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Christian Jonathan Haverkampf

Therapy Readiness: How to Know When Professional Help May Be Needed

Narrative Literature Review

Abstract—People may postpone psychotherapy because they do not feel 'ready,' while others enter treatment under external pressure without a shared purpose or sufficiently safe conditions. Readiness is best understood as a dynamic, context-dependent state rather than a fixed trait or prerequisite for care. It reflects perceived need, understanding of the problem, hope, access, safety, treatment expectations, cultural meaning, and willingness to take a next step. This narrative review considers indications for professional assessment, including persistent distress, functional impairment, recurrent patterns, harmful coping, diagnostic uncertainty, and risk, together with evidence on stages of change, barriers to help-seeking, stigma, and the therapeutic alliance. In crisis, urgent assessment does not depend on ideal motivation. Outside crisis, ambivalence can be explored directly and may itself become an initial therapeutic focus. Preparation can include defining the problem, identifying a meaningful goal, considering modality and clinician competence, clarifying confidentiality and practical arrangements, and agreeing how progress and fit will be reviewed. Professional help may involve psychotherapy, medical or psychiatric assessment, addiction or occupational services, social support, or safeguarding; psychotherapy is not always the first or only intervention required. Readiness may therefore be present when a person can engage in one feasible, sufficiently safe next step, even while uncertainty remains.

Index Terms—psychotherapy, readiness, help-seeking, stages of change, therapeutic alliance, stigma, professional help, risk

I. INTRODUCTION

People who ask, ' Am I bad enough for therapy?' or ' What if I am not ready?' often express the same uncertainty: whether distress is legitimate and whether change is possible. Waiting for complete certainty can prolong avoidable suffering. Entering therapy without meaningful consent, a shared rationale, or a reasonable fit may also be unhelpful. Readiness should therefore be explored and formulated rather than judged.

Earlier JPPC articles on anxiety, depression, and questions in therapy considered the role of communication in therapeutic work (Haverkampf, 2017a; Haverkampf, 2017b; Haverkampf, 2017c). The present review broadens that discussion by examining stages of change, barriers to help-seeking, stigma, access, and the therapeutic alliance. Its central proposition is that a person may be ready for assessment or consultation without yet being ready to commit to a longer course of treatment.

II. SCOPE AND REVIEW METHOD

This article is a narrative literature review based on searches conducted through 28 February 2026, before the issue date of 31 March 2026. Searches covered psychotherapy readiness, stages of change, help-seeking barriers, stigma, therapeutic alliance, service access, treatment fit, risk, and shared decision-making. Priority was given to professional guidance available by the cutoff date, systematic or umbrella reviews, meta-analyses, longitudinal studies, diagnostic research, and clinically informative original studies. Bibliographic details were checked against PubMed records, the Crossref DOI registry, or the issuing organization's website. Relevant JPPC articles were also consulted where they materially informed the present question.

This is not a systematic review and no pooled effect estimate is presented. Its purpose is to support recognition, formulation, and shared clinical reasoning rather than to provide an exhaustive account of the literature. The applicability of group findings to an individual depends on the clinical setting, developmental and cultural context, medical status, relevant exposures, and the quality of assessment. Guidance should be checked for subsequent updates before clinical use. Unless otherwise stated, the tables and boxed frameworks are author-developed clinical syntheses rather than validated instruments.

Christian Jonathan Haverkampf, M.D., LL.M., is a psychotherapist working in private practice in Dublin, Ireland. Correspondence: jonathanhaverkampf@gmail.com. Website: www.jonathanhaverkampf.com.

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Core propositions

- Readiness is dynamic and context-dependent, not a moral prerequisite for care.
- Persistent distress or impairment, recurrence, harmful coping, diagnostic uncertainty, or risk are reasonable prompts for professional assessment.
- Ambivalence can be an appropriate first topic for assessment or therapy rather than a reason for rejection.
- Treatment fit includes goals, modality, competence, culture, accessibility, boundaries, and therapeutic alliance.
- Urgent safety needs take priority over expectations of ideal motivation.

III. WHEN PROFESSIONAL HELP MAY BE NEEDED

Professional consultation is reasonable when distress persists, recurs, or restricts functioning; coping increasingly relies on substances, self-harm, compulsions, or avoidance; or a troubling change is difficult to understand. A formal diagnosis is not required. Early assessment can distinguish watchful waiting, practical support, medical assessment, psychotherapy, or another pathway. For anxiety and panic, stepped-care guidance similarly matches intervention intensity to impairment, risk, preference, and response (National Institute for Health and Care Excellence, 2011).

Severity is not limited to visible crisis. A person may remain employed while using most non-working hours to recover or relying on others for basic tasks. Conversely, intense distress after a major loss may not require immediate psychotherapy when safety, functioning, preference, and recovery remain adequate. Context and trajectory matter.

Psychotherapy is not a universal answer. Chest pain, delirium, medication adverse effects, sleep apnea, substance withdrawal, domestic violence, housing crisis, or an unsafe workplace may require medical, emergency, safeguarding, legal, occupational, or social intervention. Psychological care may accompany these responses but should not replace necessary practical or medical action. Symptom measures can support recognition and monitoring, but assessment must also consider functional impairment, differential diagnosis, and risk rather than relying on a score alone (Spitzer et al., 2006; Kroenke et al., 2001; Craske et al., 2017; Malhi & Mann, 2018).

IV. READINESS AS A CHANGING STATE

Stages-of-change models describe movement among not considering change, considering it, preparing, acting, and maintaining change, with movement between stages rather than a single linear progression. Norcross et al. (2011) summarize stage-sensitive clinical implications, and Krebs et al. (2018) found a moderate association between pretreatment stage of change and psychotherapy outcome across 76 studies. The model may therefore inform tailoring, but it should not become a label that restricts access to care. A 2024 review of motivational readiness in cognitive behavioral therapy found generally positive but heterogeneous associations with symptom outcome, while evidence concerning attendance was limited and inconclusive (Crane et al., 2024).

Stage-sensitive work adapts the immediate task: a person considering change may need feedback and options, whereas someone preparing or acting may need planning, skills, and review (Norcross et al., 2011). Action is not invariably preferable; pausing, changing targets, declining a method, or prioritizing safety can be rational when the next step remains informed, feasible, and proportionate to values and risk.

A person may be ready in one domain and not another: willing to address sleep but not trauma, ready to gather information but not disclose concerns to family, or willing to attend but unable to afford weekly sessions. Readiness can also change within an appointment. Respect for autonomy may support engagement, whereas coercive pressure can produce attendance or compliance without meaningful participation.

Ambivalence is clinically informative. What benefits or protective functions might the current pattern serve? What might change involve or cost? Is therapy associated with weakness, blame, cultural betrayal, loss of privacy, or previous harm? The aim is not to overcome ‘resistance’ as a fixed trait, but to understand competing values and identify a feasible, sufficiently safe next step.

Dimensions of therapy readiness

Dimension	Questions
Need	What is happening, and what is its cost?
Goal	What difference would make help worthwhile?
Agency	Is participation chosen, pressured, or legally mandated?
Hope/expectation	What is therapy expected to do, and what prior experience shapes that expectation?
Practical access	Time, money, transport, privacy, language, disability, childcare?
Safety	Can disclosure and attendance occur without increasing risk or danger?
Fit	Clinician competence, modality, culture, boundaries, and review process?

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V. BARRIERS TO HELP-SEEKING AND ENGAGEMENT

Help-seeking can be hindered by stigma, confidentiality concerns, limited mental-health literacy, self-reliance, and doubts about services (Gulliver et al., 2010; Clement et al., 2015). These barriers should not be reduced to internal resistance. Assessment should therefore distinguish willingness from opportunity and identify alternatives or interim safety arrangements when the proposed treatment cannot be accessed safely.

Service readiness is also observable. A service that offers only inaccessible times, cannot arrange an interpreter, does not explain confidentiality, or cannot identify responsibility during deterioration may convert practical exclusion into apparent disengagement. Assessment should record what option was actually offered, whether it was understandable and feasible, and what alternative or interim support was made available. This protects against treating attendance as a pure measure of motivation.

Cost, waiting lists, inaccessible buildings or technology, immigration concerns, language barriers, racism, previous coercion, and lack of culturally safe care can reasonably impede attendance. Teletherapy may improve access for some people while creating privacy, technology, or digital-exclusion problems for others. A readiness formulation should therefore distinguish unwillingness from inability and identify which barriers the service may be able to change.

Previous harmful experiences in therapy warrant direct inquiry. Boundary violations, invalidation, discrimination, premature interpretation, or breaches of confidentiality can shape current fear and mistrust. A new clinician should not assume trust; transparency about boundaries, limits, uncertainty, and the possibility of repair can allow trust to develop over time.

VI. WHAT THERAPY CAN AND CANNOT DO

Psychotherapy may provide structured assessment, a reliable therapeutic relationship, emotional processing, behavioral learning, cognitive change, communication practice, and support for valued action. Different modalities emphasize different mechanisms and techniques. Evidence for one diagnosis or intervention cannot be generalized to every problem, patient, or therapist. The rationale for treatment should therefore be linked to the individual's formulation and goals.

Treatment selection should reflect the presenting problem, evidence base, developmental needs, preferences, previous response, risk, language, access, and clinician competence. Individual, group, couple, family, and remote formats have different demands and confidentiality boundaries; willingness to talk does not by itself establish suitability for a particular method. A brief consultation may appropriately lead to psychotherapy, medication review, medical assessment, social or occupational intervention, or another service rather than a therapy contract.

A useful referral makes the next step concrete. It identifies the clinical question, urgency, relevant access or communication needs, what information may be shared, who remains responsible while the person waits, and how the recommendation will be reviewed. Giving a list of services without navigation may improve the description of the problem without improving access. Where options are limited, the clinician should distinguish the preferred evidence-based intervention from the feasible interim plan and state the limits of both.

Informed consent should address the problem targeted, treatment rationale and evidence, foreseeable benefit and burden, alternatives, review arrangements, and routes for urgent support. When severe illness is suspected, urgent assessment may be required before routine treatment options can be compared.

Psychotherapy cannot guarantee symptom elimination, make an unsafe relationship safe, replace necessary medical investigation, or provide housing or income. It may support decision-making and coping while practical systems respond. Informed expectations should address the work and uncertainty involved, the possibility of temporary distress, limits of confidentiality, fees and cancellation policies, record keeping, contact between sessions, and how treatment will be reviewed and ended.

An initial consultation is also an opportunity to assess the service and proposed treatment. A person can ask about qualifications, regulatory status, experience with the presenting problem, treatment model, alternatives, evidence, risks, supervision, and what will happen if treatment is not helping. A credible clinician should be able to explain uncertainty and referral limits. Treatment evidence is problem-specific: CBT has broad support across anxiety-related disorders, while evidence concerning sleep, dietary, and exercise interventions addresses more specific populations and outcomes; these approaches should not be treated as interchangeable with disorder-focused psychotherapy (Carpenter et al., 2018; Freeman et al., 2017; Trauer et al., 2015; Firth et al., 2019; Schuch et al., 2018). Therapy may evoke sadness, anxiety, memories, interpersonal discomfort, or temporary symptom fluctuation, but deterioration should

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not be normalized as inevitable or desirable; patients need a clear route to report adverse effects and criteria for changing pace, method, or level of care.

VII. ALLIANCE, FIT, AND PRODUCTIVE DISCOMFORT

First-contact communication should reduce avoidable uncertainty without promising a particular outcome. State what the meeting can decide, what information is optional or necessary, who will see the record, how disagreement can be raised, and when the person will hear about the next step. A person who cannot give a polished history because of distress, language, cognition, fear, or crisis should still receive an accessible assessment; preparation aids are supports, not admission tests.

The therapeutic alliance is commonly understood to involve agreement on goals and tasks and a relational bond. Meta-analytic research shows a consistent association between alliance and psychotherapy outcome, but the association does not itself establish causal direction (Horvath et al., 2011). Fit extends beyond liking the therapist: respectful challenge may be uncomfortable, while warmth without a coherent clinical rationale may be insufficient.

Suitability for remote care should be reviewed rather than assumed to remain stable. Housing changes, coercive relationships, cognitive or sensory needs, escalating risk, unreliable connectivity, and lack of a confidential space may alter what can be discussed or managed safely. The clinician should explain any location or emergency-contact requirements, agree how an interrupted session will be handled, and provide another route to care when the remote format no longer permits adequate assessment. After a first concrete step, review whether the person gained useful information, felt sufficiently safe, understood the proposed task, and encountered unresolved access barriers; the next step may be treatment, another assessment, a different clinician, practical support, or a defined pause.

A reviewable start also needs stopping and escalation criteria. Continued attendance is not evidence of benefit when symptoms, functioning, safety, alliance, or adverse effects are worsening. Conversely, discomfort during meaningful change does not by itself establish harm. The distinction depends on the agreed rationale, temporal course, observable consequences, the person's account, and whether adjustment restores a credible path toward the target.

Before remote therapy begins, the therapist and patient should agree the platform, private setting, backup contact, location when required for safety, and the response to connection failure. In-person assessment remains necessary when the person cannot speak safely or when remote care cannot support an adequate assessment.

Warning signs include unexplained boundary crossings, pressure to disclose, retaliation for disagreement, unsubstantiated claims of cure, discouraging appropriate medical care, lack of transparency about qualifications, or routinely attributing lack of progress to the patient. Ordinary therapeutic ruptures—misunderstanding, disappointment, or disagreement—can be clinically informative when they are acknowledged and repaired.

Readiness may develop within a reliable therapeutic relationship. A person may initially bring only a practical concern, test the limits of confidentiality, or remain uncertain about goals. Early work can focus on making the process safe, understandable, and collaborative rather than requiring immediate in-depth disclosure.

VIII. INITIAL PREPARATION AND EXPECTATIONS

Preparation for an initial consultation can be simple: note what is happening, when it began, what has changed, relevant treatment and medication, any safety concerns, and one hoped-for difference. Records can be brought when useful and appropriate. A polished narrative is unnecessary; difficulty organizing the history may itself provide clinically relevant information.

Practical arrangements may include privacy, transport, accessibility, payment, childcare, and a plan for managing distress after sessions. For teletherapy, location and emergency arrangements should be clarified when clinically or legally required. If another person is pressuring attendance, the clinician should identify what remains voluntary and what information, if any, may be shared.

When clinically appropriate, a time-limited trial with an explicit review point can make the decision to continue treatment less all-or-nothing. Early indicators might include better understanding, a behavioral change, reduced risk, or improved functioning, alongside criteria for modifying treatment or referring elsewhere. Lack of improvement is clinically relevant information, not evidence that the person has ‘failed’ therapy. Research on self-compassion may also help clinicians understand shame about help-seeking, but there is no requirement that a person first master self-kindness before entering treatment (Neff, 2003; MacBeth & Gumley, 2012).

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Possible next steps at different levels of readiness

Current position	Possible next step
Unsure there is a problem	Track concrete episodes, impact, and trajectory for a defined period
Concerned but fearful	Information-focused consultation; list concerns and confidentiality questions
Willing but blocked	Address access, privacy, language, disability, or cost barriers
Ready to try	Agree a goal, method, baseline, boundaries, and review point
In therapy but stuck	Review rupture, fit, formulation or diagnosis, task, dose, and alternatives
In crisis	Prioritize urgent assessment and safety; revisit therapy readiness once immediate risk is addressed

IX. WHEN THERAPY IS RECOMMENDED BY OTHERS

Partners, parents, employers, schools, or courts may recommend therapy. Concern is usually more useful when expressed through concrete observations and limits rather than diagnostic labels. ‘I am worried because you have not slept and drove dangerously’ is more actionable than ‘You need therapy.’ The person retains autonomy except where emergency or legal frameworks lawfully limit choice.

Family involvement can support access and provide collateral information, but it may also inhibit disclosure or increase risk. The clinician should clarify whose treatment it is, what information may be shared, and whether individual or joint work is appropriate. With adolescents, developmental autonomy, parental responsibility, safeguarding, capacity, confidentiality, and local law all require consideration. A questionnaire can organize inquiry and provide a baseline, but a score is neither a diagnosis nor a treatment decision; chronology, concrete examples, function, risk, strengths, and appropriately consented collateral information remain necessary, and the formulation should change when new information does not fit.

Review should include the possibility of changing or ending treatment. Appropriate reasons include goals being met, consent changing, persistent poor fit, adverse effects, emergence of a medical or substance-related cause, need for another level of care, or inability of the service to deliver the agreed method. A planned ending records gains, unresolved needs, early warning signs, responsibility for current risk, and a feasible route back to care. Ending one treatment is not equivalent to abandoning help.

An employer can address performance and safety concerns and offer occupational support, but should not receive therapy content without valid consent or another lawful basis. Therapy should not be used as a substitute for addressing harassment, unsafe work, or unreasonable occupational demands. The intervention should match the level at which the problem primarily occurs.

X. CONTEXT, EQUITY, AND ACCESS

Clinical thresholds must be interpreted in social and cultural context. Opportunity, exposure, power, language, disability, service design, and previous treatment can affect both symptoms and the information available during assessment. Equity does not require less rigorous clinical reasoning; it requires better contextual information and care not to misinterpret structural constraints as individual pathology.

Access. Cost, waiting time, disability, language, childcare, privacy, transport, and digital exclusion are service barriers, not evidence that a patient is unready. Ask which step is blocked, who has the ability to change it, and what practical or service support could make participation possible. Treatment that was unavailable or inaccessible should not be recorded as refused care, treatment resistance, or lack of motivation.

Cultural safety. Therapy models, expectations about disclosure, and the meaning of help-seeking should be explained and adapted without assuming that one style of participation is universally appropriate. The formulation should ask what feels safe, legitimate, private, or acceptable within the person's cultural and family context, and which service changes would support meaningful choice. Engagement should be interpreted in light of language, previous care, access, and the person's own explanatory framework.

Coercion. Pressure from a school, employer, family, court, or institution changes the conditions of consent and should be stated explicitly. Clarify what is required, what remains voluntary, who may receive information, and what consequences, if any, follow nonparticipation. The formulation should identify how meaningful choice can be protected within those limits. Attendance under pressure should not be mistaken either for genuine agreement or for evidence that later difficulties reflect poor motivation.

XI. MEASUREMENT, FOLLOW-UP, AND REVISION

Follow-up should begin before intervention by defining what will be observed, at what interval, and by whom. Symptom measures can be useful, but they should be

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considered alongside functioning, safety, adverse effects, and the person's priorities. The aim is not to accumulate data, but to determine whether the working formulation remains useful and whether the chosen intervention produces clinically meaningful benefit relative to its burden.

Domains for monitoring outcome

Domain	Examples of outcomes to monitor
Symptoms and course	Severity, frequency, duration, and trajectory of the presenting problem
Function and participation	Work, study, self-care, relationships, and valued activities
Safety and health	Risk, sleep, substance use, adverse effects, and relevant medical concerns
Therapeutic process	Engagement, alliance, rupture and repair, and treatment burden
Treatment fit and goals	Progress toward agreed goals and need for modification, referral, or ending

XII. CLINICAL INTERVIEW DOMAINS

Readiness is usually better explored in conversation than treated as a trait score. Ask what is happening, what impact it has, what the person hopes might change, and what they fear therapy could expose, demand, or take away. Clarify safety, urgency, access, privacy, culture, clinician fit, and a worthwhile initial goal. Agreement need not be complete; ambivalence often identifies the conditions under which help could become usable. The clinician should explain boundaries and options, check understanding, and agree when continuation, modification, referral, or ending will be reviewed.

These domains should guide inquiry without turning readiness into a rigid checklist. Use prompts flexibly and at a pace appropriate to safety, development, capacity, consent, culture, and the clinical setting. Begin with recent concrete examples and compare them with the person's usual pattern. When collateral information may be helpful, explain its purpose and limits, clarify consent and confidentiality, and record the source's relationship to the person, opportunity to observe, and possible bias.

Begin with the problem and its impact. Ask what happens, how often, when it began, and which functions, relationships, roles, or choices have been affected. Exploring a recent episode from its antecedents through immediate and later consequences, and asking when the problem is absent or less severe, can prevent broad descriptions such as ‘overwhelmed,’ ‘anxious,’ or ‘stuck’ from being treated as if they already constitute a formulation.

A single account may support several hypotheses, while silence may reflect uncertainty, memory, shame, language, fear, or the way a question was asked. Record whether information comes from the patient, records, observation, or another person and indicate relevant uncertainty. If the reported impact does not fit the wider course, clarify the example, review relevant medical or treatment information, seek appropriately consented collateral information when indicated, or observe the pattern over time before deciding on a pathway.

Risk and urgency assessment should establish whether the person can remain safe and whether medical, psychiatric, addiction, safeguarding, crisis, or emergency care is needed now. When clinically indicated, ask directly about suicidal thoughts and intent, self-harm, risk to others, psychotic or manic symptoms, severe intoxication or withdrawal, abuse or exploitation, severe self-neglect, and inability to meet basic needs. Establish onset, current intent or exposure, protective factors, and what has changed from baseline.

Ambivalence about therapy must not delay necessary emergency assessment. Interpret risk in relation to medical status, capacity, development, and context, and document the source and limitations of the available information. When accounts conflict or the person cannot provide a full history, consider whether urgent examination, collateral history, observation, safeguarding action, or a different level of care is required. Explain the reason for escalation and preserve choice wherever safety permits.

The goal domain asks what observable difference would make professional help worthwhile. A goal may involve fewer crises, restored sleep, clearer understanding, safer coping, better participation, a relationship decision, or another valued function. Ask how the person would notice the difference in daily life and what early sign would indicate movement. Goals can remain provisional while assessment clarifies diagnosis, formulation, and treatment options.

Goals should be distinguished from demands imposed by family, school, an employer, or a service. Record whose aim is being described and how strongly the person endorses it. When goals conflict, make the disagreement explicit and identify a limited shared task, such as assessment, information gathering, or safety planning. Review the goal when new evidence, changing risk, or experience of treatment alters what appears worthwhile.

The ambivalence domain asks what is hoped for and what therapy might expose, demand, change, or take away. Explore fears of blame, cultural betrayal, loss of privacy, painful memories, previous treatment harm, financial cost, dependence, or pressure to accept an unwanted explanation.

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Ask also whether current coping has perceived benefits or protective functions. Competing values may explain hesitation better than a label of 'resistance.'

The purpose is to understand ambivalence, not defeat it. Avoid inferring motivation from attendance or disclosure alone; check interpretations with the person. A consultation focused on information, a narrower target, a different modality, involvement of a support person, or a time-limited trial may make the next step more feasible. If hesitation reflects danger, coercion, or an inaccessible service, the response should address that condition rather than demand stronger commitment.

Access includes cost, time, privacy, language, disability, transport, childcare, digital access, waiting lists, and the safety of attendance or disclosure. Ask what happens between deciding to seek help and reaching the first useful appointment. Distinguish preference from inability and identify whether the main barrier lies with the person, the service, another institution, or the wider environment.

Access information changes how nonattendance and outcome should be interpreted. Record what option was offered, whether it was understandable and feasible, and what support was available. When the proposed route cannot be used, consider an accessible format, interpreter, different setting, practical assistance, an alternative service, or review while waiting. Unavailable treatment should not be described as a patient-level treatment failure.

Preparation can reduce uncertainty without requiring a polished account. A brief note may include the main concern, onset, a recent example, current medication and substance use, relevant medical conditions, previous treatment, safety concerns, and the hoped-for change. It is a prompt, not a test. People unable to prepare because of distress, language, cognition, privacy, or crisis should still receive assessment, with accessible formats or a support person where appropriate.

Consent can be made concrete by asking what problem the treatment addresses, what evidence supports it, what sessions involve, which alternatives exist, how benefit or harm will be reviewed, and what happens if urgent support is needed. A clinician may not know every answer with certainty, but should explain the basis of the recommendation, important uncertainties, and responsibility for follow-up.

Decision aids should not imply that all options are equally effective or safe. They can present benefits, burdens, time, cost, accessibility, privacy, and strength of evidence while preserving preference. Severe illness may make urgent assessment or safety the immediate decision rather than a choice among routine therapies. Capacity, coercion, and safeguarding remain jurisdiction-specific, but shared decision-making can still include explanation, the person's values, and review as circumstances change.

Readiness can be reviewed after a first concrete step: did the person gain useful information, feel sufficiently safe, understand the proposed task, and encounter unresolved access barriers? The next step may be treatment, another assessment, a different clinician, practical support, or a defined pause. This prevents 'not ready' becoming a static label and keeps both patient and service factors in view.

XIII. ASSESSMENT AS A SEQUENCE, NOT A LABEL

A readiness assessment should describe the presenting problem, its impact, desired change, risk, previous help, expectations, ambivalence, practical access, cultural meaning, and service fit. It should distinguish urgent care needs from readiness for elective psychotherapy and consider whether medical, psychiatric, addiction, occupational, social, family, safeguarding, or legal intervention should precede or accompany therapy.

A questionnaire can organize inquiry and provide a baseline, but a score is neither a diagnosis nor a treatment decision. Scores are affected by time frame, context, literacy, language, expectations, and comorbidity. A clinically useful assessment adds chronology, concrete examples, collateral information when appropriate and consented, functional consequences, strengths, risk, and observation over time. The working formulation should be revised when new information does not fit.

Readiness often changes when the process is communicated clearly. Explain the purpose of the first meeting, what confidentiality covers, its limits, and what choices remain. Questions themselves can be therapeutically useful when they help the person identify competing goals and select a next step (Haverkampf, 2017c).

XIV. SAFETY, URGENCY, AND BOUNDARIES

A person does not have to feel ready before receiving crisis or emergency assessment. Imminent risk of suicide or violence, severe psychosis or mania, delirium, dangerous intoxication or withdrawal, immediate danger related to abuse, or inability to maintain basic safety may require urgent or emergency action. Safeguarding concerns require proportionate assessment and response. Coercion and capacity are governed by local law and ethics; a general review cannot determine them for an individual.

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Urgent and safeguarding considerations

- Use urgent or emergency services for imminent self-harm or violence risk, severe psychosis or mania, delirium, dangerous withdrawal, or inability to maintain basic safety.
- If abuse or coercive control is possible, assess whether attendance, messages, bills, shared devices, or records could increase danger.
- Clarify crisis contacts and limits of confidentiality before treatment, especially in teletherapy and work- or school-linked services.
- Ask directly about suicidal thoughts and intent, self-harm, violence risk, exploitation, inability to meet basic needs, severe intoxication or withdrawal, and safeguarding concerns when clinically indicated.
- Escalate urgently for a new focal neurological sign, delirium, catatonia, marked behavioral change, severe medical symptoms, or a rapidly deteriorating mental state.
- A general review cannot determine an individual's diagnosis, fitness for work, medication plan, or level of care; such decisions require an appropriately qualified clinician with access to the person and relevant records.

XV. LIMITATIONS AND RESEARCH NEEDS

Stages-of-change constructs vary by problem and measure, and an association with outcome does not establish that readiness itself causes improvement. Help-seeking studies often assess intentions rather than actual attendance, while alliance findings partly reflect reciprocal change over time. Fit remains difficult to operationalize, and service availability, cost, culture, access, and coercion all limit accounts that locate readiness only within the individual.

A systematic review found that clinician-patient alliance and communication were generally associated with treatment adherence, although intervention evidence was limited and study methods were heterogeneous (Thompson & McCabe, 2012). Research should examine observable communication, access barriers, engagement, benefit, adverse effects, and reasons for stopping without treating nonattendance as a patient defect. It should also distinguish a person's willingness from the service conditions required to make participation possible.

XVI. CONCLUSION

Therapy readiness is not the absence of fear and should not function as a test that a person must pass. Professional assessment is reasonable when distress or impairment persists, patterns recur, coping becomes harmful, diagnosis is unclear, or safety is at stake. Readiness can begin with an information-gathering consultation and may grow through clear boundaries, accessible care, a credible rationale, and a collaborative goal. Ambivalence can clarify goals, fears, costs, and treatment fit. In routine care, the practical threshold may be willingness and ability to take one feasible, sufficiently safe next step; when safety is at immediate risk, urgent assessment takes priority.

XVII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). CFT is discussed as a formulation perspective and not as a substitute for established diagnostic assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

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