



Convenient Psychotherapy: The Professional Dilemma of Ill-Trained, Unprepared, and Overworked Managers Compelled to Counsel their Subordinates

A Conceptual Review of Workplace Mental Health in African Contexts

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ABSTRACT

Workplaces in many African countries have absorbed a global shift in which employee mental health became a managerial responsibility, and with it the expectation that line managers will personally support struggling staff. In many organisations this expectation has quietly expanded from sympathetic supervision into something resembling de facto counselling or psychotherapy, delivered by managers who are clinically untrained, professionally unprepared, and already stretched. This article names that arrangement convenient psychotherapy: the substitution of competent, confidential, and appropriately bounded mental-health support with the nearest and cheapest available person, in a trade that favours organisational convenience over the safety of the recipient and the wellbeing of the manager. The dilemma is sharpened in many African settings, where the World Health Organization reports medians of only 1.1 to 2.4 specialised mental-health workers per 100,000 population in low- and lower-middle-income countries against a global median of 13.5, although workforce, regulation, labour markets, and healthcare systems differ markedly between countries and sectors. Using a conceptual review design grounded in a structured narrative synthesis of the workplace-counselling evidence base, role and dual-relationship theory, professional-ethics codes, the literatures on emotional labour and burnout, and the critique of therapeutic culture, the article argues that the manager-counsellor occupies a structurally compromised position that brief training cannot repair, because the same person holds power over the subordinate's pay, appraisal, and continued employment. Crucially, task-sharing programmes in several African countries — group interpersonal therapy in rural Uganda, Zimbabwe's Friendship Bench, and the PRIME programme in Ethiopia, South Africa, and Uganda — show that non-specialists can deliver effective psychological care, but only under deliberate selection, structured training, ongoing supervision, role clarity, and bounded scope: precisely the safeguards convenient psychotherapy lacks. The article further raises a regulatory question the workplace wellbeing literature has scarcely addressed: whether sustained psychological support by unregistered supervisors engages statutory scope-of-practice provisions in jurisdictions where psychological practice is regulated. It formally distinguishes convenient psychotherapy from legitimate managerial support, psychological first aid, peer support, and structured task-sharing. It then offers a practical framework separating the supportive functions of the line manager (noticing, signposting, accommodating) from the therapeutic functions that belong to trained and supervised providers, meets the objection that referral presupposes somewhere to refer to, and proposes eight conditions for distinguishing defensible task-sharing from convenient improvisation.

Keywords: workplace counselling; line managers; role conflict; role ambiguity; dual relationships; scope of practice; mental health at work; task-sharing; psychological first aid; peer support; professional ethics; emotional labour; Africa; ubuntu; conceptual review



INTRODUCTION

Over the past two decades, employee mental health has moved from the margins of organisational concern to the centre of the human-resources agenda. National reviews, professional bodies, and employers have come to treat psychological wellbeing as a legitimate object of workplace policy, and one of the most consequential effects of this shift has been the recasting of the line manager as a frontline custodian of staff mental health. The influential United Kingdom review of mental health and employers placed line managers at the heart of its recommended standards (Stevenson & Farmer, 2017), and comparable expectations have since diffused widely — through multinational subsidiaries, donor-funded organisations, universities, parastatals, and the human-resources profession itself — into workplaces in many African countries, most visibly in the formal sector.

This diffusion matters because the expectation lands on a different substrate in many African settings, although not a uniform one. The most recent edition of the World Health Organization's Mental Health Atlas reports a global median of 13.5 specialised mental-health workers per 100,000 population, falling to between 1.1 and 2.4 per 100,000 in low- and lower-middle-income countries, the income groups into which most countries of the WHO African Region fall (World Health Organization, 2025). These are medians, compiled from government returns of uneven completeness, and they conceal wide variation between and within countries. Atlas data reported a decade earlier, for example, showed South Africa and Botswana each with a mental-health workforce of around 11 to 12 full-time equivalents per 100,000 population, while close to half of sub-Saharan African countries reported one or fewer (Institute of Medicine, 2013). Country-level estimates show how large the resulting treatment gap can be, and how much it depends on the health system concerned. In South Africa, the South African Stress and Health study, conducted in 2003–2004, found that only about a quarter of adults with a 12-month mental disorder had received any treatment in the preceding year (Williams et al., 2008). A national costing of public mental-health services for 2016/17 later estimated, crudely, that approximately 92% of the uninsured population needing care for mental disorders, epilepsy, or intellectual disability received none, and found that inpatient care absorbed 86% of public mental-health expenditure while primary-level services received only 7.9% (Docrat, Besada, Cleary, Daviaud, & Lund, 2019). South Africa has one of the better-resourced mental-health systems on the continent, alongside a separate private sector serving the medically insured minority; comparable national estimates are unavailable for many other countries, which is itself an indication of how thin provision is. The direction of the disparity is not in doubt, but its depth differs from one country, sector, and health system to the next, and the argument that follows is sensitive to that difference.

Where specialist provision is this thin, the pressure to find help somewhere — anywhere — is intense, and the line manager, already in the room and already on the payroll, becomes the obvious candidate to absorb it.

In principle, a manager who notices distress, responds with humanity, and helps a struggling employee find appropriate help is an unambiguous good. The difficulty arises when this reasonable expectation slides, often without acknowledgement, into something far more demanding: the expectation that the manager will personally provide the psychological support the employee needs. In practice, managers in many African organisations can find themselves conducting what amount to counselling sessions — absorbing disclosures of depression, grief, trauma, suicidal thoughts, bereavement, and acute economic crisis — with no clinical training, no supervision, no confidential boundary, and no time set aside for the task. The supportive manager becomes, by default, an unqualified therapist.

This article examines that drift and the dilemma it creates across African workplaces. It argues that the arrangement is best understood as convenient psychotherapy: a substitution in which the organisation's duty to make competent mental-health support available is quietly discharged by delegating it to the nearest, cheapest, and least protected person in the structure. The convenience is real — it is immediate, costs little, and signals care — but it is convenience purchased at the expense of two parties who cannot easily refuse: the subordinate, whose safety and confidentiality are placed at risk, and the manager, whose competence is overstretched and whose own wellbeing is eroded. After setting out the review approach, the analysis traces how the manager-counsellor role emerged, defines the construct and distinguishes it from adjacent forms of legitimate support, and examines three intersecting problems — competence, structural role conflict, and capacity — and the



harms that follow, before turning to the instructive contrast offered by Africa's own task-sharing programmes and a constructive reframing of what managers should and should not be asked to do, summarised in a practical framework that separates managerial responsibilities from functions requiring trained mental-health professionals.

A note on scope is needed at the outset, because "Africa" is not a single workplace setting and the article does not treat it as one. The continent's countries differ in the size of their mental-health workforces, in whether and how psychological practice is regulated, in the organisation and financing of their healthcare systems, and in the character of their labour markets. The last of these deserves emphasis. The International Labour Organization estimates that 85.8% of employment in Africa is informal (International Labour Organization, 2018), whereas the relationship on which this article's analysis turns — a supervisor with formal authority over appraisal, pay, and continued employment — is characteristic of formal employment. The argument is therefore addressed principally to formal-sector organisations: public services and parastatals, universities, banks, mining and manufacturing firms, multinational subsidiaries, and donor-funded non-governmental organisations. Within that sector, too, conditions vary, from large employers with in-house occupational health services or contracted employee assistance programmes to small enterprises with neither, and organisational cultures differ in how readily distress is disclosed at work and to whom. Where the article draws on country-specific evidence, it names the country and setting; where it generalises, it generalises about a mechanism — the structural position of the manager-counsellor — rather than about African workplaces as such.

REVIEW DESIGN AND APPROACH

This article is a conceptual review built on a structured narrative synthesis of the literature. It advances an argument about a workplace arrangement rather than estimating an effect, and it draws on existing literature to construct and defend a construct rather than to synthesise findings on a single answerable question. It is therefore not a systematic review, and makes none of the claims to exhaustiveness or replicability that such reviews properly make. The approach taken is nonetheless set out here, both because narrative reviews are strengthened by transparency about how their evidence was assembled and because the argument depends on bringing together bodies of work that do not ordinarily speak to one another. In reporting the approach we have been guided by the SANRA criteria for the quality of narrative review articles (Baethge, Goldbeck-Wood, & Mertens, 2019). In Jaakkola's (2020) typology of conceptual articles, the article is closest to a theory-synthesis design: it integrates several literatures around a single focal phenomenon in order to offer a new conceptualisation of it.

Information sources. Literature was identified through searches of PsycINFO, PubMed/MEDLINE, Scopus, Web of Science, and African Journals OnLine, supplemented by backward and forward citation tracing from key sources, including the foundational boundary frameworks of Gutheil and Gabbard (1993) and Gottlieb (1993) and recent meta-analyses of emotional labour and role stress (Kammeyer-Mueller et al., 2013; Sawhney et al., 2026). Three categories of documentary material were also searched directly: guidance from the World Health Organization and the International Labour Organization, including the WHO guidelines on mental health at work, the psychological first aid guide, and the Mental Health Atlas series; the ethics codes of psychology bodies; and health-professions legislation and regulations in Zimbabwe, South Africa, and Kenya, selected as jurisdictions in which the regulation of psychological practice could be verified from primary legal texts. Searches covered material published between 1964, the date of the foundational study of role stress (Kahn et al., 1964).

Search strategy. Searches combined terms for the managerial role ("line manager", "supervisor", "manager"), for the support function ("mental health support", "wellbeing", "counselling", "emotional support"), and for the constructs of interest ("role conflict", "role ambiguity", "emotional labour", "burnout", "dual relationship", "task-sharing"), with African and Southern African geographic terms applied in a separate pass to identify regional literature. A further pass targeted the adjacent forms of support from which the construct is distinguished in Section 4.1, using the terms "psychological first aid", "mental health first aid", "peer support", "employee assistance programme", "task-sharing", and "task-shifting". **Eligibility.** Sources were included where they contributed to one of the four literature streams identified below, or provided empirical or



documentary evidence about the African context. Priority was given to systematic reviews and meta-analyses where these existed, to primary empirical studies where they did not, and to foundational theoretical works where a construct's original formulation was at issue. Sources were excluded where they addressed clinical supervision or psychotherapy delivery outside an employment context, where they concerned manager behaviour unrelated to employee mental health, or where claims could not be traced to a verifiable primary source.

Selection. Screening was conducted by «both authors independently / the first author with the second author reviewing» at title and abstract level, with full texts retrieved for sources meeting the criteria above. Disagreements were resolved by discussion. No formal record of numbers screened and excluded was maintained, consistent with the conceptual purpose of the review .

Synthesis. The argument integrates four literature streams, each answering a different question about the same arrangement. The workplace counselling and manager-training literature establishes what competent support requires and what training does and does not achieve. Role theory and the ethics literature on dual relationships establish why the manager's structural position is compromised independently of their skill. The literatures on emotional labour and burnout establish the cost to the manager. The critique of therapeutic culture establishes what the arrangement accomplishes for the organisation that adopts it. These were integrated by taking the construct of convenient psychotherapy as the organising object and asking of each stream what it reveals about that object, rather than by pooling findings across streams, which their methodological heterogeneity would not support. Two further bodies of material are used as case evidence rather than as streams: African task-sharing programmes, which supply the contrast case in Section 9, and health professions legislation, which supplies the regulatory question raised in Section 8. Professional-ethics codes and the guidance documents that define adjacent support roles are used in the same way, to fix the boundaries of the construct in Section 4.1. Where evidence was country-specific, the country and setting are reported with it, and findings from one national context are not generalised to the continent without qualification.

Limitations of the approach. The review is selective by design, and a different selection might have produced a different emphasis. The empirical literature on line managers providing mental health support is drawn predominantly from high-income settings, and the African evidence on which the article draws is concentrated in a few countries, notably South Africa, Zimbabwe, Uganda, and Ethiopia. The article treats this unevenness as part of its subject rather than merely as a constraint, and does not assume that findings from these countries hold elsewhere on the continent. Where claims about the African context could not be supported from published sources, this is stated rather than glossed.

THE MAKING OF THE MANAGER-COUNSELLOR

The manager-counsellor did not appear by design. The role accreted from several converging pressures. The first is the genuine and welcome de-stigmatisation of mental health, which made it acceptable, even expected, for distress to be spoken about at work. Once distress is speakable, someone must receive it, and the line manager is the most immediate candidate. The second is the institutionalisation of wellbeing as a managerial responsibility. When policy frameworks and corporate strategy designate line managers as the people who will “support” staff mental health, the boundary of that support is rarely specified; in the absence of a clear limit, support expands to fill whatever the employee in front of the manager appears to need (Stevenson & Farmer, 2017).

A third pressure is structural and economic, and it is especially sharp in Africa. Formal provision — occupational health services, employee assistance programmes, in-house counsellors, and external referral — is expensive and, in many African countries, thin, urban-concentrated, or simply absent. The picture is uneven, however: South Africa has an established employee assistance sector and a professional association to go with it, whereas elsewhere such provision may be confined to multinational subsidiaries and a few large employers. Where such provision is scarce, the line manager becomes the path of least resistance: the support that is already on the payroll and already in the room. A fourth pressure is cultural. The spread of what has been described as a therapeutic ethos has normalised emotional disclosure and the language of vulnerability across



institutions, so that organisations increasingly frame ordinary difficulties in therapeutic terms and present emotional support as a routine managerial competency (Furedi, 2004). The cumulative effect is an expectation that competent emotional caretaking is simply part of good management, available on demand and at no marginal cost.

Ubuntu, solidarity, and the conscription of a relational ethic

A distinctively African dimension deserves separate attention, because it shapes how the expectation on managers is justified rather than merely where it lands. Many African workplaces operate within a communal relational ethic widely articulated through the concept of ubuntu, expressed in the aphorism *umuntu ngumuntu ngabantu* — a person is a person through other persons — and developed philosophically as an account of personhood constituted through relationship and of morality as the pursuit of communal harmony (Ramose, 1999; Metz & Gaie, 2010). The term, and its Sotho-Tswana counterpart *botho*, belong to the languages of Southern Africa (Metz & Gaie, 2010). Communal ethics with comparable emphases have been described elsewhere on the continent, but the article does not assume that ubuntu, or any single relational ethic, characterises workplaces across Africa; its concern is with what happens when such an ethic is invoked, wherever that occurs.

The concept is contested, and the article's use of it should be clear about that at the outset. Scholars have long noted its interpretive looseness and the difficulty of specifying what it requires in any given case (Metz, 2011; West, 2014). Mboti (2015) goes further, challenging the dominant harmonious reading of the aphorism directly and arguing that definitions of ubuntu have remained persistently and, he suggests, purposefully imprecise. Nothing in what follows requires the harmony account to be correct. What matters here is not what ubuntu most defensibly means but what invoking it accomplishes in an organisational setting — and on that question, its very indeterminacy turns out to be the operative feature.

As a relational ethic, ubuntu is a genuine strength in working life. It makes solidarity, mutual support, and the noticing of distress natural rather than exceptional; it disposes colleagues to attend to one another; and it constitutes a real protective resource of a kind that more individualistic workplace cultures must construct deliberately. The argument here is emphatically not that communal obligation is a problem to be managed away.

The difficulty is that a relational ethic can be enlisted for purposes it does not itself endorse, and this has been observed before. A critical literature on ubuntu in business ethics and corporate social responsibility reports the argument that ubuntu language has been marketed in South Africa in ways that accommodate rather than challenge prevailing commercial arrangements, with little evidence that the rhetoric has altered corporate practice, and a recent review describes the use of ubuntu as a theory of corporate social responsibility in Africa as contested (Makwara, Dzansi, & Chipunza, 2023). Praeg (2014) mounts a related critique of the gap between invocation and conduct. The general claim, then, is not new.

What this article adds is a specific mechanism in a specific setting. When an organisation appeals to communal obligation to explain why a manager should absorb whatever a subordinate brings, three things happen at once. The obligation is made unlimited, because a relational ethic specifies no threshold at which care properly stops. It is made unrefusable, because declining is construed not as a professional boundary but as a failure of personhood. And it is made costless to the employer, because what is framed as a moral disposition need not be budgeted, staffed, or supervised. The conceptual indeterminacy documented by ubuntu's critics is precisely what makes this possible: a demand grounded in a concept that resists specification cannot be met at any determinate point, and a manager cannot appeal to a limit that the justifying framework declines to supply. This is the same unbounded quality analysed as role ambiguity in Section 6, arriving by a cultural rather than an administrative route, and it is harder to resist in that form, because objecting appears to be a rejection not of a workload but of a shared ethic.

A relational good is thereby converted into an instrument of cost-saving. The distinction that matters is between ubuntu as a reciprocal obligation distributed across a community — which would place the org-



anisation itself under a duty of care toward the manager — and ubuntu as a one-directional expectation loaded onto a single individual who cannot decline it. The first is the ethic as its philosophical proponents describe it. The second is its conscription. The communal ethic is not the problem; its conscription into convenient psychotherapy is.

It is important to be precise about what this expectation displaces. There is a respectable evidence base indicating that workplace counselling, when delivered by trained counsellors, is generally associated with reductions in psychological distress and sickness absence and with modest improvements in attitudes to work (McLeod, 2010). The strength of that evidence has been debated, with attention drawn to variation in study quality and to the risk of publication bias in the underlying literature (McLeod & Henderson, 2003; McLeod, 2010), but the broad point stands: the support that organisations have in mind when they speak of helping employees is professional support delivered by people trained to deliver it. Convenient psychotherapy borrows the legitimacy of that professional model while removing almost everything that makes it work.

NAMING THE PROBLEM: WHAT CONVENIENT PSYCHOTHERAPY IS

Convenient psychotherapy is here defined as *the routine provision of de facto psychological treatment to employees by line managers who lack the training, the role conditions, and the spare capacity that competent and ethical mental-health support requires, adopted by organisations because it is cheaper, faster, and more reassuring than securing properly resourced provision*. The word *convenient* carries the argument. The arrangement is convenient for the organisation: it is inexpensive, it is immediately available, and it produces the appearance of a caring employer without the cost of building referral pathways or funding specialist services — services that, in many African settings, would have to be built almost from scratch. It is convenient, too, as a way of locating the problem inside the individual employee rather than in the conditions of the work.

Three features distinguish convenient psychotherapy from legitimate forms of help. First, it is unbounded: there is no agreed limit to what the manager is expected to handle, so the role expands from noticing distress to managing crisis. Second, it is unsupported: the manager works without clinical supervision, without a confidential frame, and without a referral net beneath them. Third, it is unchosen by either party in any meaningful sense — the employee discloses to the person who happens to hold authority over them, and the manager absorbs the disclosure because refusing would appear callous. The result has the surface form of therapy and almost none of its safeguards.

Boundaries of the construct: what convenient psychotherapy is not

Because the construct is critical, its boundaries need to be drawn with care; a term that condemned every supportive act by a manager would be both unfair and useless. Convenient psychotherapy is not identified by who offers support, nor by the fact that support is offered at work. It is identified by a conjunction of four features: the *function* performed, which is therapeutic rather than supportive; the *scope* of that function, which is open-ended rather than bounded by a threshold for handover; the *preparation and oversight* of the helper, which are absent rather than structured; and the *relationship* within which help is given, in which the helper holds evaluative and disciplinary power over the recipient. Each of the adjacent forms of support considered below shares one or more of these features with convenient psychotherapy. None shares all four. Table 1 summarises the comparison.

Legitimate managerial support. The first and most important comparator is the ordinary supportive conduct of a good line manager, which the organisational literature treats as a resource rather than a hazard. Meta-analytic evidence shows that perceived supervisor support, particularly support specific to the demands employees face, is associated with lower work–family conflict (Kossek, Pichler, Bodner, & Hammer, 2011), and the World Health Organization now recommends training managers to recognise and respond to workers in distress and to address stressors in working conditions (World Health Organization, 2022). The same guidance is explicit that such training is not intended to turn managers into mental-health care providers (Malik et al., 2023). Legitimate managerial support is therefore defined by what it does within the manager’s existing



authority: noticing change, holding a brief and humane conversation, adjusting workload, scheduling, or duties, protecting the employee from further harm at work, and facilitating access to help. Its instruments are managerial rather than clinical. Interview research with Australian managers who had supervised an employee with a mental-health issue found the experience to be both a source of stress and an opportunity for professional growth, and concluded that managers need implementation support, including guiding policy, training, and emotional support, to carry out even this bounded role (Martin, Woods, & Dawkins, 2018).

Psychological first aid. Psychological first aid describes humane, supportive, and practical help offered to people in the immediate aftermath of a seriously distressing event: attending to safety and basic needs, listening without pressing people to talk, comforting, and connecting them with information, services, and social support (World Health Organization, War Trauma Foundation, & World Vision International, 2011). It is designed to be learned quickly by non-specialists, and the guidance distinguishes it expressly from professional counselling. A manager who responds in this way after a workplace accident, an armed robbery, or a sudden bereavement in the team is not engaged in convenient psychotherapy. Psychological first aid shares the manager-counsellor's non-specialist status, but differs in scope and duration: it is a time-limited response to an acute event, not an open-ended course of emotional treatment.

Mental health first aid. Mental Health First Aid, with which psychological first aid is sometimes confused, trains members of the public to recognise mental-health problems, offer initial help, and guide people toward appropriate professional support (Kitchener & Jorm, 2002). Its scope is recognition, initial response, and signposting rather than treatment. What it does and does not achieve as preparation for helping is considered in Section 5.

Peer support. Peer support rests on a relationship of mutuality between people who share an experience, and draws its value from reciprocity, shared understanding, and the deliberate absence of hierarchy (Mead, Hilton, & Curtis, 2001; Solomon, 2004). The manager-counsellor resembles a peer supporter in lacking clinical qualifications but is structurally the opposite of one: the defining feature of peer support is equality between helper and helped, and the defining feature of the managerial relationship is authority.

Structured task-sharing. Task-sharing in mental health is the planned delegation of defined psychological tasks to non-specialists who are selected, trained in a specified intervention, supervised by specialists, and embedded in a referral system (World Health Organization, 2008; Patel et al., 2018). It is the comparator closest to convenient psychotherapy in function, because the non-specialist may genuinely deliver a psychological intervention. It differs in everything that surrounds the function, and Section 9 examines three African programmes that show what that surrounding structure involves.

Professional counselling and psychotherapy. Finally, the therapeutic function proper belongs to trained and, in many jurisdictions, registered practitioners bound by ethical codes that require them to practise within the boundaries of their competence and to refrain from multiple relationships that could impair their objectivity or risk exploitation or harm to the client (American Psychological Association, 2017; Health Professions Council of South Africa, 2016). Workplace counselling delivered by such practitioners, whether in-house or through an employee assistance programme, is the model that convenient psychotherapy imitates (McLeod, 2010).

Table 1. Convenient psychotherapy distinguished from adjacent forms of workplace psychological support

Form of support	Primary function	Scope and duration	Preparation and oversight	Relationship to recipient
Legitimate managerial support	Noticing, humane conversation, work adjustments, facilitating access to help	Bounded by the manager's existing authority; ongoing but light-touch	Management training in recognition and response; no clinical role	Line authority, acceptable because no therapeutic function is performed



Psychological first aid	Safety, comfort, practical help, and linkage after an acute distressing event	Time-limited to the immediate aftermath of the event	Brief standardised training; expressly not counselling	Any helper present, including a manager, for the duration of the crisis response
Mental health first aid	Recognition, initial response, and guidance toward professional help	Initial contact, ending at referral	Short course; no ongoing supervision	Typically a colleague or member of the public
Peer support	Mutual support grounded in shared experience	Ongoing but non-clinical	Selection and training vary; value lies in shared experience	Reciprocal and non-hierarchical by definition
Structured task-sharing	A specified psychological intervention delivered by a non-specialist	Defined intervention with explicit thresholds for referral	Selection, manualised training, and ongoing specialist supervision	No authority over the recipient; outside the recipient's line of employment
Professional counselling or psychotherapy	Assessment and psychological treatment	Contracted, with agreed goals and an ending	Professional qualification, registration where regulated, ethical codes, supervision	Confidential professional relationship; multiple relationships avoided
Convenient psychotherapy	De facto psychological treatment	Open-ended, with no threshold for handover	None, or brief awareness training; no supervision	Line authority over pay, appraisal, discipline, and employment

Note. Compiled from Kitchener and Jorm (2002), Mead et al. (2001), Patel et al. (2018), World Health Organization (2022), World Health Organization et al. (2011), and American Psychological Association (2017).

Set against these comparators, convenient psychotherapy can be stated precisely. It occurs when a person who holds line authority over an employee comes, by expectation rather than design, to perform a therapeutic function of indefinite scope, without the preparation, supervision, confidentiality, or referral structure that makes non-specialist help safe. Remove any one of these features and the arrangement moves toward one of its legitimate neighbours. A manager who confines themselves to noticing, adjusting, and signposting is offering legitimate managerial support; a trained and supervised helper outside the management line is engaged in task-sharing or peer support; a time-limited response to an acute event is psychological first aid. The construct therefore does not ask managers to care less. It asks organisations to be clear about which of these things they are asking managers to do.

THE COMPETENCE DEFICIT

The most obvious objection to convenient psychotherapy is that managers are not trained to do it. Competence is not merely a credential; it is the working knowledge that allows a helper to distinguish ordinary distress from clinical risk, to avoid causing harm, and to know the limits of their own usefulness. A manager without that knowledge may miss the signs of a serious condition, mishandle a disclosure of suicidal thinking, mistake a treatable disorder for a motivational problem, or — with the best intentions — offer reassurance or advice that compounds the difficulty. The principle that practitioners should work only within the boundaries of their competence is foundational to every mental-health profession precisely because the costs of exceeding those boundaries fall on vulnerable people.



The natural rejoinder is that managers can be trained, and it deserves a fair hearing, because the evidence for such training is better than critics of workplace wellbeing initiatives sometimes allow. A systematic review and meta-analysis of controlled trials of manager mental-health training found significant pooled effects favouring the intervention on managers' mental-health knowledge (SMD = 0.73), non-stigmatising attitudes (SMD = 0.36), and self-reported behaviour in supporting employees experiencing mental-health problems (SMD = 0.59) (Gayed et al., 2018). Training managers in this domain demonstrably changes what they know, what they think, and what they report doing.

What it has not been shown to change is the mental health of the employees on the receiving end. In the same meta-analysis, the pooled effect on employees' psychological symptoms was not significant, and the authors are explicit that this finding remains preliminary because so few trials have measured employee outcomes at all (Gayed et al., 2018). The pattern recurs in the evaluation of brief public-facing programmes: a systematic review of Mental Health First Aid, the best known of them (Kitchener & Jorm, 2002), found mixed effects on whether trainees actually used the skills they were taught, and no demonstrated effect on the helpfulness of their actions or on the mental health of those they helped (Forthal et al., 2022). Two literatures, examining different interventions, converge on the same asymmetry: the proximal gains in the helper are real and measurable; the distal benefit to the person helped is unevidenced. This is the precise sense in which confidence is not competence. A manager may know more, believe more helpful things, and report behaving better, and none of that establishes that the employee in front of them is any better off.

There is a further point, and it is the one that matters most for the argument advanced here. Every intervention in this evidence base trains managers for a bounded role — recognising distress, responding supportively, holding an appropriate conversation, facilitating access to help. None trains managers to provide psychological treatment, because no responsible programme proposes that they should. The training literature is therefore evidence about notice-and-refer, and cannot be borrowed as warrant for something it has never tested. An organisation that sends supervisors on a mental-health course and thereafter treats them as an available source of counselling has not acted on the evidence; it has invoked the evidence for one role in order to license a different and far more demanding one.

This matters because brief training can create a dangerous halfway state. A manager who has completed a one-day course may feel equipped to handle situations that in fact require specialist care, and that misplaced confidence can delay appropriate referral — a delay that is especially costly where the nearest specialist may be a province or a salary away. The competence deficit, in other words, is not only an absence of skill but a risk of false assurance: for the manager, whose self-reported capability the evidence shows will rise whether or not their effectiveness does; for the employee, who may receive improvised help in place of the help they needed; and for the organisation that believes it has discharged its duty by sending supervisors on a course.

THE STRUCTURAL TRAP: ROLE STRESS AND THE DUAL RELATIONSHIP

Even a manager who happened to be a trained therapist would face a problem that no training removes. The manager-counsellor occupies two roles that are fundamentally incompatible. As manager, they evaluate the employee's performance, allocate work, decide on advancement, and may participate in discipline or dismissal. As counsellor, they are expected to offer a safe, confidential, non-judgemental space in which the employee can disclose weakness, fear, and failure. These two roles pull in opposite directions, and the contradiction is structural rather than a matter of personal skill.

Role theory has long recognised that occupying incompatible expectations within a single position produces role conflict, with predictable costs to performance and wellbeing (Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1964). Contemporary evidence refines this in a way that matters for the present argument. A recent meta-analysis consolidating several decades of role stressor research across more than five hundred studies treats role ambiguity, role conflict, and role overload as empirically distinct, and finds role ambiguity the most damaging of the three across a wide range of individual and organisational outcomes (Sawhney et al., 2026). The manager-counsellor suffers from both, but the ambiguity is the more consequential and the less often named. As argued above, the expectation to "support" staff mental health is issued without a stated limit; the



manager is told to help but not told how far, not told where their responsibility ends, and not told what to do when it exceeds them. That is role ambiguity in its textbook form, and it is generated by the very vagueness that makes the arrangement attractive to organisations. Where mental health specifically is concerned, both stressors are implicated: meta-analytic work has found comparable associations for role ambiguity and role conflict with depressive symptoms (Schmidt et al., 2014), and meta-analytic work in samples of psychotherapists has linked both to burnout (Lee et al., 2011).

The counselling and clinical ethics literature names a second and distinct hazard: the dual or multiple relationship, in which a helper simultaneously holds another role with respect to the person they are helping (Kitchener, 1988). It should be acknowledged that this literature has developed considerably, and no longer treats every such arrangement as impermissible. Following the distinction between boundary crossings and boundary violations (Gutheil & Gabbard, 1993), a substantial body of work argues that multiple relationships are sometimes unavoidable — in rural practice, in small or closed communities, in settings where the only available helper is also a neighbour — and that the appropriate response is structured ethical judgement rather than prohibition (Gottlieb, 1993; Younggren & Gottlieb, 2004). This qualification deserves to be taken seriously here, not least because the conditions that make dual relationships unavoidable elsewhere — few practitioners, dense social networks, limited alternatives — describe many African settings well.

Taken seriously, however, it convicts the manager-counsellor rather than excusing them. Gottlieb's widely used model assesses a prospective dual relationship along three dimensions: the power differential between the parties, the duration of the relationship, and the clarity of its termination. The manager-counsellor sits at the extreme of all three. The power differential is not incidental but supervisory, carrying direct influence over pay, appraisal, advancement, and continued employment. The duration is indefinite, coextensive with the employment relationship itself. And there is no termination whatsoever: the employee cannot conclude the helping relationship and walk away, because the other relationship continues every working day. On the profession's own more permissive contemporary criteria — the criteria designed precisely to license the defensible cases — this is among the least defensible configurations available. The rural practitioner who counsels a neighbour holds no power over that neighbour's livelihood; the manager does.

The practical consequences are severe, and they are magnified where jobs are scarce and economic security precarious. Confidentiality, the precondition of therapeutic disclosure, cannot be genuinely offered: a manager who learns that an employee is struggling with addiction, say, or is experiencing a mental-health crisis, may be unable to ring-fence that knowledge from decisions about workload, promotion, or capability. The employee, sensing this, faces an impossible calculation — disclose honestly and risk that the disclosure is later used against them, or withhold and forgo support. Power asymmetry contaminates everything: the employee cannot freely decline the manager's "help," cannot easily set limits on it, and cannot complain about it without jeopardising the relationship on which their job depends. A disclosure made in a moment of trust can resurface, months later, as evidence in a performance process. The structure does not merely make good counselling difficult; it makes safe counselling impossible.

THE OVERWORKED COUNSELLOR: EMOTIONAL LABOUR, CAPACITY, AND HARM TO MANAGERS

Convenient psychotherapy is usually discussed, if at all, in terms of risk to employees. Its cost to managers is just as real and far less acknowledged. The manager asked to counsel subordinates is performing emotional labour — the work of managing and displaying feeling as part of the job — on top of a role that is already demanding (Hochschild, 1983). This labour is invisible in workload planning, unrewarded in appraisal, and uncapped in volume. It is added to the manager's existing responsibilities rather than substituted for them, so the time spent absorbing a colleague's distress is time stolen from sleep, from family, or from the manager's own recovery.

The subsequent literature permits a more exact account of where the damage lies, and the precision matters. Emotional labour is not uniformly harmful. Meta-analytic evidence distinguishes deep acting, in which the helper genuinely realigns what they feel with what they must display, from surface acting and emotion-rule



dissonance, in which the required display and the felt emotion come apart. It is the latter two that carry substantial associations with impaired wellbeing, while deep acting shows only weak relationships with the same outcomes (Hülshager & Schewe, 2011). Later reviews converge on the same asymmetry (Grandey & Gabriel, 2015; Kammeyer-Mueller et al., 2013).

This is precisely the manager-counsellor's position, and it identifies a mechanism the general appeal to emotional labour does not. The manager receiving a disclosure of suicidal thinking, or of a bereavement they have no idea how to respond to, is required to project calm, competence, and unhurried attention while privately feeling alarm, inadequacy, or the pressure of the meeting they are now late for. They cannot express the alarm without frightening the employee, cannot admit the inadequacy without withdrawing the support that has been asked of them, and cannot acknowledge the time pressure without appearing to dismiss the person in front of them. The gap between what must be shown and what is felt is not incidental to the role; it is constitutive of it. Convenient psychotherapy is an arrangement that manufactures emotion-rule dissonance and then leaves the manager alone with it.

The predictable result is strain, and here too the contemporary framing is sharper than a general appeal to exhaustion. The components of burnout — emotional exhaustion, cynicism or depersonalisation, and a diminished sense of accomplishment — map closely onto what happens to a person required to provide sustained emotional support without training, boundaries, or relief (Maslach, Schaufeli, & Leiter, 2001). Burnout is further understood as the outcome of sustained mismatch between a person and their work across six domains — workload, control, reward, community, fairness, and values (Maslach & Leiter, 2016). The manager-counsellor is mismatched on at least four of them simultaneously. The workload is an unbounded second job added to a full first one. Control is absent, since the manager has no authority over whether real provision exists and no power to create the referral pathway they need. Reward is absent by design: the work is invisible in appraisal, uncompensated, and frequently unacknowledged even in conversation. And the values mismatch is the sharpest of all, because the manager is required to offer a confidentiality they know they cannot honour and a competence they know they do not have — asked, in effect, to enact care in a form that their own judgement tells them is unsafe.

It is worth noting what burnout is and is not in this context. The World Health Organization's eleventh revision of the International Classification of Diseases includes burnout as an occupational phenomenon arising from chronic workplace stress that has not been successfully managed, classified among factors influencing health status rather than as a medical condition in its own right (World Health Organization, 2019). The classification is apt here in a way that is easily missed. Burnout is defined by the failure to manage chronic workplace stress — which locates responsibility with the organisation that designed the arrangement, not with the manager who could not sustain it. A manager who breaks under convenient psychotherapy has not failed personally; they have been placed in conditions that the definition itself identifies as unmanaged.

There is a grim circularity in all of this: an arrangement justified as a way of protecting employee mental health steadily damages the mental health of the manager, who is also an employee. Capacity, moreover, is not only emotional but temporal. The manager who is counselling is not doing the job they were hired and trained to do, and the organisation rarely adjusts expectations to reflect this. The manager is therefore squeezed between two open-ended demands — deliver the operational results and absorb the team's emotional needs — with no acknowledgement that the second has displaced part of the first. Overwork is not an incidental feature of convenient psychotherapy; it is built into a model that adds a second unbounded job to an already full one and provides no resources for either.

HARMS TO SUBORDINATES AND TO THE ORGANISATION

The harms to employees follow directly from the structural and competence problems already described. The most serious is the risk of clinical harm: a manager may miss or mishandle a presentation that needed specialist attention, and the delay or the misstep can have real consequences. Beyond this lies the harm of coerced or unsafe disclosure. Because the manager holds power, an employee may feel pressured to disclose more than they wish, and what they disclose is not protected. Disclosures made as cries for help can later shape,



consciously or not, decisions about reliability, promotion, or retention — a chilling prospect that may also deter the employees who most need help from seeking it at all.

A subtler harm is the medicalisation of ordinary difficulty. When emotional support becomes a routine managerial transaction, normal responses to legitimately difficult circumstances — grief, frustration, the strain of an unreasonable workload, the pressure of economic insecurity — may be reframed as individual psychological problems to be managed through support, rather than as signals about the conditions of the work. This reframing is convenient for the organisation because it relocates the source of distress from the structure to the person. The critique of therapeutic culture captures the move precisely: the vocabulary of wellbeing can function to individualise problems that are organisational in origin, encouraging employees to adjust to conditions that ought themselves to change (Furedi, 2004). In settings where the structural drivers of distress — job insecurity, low pay, economic precarity — are especially acute, treating distress as a personal matter for managerial support is especially misleading. Convenient psychotherapy is, in this light, not merely an inadequate response to distress but sometimes an active substitute for addressing its causes.

An unexamined regulatory question

There is a further dimension that the workplace wellbeing literature has scarcely addressed, and it is one on which African jurisdictions have more to say than is commonly recognised. Psychological practice in much of the region is statutorily regulated, with registration a precondition of lawful practice and the performance of reserved professional acts by unregistered persons constituted an offence.

In Zimbabwe, the Health Professions Act [Chapter 27:19] establishes the Allied Health Practitioners Council of Zimbabwe, under which psychologists are registered, and provides for offences by unregistered persons who perform acts specially pertaining to a health profession for which a register is kept. The Council states that practice without registration constitutes a criminal offence, and the professional position in Zimbabwe is that only registered psychologists holding current practising certificates may lawfully practise psychology. In South Africa, section 17 of the Health Professions Act 56 of 1974 makes registration a prerequisite for practising a health profession, and provides that an unregistered person who practises such a profession is guilty of an offence carrying a fine or imprisonment; the scope of the profession of psychology is further delineated by regulation, framed expressly to protect defined psychological acts from performance by unregistered persons (Regulation 993 of 16 September 2008). Regulatory arrangements are not uniform across the continent. Kenya's Counsellors and Psychologists Act of 2014, for example, extends registration and licensing to counsellors as well as psychologists and creates offences for practice by unregistered or unlicensed persons, and the scope and enforcement of comparable provisions differ from one jurisdiction to another. The question raised below therefore has a different legal character in different countries.

The question this raises has not, to our knowledge, been put to the organisations that rely on convenient psychotherapy. If a line manager is conducting what amounts to a course of counselling — repeated sessions, in which distress is explored and responses to it are offered — is that manager performing acts reserved to a registered profession? We do not assert that they are. Whether informal managerial support crosses into regulated practice is a genuine legal question, sensitive to jurisdiction, to the precise statutory definitions, and to the facts of the particular arrangement, and it is a question for legal determination rather than for psychological commentary. But it is a question that has not been asked, and the burden of answering it should sit with the employer. An organisation that has constructed an expectation of ongoing psychological support by unregistered supervisors has, at minimum, an obligation to satisfy itself that what it is asking for falls outside the reserved scope. Few, we suspect, have considered the matter at all.

The regulatory framing also points toward the constructive argument developed below. Regulation is not merely a constraint on improvisation; it is also the mechanism by which bounded non-specialist roles are made legitimate. South Africa's creation of a registered counsellor category, subject to defined scope, training requirements and professional accountability, illustrates the alternative: where a need exists for accessible support short of specialist psychotherapy, the regulated response is to constitute a role and hold it to standards, not to leave the work to whoever is nearest.



The organisation does not escape unharmed in other respects either. It exposes itself to ethical and legal liability when untrained managers mishandle sensitive situations. It generates a false reassurance that lets genuine gaps in provision persist unexamined. And it corrodes trust: once employees learn that “support” from a manager is neither confidential nor safe, the credibility of the organisation’s entire wellbeing apparatus is undermined. What looked like a cost-free way to demonstrate care turns out to carry costs that are simply deferred and dispersed.

THE AFRICAN LENS: WHAT TASK-SHARING TEACHES

The pressures that produce convenient psychotherapy are most intense precisely where formal services are scarcest, and that scarcity is severe in many African countries. The gap between the need for mental-health care and the specialist workforce available to meet it is vast, and the global mental-health field has responded with task-sharing — the delivery of evidence-based psychological care by trained non-specialists — endorsed through the World Health Organization’s Mental Health Gap Action Programme and the broader global mental-health movement (World Health Organization, 2008; Patel et al., 2018). At first glance this might seem to legitimise the manager-counsellor: if community members without clinical degrees can be enlisted to deliver care, why not supervisors? The answer lies in the conditions under which task-sharing actually works — conditions that African programmes themselves make unusually clear.

Some of the foundational evidence for non-specialist psychological care comes from Africa. In the Masaka and Rakai districts of rural south-western Uganda, a cluster-randomised controlled trial showed that group interpersonal psychotherapy delivered by trained local facilitators substantially reduced depression compared with usual care — among the first such trials conducted on the continent, and a landmark demonstration that lay-delivered therapy can work (Bolton et al., 2003). The point was never that anyone could deliver it, but that carefully prepared facilitators, working to a defined protocol, could.

Zimbabwe’s Friendship Bench made the same point at scale. It trains lay health workers — many of them older community women — to deliver a structured, problem-solving intervention for common mental disorders from benches in the grounds of municipal primary-care clinics in Harare (Chibanda et al., 2015), and in a cluster-randomised trial across 24 of those clinics this lay-delivered intervention produced significant reductions in symptoms of depression and anxiety relative to usual care (Chibanda et al., 2016). The wider evidence base has since become more contested: a recent meta-analysis pooling several Friendship Bench trials among people living with HIV and other high-risk groups reported substantial heterogeneity across studies and concluded that the pooled evidence was insufficient to confirm effectiveness, identifying differences in outcome measures and populations as principal sources of that variation (Li et al., 2026). This does not disturb the argument made here, which concerns the conditions under which non-specialist delivery is defensible rather than the magnitude of any particular programme’s effect. If anything it reinforces the point: where a task-sharing programme is well designed, its effects can be evaluated, contested, and refined, because the intervention is specified clearly enough to be tested. Convenient psychotherapy admits of no such scrutiny, because there is no defined intervention to evaluate. The PRIME programme, working at district level in Ethiopia, South Africa, and Uganda as well as in India and Nepal, set out to integrate mental-health care, delivered in part by non-specialists, into routine primary care, with each country’s plan designed around its own health system (Lund et al., 2012). Taken together, these efforts are among the strongest evidence anywhere that non-specialists can extend the reach of mental-health care.

Three cautions are needed before drawing lessons from these examples. First, they come from particular places — rural south-western Uganda, urban Harare, and selected districts in the PRIME countries — and their results cannot be assumed to hold in other countries, or even in other regions of the same country. Second, all three were delivered through community or primary-care health services rather than through employers: none was a workplace programme, and none tested a model in which the helper was the recipient’s supervisor. Third, the health systems into which they were placed differ substantially; South Africa’s combination of a public system and a private sector serving the medically insured has little in common with district primary care in rural Uganda or Ethiopia (Docrat et al., 2019; Lund et al., 2012). What transfers from these programmes to the



workplace is therefore not an effect size but a set of design conditions: the conditions under which non-specialist psychological help has been found to be deliverable at all.

They are instructive for exactly the reason they offer no cover for convenient psychotherapy. Effective task-sharing rests on a set of safeguards. The helpers are deliberately selected for suitability rather than conscripted by their position. They are trained in a specific, manualised intervention with a defined scope, not asked to handle whatever walks up. They receive ongoing supervision from clinical professionals, with clear routes to escalate cases beyond their competence. Their role is bounded and distinct: the lay worker has no authority over the person they are helping, no competing institutional interest, and no power to affect that person's livelihood. Confidentiality and a clear referral pathway are built in. Compare this with the manager-counsellor, who is selected by accident of hierarchy, trained in nothing in particular, unsupervised, unbounded in scope, and entangled in the deepest possible role conflict with the person they are meant to help. The contrast does not soften the critique; it states it exactly. Africa's own evidence shows that non-specialists can help — under conditions that convenient psychotherapy systematically violates.

REFRAMING THE MANAGER'S ROLE: FROM “DIAGNOSE AND TREAT” TO “NOTICE AND REFER”

None of this implies that managers should be indifferent to their staff's mental health. The argument is not that managers should do nothing, but that they should do the right thing, within limits that protect everyone. The constructive move is to separate two roles that convenient psychotherapy fuses. The first is the supportive role, which properly belongs to the line manager: noticing when someone is struggling, responding with humanity, holding a brief and compassionate conversation, making reasonable adjustments to workload or conditions, and — crucially — signposting the employee toward appropriate help. The second is the therapeutic role, which belongs to trained, supervised, confidential providers and which the manager should neither attempt nor be asked to attempt. The watchword for the manager is notice and refer, not diagnose and treat.

Several conditions make this separation workable, and several speak directly to the African context. Managers need bounded mental-health literacy that teaches not only recognition but, just as importantly, the limits of the role and the point at which to hand over — a curriculum that builds humility rather than false confidence. Organisations must provide somewhere to refer to: an accessible referral pathway, whether an employee assistance programme, occupational health, a community clinic, or an external service, so that signposting leads somewhere real rather than back to the manager. Where formal services are genuinely scarce — as they are in many African settings, though not all — the lesson of Africa's task-sharing programmes is to invest in properly designed non-specialist provision (selected, trained, supervised, and bounded, and held separate from the management line) rather than to dress up the supervisor as a therapist. Managers themselves need protection: realistic acknowledgement of the emotional labour involved, supervision and support for the supportive parts of their role, and limits that prevent that role from consuming them. The communal ethic of ubuntu can be enlisted here in its proper form — to surround both employees and managers with genuine collective support — rather than as a justification for loading care onto one overstretched person. And organisations must keep faith with the structural sources of distress, resisting the temptation to treat individual support as a substitute for addressing workload, job security, and control over work.

A practical framework: managerial responsibilities and professional functions

The distinction between the supportive and the therapeutic role can be made operational. Table 2 sets out, domain by domain, the responsibilities that fall appropriately to a line manager, the functions that require a trained mental-health professional, and the signals that should prompt handover from the first to the second. It draws on the WHO guidelines on mental health at work (World Health Organization, 2022), the psychological first aid guidance (World Health Organization et al., 2011), and the ethical principle that helping should remain within the boundaries of competence (American Psychological Association, 2017). It is offered as a template for organisations to adapt, not as a clinical protocol, and two adjustments are always required. The first concerns availability: the professional column assumes that someone can perform those functions, and where no such provider is accessible, the handover column still marks the point at which the manager's role



ends; the gap must then be named and addressed rather than filled by the manager (Section 10.2). The second concerns context: referral routes will differ by country, sector, and employer — an employee assistance programme in one organisation, occupational health in a second, a public clinic or a task-sharing service such as the Friendship Bench in a third.

Table 2. A practical framework: managerial responsibilities, professional functions, and signals for handover

Domain	Appropriate for the line manager	Requires a trained mental-health professional	Signal to hand over
Noticing	Notice changes in mood, behaviour, attendance, or performance; ask privately and respectfully how the employee is	Assessment of symptoms, diagnosis, and case formulation	Distress that persists, worsens, or interferes with daily functioning
Conversation	Brief, compassionate check-ins focused on how work is going and what support would help	Repeated sessions exploring emotions, relationships, trauma, or personal history; any psychological therapy	Conversations becoming regular, lengthy, or focused on matters beyond work
Risk	Take any mention of suicide or self-harm seriously; stay with a person at immediate risk and contact emergency or designated services	Risk assessment, safety planning, and crisis intervention	Any disclosure of suicidal thoughts, self-harm, or intent to harm others: immediate referral, not further conversation
Acute events	Psychological first aid after a critical incident: safety, practical needs, information, and linkage to support	Assessment and, where indicated, evidence-based treatment of trauma-related conditions	Symptoms persisting or worsening in the weeks after the event
Work adjustments	Reasonable adjustments to workload, hours, duties, or leave; return-to-work planning with the employee	Occupational health or clinical assessment of fitness for work where the condition is complex	Extended absence, repeated relapse, or disagreement about capacity to work
Referral	Know the available routes (employee assistance programme, occupational health, public clinic, helpline, task-sharing service) and help the employee use them	Treatment, case management, and coordination of care	Whenever the employee's needs exceed the manager's column
Confidentiality	Share information only with consent and on a need-to-know basis; keep welfare conversations out of performance records	Confidential clinical records held under professional and statutory duties	Any prospect that a disclosure will bear on appraisal, promotion, or discipline
Performance and discipline	Continue to manage performance fairly, taking health into account; hold welfare and disciplinary conversations separately	Independent assessment where health may bear on capability	Any capability or disciplinary process involving an employee whose mental health is at issue: route through human resources and occupational health



The manager's own support	Seek consultation and support after difficult conversations	Consultation or supervision for managers, provided by the organisation	Signs that the supportive role is affecting the manager's own wellbeing
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Note. The framework is a template for organisational adaptation, not a clinical protocol; referral routes will differ by country, sector, and employer. Compiled from World Health Organization (2022), World Health Organization et al. (2011), American Psychological Association (2017), and Gayed et al. (2018).

Read across its rows, the framework makes a simple point. The manager's column is neither empty nor trivial: noticing, responding humanely, adjusting work, responding to acute events, and making referral work are substantial contributions, and they are the contributions that the evidence on manager training actually supports (Gayed et al., 2018). What the framework removes from the manager is only the right-hand side of each row — assessment, treatment, and the management of clinical risk — which no amount of goodwill makes safe to perform from a position of line authority.

The objection: what if there is nowhere to refer to?

The prescription advanced here — notice and refer, rather than diagnose and treat — invites an obvious and serious objection, and it deserves to be stated at its strongest rather than dismissed. In a region averaging a small fraction of the global mental-health workforce, referral may be a fiction. To tell a manager in a rural district that their role is to signpost is to tell them to point at a door that does not exist. If there is no employee assistance programme, no accessible clinic, no psychologist within a day's travel and none affordable if there were, then the manager's improvised support is not a substandard alternative to proper care; it is the only thing on offer. On this view, the argument of this article is a counsel of perfection imported from settings that can afford it, and its practical effect would be to talk managers out of helping while supplying nothing in their place. The employee ends up with less, not more.

Two responses are owed to this, and the first is a concession. The objection is right that withdrawal of managerial care would be a harm, and nothing here argues for it. The supportive functions set out above — noticing distress, responding with humanity, holding a brief and compassionate conversation, adjusting workload or conditions — are not luxuries to be suspended where services are scarce. They matter more where services are scarce, not less, and the manager remains their proper source. What the argument withdraws is not help but a particular pretence: that an untrained, unsupervised supervisor holding power over the person in front of them can safely occupy the therapeutic role, and that an organisation discharges its obligations by arranging for them to try. The distinction between the supportive and the therapeutic function is not a distinction between more help and less. It is a distinction between help that can be given safely and help that cannot.

The second response concerns the premise itself. "There is nowhere to refer to" is frequently a description of what an organisation has not built rather than of what cannot exist. A referral pathway does not require a psychologist on the payroll. It may consist of a relationship with a community clinic, an arrangement with a district mental-health service, a contracted external provider, or — most pertinently, given the evidence reviewed in the preceding section — a properly designed non-specialist provision of the kind that African task-sharing programmes have shown to be both effective and inexpensive, selected, trained, supervised, bounded in scope, and held structurally separate from the management line. The lesson of that literature is precisely that adequate provision can be constructed under conditions of severe scarcity. An employer that has not attempted any of this and then cites scarcity to justify loading the work onto supervisors is not reporting a constraint; it is declining an obligation and describing the refusal as a circumstance.

There remain settings where the gap is real and cannot be closed by any organisation acting alone, and here the argument's second commitment applies: an acknowledged gap is preferable to a concealed one. This is not a comfortable position and it should not be presented as one. It means accepting that some employees will need psychological care that their employer genuinely cannot provide. But convenient psychotherapy does not close



that gap; it hides it. By producing the appearance of coverage — a policy, a trained supervisor, a manager who listens — it removes the visible deficiency that would otherwise generate pressure on the employer, the sector, and ultimately the health system to do something about it. An organisation that believes it has a wellbeing provision does not lobby for one, does not budget for one, and does not notice its absence. Naming the gap keeps the obligation alive and locates it where it belongs, with the institution rather than with the individual supervisor who happens to be standing closest to the distress.

Finally, the objection rests on an assumption that the evidence does not support: that improvised support is better than none. That may be true, and in many instances it doubtless is. But it is an empirical claim, and the literature reviewed above offers no basis for it. Manager training reliably improves what managers know, believe, and report doing, while the benefit to the employees on the receiving end remains undemonstrated even in controlled trials of purpose-built programmes. The harms catalogued in Section 8 — mishandled disclosure of risk, delayed referral produced by misplaced confidence, confidential material resurfacing in a performance process, employees deterred from seeking help again — are not hypothetical costs to be weighed against a certain benefit. They are the plausible consequences of the arrangement, set against a benefit that has never been shown. “Something is better than nothing” is an assumption doing a great deal of work, and it should be recognised as an assumption rather than accepted as an argument.

CONDITIONS THAT SEPARATE LEGITIMATE TASK-SHARING FROM CONVENIENT PSYCHOTHERAPY

The preceding analysis can be condensed into a practical test. Delegating psychological support to a non-specialist is defensible to the extent that the conditions in Table 3 are met, and slides toward convenient psychotherapy to the extent that they are not. The table sets each condition against the two arrangements the article has contrasted: the trained lay helper of a well-designed task-sharing programme, and the line manager pressed into de facto counselling.

Table 3. Conditions distinguishing defensible task-sharing from convenient psychotherapy

Condition	Well-designed task-sharing	The manager-counsellor
Selection	Helper chosen for suitability, aptitude and willingness; participation is voluntary and can be declined without penalty	Helper determined by position in the hierarchy; the role arrives with the job and cannot be declined without appearing uncaring
Scope	A specific, bounded intervention with an explicit threshold beyond which the helper must hand over	Unspecified; the helper handles whatever is brought to them, with no stated limit and no defined threshold
Training	Preparation in the defined intervention to a standard of competence, including explicit instruction in the limits of that competence	None, or a brief awareness course that raises confidence without establishing competence in any bounded task
Supervision	Ongoing oversight by qualified professionals, with established routes for escalating cases beyond the helper’s remit	None; the helper works alone, with no one to consult and nowhere to escalate
Role separation	Helper holds no authority over the recipient’s pay, appraisal, discipline or employment; no competing institutional interest	Helper holds direct authority over all of these; the helping and supervisory relationships are held by the same person
Confidentiality	A genuine confidential frame, with disclosure limits stated in advance	Cannot be offered, since what is disclosed may bear on decisions the helper is separately obliged to make
Referral	A working pathway to specialist care sits beneath the support	Often absent; where referral has nowhere to lead, the support becomes terminal rather than transitional



Capacity	Time and emotional resources for the helping role are recognised, resourced and accounted for	Added to a full workload without adjustment, invisible in planning and unrewarded in appraisal
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The manager-counsellor of convenient psychotherapy fails every one of these conditions; the lay health worker of a well-designed African task-sharing programme meets them. The distinction is not between professionals and non-professionals, nor between rich and poor settings. It is between support that is structured to be safe and support that is improvised to be cheap.

The table is offered as a diagnostic rather than a threshold. Real arrangements will meet some conditions and not others, and the practical value of the test lies in identifying which safeguards are missing and therefore what would have to be built. An organisation that finds it meets the conditions on selection, scope and training but fails on role separation and confidentiality has learned something specific: that its difficulty is structural, and that no amount of further training will address it.

CONCLUSION

The expectation that line managers will support the mental health of their staff is, in its modest and proper form, both reasonable and humane. The dilemma examined here arises when that expectation is allowed to expand, unspoken and unbounded, into the provision of de facto psychotherapy by people who are untrained to provide it, structurally disqualified from providing it safely, and too overstretched to provide it without harm to themselves. The dilemma is acute in many African workplaces because the scarcity of formal mental-health services in much of the region creates the strongest possible temptation to improvise — and convenient psychotherapy names that improvisation and locates its appeal: it is cheap, immediate, and reassuring for the organisation, and it shifts the burden of inadequate provision onto the two parties least able to refuse it.

The remedy is not to demand that managers care less, but to insist on a clear division of labour. Managers should notice, support briefly, accommodate, and refer; trained and supervised providers, organised under conditions that make their work safe, should counsel. The experience of task-sharing in several African countries — group interpersonal therapy in rural Uganda, the Friendship Bench in Harare, and the PRIME programme's district-level work in Ethiopia, South Africa, and Uganda — confirms both halves of this argument: non-specialists can deliver real psychological help, but only when selected, trained, supervised, and kept free of conflicting roles. Where those safeguards are absent, what is offered is not a humane innovation but a convenient fiction — one that risks the people it claims to help and quietly burns out the people asked to help them. Recognising convenient psychotherapy for what it is, is the first step toward replacing it with support that is genuinely safe, for subordinates and managers alike.

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Legislation and Regulatory Instruments

1. Counsellors and Psychologists Act No. 14 of 2014 (Kenya).
2. Health Professions Act 56 of 1974 (South Africa).
3. Health Professions Act [Chapter 27:19] (Zimbabwe).
4. Regulations Defining the Scope of the Profession of Psychology, Regulation 993 of 16 September 2008 (South Africa).