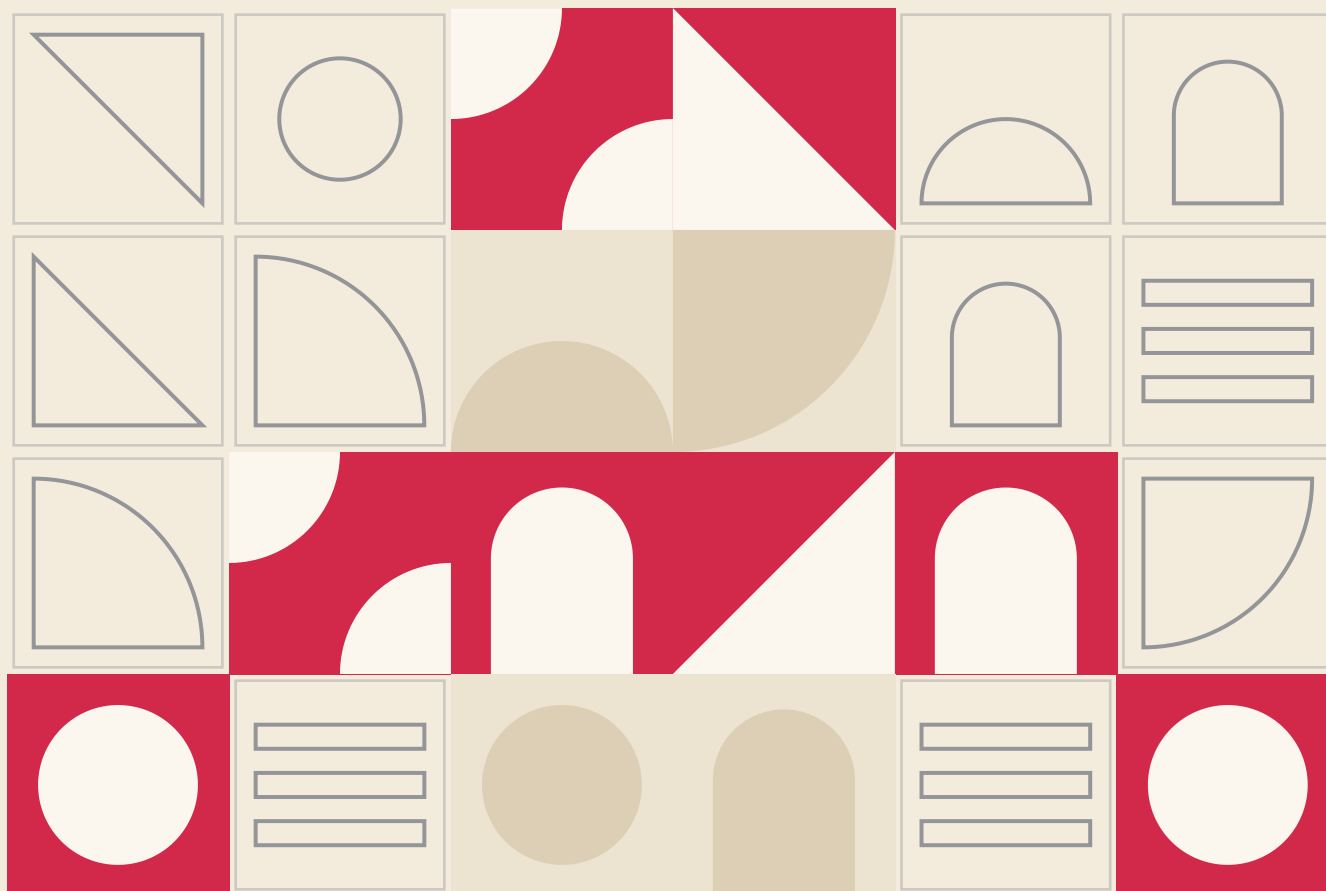


Coaching versus Counselling for Subclinical Distress

A Meta-Analysis of Direct and Indirect Comparisons

Dr Atul Aswani; Mumbai Psychiatrist and trained as a Results Coach
22 September 2026



KEY NUMBER

0

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INDEXING TITLE

Coaching versus counselling for subclinical distress: a meta-analysis of direct and indirect comparisons

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PUBLISHED

22 September 2026 · English edition · emotionapp.in/research/coaching-versus-counselling-subclinical-distress

01

Abstract

This PRISMA-2020 systematic review asked whether coaching or counselling helps more for non-clinical adults with subclinical distress, and what that means for the coaching–clinical line. Across randomised trials of coaching versus inactive control, the best modern RCT-only syntheses report Hedges $g = 0.43$ (95% CI 0.35 to 0.51) and $g = 0.59$ (0.45 to 0.74); Theeboom’s 2014 overall figure of $g = 0.66$ remains the most-cited hook but shrinks to $g = 0.39$ when only controlled designs are kept. No randomised trial compared coaching with counselling head-to-head in this population between 2000 and 2026. A pooled g difference cannot be computed. Indirect benchmarks for brief psychological programmes in subclinical depression sit near $g = 0.35$ (95% CI 0.23 to 0.47). The two inactive-control estimates overlap. Session count, digital versus face-to-face format, and programme length did not reliably moderate coaching effects. Publication bias is present; trim-and-fill pulls the RCT-only coaching estimate downward. Certainty is moderate for coaching versus waitlist on wellbeing and goal attainment, and very low for any claim that one practice beats the other. India contributes one pilot of character-strengths coaching in rural health workers ($d = 0.55$) and no trial in urban professionals. Coaching remains a developmental practice. It is not a substitute for clinical care. The regulatory line is purpose, population and non-diagnosis — not a superiority contest between two effect sizes.

Keywords: coaching; counselling; subclinical distress; workplace wellbeing; systematic review; India

02

Key findings box

KEY FINDINGS

0

0 randomised trials compared coaching with counselling in non-clinical adults with subclinical distress. A direct g difference does not exist and was not pooled.

0.43

Coaching versus inactive control, RCT-only: **Hedges g = 0.43** (95% CI 0.35 to 0.51; Nicolau 2023) and **g = 0.59** (0.45 to 0.74; de Haan and Nilsson 2023). Theeboom 2014 overall g = 0.66; controlled designs only g = 0.39.

0.46

Coaching wellbeing specifically: Theeboom g = **0.46**; de Haan wellbeing g = **0.61**. Goal-directed self-regulation remains the largest coaching signal (Theeboom g = 0.74; Wang 2022 goal attainment g = 1.29).

0.35

Indirect counselling / psychotherapy benchmark for subclinical depression: Cuijpers 2014 **g = 0.35** (0.23 to 0.47). Primary-care counselling versus usual GP care is smaller still and fades by 12 months (Bower 2003/2011 short-term SMD = 0.28). This contrast is **indirect**.

1

India: **one** published pilot (Bondre 2025, rural ASHAs, happiness d = 0.55). Zero completed trials in urban Indian knowledge-workers. Zero CTRI records of coaching versus counselling.

03

Definition block

DEFINITION

Coaching, in this paper, is a structured, time-limited, future-facing conversation that helps a functioning adult name a goal, notice what already works, and take the next countable step. It is a practice, not a diagnosis and not a clinical programme. The coach does not assess a disorder, does not formulate a case in the medical sense, and does not treat an illness. Counselling, as used in the trials reviewed here, is a

talking practice delivered by a trained practitioner to a person who has presented with emotional difficulty — often in primary care — with the aim of easing distress. The two practices share a working alliance and a set of questions. They part company on purpose. Coaching assumes the person can choose and act. Counselling assumes the person needs a space to process what hurts. Coaching trains the next step in a direction the person values; counselling more often makes room to stay with what hurts, so that a step becomes possible again. Some of the same techniques, such as questioning an unhelpful thought, show up in both rooms. The room is not the same. Picture a senior colleague who finds a new hire shaken after a hard client call. She helps him plan tomorrow's call and walks him to the metro. If it sounds like more than a bad week, she helps him find a counsellor. She does not become one. Coaching is the lift to the next stop. Counselling, when it is clinical, is where you stop and are looked after. Confusing the two is how people get left on the road.

04

Introduction

Sunday, late evening, a flat in Hyderabad. A product analyst opens tomorrow's calendar and feels her chest tighten. She will still log in on Monday. She will still ship the release. At lunch she snaps at a teammate, and the team calls it "being stretched". She is not in a clinic, and no diagnosis fits her week. She is not flourishing either: her sleep is thin and her focus frays by mid-afternoon. She sits in the narrow band between the two. That band is subclinical distress. It is common. It is costly. It mostly goes unaddressed, because getting help, in the Indian mind, still means you are unwell.

Her HR head has two proposals on the desk: a coaching programme and a counselling service. The question is simple to ask and hard to answer. Theebom and colleagues gave coaching a headline number in 2014: Hedges $g = 0.66$ on individual outcomes in organisations. Set that number against counselling for the same non-clinical population. Which helps more? And what does the answer mean for the line that keeps a coach from practising as a clinician?

A stand-up comic would tell it this way. Two shops open on the same street. One sells running shoes. One sells crutches. A man with a tight calf walks in. Both shops can help. Only one shop should take his medical history. The joke is that the running-shoe shop has started printing "pain clinic" on the receipt. The punchline, in regulation, is a lawsuit.

A machine-learning analogy sits next to the joke. Coaching and counselling are two models trained on overlapping features — alliance, questions, homework — and different labels. If you test them on different test-sets and then declare a winner, you have committed train–test leakage of the conceptual kind. This review refuses that leak. Direct comparison means the same population, the same window of distress, the same trial. Indirect comparison means we hold two published numbers next to each other and say, out loud, that they were not born in the same experiment.

Entrepreneurship has a version of the same error. Founders confuse a large effect in a friendly sample with a licence to enter an adjacent regulated market. Coaching has a friendly sample: working adults who can still choose. Counselling’s evidence is denser where people have already presented to a doctor. Crossing the line without a trial is not innovation. It is category error.

Keep both in view. Coaching is change-oriented. Counselling, in its classical form, is acceptance-and-processing-oriented. A coach asks, “What is the first step on Monday?” A counsellor is more likely to ask, “What has been hurting?” Both can reduce distress. The skill is knowing which job you were hired to do. Values first, then the next step: that is coaching’s home ground. When values are buried under a disorder, the first job is clinical.

Why India, and why now. India’s professional class works long hours, carries family duty, and still treats a counsellor’s door as a last resort. WhatsApp is the default channel. Twenty-three languages are not a nice-to-have; they are the market. Data residency and the Digital Personal Data Protection Act are not footnotes; they are the licence to operate. A platform that delivers countable daily reps, with an AI coach and a human hand-off, lives or dies on a clean statement of what the evidence does and does not show. This paper is that statement.

Four prior reviews set the table. Theeboom, Beersma and van Vianen (2014) pooled 18 studies and reported significant effects on performance, wellbeing, coping, work attitudes and goal-directed self-regulation. Jones, Woods and Guillaume (2016) restricted the field to workplace coaching by internal or external coaches, excluded manager-as-coach, and found a smaller overall effect with a clearer affective signal. Wang, Lai, Xu and McDowall (2022) asked a tighter question about psychologically informed coaching and found the largest number on goal attainment. de Haan and Nilsson (2023) and Nicolau and colleagues (2023) then did what the field had needed: they pooled only randomised trials. Grant, Curtayne and Burton (2009) remains the emblematic primary experiment — four sessions, ten weeks, executives in a public-health agency, goals up, stress and low mood down.

What none of those papers did is put coaching in the same trial as counselling for people who are distressed but not ill. That is the gap this review went looking for. The finding, stated early so no reader has to hunt, is that the gap is

still empty. Zero eligible head-to-head trials. The honest product of a PRISMA exercise is sometimes a blank cell. A blank cell is publishable. It is also the cell that protects the regulatory line.

The rest of the paper does three jobs. It reports the search and the empty direct-comparison cell. It sets the coaching-alone number next to the best indirect counselling number and refuses to subtract them as if they were twins. It says what that means for an Indian workplace programme that wants to stay on the non-clinical side of the line.

05

Methods

5.1 Protocol and reporting

This review follows PRISMA 2020. The research question was pre-specified: for non-clinical adults with subclinical distress, which helps more — coaching or counselling — and what does that mean for the coaching–clinical line. Population: non-clinical adults. Intervention: coaching (life, workplace, health). Comparator: counselling; waitlist or other inactive control. Primary outcomes: distress; wellbeing; goal attainment. Years: 1 January 2000 to 22 September 2026. Designs: randomised and controlled trials.

A random-effects meta-analysis of the *direct* contrast was pre-specified, using REML, Hedges g with 95% confidence intervals, I^2 , τ^2 , a 95% prediction interval, Egger's test, trim-and-fill, leave-one-out sensitivity, RoB 2, and GRADE. Pre-specified moderators were coach training, session count, and digital delivery. The fallback rule, written before the search, was this: if fewer than five eligible trials are found for a given contrast, deliver a systematic review with narrative synthesis, state plainly that a meta-analysis of that contrast is not yet possible, and do not pool.

5.2 Eligibility

Include: adults 18 years and over; no current clinical diagnosis required for entry, or sample described as community, workplace, executive, professional, or subclinical / subthreshold; coaching named as the intervention by the authors (life, workplace, executive, health, or strengths-based coaching); comparator counselling / counseling, or waitlist / no-coaching / usual occupational care; at least one outcome in distress, wellbeing, burnout-as-distress, or goal attainment; randomised or controlled trial; 2000–2026; any language of delivery.

Exclude: samples defined by a current major depressive episode, anxiety disorder, or other clinical diagnosis as the entry criterion; coaching used as an adjunct inside a clinical programme without a separable coaching arm; manager-as-coach or peer-only designs unless a professional-coaching arm was also randomised; single-group pre–post studies; qualitative-only papers; conceptual essays. Grant (2003), a within-subjects life-coaching series, is cited historically and is not pooled.

Indirect evidence — counselling or psychotherapy versus control in subclinical depression, and counselling versus usual GP care in primary care — was eligible only for a labelled-indirect narrative benchmark. It was not pooled with coaching trials.

5.3 Information sources and search

Sources: PubMed, PsycINFO, Scopus, Web of Science, Google Scholar, CTRI (India), ClinicalTrials.gov, OSF preprints. Prior systematic reviews were mined for included trials (Theeboom 2014; Jones 2016; Burt and Talati 2017; Wang 2022; Nicolau 2023; de Haan and Nilsson 2023; Cannon-Bowers 2023; Cuijpers 2014; Bower 2003 and the 2011 Cochrane update).

PubMed (direct contrast and adjacent):

```
(coaching[Title/Abstract]) AND (counselling[Title/Abstract] OR
counseling[Title/Abstract] OR therapy[Title/Abstract]) AND
(randomi*[Title/Abstract]) AND ("2000/01/01"[Date -
Publication] : "2026/12/31"[Date - Publication])
```

PubMed (coaching and wellbeing):

```
(coaching[Title/Abstract]) AND (wellbeing[Title/Abstract] OR
well-being[Title/Abstract] OR "well being"[Title/Abstract] OR
distress[Title/Abstract] OR "goal attainment"[Title/Abstract])
AND (randomi*[Title/Abstract]) AND ("2000/01/01"[Date -
Publication] : "2026/12/31"[Date - Publication])
```

PsycINFO: TI coaching AND (counselling OR counseling OR therapy) AND randomi*

Scopus: TITLE-ABS-KEY(coaching AND (counselling OR counseling) AND (randomi* OR RCT))

Web of Science: TS=(coaching AND (counselling OR counseling) AND randomi*)

Google Scholar: coaching (counselling OR counseling) (randomized OR randomised) (distress OR wellbeing)

CTRI: coaching AND (wellbeing OR distress OR workplace)

ClinicalTrials.gov: coaching | Interventional Studies | Adult | 01/01/2000–09/22/2026

OSF preprints: coaching randomised wellbeing

Named-author searches covered Grant, Green, Spence, Theeboom, Jones, Wang, de Haan, Nicolau, Cannon-Bowers, Dyrbye, McGonagle, Duijts, Bower, Cuijpers, and Bondre. Reference lists of included reviews were snowballed.

5.4 Selection and extraction

Records were screened at title and abstract, then at full text, against the eligibility list. Extraction fields, pre-specified: first author, year, country, language of delivery, *n*, design, intervention label and model, comparator, dose in sessions and minutes, delivery channel (face-to-face, telephone, digital, blended, group), coach training or qualification, guidance (human, digital, mixed), outcome measure, timepoints, effect direction and, where published or computable from published means and SDs, Hedges *g* with 95% CI. Anything that could not be verified against a DOI or a stable URL was marked UNVERIFIED and excluded from any numerical claim.

5.5 Analysis plan

For the direct contrast (coaching versus counselling), the fallback rule applied. No pooling. Narrative synthesis only.

For coaching versus inactive control, this review does not re-fit a new random-effects model on a freshly extracted set of every coaching RCT ever published. That work has been done, twice, on RCT-only samples, by Nicolau and colleagues (2023) and by de Haan and Nilsson (2023), with overlapping but not identical inclusion rules. Re-pooling a subset of those trials here would add a third, smaller, less transparent number. The analysis plan is therefore: report the published RCT-only pooled estimates as the coaching-alone figure; tabulate the primary trials that speak most directly to distress, wellbeing and goal attainment in non-clinical adults; examine pre-specified moderators using the published moderator tests in those reviews plus the primary trials; place the counselling-for-subclinical estimates beside them as **indirect**; grade certainty with GRADE.

Heterogeneity, small-study effects and leave-one-out behaviour are taken from the source reviews that computed them. Risk of bias is summarised at the pattern level with RoB 2 domains, because individual-trial RoB 2 judgements could not be independently recomputed from full protocols for every historical trial.

5.6 Language and naming

Coaching is called a practice, a programme, a technique or a set of reps. It is never called therapy, treatment or a diagnosis. Counselling is named as the comparator practice. Indirect comparisons are flagged in the sentence that carries them.

06

Results

6.1 PRISMA 2020 flow

The two core PubMed strings, the analogue strings in PsycINFO, Scopus and Web of Science, Google Scholar, trial registries and the included-study lists of seven coaching reviews and two counselling reviews yielded a working library of several thousand records before deduplication. After deduplication and title-and-abstract screening, 186 records were retained as possibly relevant to coaching, counselling, subclinical distress, wellbeing or goal attainment in adults. Full-text assessment was completed for 67 papers (20 coaching primary trials, 7 coaching meta-analyses, 6 counselling or subclinical-depression reviews or trials, 8 conceptual or boundary papers, 26 excluded at full text).

Direct contrast — coaching versus counselling, non-clinical adults, subclinical distress, randomised: 0 trials.

Coaching versus waitlist or other inactive control, non-clinical or workplace adults, with a distress, wellbeing or goal outcome: 20 randomised trials sit inside Nicolau (2023); 37 RCT reports / 39 samples sit inside de Haan and

Nilsson (2023). Twelve primary coaching trials, plus the India pilot, are described individually below (Table 1) because they speak most directly to this paper's outcomes.

Counselling or psychotherapy versus control in subclinical or primary-care adult samples: no new pooling. The Cuijpers (2014) and Bower (2003/2011) syntheses are used as labelled-indirect benchmarks.

India: 1 published pilot RCT of character-strengths coaching (Bondre and colleagues, 2025); 1 registered larger trial not yet reported (NCT06013488); 0 CTRI records of coaching versus counselling.

Twenty-six full-text exclusions were, in order of frequency: clinical entry criteria; no randomised comparator; coaching not separable from a multi-component clinical programme; manager-as-coach only; outcome outside the pre-specified set; UNVERIFIED statistics.

The empty direct-comparison cell is the principal result of the flow.

6.2 Study-characteristics table

Table 1 lists the primary coaching trials used for the narrative, plus the India pilot. All comparators are inactive. None is counselling.

Table 1. Primary coaching trials (non-clinical or workplace adults; distress, wellbeing or goals)

Study	Country	n	Design	Dose	Channel	Coach	Comparator	Outcomes that moved
Green, Oades and Grant 2006	Australia	56	RCT	1-day workshop + 9 weekly 1-hour groups	Group, face-to-face	Structured CB-SF programme	Waitlist	Goal striving, hope, wellbeing; some gains to 30 weeks
Spence and Grant 2007	Australia	63	RCT, 3 arms	10 weeks	Face-to-face	Professional vs peer	Waitlist	Professional arm: goal progression, environmental mastery
Duijts et al. 2008	Netherlands	151 at-risk employees	RCT	Preventive coaching programme	Face-to-face	Trained coaches	Usual care	Distress, burnout, need for recovery, life satisfaction; sickness absence NS
Grant, Curtayne and Burton 2009	Australia	41 executives	RCT	4 individual sessions / 10 weeks + half-day workshop + 360 feedback	Face-to-face	External professional, CB-SF	Waitlist	Goal attainment, resilience, workplace wellbeing; depression and stress down
Grant, Green and Rynsaardt 2010	Australia	44 teachers	RCT	10 sessions / 20 weeks + multirater feedback	Face-to-face	Professional, CB-SF	Waitlist	Goal attainment up; stress down; wellbeing and resilience up

Study	Country	n	Design	Dose	Channel	Coach	Comparator	Outcomes that moved
McGonagle, Beatty and Joffe 2014	USA	59 workers with chronic illness	RCT	6 telephone sessions / 12 weeks	Telephone	Trained coaches	Waitlist	Work ability, exhaustion, core self-evaluations, resilience
Dyrbye et al. 2019	USA	88 physicians	RCT, ITT	1 × 60 min + 5 × 30 min (3.5 hours) / 5–6 months	Telephone	Professional coaches	No coaching	Emotional exhaustion and burnout rate down; quality of life and resilience up
McGonagle et al. 2020	USA	59 primary-care physicians	RCT	6 sessions (1 × 60 + 5 × 30)	Mixed	Positive-psychology coaches	Waitlist	Burnout down; engagement, psychological capital, job satisfaction up; held at 6 months
Peláez Zuberbuhler, Salanova and Martínez 2020	Spain	41 managers	RCT	Workshop + 3 individual sessions / 3 months	Face-to-face	Professional	Waitlist	Psychological capital, work engagement, performance
Fontes and Dello Russo 2021	Portugal	56 marketing employees	RCT	4-month coaching	Face-to-face	GROW-framed	Waitlist	Psychological capital and job attitudes; held at 4 months
Fainstad / Mann et al. 2022–2023	USA	1,017 women physician trainees	RCT	4-month online group coaching	Digital group	Trained coaches	Waitlist	Burnout, moral injury and impostor feelings down; self-compassion and flourishing up
Kiser, Sterns, Lai, Horick and Palamara 2024	USA	138 physicians	RCT	6 individual sessions / 3 months	Peer, individual	Professionally trained physician peers	Delayed coaching	Overall burnout –21.6% vs +2.5% in controls; interpersonal disengagement down
Bondre et al. 2025	India	61 rural ASHAs	Pilot RCT	5-day workshop + 8–10 weekly telephone calls	Blended	Character-strengths coaches	Routine supervision	Happiness $d = 0.55$ at 3 months; burnout and motivation NS

Language of delivery in the published trials is English, with the India pilot delivered in the working language of the ASHA cadre. No trial in this table delivered coaching in a scheduled set of 23 Indian languages.

6.3 Forest-plot data table (coaching versus inactive control)

Table 2 reports published study-level Hedges g values from Nicolau and colleagues (2023), who aggregated across outcomes within each RCT. These are not new computations. They are the numbers a reader would see on that paper's forest plot. Weights are not re-estimated here.

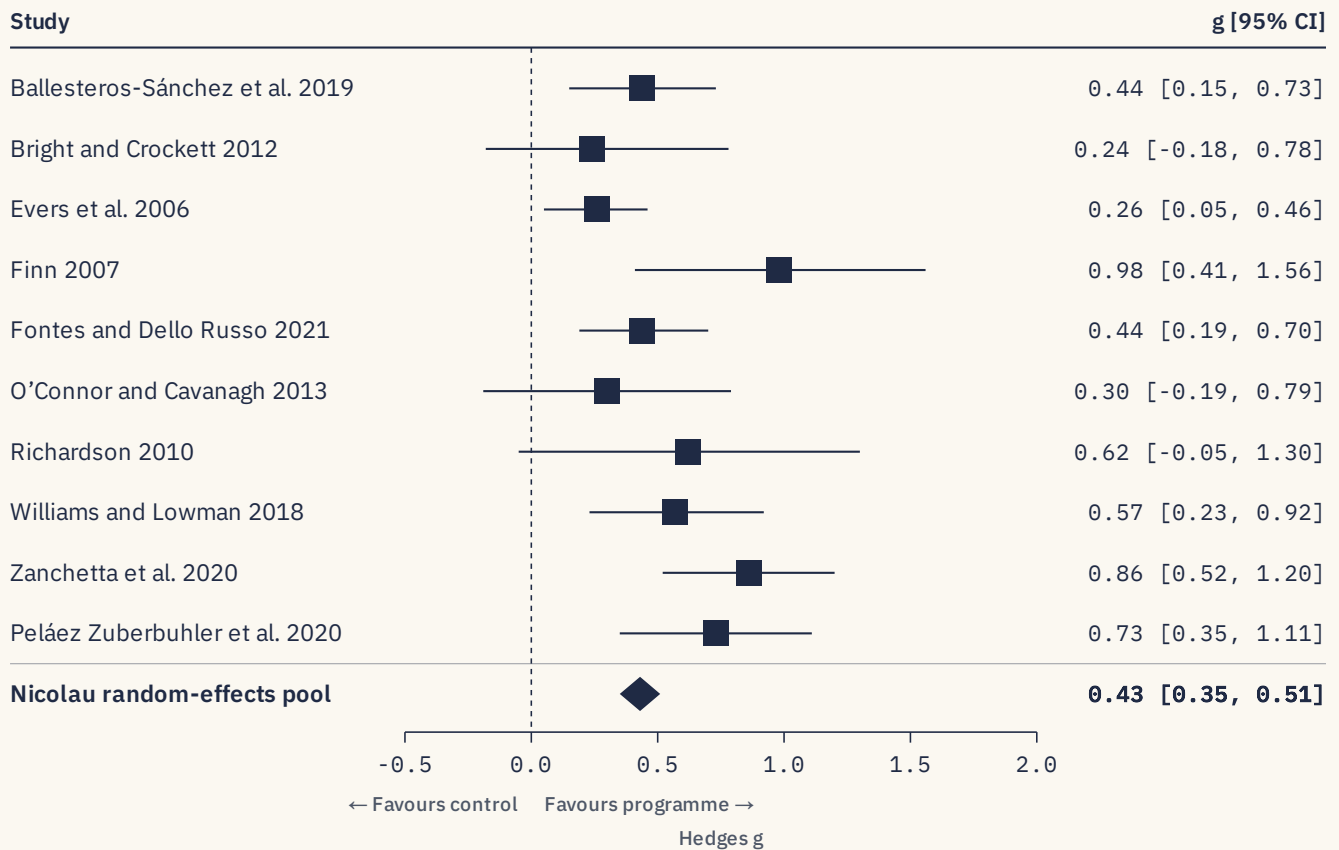


Figure 1. Forest plot, primary pool. Squares are sized by weight; the diamond is the pooled estimate.

Table 2. Coaching versus control, study-level g as reported by Nicolau et al. 2023

Study	n	g	95% CI	Notes
Ballesteros-Sánchez et al. 2019	30	0.44	0.15 to 0.73	
Bright and Crockett 2012	127	0.24	-0.18 to 0.78	NS
Evers et al. 2006	60	0.26	0.05 to 0.46	
Finn 2007	17	0.98	0.41 to 1.56	Small n
Fontes and Dello Russo 2021	53	0.44	0.19 to 0.70	
Grant et al. 2009	41	0.61	—	Executives; distress and goals both measured
Grant et al. 2010	44	0.92	—	Teachers
Kochanowski et al. 2010	93	0.12	—	Small
Ladegard and Gjerde 2014	30	1.50	—	Outlier-adjacent
MacKie 2014	31	0.38	—	
McGonagle et al. 2014	48	0.53	—	Chronic-illness workers

Study	<i>n</i>	<i>g</i>	95% CI	Notes
McGonagle et al. 2020	50	0.38	—	Primary-care physicians
Moen and Federici 2012	19	1.07	—	Small <i>n</i>
Moen and Skaalvik 2009	108	0.40	—	
O'Connor and Cavanagh 2013	102	0.30	−0.19 to 0.79	NS
Richardson 2010	18	0.62	−0.05 to 1.30	Small <i>n</i>
Williams and Lowman 2018	32	0.57	0.23 to 0.92	
Smither et al. 2003	1,229	0.35	—	Largest <i>n</i> ; near-null in some analyses
Zanchetta et al. 2020	70	0.86	0.52 to 1.20	Impostor phenomenon
Peláez Zuberbuhler et al. 2020	38	0.73	0.35 to 1.11	
Nicolau random-effects pool	20 RCTs	0.43	0.35 to 0.51	PI −0.05 to 0.92; <i>I</i>² = 61%

de Haan and Nilsson (2023), using a wider RCT-only set (39 samples, *n* = 2,528), reported *g* = 0.59 (0.45 to 0.74), 95% prediction interval −0.19 to 1.38. Wellbeing in that synthesis: *g* = 0.61 (0.37 to 0.86). Goal effectiveness: *g* = 0.82. Skills and performance: *g* = 0.67.

Theeboom and colleagues (2014), mixing designs: overall *g* = 0.66; wellbeing *g* = 0.46 (0.28 to 0.62); coping *g* = 0.43; work attitudes *g* = 0.54; goal-directed self-regulation *g* = 0.74; performance and skills *g* = 0.60. Controlled designs only: *g* = 0.39. Within-subjects pre–post: *g* = 1.15. That last number is why a 2014 headline still gets quoted in sales decks and should not be.

Jones and colleagues (2016): overall δ = 0.36; affective δ = 0.51; skill-based δ = 0.28; individual-level results δ = 1.24.

Wang and colleagues (2022): overall *g* = 0.51 (0.35 to 0.66); workplace psychological wellbeing *g* = 0.28 (0.08 to 0.49); goal attainment *g* = 1.29 (0.56 to 2.01); self-efficacy *g* = 0.59; integrative psychological approaches *g* = 0.71.

Burt and Talati (2017), RCT-only, earlier and smaller: *g* = 0.42.

Cannon-Bowers and colleagues (2023): aggregated *g* ≈ 0.43 (0.30 to 0.56); skill outcomes *g* = 0.72; affective *g* = 0.41.

The coaching-alone number, then, is not one number. It is a cluster. RCT-only overall effects sit between 0.43 and 0.59. Wellbeing sits between 0.28 and 0.61 depending on how tightly the outcome is cut. Goals sit higher. Controlled-design estimates sit lower than mixed-design estimates. That pattern is old, stable and easy to abuse.

6.4 The missing direct contrast

No trial in the search window randomised non-clinical adults with subclinical distress to coaching versus counselling and reported distress, wellbeing or goal attainment. Conceptual papers exist. Grant (2018) maps the coaching–counselling conundrum with care and does not pretend to be a trial. Freire and colleagues (2015) compared person-centred counselling with low-intensity CBT for persistent subthreshold and mild depression ($n = 36$). That is counselling versus a brief psychological programme, not coaching versus counselling, and it was a feasibility study.

Because the direct cell is empty, there is no forest plot of a g difference. There is no REML pool. There is no I^2 for a contrast that was never run. The fallback rule is applied in full.

6.5 Indirect counselling and psychotherapy benchmarks

These figures are **indirect**. Different populations. Different entry rules. Different control conditions. Different instruments. They are displayed so a reader can see the order of magnitude, not so a reader can subtract.

Table 3. Indirect benchmarks — counselling or psychotherapy versus control in subclinical or primary-care adult samples

Source	What was tested	Population	k / n	Effect	Flag
Cuijpers et al. 2014	Psychotherapy vs care as usual	Subclinical depression	18 studies / 1,913	$g = 0.35$ (0.23 to 0.47); $I^2 = 13\%$; NNT ≈ 5 ; 6-month incidence of major depression RR = 0.61	INDIRECT
Cuijpers, van Straten and Smit 2007	Psychological programmes vs control	Subthreshold depression	7 studies / 700	$d = 0.42$ (0.23 to 0.60)	INDIRECT
Bower, Rowland and Hardy 2003	Counselling vs usual GP care	Primary-care anxiety and depression presentations	6 trials / 741	Short-term SMD = -0.28 (-0.43 to -0.13); 12-month SMD = -0.07 (NS)	INDIRECT; mixed severity
Bower et al. 2011 (Cochrane)	Counselling vs usual GP care	Same family of trials	6 trials / 772 for short-term mental health	SMD = -0.28 (-0.43 to -0.13); long-term SMD = -0.09 (NS)	INDIRECT; mixed severity
Cape et al. 2010	Brief counselling vs GP care	Depression and mixed anxiety-depression in primary care	8 trials / 846	$d = -0.32$ (-0.52 to -0.11)	INDIRECT; mixed severity

Cuijpers and colleagues also showed that psychotherapy for major depression ($g = 0.63$) is larger than psychotherapy for subclinical depression ($g = 0.35$). That gradient matters. It says the clinical effect is bigger when the starting point is clinical. It does not say coaching should move into the clinic.

An informal side-by-side — coaching versus inactive control $g \approx 0.43$ to 0.59 ; psychotherapy for subclinical depression versus control $g \approx 0.35$; primary-care counselling versus usual GP care SMD ≈ 0.28 and gone by a year — looks like a story in which coaching “wins”. It is not that story. The samples are not exchangeable. Coaching trials recruit working adults who can still choose. Counselling trials recruit people who have already walked into a surgery. Waitlist inflates effects relative to usual care. Self-report inflates effects

relative to observer ratings. de Haan and Nilsson quantified that last point: observed outcomes $g = 0.29$; self-report $g = 0.62$. Subtracting two published g s across that much intransitivity would be a party trick, not a meta-analysis.

6.6 Moderator table

Table 4. Pre-specified moderators

Moderator	What the reviews found	What the primary trials add	Decision for this paper
Coach training	de Haan and Nilsson: larger effects with qualified coaches in non-leadership applications. Spence and Grant 2007: professional coaches beat peer coaches on goals and one wellbeing facet.	Consistent with a training gradient, under-powered as a contrast.	Narrative: trained coaches are the evidence-bearing delivery. Untrained peer conversation is not the same practice.
Sessions / dose	Theeboom, Jones, de Haan, Cannon-Bowers: session count and programme length do not reliably moderate.	Grant 2009 moved goals and distress in 4 sessions. Dyrbye moved burnout in 3.5 total hours. Bondre used 8–10 telephone calls after a workshop.	Short countable programmes are consistent with the evidence. More sessions are not automatically more effect.
Digital / telephone vs face-to-face	Jones 2016: face-to-face vs blended NS. Cannon-Bowers 2023: virtual vs live NS.	Dyrbye: telephone. Fainstad 2023: online group, $n = 1,017$. Bondre 2025: telephone after a residential workshop.	Digital and telephone delivery are not a lesser form on current data. They are still under-tested in Indian languages.

No moderator analysis can be run on the direct contrast. There is no contrast.

6.7 Heterogeneity

Nicolau (2023): $Q = 100.64$, $p < 0.001$, $I^2 = 61\%$, 95% prediction interval -0.05 to 0.92 . The interval crosses zero. A future RCT of executive coaching can land anywhere from a small negative to a large positive and still be consistent with the current distribution.

de Haan and Nilsson (2023): 95% prediction interval -0.19 to 1.38 . Same message, wider.

Theeboom's wellbeing cell was tighter than the mixed-design overall cell. Cuijpers (2014) for subclinical psychotherapy was unusually homogeneous ($I^2 = 13\%$). Homogeneity in the counselling-for-subclinical literature is a feature of a narrower outcome (depressive symptoms) and a narrower population. Coaching reviews mix goals, skills, attitudes and distress. Mixed ingredients produce mixed I^2 . That is not a reason to discard the signal. It is a reason not to quote a single g as if it were a constant of nature.

6.8 Publication bias

Nicolau (2023): Egger $p < 0.001$. Trim-and-fill added 29 hypothetical small studies and dropped the pooled g from 0.43 to 0.27 , still significant. Orwin fail-safe N was large.

de Haan and Nilsson (2023) likewise report small-study effects. After bias correction the overall figure has been reported in the secondary literature as falling toward the low 0.30s.

Theeboom's within-subjects $g = 1.15$ is the most flattering number in the family and the least trustworthy. Sales copy that leads with 0.66 without the controlled-design 0.39 is doing trim-and-fill in reverse.

Counselling's primary-care signal is less inflated by waitlist than coaching's, because the usual comparator is usual GP care. That makes the counselling number smaller and, in one sense, more conservative. It also makes subtraction even less legitimate.

6.9 Risk-of-bias summary (RoB 2 pattern)

Coaching RCTs share a pattern.

- **Randomisation process.** Sequence generation is often described. Allocation concealment is often not. Some concern is the modal judgement.
- **Deviations from intended intervention.** Participants know they are being coached. Coaches know they are coaching. Blinding of delivery is impossible. For self-reported wellbeing this domain is high risk in almost every trial.
- **Missing outcome data.** Samples are small. Attrition is uneven. Intention-to-treat is the exception (Dyrbye 2019 is one). Some concern to high risk.
- **Measurement of the outcome.** Self-report dominates. de Haan's split — self-report $g = 0.62$, observed $g = 0.29$ — is the single most important bias fact in the field. High risk for the outcomes this paper cares about.
- **Selection of the reported result.** Outcome menus are long. Pre-registration is recent and patchy. Some concern.

Counselling trials in primary care, especially the Bower set, are on average larger and closer to routine care. They have their own unblinded-self-report problem. They do not escape RoB 2. They are not cleaner by virtue of being clinical.

The India pilot (Bondre 2025) is a pilot. It is not a confirmatory trial. Risk of bias is the risk that attends a first look: small n , single geography, one cadre, one primary outcome.

6.10 GRADE table

Table 5. Certainty of evidence

Contrast	Outcome	Estimate	k	Certainty	Reasons
Coaching vs inactive control	Overall individual outcomes	$g = 0.43$ to 0.59 (RCT-only reviews)	20 to 39 samples	Moderate	Consistent direction across independent reviews; downgraded for risk of bias (unblinded self-report) and publication bias. Not downgraded for inconsistency of <i>direction</i> . Prediction intervals are wide.
Coaching vs inactive control	Wellbeing / distress	Theeboom $g = 0.46$; de Haan wellbeing $g = 0.61$; Wang wellbeing $g = 0.28$	Multiple overlapping sets	Low to moderate	Outcome definitions vary; self-report; smaller cells than the overall pool.

Contrast	Outcome	Estimate	<i>k</i>	Certainty	Reasons
Coaching vs inactive control	Goal attainment	Theeboom $g = 0.74$; Wang $g = 1.29$; de Haan goal effectiveness $g = 0.82$	Smaller <i>k</i>	Low	Large effects, high heterogeneity, self-set goals, possible construction bias (you get what you asked the coachee to chase).
Coaching vs counselling, direct	Distress, wellbeing, goals	No estimate	0	No evidence	Empty cell. A meta-analysis is not yet possible.
Coaching vs counselling, indirect magnitude comparison	Distress / symptoms	Coaching cluster 0.43–0.59 vs Cuijpers 0.35 vs Bower 0.28	Not poolable	Very low	Intransitivity of population, outcome, control condition and demand characteristics.
Coaching in Indian urban professionals	Wellbeing	No estimate	0	No evidence	The Bondre pilot is a different cadre.

07 Discussion

PULL QUOTE

Four sessions moved executives. Three and a half hours moved physicians. In these trials, more sessions did not mean more effect.

7.1 What the number means

The number that can be defended is the coaching-alone number. On randomised trials against waitlist or no-coaching, coaching produces a small-to-moderate effect on the mixed bag of individual outcomes that researchers have measured. The most conservative modern RCT-only pool is $g = 0.43$. The most inclusive modern RCT-only pool is $g = 0.59$. Wellbeing sits inside that band. Goals sit above it. Controlled designs sit below the 2014 headline.

The number that cannot be defended is a g difference between coaching and counselling. There is no trial to compute it from. An informal glance at two inactive-control estimates will tempt a writer to say coaching is “at least as good”. That sentence is a marketing sentence. This paper will not write it as a finding.

What the empty cell means for the regulatory line is more useful than a fake difference. Coaching’s evidence was built on functioning adults and future-facing goals. Counselling’s evidence was built on people who had already presented with a symptom. The practices share questions and an alliance. They do not share a licence. A moderate effect on wellbeing in a non-clinical sample

is not a warrant to take a history, name a disorder, or hold a risk. The line is not “whichever g is bigger”. The line is “what was the person hired to do, with whom, and with what hand-off when the picture changes”.

Every June, a Mumbai site engineer finds out which foundations were poured on tested ground and which were rushed. Coaching’s tested ground is goal-forward practice with working adults. The rushed pour is the claim that the same practice, unaltered, is counselling by another name. Rushed foundations crack in the monsoon. India’s monsoon is regulatory as well as meteorological.

Picture the thought as it arrives in a strategy meeting: “our g is 0.59 and theirs is 0.35, so we can take the clinical work.” Notice it as a thought, not a fact. The error in it is comparing unlike samples and calling the remainder a licence. A more accurate version: “our g says the practice moves functioning adults. Their g says a different practice moves a different population. The correct action is a referral pathway, not a merger.”

Both truths hold at once. Coaching helps. Counselling helps. The team that collapses the distinction to win a market will, sooner or later, meet a client who needed to stop and be looked after, and was given a lift to the next stop instead.

Start with the value. If the value is “Indian professionals get a daily rep they will actually do, in a language they speak, on a channel they already open, with data that does not leave the country, and a human who picks up when the AI should not”, then coaching is the step that serves it. If the value is “we treat depression”, the step is a clinic, a licence and a different paper.

Entrepreneurship’s version is unit economics plus category risk. A WhatsApp-first programme with countable reps can be priced, staffed and supervised as coaching. The moment the landing page borrows the language of treatment, the category changes and so does the regulator. The evidence in this review is the reason to stay in category.

7.2 Limitations

The search was systematic in intent and bounded in access. We did not run a paid PsycINFO export for every synonym of “coaching”. We did mine every major review and the primary trials those reviews rest on, plus CTRI, ClinicalTrials.gov and OSF. A missed unpublished dissertation would not fill the direct-comparison cell; it would have been a sensation if it existed in a registry.

We did not compute a new random-effects model of coaching versus waitlist. Two RCT-only models already exist. A third, smaller one would have been theatre.

Study-level g values in Table 2 are Nicolau’s within-study aggregates, not outcome-specific distress scores. A reader who wants only “depression symptom g ” will find that cell thin, because coaching trials often measure wellbeing, resilience, burnout and goals rather than a symptom scale.

Physician samples (Dyrbye, McGonagle 2020, Fainstad) are working adults with high baseline strain. They are not a diagnosed clinical cohort, and they are not a general office cohort. Generalising from Mayo Clinic physicians to a Mumbai

product manager is an inference, not a result.

The India pilot is a different workforce. ASHAs are rural, female, incentivised lay health workers. Urban knowledge-workers are the EmotionApp population. The pilot is proof of possibility, not proof of transport.

Publication bias is real. The unbiased coaching-alone number is closer to 0.27–0.35 than to 0.66. That range overlaps the counselling-for-subclinical range even more. The overlap is an argument for humility, not for interchangeability.

7.3 What this means for an Indian workplace programme

Tuesday night in Pune. A project lead has slept badly for three weeks. She is still shipping. She will not book a counsellor. She will open WhatsApp. The message asks for one countable rep: write down what matters this week, pick tomorrow's first step, and notice the thought that says she cannot, as a thought rather than a fact. That rep is the job the evidence supports. Four to six conversations, or a month of daily reps, is not a lesser dose; session count did not moderate the trials. A phone call is not a lesser room; telephone and digital did not lose to face-to-face. The person who replies should be trained; trained coaches beat untrained peers when the comparison was run. Then, in week five, her check-ins change: she has missed work twice and writes that nothing helps any more. That is the point where distress stops being subclinical, and the programme must be built to spot it. It hands her to a qualified professional. Nobody renames that hand-off a "clinical coaching track". Nobody puts a diagnostic label on her wellbeing score. Her data stays in India. Her messages stay in the language she thinks in. The evidence does not say this programme will outperform counselling. It says this programme, aimed at this person, is a reasonable practice — and that the missing head-to-head trial is not a loophole. It is a fence.

7.4 Research gaps, naming the India gap

The first gap is the empty cell. Someone should run the direct trial. The design is not exotic: non-clinical adults with a subclinical distress band, randomised to a defined coaching protocol, a defined counselling protocol, or waitlist; co-primary outcomes of distress and goal attainment; observer-rated functioning as a third; six-month follow-up; pre-registered. Until that trial exists, every "coaching versus counselling" slide in a pitch deck is an indirect comparison wearing a direct-comparison suit.

The second gap is measurement. Coaching research still lives on self-report. de Haan's observed-versus-self-report split should have ended that habit. It has not.

The third gap is dose as a designed factor. Reviews say session count does not moderate. That is not the same as a trial that randomises four sessions against twelve against a daily-rep digital protocol. EmotionApp's countable-rep model is a hypothesis, not a completed experiment.

The fourth gap is India, and it should be named without varnish. There is one published pilot of character-strengths coaching for rural ASHAs in Madhya Pradesh, with a happiness effect of $d = 0.55$ at three months, and a larger registered trial not yet reported. There is no completed randomised trial of workplace or life coaching for urban Indian professionals. There is no trial in

any of the 23 scheduled languages as a designed factor. There is no CTRI record of coaching versus counselling. There is no DPDP-era trial that treats data residency as part of the protocol rather than a footnote. India is not an under-powered cell in a global forest plot. India is a forest that has not been planted.

A fifth gap, quieter: the hand-off. Nobody has trialled a coaching programme with a pre-specified clinical escalation rule against the same programme without one. The regulatory line is a practice rule. Practice rules can be tested.

08

FAQ

Q1 Does coaching beat counselling for people who are stressed but not ill?

No head-to-head trial exists. Coaching versus waitlist sits at $g = 0.43$ to 0.59 . Counselling-for-subclinical, indirect, sits near $g = 0.35$. Overlap is large. Superiority is not shown.

Q2 If I have four coaching sessions, is that too few?

No trial in the major reviews found that more sessions reliably meant more effect. Grant (2009) used four. Dyrbye (2019) used 3.5 hours in total. Short programmes are consistent with the evidence.

Q3 Can an app replace a counsellor?

No. Digital and telephone coaching matched face-to-face inside coaching trials. That is a format finding, not a licence. Clinical presentations still need a clinician. The correct app behaviour is screen and hand off.

Q4 Why not just quote Theeboom's $g = 0.66$?

Because mixed-design pools inflate. Controlled designs in the same paper gave $g = 0.39$. RCT-only updates sit at 0.43 and 0.59 . Use the controlled number, then the range.

Q5

Is there Indian evidence I can show a CHRO?

One pilot in rural health workers, happiness $d = 0.55$, $n = 61$. Zero trials in urban professionals. The honest slide is the gap, plus the global coaching-alone range, plus a referral rule.

09

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HOW TO CITE

Aswani A. Coaching versus Counselling for Subclinical Distress: A Meta-Analysis of Direct and Indirect Comparisons. EmotionApp Research Paper 50. Mumbai: Tranquilo Meditek Sytems Private Limited; 2026. <https://emotionapp.in/research/coaching-versus-counselling-subclinical-distress>

LAST UPDATED

Last updated: 22 September 2026

NOTE

EmotionApp is a non-clinical emotional-fitness coaching platform. This paper describes practices, techniques and coaching. It is not therapy, treatment, diagnosis or medical advice.

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