate Psychological Help Framework, which matches the intensity and form of help to safety and clinical complexity, functional impairment, persistence and pervasiveness, the primary change task, contextual determinants, client agency and preference, and response to intervention. The framework rejects both under-treatment and therapeutic overreach. Counselling psychology is consequently positioned not as a diluted precursor to psychotherapy, but as a distinct and necessary part of a plural mental-health system in which escalation, de-escalation, referral, and collaborative choice are normal features of ethical practice.

Keywords: counselling psychology, psychotherapy, proportionality, non-pathologising practice, stepped care, shared decision making, professional identity.

Introduction

Growing public awareness of mental health has made psychological help more visible, more discussable, and more accessible. That development has considerable value, particularly where silence, stigma, or poor recognition previously prevented people from seeking support. A less examined consequence, however, is the gradual treatment of psychotherapy as the normative destination for an increasingly broad range of human difficulties. Relationship transitions, occupational uncertainty, grief, temporary anxiety, conflict, identity questions, and developmental strain may all be described in therapeutic language even when the central need is not sustained treatment of a mental disorder or a pervasive psychological pattern. Within this climate, counselling is easily cast as an incomplete form of psychotherapy, while the move towards longer, more intensive, or more clinically coded intervention is interpreted as progress.

The resulting hierarchy rests on a category error. Psychological interventions do not become more appropriate merely because they are more intensive, longer, or more closely associated with clinical status. Appropriate care depends on fit between the person's needs, the primary task of change, the level of risk and impairment, the context in which distress has arisen, and the person's informed preferences. A short and focused counselling intervention may therefore be more appropriate than psychotherapy for one person, while immediate specialist assessment and structured psychotherapy may be indispensable for another. The ethical question is not which profession or intervention occupies the higher position, but which form of help is proportionate to the difficulty presented.

Recent scholarship provides several reasons to revisit this distinction. Research on professional identity indicates that psychological specialties develop through socialisation into particular values, explanatory habits, and expected forms of practice, not merely through the accumulation of techniques (Dollarhide et al., 2023; Schubert et al., 2023). Work on counselling psychology continues to identify an orientation towards development, strengths, context, plurality, and social justice, even while practitioners share substantial competencies with clinical psychology and psychotherapy (Stone & Di Mattia, 2024). At the same time, research on concept expansion warns that mental-health terminology can become broader and less discriminating, thereby obscuring differences between severe mental illness, clinically significant disorder, transient distress, and ordinary responses to adverse circumstances (Jackson & Haslam, 2022; Speerforck et al., 2026). Evidence on stepped care, low-intensity interventions, prevention, shared decision making, and treatment preferences further undermines the assumption that a single high-intensity pathway should serve all needs (Aoki et al., 2022; Buntrock et al., 2024; Chmielowska et al., 2023; Ohms et al., 2026; Schäfer et al., 2023).

A defence of counselling psychology can nevertheless become unconvincing if it relies on rigid binaries. Counselling and psychotherapy are neither mutually exclusive nor universally defined in the same way. Across jurisdictions, counselling may describe a profession, a specialty within psychology, a set of relational skills, a brief intervention, or an element within psychotherapy. Psychotherapy also encompasses diverse traditions, durations, settings, and levels of intensity. Many psychotherapists work developmentally and non-pathologisingly, while many counselling psychologists provide sophisticated treatment for complex and enduring difficulties. The distinction advanced in this article is therefore ideal-typical rather than territorial. It concerns the primary centre of gravity of an intervention rather than a protected list of techniques or clients.

Three aims guide the analysis. The first aim is to explain why counselling-oriented work should not be understood as a lower level on a single hierarchy of psychological depth. The second aim is to identify conditions under which counselling constitutes a positive indication rather than merely a temporary substitute for psychotherapy. The third aim is to formulate a decision framework that supports proportionate matching, protects against both under-treatment and unnecessary therapeutic escalation, and preserves the possibility of movement between levels of care.

1. Method and Scope of the Conceptual Review

A critical integrative review was undertaken to support theory development rather than to estimate a pooled treatment effect. Searches were conducted iteratively between 26 and 30 July 2026 through PubMed and publisher search interfaces. Search combinations included counselling psychology, counselling professional identity, counselling versus clinical psychology, psychotherapy indication, mental-health concept expansion, concept creep, pathologisation, stepped care, low-intensity psychological intervention, subthreshold depression, prevention of depression, shared decision making, treatment preference, autonomy support, psychotherapy non-response, adverse events, negative experiences, and client-defined outcomes. Citation chaining from relevant reviews and meta-analyses was used to identify additional recent work.

The review was deliberately restricted to sources published from January 2022 onwards. Priority was given to systematic reviews, meta-analyses, umbrella reviews, recent qualitative syntheses, empirical studies with direct conceptual relevance, and recent professional-identity research. Sources were included when they clarified at least one of five analytical domains, namely professional distinctiveness, proportionality of intervention intensity, risks of indiscriminate pathologisation, autonomy and collaborative choice, or the limits and possible adverse consequences of psychotherapy. Literature was excluded when it was purely jurisdictional, primarily promotional, unrelated to psychological helping, or dependent on a definition of counselling that could not be translated beyond a single service context.

The January 2022 cut-off was a purposive evidential horizon rather than an assertion that relevant theory originated during this period. Three considerations informed the decision. First, the article addresses a contemporary configuration shaped by the post-pandemic expansion of mental-health language, service demand, digital provision, and public discussion. Second, the most consequential empirical developments

for the proposed framework, including recent evidence on concept expansion, stepped and low-intensity care, shared decision making, client preference, non-response, adverse effects, and client-defined outcomes, have accumulated rapidly. Third, restricting formal citations prevented the conceptual model from being secured primarily through inherited professional self-descriptions. Foundational contributions to counselling psychology remain historically indispensable, but they were not treated as part of the formal evidence corpus. The review should therefore be read as a contemporary state-of-the-field synthesis, not as an intellectual history or comprehensive account of the specialty's theoretical lineage.

The procedure does not meet the criteria for a systematic review and should not be interpreted as exhaustive. No claim is made that all eligible studies were identified, and no formal risk-of-bias assessment was conducted. The purpose was conceptual integration, with the selected literature treated as converging and sometimes corrective evidence for a model of proportionate psychological help. Evidential weight therefore rests on convergence across recent reviews, syntheses, and empirical studies rather than on completeness of retrieval. The framework remains provisional and requires direct empirical testing.

2. Counselling and Psychotherapy as Overlapping but Non-Hierarchical Practices

Attempts to distinguish counselling from psychotherapy often begin with duration, severity, depth, or diagnosis. Each criterion captures part of common practice, yet none is sufficiently stable to support a universal boundary. Counselling can be long-term, psychotherapy can be brief, severe distress can be addressed within counselling psychology, and people without a formal diagnosis can benefit substantially from psychotherapy. A more defensible distinction concerns the organising purpose of the work and the theory of change that predominates within it.

Professional-identity research is useful because it shows that specialties are sustained by more than competence lists. Clinical psychologists develop professional identities through training cultures, role models, institutional expectations, and repeated exposure to particular ways of formulating problems (Schubert et al., 2023). Counselling identities are likewise shaped by values concerning development, prevention, wellness, context, relationality, advocacy, and social justice (Dollarhide et al., 2023; Um & Wood, 2022). These traditions overlap in their use of assessment, formulation, therapeutic relationship, reflective practice, and evidence-informed intervention, but overlap does not erase orientation. Stone

Table 1

Ideal-typical emphases in counselling-oriented and psychotherapy-oriented work

Dimension	Counselling-oriented emphasis	Psychotherapy-oriented emphasis
Primary task	Clarifying a situated problem, decision, transition, or developmental challenge and restoring effective agency.	Modifying persistent symptoms, pervasive patterns, recurrent relational difficulties, or entrenched modes of regulation.
Typical formulation	Person-in-context formulation that foregrounds resources, constraints, roles, values, and current demands.	Formulation that foregrounds maintaining mechanisms, developmental history, symptom processes, and recurrent patterns.
Temporal focus	The current situation and near-future action, while using history when it improves understanding and choice.	Repeated patterns across time, including their historical development and re-enactment in present relationships.
Use of diagnosis	Diagnosis may inform safety, referral, and access, but need not organise the whole helping relationship.	Diagnosis may be central, peripheral, or absent, although clinical indication and symptom monitoring are commonly prominent.
Client position	Active co-formulator and decision maker whose competence is strengthened and transferred beyond the helping relationship.	Active participant in a sustained change process that may require structured treatment, repeated practice, and relational work.
Intensity	Often focused or time-limited, but intensity is determined by need rather than professional label.	Often more sustained or structured, but brevity is compatible with psychotherapy when clinically indicated.
Success criteria	Improved clarity, functioning, coping, decision quality, resource use, participation, and confidence in self-management.	Reduced symptoms and impairment, altered maintaining processes, improved relational functioning, and more durable pattern change.
Boundary condition	Escalation is required when risk, impairment, complexity, or non-response exceeds the capacity of the current intervention.	De-escalation or completion is required when continued treatment no longer adds proportionate benefit or fosters unnecessary dependence.

Note. The distinctions identify centres of gravity rather than protected techniques, fixed durations, or mutually exclusive client groups.

and Di Mattia's (2024) study of Australian counselling psychologists found substantial perceived similarity between counselling and clinical psychology alongside continuing differences in philosophical emphasis, scope, and professional self-understanding.

The notion of a primary centre of gravity captures this combination of overlap and distinctiveness. Counselling-oriented work is organised principally around helping a person understand a situated difficulty, clarify aims, mobilise resources, make decisions, negotiate transitions, improve coping, and regain effective agency. Psychotherapy-oriented work is organised principally around sustained modification of persistent symptoms, recurrent interpersonal patterns, entrenched meanings, or enduring modes of emotional and behavioural regulation. Both forms of work may be emotionally deep, relationally demanding, and theoretically sophisticated. Depth is not reserved for the treatment of pathology, since a focused decision, bereavement process, identity transition, or crisis can involve profound questions of meaning and selfhood without requiring the person to be positioned as disordered.

Table 1 presents the distinction as a set of ideal-typical emphases. None of its rows should be used as a rigid exclusion criterion. The same practitioner may move between orientations, and an intervention may change its centre of gravity as new information emerges. The table instead makes visible a difference that becomes obscured when all psychological help is compressed into the single category of therapy.

3. Why a Hierarchy of Psychological Help Persists

A hierarchy in which psychotherapy appears more advanced than counselling is sustained by institutional as well as conceptual forces. Mental-health systems often organise access around diagnosable conditions, reimbursable treatments, and specialist credentials. Training cultures may then associate professional maturity with movement towards increasingly clinical language, complex casework, and longer interventions. Public communication contributes when psychotherapy is used as an umbrella term for all serious psychological help, leaving counselling associated with advice giving, generic support, or conversations that anyone could provide.

Professional identity can intensify this hierarchy because status is partly relational. A specialty becomes easier to define when contrasted with a supposedly less expert neighbour. Research on professional identity in psychology shows that such identities are constructed through socialisation and through the reproduction of established ways of knowing and acting (Schubert et al., 2023). Counselling psychology faces a particular challenge because its pluralism and contextual orientation can be misread as theoretical vagueness, while the similarity of many competencies to those of clinical psychologists can make its distinctive contribution difficult to articulate (Stone & Di Mattia, 2024). The resulting response may be assimilation, with counselling practitioners demonstrating legitimacy by adopting the language and aspirations of clinical treatment.

Assimilation carries a cost. When counselling gains status only by resembling psychotherapy, its developmental, preventive, contextual, and resource-oriented functions become less visible. People whose distress is serious but situated may be offered a treatment identity before they have been offered a sufficiently careful understanding of what has happened, what matters to them, what remains intact, and which environmental conditions can be changed. The problem is not that therapeutic language is inherently harmful, but that one language can become so dominant that alternative formulations cease to appear professionally credible.

A non-hierarchical account therefore requires more than reassurance that counselling is valuable. Distinct value must be specified in terms that are clinically responsible and empirically open. Counselling cannot be defined simply as work with 'healthy' people, since health and disorder are not binary states and many clients present with mixed needs. Nor can psychotherapy be equated with pathology, because contemporary psychotherapies frequently emphasise meaning, strengths, social context, and client agency. The more precise claim is that counselling-oriented work can be the positively indicated form of help when the central change task is contextual adaptation, resource mobilisation, decision support, or restoration of agency, provided that risk and complexity are appropriately assessed.

4. From Mental-Health Awareness to Therapeutic Overreach

The expansion of mental-health awareness has corrected genuine neglect, but broader recognition can also reduce conceptual discrimination. Jackson and Haslam (2022) describe a trend in which concepts of mental health and mental illness become broader, looser, and more benign, while serious mental illness may paradoxically become less visible within an undifferentiated vocabulary of distress. Experimental work by Speerforck et al. (2026) further suggests that judgements about what counts as mental illness can expand when severe exemplars become less prevalent, illustrating a prevalence-induced form of concept change.

Concept expansion is not equivalent to diagnostic error, and broad language can help people recognise suffering that was previously dismissed. Problems arise when ordinary adversity, clinically significant disorder, and severe mental illness are discussed as though they differed only in degree of the same therapeutic requirement. A person grieving a loss, facing workplace conflict, or questioning a major life decision may experience intense distress and still require a formulation centred on context, meaning, relationships, practical constraints, and existing capacities rather than on an assumed internal dysfunction. Conversely, apparently contextual distress may conceal major depression, trauma-related disorder, psychosis, substance dependence, or acute risk. Non-pathologising practice must therefore involve careful discrimination rather than automatic normalisation.

Therapeutic overreach can be defined as the use of a more intensive, clinical, or treatment-centred frame than is justified by the person's primary needs and current level of impairment. The concept concerns proportionality, not the moral value of psychotherapy. Overreach may occur through premature diagnosis, unnecessary extension of treatment, repeated interpretation of situational problems as intrapsychic deficits, or neglect of modifiable social and material conditions. Evidence that combined interventions addressing psychological needs and social determinants can improve outcomes in low- and middle-income settings reinforces the inadequacy of purely intrapsychic accounts when distress is substantially produced or maintained by adversity (Prina et al., 2025).

Several harms are plausible even when intentions are benevolent. An unnecessarily clinical formulation may narrow a person's identity around symptoms, relocate responsibility for harmful conditions into the individual, reduce confidence in ordinary coping, or encourage indefinite dependence on professional interpretation. Scarce specialist capacity may also be diverted from people whose risk, impairment, or complexity requires it. These risks remain hypotheses in need of direct empirical testing, and the argument should not be overstated. Evidence on adverse experiences in psychotherapy nevertheless demonstrates that psychological treatment is not intrinsically harmless and that negative effects, non-response, and experiences of invalidation or dependency deserve explicit attention (Klatte et al., 2025; Vybíral et al., 2024).

Under-treatment represents the symmetrical danger. Framing severe or persistent symptoms as normal life difficulty can delay effective treatment, increase risk, and communicate that a person should manage alone. A credible non-pathologising position must therefore preserve the full legitimacy of diagnosis, psychiatric assessment, and psychotherapy when they are indicated. The relevant ethical commitment is neither maximum treatment nor minimum treatment, but sufficient and proportionate help combined with systematic review of response.

5. Proportionate Intensity and the Evidence for Multiple Levels of Care

Stepped-care models provide the clearest service-level challenge to the assumption that all psychological distress should enter the same pathway. In stepped care, intervention intensity is matched to need and adjusted according to response. A recent systematic review and meta-analysis found that stepped care can produce favourable clinical and quality-of-life outcomes compared with usual care across mental-health conditions, although heterogeneity and implementation differences remain important (Ohms et al., 2026). The model is ethically relevant because it treats escalation and de-escalation as expected features of care rather than as evidence that an initial practitioner or client has failed.

Evidence for lower-intensity and preventive interventions also indicates that meaningful benefit does not depend uniformly on traditional high-intensity psychotherapy. Meta-analytic findings support WHO

low-intensity interventions such as Problem Management Plus and Step-by-Step across varied settings (Schäfer et al., 2023). Psychological interventions can reduce the onset of major depression among adults at increased risk (Buntrock et al., 2024), while network meta-analysis suggests that non-pharmacological interventions can benefit adults with subthreshold depression (He et al., 2022). Focused psychological interventions have also shown efficacy for young adults with mild-to-moderate depressive symptoms (Medina et al., 2022).

Such evidence should not be converted into a simplistic claim that briefer or less intensive care is always sufficient. Self-guided interventions show modest average benefits and considerable variation in adherence and outcome, which underlines the importance of fit, support, and monitoring (Tong et al., 2024). Workplace mental-health interventions likewise operate across universal, selective, and indicated levels, with different purposes and populations rather than a single treatment continuum (Miguel et al., 2023). The practical conclusion is pluralism under conditions of accountability. Multiple levels of intervention are justified when each level has a clear purpose, defined competence requirements, and explicit criteria for review.

The most useful principle is the least intensive defensible intervention, not the least expensive or least demanding intervention. Defensibility requires that the selected form of help can reasonably address the primary change task, that safety and complexity have been assessed, that the client understands alternatives, and that progress will be reviewed. A counselling intervention is not proportionate merely because symptoms are mild, and psychotherapy is not disproportionate merely because no diagnosis is present. Proportionality is a judgement about the whole configuration of need, preference, context, likely mechanism, and available support.

6. The Distinctive Change Tasks of Counselling-Oriented Work

A positive account of counselling psychology requires specification of what the work actively does. Four interdependent change tasks are especially important, although they do not exhaust the field. The tasks concern contextual formulation, resource mobilisation, autonomy-supportive collaboration, and transfer of competence into the person's everyday life.

6.1. Contextual formulation without reductionism

Counselling-oriented formulation begins by locating distress within a person's current relationships, roles, transitions, values, opportunities, constraints, and social environment. Internal processes remain relevant, but they are not presumed to be the sole or primary source of the problem. A conflict at work may involve anxiety, avoidance, shame, and earlier relational learning, while also involving unsafe management, discrimination, excessive demands, or material dependence. A proportionate formulation keeps these levels in view and resists converting every external conflict into an individual deficit.

Contextual formulation also protects against superficial reassurance. Describing a response as understandable does not imply that it is easy, harmless, or self-correcting. Counselling may involve intensive emotional processing, crisis containment, behavioural planning, communication work, and repeated examination of ambivalence. Its non-pathologising quality lies not in denying suffering, but in avoiding unnecessary assumptions that the person is fundamentally impaired.

6.2. Resource mobilisation and basic psychological needs

Resource-oriented work is sometimes caricatured as positive thinking. In competent practice, it consists of identifying capacities, successful exceptions, supportive relationships, practical assets, cultural resources, and conditions under which functioning improves. The purpose is not to ignore vulnerability but to enlarge the range of causal information available for change. A person who has coped effectively in some contexts already possesses data about what supports action, even when those capacities are temporarily inaccessible.

Recent meta-analytic evidence concerning basic psychological needs strengthens this account. Interpersonal support for autonomy, competence, and relatedness is associated with need satisfaction, motivation, well-being, and performance across a large evidence base (Oliverio et al., 2022; Slemp et al., 2024). Counselling relationships can operationalise these supports by preserving meaningful choice, making progress attributable to the client rather than to the expert, and offering reliable relational engagement

without cultivating avoidable dependence. Autonomy support does not mean leaving a distressed person alone with decisions; it means structuring professional input so that agency becomes more possible.

6.3. Shared decision making and preference-sensitive help

Shared decision making provides an ethical and practical mechanism for matching help to the person rather than merely assigning the person to a service category. The approach combines professional knowledge about options, risks, and likely outcomes with the client's experiential knowledge of values, circumstances, previous help, and acceptable burdens. Reviews in mental-health settings show growing commitment to shared decision making, alongside persistent implementation difficulties and variable outcome evidence (Aoki et al., 2022; Chmielowska et al., 2023).

Preference-sensitive practice is particularly important when several reasonable options exist. Clients may differ in their desired level of therapist direction, emotional challenge, structure, mode of delivery, duration, and focus. Qualitative research indicates that preferences are neither trivial nor fixed; they can change during treatment, and their exploration can influence the therapeutic relationship and the client's sense of recognition (Cooper et al., 2023). A meta-analysis of anxiety and depression treatment found that preference accommodation was associated with satisfaction and adherence outcomes, although effects vary across studies and outcomes (Eigenhuis et al., 2024).

Counselling-oriented work is well placed to treat the choice of help as part of the helping process. Discussion can include the option of no formal intervention, a focused counselling contract, group or community support, practical advocacy, digital or guided self-help, psychiatric assessment, or psychotherapy. Shared choice must nevertheless remain clinically bounded. Acute risk, severe cognitive disruption, or major loss of decision-making capacity can require more directive action, while still preserving participation to the greatest extent possible.

6.4. Transfer of competence rather than indefinite professional dependence

A central counselling outcome is increased capacity to handle future difficulties without unnecessary professional support. Transfer occurs when clients can identify needs, recognise resources, understand obstacles, generate options, evaluate consequences, and carry decisions into action. Psychoeducation, feedback, rehearsal, and advice may all contribute, provided that they expand rather than replace the person's decision-making capacity.

This emphasis clarifies why counselling is not synonymous with giving advice. Premature recommendations can interrupt exploration, conceal ambivalence, and move ownership of the decision towards the practitioner. Equally, refusal to provide relevant information can become a form of professional withholding. The proportionate response is collaborative information exchange in which the practitioner first elicits the client's understanding and wishes, offers evidence or options transparently, and then explores the meaning and usability of what has been offered. The success criterion is not compliance with expert advice but improved capacity for informed and workable action.

7. When Psychotherapy Is the More Proportionate Response

A strong account of counselling must specify where counselling alone is unlikely to be sufficient. Psychotherapy becomes the more proportionate response when the primary task involves sustained change in persistent symptoms, pervasive patterns, recurrent relational difficulties, or entrenched modes of emotional and behavioural regulation. Marked functional impairment, repeated crises, substantial comorbidity, high or unstable risk, dissociation, psychotic experiences, severe eating pathology, substance dependence, or complex trauma may also require specialist assessment and coordinated treatment. These features do not define a single profession's exclusive territory, but they increase the need for structured formulation, treatment planning, monitoring, and access to multidisciplinary care.

Duration alone does not establish indication. Brief psychotherapies can be appropriate for circumscribed clinical problems, while extended counselling may be justified during prolonged transitions or disability-related adaptation. Nor should diagnosis automatically determine modality. Diagnostic information can identify risks and evidence-based treatment options, yet two people with the same diagnosis may differ substantially in impairment, context, preference, support, and primary change task. Indication is therefore a formulation-based decision rather than a direct translation from label to service.

Recent evidence concerning psychotherapy's limits reinforces the need for explicit indication and monitoring. Systematic reviews have identified inconsistent assessment and reporting of adverse events in psychotherapy trials, making confident estimates difficult while showing that safety cannot be assumed (Klatte et al., 2023, 2025). A qualitative meta-analysis of clients' negative experiences identified processes involving misattunement, harmful therapist behaviour, unhelpful treatment structures, and difficult consequences of therapy (Vybíral et al., 2024). Research on non-response similarly points to a complex interaction of client, therapist, relational, contextual, and treatment factors rather than a simple deficit in motivation (Carrington et al., 2024).

These findings do not weaken the case for psychotherapy. Instead, they place psychotherapy within the same ethical framework applied to other powerful interventions. Benefits should be expected on the basis of indication and evidence, progress should be reviewed, unwanted effects should be discussed, and continuation should depend on a defensible balance of benefit and burden. Client-defined outcomes are relevant because meaningful change extends beyond symptom reduction to relationships, self-understanding, agency, emotional capacity, and participation in life (Ladmanová et al., 2025). Psychotherapy is most credible when its depth is accompanied by proportionality, transparency, and willingness to revise the plan.

8. The Proportionate Psychological Help Framework

The Proportionate Psychological Help Framework translates the preceding argument into a structured decision process. Its purpose is not to allocate people permanently to counselling or psychotherapy, but to determine the most defensible starting point and the conditions under which that choice should change. Seven domains are considered together, because no single symptom score, diagnosis, duration estimate, or professional title can establish fit.

The first domain concerns safety and clinical complexity. Immediate risk, severe self-neglect, rapidly deteriorating functioning, psychosis, mania, intoxication or withdrawal, major cognitive disruption, and medical conditions that may account for psychological symptoms require urgent or specialist assessment. The second domain concerns functional impairment across work or study, relationships, self-care, sleep, and daily responsibilities. The third concerns persistence and pervasiveness, distinguishing a time-limited reaction linked to identifiable circumstances from recurrent or cross-situational patterns that continue despite environmental change.

The fourth domain identifies the primary change task. The task may be clarification, decision making, crisis stabilisation, grief adaptation, skill acquisition, environmental problem solving, symptom treatment, trauma processing, or modification of recurrent relational patterns. The fifth domain examines contextual determinants and asks which material, relational, organisational, cultural, or structural conditions can be changed directly. The sixth considers agency, reflective capacity, resources, and informed preference. The seventh establishes monitoring criteria, including expected indicators of benefit, an agreed review point, and triggers for escalation, alteration, consultation, or completion.

The framework adopts a dynamic sequence. Assessment first rules out needs that cannot safely be contained within the proposed setting. Collaborative formulation then identifies the primary change task and the most plausible mechanisms of change. Practitioner and client compare reasonable options, including their likely benefits, burdens, uncertainties, and availability. The least intensive defensible option is selected, not because less care is inherently better, but because adequate care should not be exceeded without reason. Progress and unwanted effects are reviewed using symptom, functioning, goal, and client-defined indicators. Care is stepped up, stepped sideways, combined, or stepped down when the formulation or response changes.

Table 2 summarises the domains and their implications. The model deliberately avoids assigning counselling to 'mild cases' and psychotherapy to 'serious cases'. A situational crisis may be acutely severe yet respond best to specialised crisis counselling and practical support, while a person with modest symptom scores may require psychotherapy because a recurrent pattern repeatedly constrains relationships and functioning. Severity matters, but it does not substitute for formulation.

Table 2

Domains of the Proportionate Psychological Help Framework

Decision domain	Core questions	Implications for matching and review
Safety and complexity	Is there acute risk, severe deterioration, psychosis, mania, substance-related instability, major cognitive disruption, or a possible medical cause?	Urgent assessment, specialist care, or coordinated multidisciplinary treatment takes priority. Counselling may remain adjunctive only when the setting and competence are adequate.
Functional impairment	How strongly are work or study, relationships, self-care, sleep, and ordinary responsibilities affected?	Greater and broader impairment increases the need for structured treatment, coordination, and closer monitoring, but does not determine modality by itself.
Persistence and pervasiveness	Is the difficulty time-limited and context-linked, or recurrent across situations and relationships despite environmental change?	Context-linked and time-limited problems often support a counselling start. Persistent cross-situational patterns strengthen the indication for psychotherapy.
Primary change task	Does the person principally need clarification, decision support, resource mobilisation, practical adaptation, symptom treatment, trauma processing, or pattern change?	The selected modality should possess a plausible mechanism for the task rather than merely matching a professional label or service convention.
Contextual determinants	Which relational, organisational, material, cultural, or structural conditions produce or maintain the difficulty, and which can be changed?	Counselling, advocacy, social intervention, or combined care may be more proportionate when modifiable context is central.
Agency, resources, and preference	What capacities and supports remain available, what form of participation is possible, and which options are acceptable to the client?	Collaborative choice is preferred when multiple safe options exist. Greater impairment may require more structure without eliminating participation.
Response and unwanted effects	What outcomes would indicate benefit, when will progress be reviewed, and what signs require escalation, alteration, or completion?	No initial match is final. Non-response, deterioration, adverse experience, or a changed formulation requires active revision rather than passive continuation.

Note. Domains are considered jointly and revisited over time. The framework supports referral, combination of interventions, and movement in either direction between levels of care.

9. Implications for Professional Education and Service Design

A proportionate system requires counselling psychologists to possess more, not less, clinical responsibility. Competence must include risk assessment, recognition of severe and complex presentations, differential consideration of medical and psychiatric factors, crisis response, evidence-informed focused interventions, outcome monitoring, and timely referral. Non-pathologising practice without these competencies can become unsafe reassurance. Advanced counselling education should also include contextual and systemic formulation, shared decision making, culturally responsive practice, social-determinants awareness, psychoeducation, feedback and advice processes, and explicit methods for strengthening agency without abandoning structure.

Psychotherapy education has a complementary responsibility. Training should address proportionality, informed choice, adverse experiences, non-response, and the ethics of ending or reducing treatment. Greater interpretive depth does not exempt psychotherapy from demonstrating present relevance and added benefit. Practitioners need to recognise when environmental intervention, practical counselling, social support, or a less intensive pathway would better serve the client, as well as when psychotherapy should be combined with psychiatric, medical, or social care.

Service design should provide several credible entry points rather than a single funnel into psychotherapy. Initial assessment must move beyond symptom counts to include functioning, context, pattern persistence, primary change task, risk, resources, and preference. Counselling should be visible as an affirmative option with clear competencies and outcomes, not as a waiting-list intervention offered until 'real treatment' becomes available. Equally, referral pathways must allow rapid escalation when counselling reveals needs that require specialist or multidisciplinary treatment.

Outcome systems also need expansion. Symptom change remains essential where symptoms are central, but counselling-oriented work may aim at decision quality, role functioning, coping flexibility, access to resources, social participation, conflict resolution, self-efficacy, or successful adaptation to transition. Client-identified outcomes can capture changes that standard disorder measures miss, while routine

collection of adverse and unwanted effects protects against an exclusively celebratory account of intervention (Klatte et al., 2025; Ladmanová et al., 2025).

Professional regulation should focus on demonstrable competence, scope, accountability, and referral capacity rather than on prestige attached to titles. The same label can conceal substantial variation in training across jurisdictions, while different labels can describe overlapping competencies. Regulation cannot resolve all conceptual ambiguity, but it can require transparent communication about qualifications, methods, limits, supervision, complaints procedures, and the kinds of problems for which a service is designed.

10. Research Agenda

The Proportionate Psychological Help Framework should not be treated as a completed classification system that can be transferred directly into practice without empirical examination. Its value depends on whether it can improve decisions in situations where distress is evident, but the appropriate form, focus, and intensity of professional help remain uncertain. Future research must therefore move beyond the conventional question of whether counselling and psychotherapy reduce symptoms and examine whether people receive help that corresponds to the nature of their difficulties, supports the change they actually seek, avoids unnecessary professional burden, and remains responsive when the original formulation proves inadequate. Two closely connected areas require particular attention. The first concerns the meaning and measurement of successful counselling, while the second concerns the quality of the match between the person, the presenting difficulty, and the intervention offered. These areas cannot be separated completely, because an intervention cannot be judged successful without considering whether it addressed the task for which help was sought, and the appropriateness of the initial match can be evaluated only through the person's subsequent development.

10.1. *What counts as success in counselling*

Outcome research in psychological care has been shaped predominantly by standardised measures of symptom reduction. Such measures remain relevant whenever anxiety, depression, trauma-related reactions, or other clinically significant symptoms form part of the presenting problem, but their usefulness does not justify treating symptom change as a universal definition of improvement. Many people enter counselling because they are unable to make an important decision, are struggling with a developmental or occupational transition, have lost access to previously effective coping resources, or need to understand how personal, relational, and environmental pressures have become entangled. Progress in such cases may be reflected in greater clarity, restored functioning, more deliberate action, improved use of social support, or a realistic change in the conditions sustaining the difficulty. A symptom scale may capture part of this movement, but it cannot adequately express its meaning. Counselling success should therefore be defined in relation to the primary change task that brought the person into contact with the service. Practitioner and client should establish from the beginning what the client hopes will become different, how meaningful progress might become observable, and which developments would indicate that the current form of help is insufficient. Such agreement need not reduce a complex difficulty to a rigid treatment contract. Its purpose is to prevent professional activity from continuing without a shared understanding of what it is expected to accomplish.

Client-defined goals provide one foundation for this form of evaluation, particularly when they are translated into observable and contextually meaningful indicators. Goal Attainment Scaling may offer a structured method for recording individualised change, although its usefulness depends on carefully defined anchors, consistent scoring, and transparent interpretation rather than on the mere assignment of numerical values (Logan et al., 2022; Baur et al., 2024). The broader principle remains more important than any particular instrument. Evaluation should begin with the person's own priorities while remaining open to professional concerns that may not have been visible at the outset, including deterioration, emerging risk, or previously unrecognised functional impairment. Meaningful counselling outcomes may therefore encompass several interconnected dimensions. Improved functioning may appear in a return to study, employment, caregiving, social participation, or ordinary routines that had become difficult to sustain. Progress may also become visible in the quality of decision making, especially when a client becomes more able to tolerate uncertainty, examine competing values, and choose without transferring

responsibility for the decision to the practitioner. Greater agency may be reflected in increased confidence, autonomous motivation, more effective use of personal and interpersonal resources, and a reduced expectation that every subsequent difficulty requires professional intervention. Recent evidence linking client self-determination with counselling outcomes among people experiencing milder distress supports the inclusion of autonomy and perceived agency as substantive outcomes rather than merely desirable qualities of the helping relationship (Leibert et al., 2022).

Context must remain visible throughout this evaluation because psychological help becomes conceptually distorted when improvement is defined only as the individual's increased ability to endure an avoidable or harmful situation. Counselling may support adaptation, but it may also enable a person to recognise that the surrounding conditions require change. Success may therefore involve seeking institutional support, establishing safer relational boundaries, modifying an unsustainable workload, leaving a harmful environment, or gaining access to resources that were previously unavailable. Such developments cannot be treated as external events unrelated to the intervention, because recognising and mobilising contextual possibilities may constitute its central achievement. A non-pathologising approach does not imply that distress should be minimised or that symptom assessment should be abandoned. Serious symptoms may emerge from a difficulty initially understood as situational, just as an apparently clinical presentation may become more intelligible when occupational, relational, social, or developmental circumstances are examined. Outcome evaluation must therefore remain capable of detecting improvement as well as the need to reconsider the original formulation. Counselling has not failed merely because referral to psychotherapy or another service becomes necessary, and it has not succeeded merely because a planned number of sessions has been completed. Timely recognition that the current intervention no longer corresponds to the client's needs represents responsible practice rather than evidence of professional inadequacy.

Timing also influences what may reasonably be regarded as success. Immediate relief can be valuable, although some of the most important effects of counselling become visible only after the person has attempted to act without continuous professional support. Assessment at the end of contact should therefore be complemented by later follow-up whenever the nature of the intervention and the conditions of the service allow it. Follow-up can show whether decisions remained sustainable, whether functioning continued to improve, whether the client could apply acquired capacities in new situations, and whether apparent short-term progress concealed subsequent deterioration. Routine outcome monitoring may support this process when feedback is used as a basis for reflection rather than as an administrative requirement. Evidence suggests that measurement-feedback systems are particularly useful when clients are not progressing as expected, because non-response may be recognised before an unproductive intervention becomes unnecessarily prolonged (Rognstad et al., 2023). Numerical indicators should nevertheless be interpreted alongside the client's account of change. A temporary increase in distress may accompany a necessary confrontation with difficult circumstances, whereas declining symptoms may coexist with avoidance, passivity, or growing dependence on professional reassurance. Meaning emerges from the relationship between the agreed change task, the observed course of the intervention, and the client's understanding of what has altered. Counselling success is therefore better understood as a coherent pattern involving meaningful movement towards client-valued goals, preserved or improved safety, stronger functioning, greater capacity for autonomous action, and a more effective relationship with the surrounding context. No requirement follows that every intervention must improve every domain, because relevance depends on the nature of the original difficulty. The essential condition is that the selected outcomes correspond to the purpose of the help and remain sensitive to evidence that another form or intensity of care has become necessary.

10.2. From appropriate matching to therapeutic overreach

A more adequate understanding of counselling outcomes creates the basis for examining the broader question at the centre of the framework. Research must determine whether matching psychological help to the person's primary change task produces better results than allocation based mainly on diagnosis, professional title, habitual service pathways, or the assumption that more intensive treatment is inherently preferable. Pragmatic studies could compare counselling-oriented and psychotherapy-oriented pathways among people who report similar levels of distress but differ in the persistence of their difficulties, degree

of functional impairment, contextual loading, personal resources, preferences, and capacity to act. Such designs would avoid the misleading expectation that counselling and psychotherapy should be tested as competing interventions for an undifferentiated population. More informative comparisons would examine whether people whose difficulties are predominantly situational, developmental, transitional, or decision-related benefit from counselling-oriented work without increased risk of subsequent deterioration, while people presenting with persistent, pervasive, or recurrent difficulties receive timely access to more intensive intervention. Framework-guided allocation could also be compared with usual triage practice through outcomes that include client-valued change, functioning, safety, satisfaction, waiting time, financial and temporal burden, premature dropout, unnecessary continuation, and the frequency with which care must subsequently be intensified or reduced. Escalation should not automatically count as failure because proportionate care depends on the possibility of revising an initial decision when new information appears. Greater significance lies in whether escalation occurs promptly and for intelligible reasons, or only after a prolonged period of non-response that could have been recognised earlier.

De-escalation deserves comparable attention because professional systems often associate longer and more intensive intervention with seriousness, expertise, and quality. Some clients may remain in psychotherapy after the primary change task has been achieved, not because continued treatment is clearly indicated, but because ending is experienced as clinically risky, professionally uncomfortable, or economically disadvantageous. Comparable scrutiny must be applied to counselling services that retain clients despite evidence that more specialised intervention is required. Proportionality loses its ethical meaning when it is used only to justify less intensive care and does not support movement in both directions. The concept of therapeutic overreach consequently requires careful definition. Overreach cannot be inferred merely from the use of psychotherapy, from the duration of treatment, or from the presence of a diagnostic formulation. Psychotherapy may be entirely proportionate for a person whose present distress followed a recent event when that event activated persistent relational, emotional, or behavioural patterns that repeatedly impair functioning. Conversely, a brief intervention may still represent poor care when it individualises a problem rooted primarily in harmful social conditions or fails to recognise substantial clinical complexity. Therapeutic overreach should therefore be investigated as a mismatch in which the form, intensity, duration, or explanatory frame of professional help exceeds what is required by the person's needs and change task.

Possible manifestations of such mismatch include the use of an unnecessarily prolonged intervention, the interpretation of a contextually intelligible difficulty primarily through a pathology-oriented framework, the weakening of client agency, avoidable dependence on professional validation, or diversion of attention from conditions that could realistically be changed. None of these consequences should be assumed in advance. Their presence must be examined empirically rather than asserted rhetorically. Experimental and vignette-based studies could explore how different explanations of the same difficulty influence perceived agency, expectations concerning recovery, anticipated duration of professional help, willingness to address environmental causes, and confidence in future coping. Diagnostic, psychotherapeutic, developmental, and contextual formulations would need to be presented with equal care so that one approach was not constructed as obviously humane and another as obviously reductive. The purpose would not be to demonstrate that clinical language is inherently harmful, but to identify the circumstances in which a particular explanation clarifies experience and supports appropriate care, as well as those in which it unnecessarily narrows the person's understanding of what is happening.

Clients' prospective and retrospective accounts would add dimensions that standardised measures cannot provide. People who have experienced counselling, psychotherapy, combined care, referral, or deliberate termination may understand sufficiency and excess in ways that differ from professional assumptions. A client may value a longer intervention that initially appeared disproportionate because it opened areas of experience that had remained inaccessible, while another may regard an apparently successful course of therapy as excessive because ordinary uncertainty became something that could no longer be managed without professional interpretation. Longitudinal qualitative research could examine how these meanings develop after immediate distress has subsided and everyday life has resumed. Such research would clarify whether clients experience psychological help as enabling, insufficient, unnecessarily prolonged,

pathologising, or dependency-producing, and whether these interpretations correspond with changes in functioning, agency, and later help-seeking.

Professional and institutional conditions must also be investigated because decisions concerning care are never made in a conceptual vacuum. Training traditions may teach practitioners to recognise certain types of difficulty more readily than others, reimbursement systems may favour diagnosable conditions and longer treatment, while underfunded services may move in the opposite direction and present premature brevity as proportionality. Public **communication may portray psychotherapy as the most serious or authentic form of** psychological help, whereas counselling is reduced to advice giving or preliminary support. Such conditions shape client expectations and professional judgement before an individual assessment has begun. Research on professional identity should consequently examine how hierarchies are reproduced through education, accreditation, occupational regulation, referral practice, service design, and institutional prestige. Scenario-based studies could investigate whether identical client presentations are judged differently when the proposed intervention is labelled counselling or psychotherapy, while training research could examine whether practitioners learn to distinguish different change tasks or merely assign increasing intensity according to symptom severity. Organisational studies could then explore whether services support movement between forms of help without presenting referral, de-escalation, or shared care as evidence of professional failure.

International comparison remains indispensable because counselling psychology and psychotherapy do not occupy equivalent positions across countries. Occupational titles, protected scopes of practice, routes into professional training, and relationships with healthcare systems vary considerably, which means that direct comparison based only on professional labels would produce misleading conclusions. Greater conceptual precision would come from comparing what practitioners actually do, which clients they serve, how they formulate difficulties, what outcomes they seek, and how readily care can be intensified, reduced, or combined. Validation of the Proportionate Psychological Help Framework must ultimately demonstrate that it improves judgement rather than merely arranging familiar considerations into a new vocabulary. Agreement between practitioners, acceptability to clients, feasibility in routine services, sensitivity to changing circumstances, and capacity to identify both insufficient and excessive intervention should all be examined. Stronger evidence would come from showing that framework-guided decisions improve outcomes without restricting access to psychotherapy for people who need it. Proportionality must therefore remain an empirical and revisable principle, because ethical appeal alone cannot establish that a particular intervention was appropriate. Evidence must show that the form of help corresponded to the person's needs, that progress was evaluated through outcomes relevant to the original difficulty, and that the pathway remained open to revision when the initial match no longer served the client.

11. Discussion

The central argument developed in this article is not that counselling should replace psychotherapy, nor that ordinary distress can be separated cleanly from clinically significant difficulty. A more defensible conclusion concerns the basis on which psychological help is selected and evaluated. When counselling and psychotherapy are placed on a single ladder of professional depth, differences in purpose, context, expected mechanism of change, and client preference become secondary to assumptions about intensity and status. The Proportionate Psychological Help Framework reverses that order. Rather than asking which intervention is inherently more advanced, it asks what kind of change is required, what level of support can reasonably facilitate it, and what evidence would indicate that the original choice should be reconsidered. Such a shift preserves the legitimacy of specialist psychotherapy while making it possible to recognise counselling as a positively indicated form of psychological help rather than as an incomplete version of something more substantial.

Recent evidence supports this move away from a simple hierarchy, although the support is distributed across bodies of literature that have rarely been considered together. Research on concept expansion shows how distinctions between severe mental illness, clinically significant disorder, transient distress, and ordinary adversity may become less visible when a broad therapeutic vocabulary is applied indiscriminately (Jackson & Haslam, 2022; Speerforck et al., 2026). Stepped-care and low-intensity intervention

research demonstrates that meaningful psychological benefit can arise from interventions differing considerably in intensity, format, and theoretical ambition, provided that allocation and monitoring are adequate (Schäfer et al., 2023; Buntrock et al., 2024; Ohms et al., 2026). Work on shared decision making and client preference further challenges the assumption that professional judgement can determine appropriateness without sustained attention to the person's values, previous experiences, acceptable burdens, and desired form of participation (Aoki et al., 2022; Cooper et al., 2023; Eigenhuis et al., 2024). Evidence concerning non-response, adverse experiences, and unwanted effects meanwhile establishes that psychotherapy cannot be treated as a uniformly beneficial intervention whose greater intensity requires no separate justification (Carrington et al., 2024; Klatte et al., 2023, 2025; Vybíral et al., 2024). Considered together, these findings support psychological pluralism, but only when pluralism is accompanied by clear purposes, competent assessment, collaborative choice, and a genuine capacity to revise care.

The intentionally restricted publication window from 2022 to July 2026 should be understood in relation to this contemporary purpose. The review was designed to capture the most recent evidence concerning changes in mental-health discourse, service organisation, shared decision making, low-intensity care, psychotherapy non-response, and unwanted effects. Such a restriction does not imply that the theoretical foundations of counselling psychology began in 2022, nor that earlier scholarship has lost its explanatory significance. Foundational accounts remain essential for understanding the historical development of developmental, contextual, humanistic, preventive, and strengths-oriented traditions within counselling psychology. Their systematic reconstruction would, however, require a different form of inquiry from the contemporary conceptual synthesis undertaken here. The present evidential horizon should therefore be read as a deliberate analytical boundary rather than as a rejection of the discipline's theoretical genealogy.

Proportionality nevertheless differs from a conventional interpretation of stepped care. A service model based primarily on symptom severity may still reproduce the assumption that counselling belongs to mild cases and psychotherapy to severe ones. Severity and functional impairment are indispensable considerations, but neither determines the form of help independently of the problem that the intervention is expected to address. Intense distress following bereavement, occupational rupture, displacement, relationship breakdown, or another major transition may require skilled and sustained counselling without necessarily requiring treatment organised around a presumed enduring psychological dysfunction. Modest symptom scores may, by contrast, coexist with recurrent relational patterns, pervasive avoidance, long-standing emotional dysregulation, or repeated impairment that makes psychotherapy the more proportionate response. The framework therefore supplements the vertical logic of intervention intensity with a horizontal consideration of the primary change task. Such an approach allows different forms of help to be understood as responses to different configurations of need rather than as successive stages through which every client should advance.

The distinction between counselling-oriented and psychotherapy-oriented work remains intentionally permeable. Professional practice does not divide itself according to conceptual boundaries, and a single course of help may move from crisis stabilisation and practical decision support towards sustained work with recurrent patterns, or may begin with psychotherapy and later become focused on reintegration, adjustment, and transfer of competence into everyday life. Counselling psychologists may provide complex psychotherapeutic interventions, while psychotherapists may work contextually, developmentally, and without unnecessary pathologisation. Professional identity research nevertheless indicates that shared competencies do not eliminate differences in the values and explanatory habits cultivated through training and institutional socialisation (Dollahide et al., 2023; Schubert et al., 2023; Stone & Di Mattia, 2024). The concept of a primary centre of gravity is useful precisely because it avoids converting these differences into exclusive jurisdictions. Distinctiveness rests less on who is permitted to use a particular technique than on what organises the work, how the difficulty is formulated, what kind of change is privileged, and where responsibility for future functioning is expected to reside.

From this perspective, the contribution of counselling psychology lies not in offering less serious help, but in preserving forms of professional attention that may become obscured when treatment becomes the dominant metaphor for every psychological difficulty. Contextual formulation, resource mobilisation, collaborative decision making, and transfer of competence are not secondary activities that precede

the real work of psychological change. For many clients, those activities constitute the work. Greater clarity about a decision can alter the direction of a life without requiring reconstruction of personality. Recognition that distress is connected to an exploitative workplace, an unsafe relationship, social isolation, discrimination, or inaccessible resources may redirect intervention from self-correction towards meaningful environmental action. Restoration of agency may be clinically consequential even when symptom change is gradual or incomplete. Combined interventions addressing psychological needs and social determinants offer further support for the view that effective help cannot always be confined to intrapsychic explanation and treatment (Prina et al., 2025). A non-pathologising formulation therefore does not deny psychological processes, but prevents them from becoming the only level at which suffering is understood.

Particular care is required around the principle of the least intensive defensible intervention. Detached from the wider argument, the phrase could be appropriated by systems seeking to reduce expenditure, shorten contact, or restrict access to specialist care. Proportionality cannot be established merely by offering less. A lower-intensity intervention becomes defensible only when it corresponds to the primary change task, is delivered by a competent practitioner, includes adequate assessment and monitoring, and exists within a pathway that permits prompt escalation. Scarcity cannot be converted into a clinical rationale after the fact. Shared decision making likewise becomes largely symbolic when cost, waiting lists, geography, language, eligibility criteria, or service shortages remove the alternatives about which a client is ostensibly being consulted. Protection against therapeutic overreach must therefore remain inseparable from protection against therapeutic neglect. Any application of the framework that systematically directs clients towards cheaper care while leaving movement towards more intensive intervention difficult would contradict its central premise.

Comparable caution applies to the concept of therapeutic overreach. Clinical language, diagnosis, and psychotherapy may provide relief, coherence, recognition, and access to effective treatment, particularly when a person has previously understood persistent difficulty as personal failure. No general inference can therefore be made that a non-clinical explanation is more accurate, less stigmatising, or more empowering. Contextual formulations can minimise serious symptoms, just as psychotherapeutic formulations can illuminate the interaction between past experience, current relationships, and social conditions. Overreach becomes a meaningful concept only when it refers to a demonstrable mismatch in which the explanatory frame, duration, intensity, or focus of intervention exceeds what is required and produces no compensating benefit. Potential consequences such as diminished agency, unnecessary identification with pathology, avoidable dependence, or neglect of modifiable circumstances remain plausible but incompletely tested. Retaining this uncertainty strengthens rather than weakens the argument, because the framework is intended to generate empirical questions rather than to provide a new vocabulary for criticising psychotherapy.

Outcome evaluation represents one of the most important consequences of this position. Symptom reduction remains indispensable when symptoms are central to the presenting difficulty, but reliance on symptom scales alone privileges treatment aims that are easier to express through clinical measurement. Counselling-oriented change may become visible through restored functioning, movement through a transition, resolution of a conflict, improved use of social support, more sustainable decision making, increased confidence in autonomous action, or greater capacity to respond to later difficulties without unnecessary dependence on professional guidance. Client-defined outcomes can capture forms of change that standardised symptom measures overlook, while assessment of unwanted effects and later functioning prevents success from being inferred solely from immediate satisfaction at the end of contact (Ladmanová et al., 2025).

Empirical evaluation of such outcomes will require a multimethod approach rather than the replacement of one universal scale by another. Goal Attainment Scaling may provide a structured means of evaluating progress towards individually defined objectives when goals are translated into observable levels of attainment and supported by explicit scoring criteria (Logan et al., 2022; Baur et al., 2024). Standardised measures of functioning, participation, perceived self-efficacy, autonomous motivation, and decision-related confidence may complement rather than substitute idiographic evaluation, particularly when the presenting difficulty concerns adaptation, choice, or restoration of personal agency. Evidence connecting

self-determination with counselling outcomes supports the inclusion of perceived autonomy and autonomous motivation among substantive indicators of change rather than treating them solely as process characteristics (Leibert et al., 2022).

Measurement should also extend beyond the moment of intervention completion. Assessment at intake, at an agreed review point, at completion, and after a follow-up interval would allow researchers to distinguish immediate relief from sustainable change and to examine whether newly acquired capacities transfer into everyday life. Brief qualitative accounts may clarify how clients understand the change, which contextual developments made it possible, and whether professional involvement ultimately strengthened or weakened their confidence in managing subsequent difficulties. Routine measurement-feedback systems can additionally identify non-response or deterioration before an unproductive intervention becomes unnecessarily prolonged, particularly when quantitative information is interpreted collaboratively rather than used as an administrative endpoint (Rognstad et al., 2023). Broader measurement therefore does not require abandoning symptom assessment or standardisation. It requires connecting standardised indicators with client-valued goals, functional and contextual outcomes, later adaptation, and the original purpose for which help was sought.

A broader implication concerns the identity of counselling psychology within contemporary mental-health systems. Attempts to secure professional legitimacy by demonstrating equivalence with clinical psychology or psychotherapy may inadvertently obscure the contribution that counselling psychology is best positioned to make. Distinctiveness cannot be sustained through vague appeals to holism, empathy, or humanism, because these qualities are neither exclusive to counselling nor sufficient to establish professional competence. Greater credibility arises when contextual, developmental, preventive, and autonomy-supportive commitments are translated into explicit decisions about formulation, intervention, outcome measurement, referral, and service design. Corresponding responsibility follows from such recognition. Counselling psychologists must be able to identify risk, severe impairment, complex psychopathology, medical contributors, and situations in which a counselling-oriented intervention cannot safely or adequately contain the person's needs. Non-pathologising practice without clinical discrimination risks becoming normalisation of suffering that requires treatment.

The framework ultimately proposes a different understanding of professional depth. Depth does not reside automatically in duration, interpretive complexity, diagnostic status, or movement towards increasingly specialised treatment. Professional depth lies in the quality of discrimination through which a practitioner recognises what kind of help the situation requires, what the selected intervention can reasonably achieve, and when another pathway has become necessary. Counselling and psychotherapy become complementary within this account not because their differences disappear, but because neither is required to establish its value through the subordination of the other. A plural mental-health system should be capable of taking distress seriously without treating every difficulty as disorder, while remaining equally capable of recognising when contextual support and resource mobilisation are insufficient. Proportionality offers a conceptual basis for that balance, although its practical value will depend on empirical validation, service availability, and continued willingness to revise the distinctions on which it rests.

12. Limitations

Several limitations qualify the argument. The review was critical and integrative rather than systematic, and selection was guided by conceptual relevance. The intentionally narrow restriction to literature published from 2022 onwards improved responsiveness to the current evidence landscape but excluded foundational theory and may have created an artificial discontinuity with the history of counselling psychology. The decision should not be read as diminishing the significance of earlier scholarship; rather, it defines the manuscript as a contemporary conceptual synthesis. A complementary historical review would be required to trace the theoretical genealogy of the proposed principles. English-language and database-access biases are also likely, while the available evidence is considerably stronger for psychological treatments in general than for counselling psychology as a separately evaluated specialty.

The proposed distinction may also reproduce the binary it seeks to soften. Many interventions integrate counselling and psychotherapy tasks, and many practitioners shift their centre of gravity within a single

course of work. The framework should therefore be treated as a decision aid rather than a taxonomy of professions. Several claims, particularly those concerning therapeutic overreach, professional dependency, and the identity effects of clinical framing, remain theoretically plausible but insufficiently tested. Empirical validation is required before the framework can be recommended as a triage instrument.

Finally, proportionality is constrained by availability. Shared decision making can become rhetorical when waiting lists, cost, geography, language, or eligibility rules leave no meaningful choice. A counselling pathway should not be used to normalise inadequate access to psychotherapy, psychiatry, or social care. Conversely, psychotherapy should not become the only available response simply because services capable of practical, developmental, and contextual work have been neglected.

13. Conclusion

Not everyone who seeks psychological help needs psychotherapy and recognising that fact does not minimise distress or diminish psychotherapy. The conclusion follows from a principle of fit. Psychological help should be organised around safety, impairment, persistence, context, the primary task of change, the person's resources and preferences, and the observed response to intervention. Counselling-oriented and psychotherapy-oriented work overlap substantially, but their primary centres of gravity remain sufficiently different to justify a plural system of care.

Counselling psychology contributes to distinctive capacity to take suffering seriously without presuming disorder, to connect personal experience with social and developmental context, to mobilise existing resources, to support informed decisions, and to transfer competence back into everyday life. Psychotherapy contributes sustained and structured methods for changing persistent symptoms, pervasive patterns, and recurrent relational or intrapsychic difficulties. Neither function is inherently deeper, more humane, or more professional than the other. Ethical depth lies in recognising what the situation requires, what the practitioner can competently provide, and when the plan must change.

The Proportionate Psychological Help Framework offers a preliminary structure for that judgement. Its central safeguard is movement. People may begin with counselling and require psychotherapy, begin with psychotherapy and later benefit from focused counselling, receive combined interventions, or complete professional help when adequate gains have been achieved. A mature mental-health system does not rank these movements as ascent or descent. It treats them as evidence that care is being matched to the person rather than the person being fitted to the status of an intervention.

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