

Safe working in the context of the counselling professions

Good Practice in Action 106
Clinical Reflections for Practice

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Context

This resource is one of a suite prepared by BACP to enable members to engage with BACP's *Ethical Framework for the Counselling Professions* in respect of practitioner safety.

Purpose

The purpose of this resource is to stimulate ethical thinking in respect of practitioner safety.

Using Clinical Reflections for Practice resources

The membership agreement with BACP establishes a contractual commitment with members to abide by the *Ethical Framework for the Counselling Professions*, which includes a responsibility for members to keep the skills and knowledge relevant to their work up to date.

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Practice issues and dilemmas are often complex, and may vary depending on clients, particular models of working, the context of the work and the therapeutic interventions provided. We therefore strongly recommend consulting your supervisor, and, wherever necessary, a suitably qualified practitioner or lawyer. Some professional insurers will provide legal advice as part of their service.

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References in this resource were up to date at the time of writing but there may be changes to the law, government departments, government policies and guidance, websites and web addresses. Organisations and agencies may also change their practice or policies, so please be alert for any changes that may affect your therapy practice.

Introduction

Whilst we hold in mind the safety of those who use our services, this resource focuses on the safety of the counselling professional, that is, their protection from danger or harm.

Whether working in an organisation or in private practice, the intimate and confidential nature of the therapeutic relationship means our practice usually happens 'behind closed doors'. Very distressing narratives, powerful unconscious dynamics and the rigours of the work can all challenge us, heightening the risk to both our physical and psychological safety. We aim to provide both physical and psychological safety to clients, helping them make best use of the service but to do this, we too must feel safe. Anything that adversely affects the safety and containment of our clients can, potentially compromise our safety. To protect both parties, we agree we will work 'to professional standards' and 'within our competence' whilst 'keeping our skills and knowledge up to date'. We ensure 'our wellbeing is sufficient to sustain the quality of the work' and that our 'resilience' (the capacity to work with a client's concerns without being personally diminished) is sustained.

We 'take precautions to protect our own physical safety' (Good Practice, point 91a). A 2019 survey of 694 BACP members reported that 79% of respondents said they worked alone, either from home or another location, whilst 15% of respondents said they had experienced violence and/or aggression whilst practising, impacting both ability and confidence. This is significantly higher than the results of a 2016-2017 Crime survey for England and Wales that showed that an estimated 1.3 % of working adults were the victims of one or more violent incident at work, including physical assaults and threats.

Whilst the vast majority of violent or aggressive incidents towards practitioners were carried out by clients or ex-clients, 22% of the affected practitioners did not report these incidents and we can wonder whether this was due to concerns regarding confidentiality (see www.bacp.co.uk/events-and-resources/ethics-and-standards/ethics-hub/lone-working-survey).

Further information relating to violence and aggression towards practitioners (including practical advice) has been developed in collaboration with the Suzy Lamplugh Trust (www.bacp.co.uk/events-and-resources/ethics-and-standards/ethics-hub/lone-working-guide).

The personal moral quality of 'Courage' (the capacity to act in spite of known fears, risks and uncertainty) is essential to our work but must be balanced with keeping ourselves safe. Both the personal moral qualities of 'Wisdom' (possession of sound judgment that informs practice) and 'Humility' (the ability to assess accurately and acknowledge one's own strengths and weaknesses) impact on our safety.

Sometimes, commitments do not sit together easily (or may even contradict each other). Occasionally, we find ourselves in the midst of a dilemma and aim to respond with ethical mindedness (see Good Practice, points 92-94 and Good Practice in Action 044 Fact Sheet: *Ethical decision making in the context of the counselling professions*). In some critical situations we might need to think or act very quickly. Although we aim to 'put clients first', this may not be feasible or sensible when our own safety is at risk.

Although this is a very complex subject, counselling professionals are not alone in this. We have the support of colleagues and our supervision (Good Practice, point 60). If we think it is necessary, we will seek 'professional support and services' (Good Practice, point 91c).

When working in the same room as a client, it is sensible to imagine the remote (but real) possibility that they might attempt to physically harm us.

This has always been one of the hazards of a counselling professional's work. However, a recent worldwide event has added to that, in the sense that whilst a client may not have meant to put us at physical risk, their close proximity and nature of their narratives may have presented a risk to practitioners.

In 2020, the Covid-19 pandemic brought changes to how many people viewed their life, relationships and ways of working. On 23 March the UK went into 'lockdown', a previously unknown experience. Most of the population were not allowed out of their houses for purposes other than buying food, taking limited exercise and other essential reasons. Clients could no longer have sessions in their therapist's rooms, supervisees could not visit their supervisors, trainees could not attend college, and many workplaces shut down. Due to the unprecedented nature of this worldwide crisis, the demand for therapy in the UK escalated.

Now, several years on, it is important to remember our previous professional experiences surrounding this and bear in mind that Covid-19 is still circulating in the community. We do not know whether surges in infection levels may again occur, increasing the risk to our safety. But that risk is not just about us becoming infected with Covid-19. Before Covid-19, we may have had the experience of listening to a client's story and realising that what they are going through bears a marked similarity to our own lives. What was different during the Covid-19 crisis was that every practitioner and every client were facing a similar situation at the same time. The Mindometer report (2021) surveyed almost 5,000 BACP members, exploring the impact that the pandemic had on practitioners themselves. Half of respondents felt more stressed and overwhelmed since the pandemic began, with almost one in five feeling more depressed or hopeless. Despite this, a massive number of practitioners had made a huge shift in how they worked. Some already provided online therapy, but many others adopted it for the first time.

In time, lockdown gave way to regional restrictions. Some practitioners returned to in-person work in their therapy rooms, perhaps due to financial or employment reasons.

For others, the decision to return was not straightforward due to concerns they had about becoming infected with Covid-19 (and perhaps passing it on to family and friends).

For those returning to their rooms, some planning was required. Familiar environments they may have worked in for years suddenly felt 'riskier' in a way practitioners never would have imagined before the pandemic. For most practitioners this was the first time they'd had to consider the risk of becoming infected by a client with what might end up being a serious (or even fatal) disease. They also had to consider the possibility that at the end of a session, a client might leave behind infectious material that could infect the next client.

Decisions had to be taken around wearing masks or face shields and Covid-19 vaccination status noted. Practitioners who requested that clients wore masks during sessions sometimes came across opposition. Instances occurred where clients made practitioners aware of their stance against Covid-19 vaccination. In a landscape that was rapidly changing, feelings on both sides ran high. Some practitioners felt they were caught in an impossible situation as they attempted to bring together conflicting principles. The placement of chairs took on a new importance. Surfaces had to be sanitised, and rooms had to be well ventilated in the face of escalating heating costs and the cost-of-living crisis. To be able to make their client their primary concern and work effectively, practitioners had to feel that the level of chance of infection was reduced to a level they could tolerate. What to do if either client or practitioner developed symptoms of Covid-19 had to be thought through. Concerns around confidentiality came into play as 'Track and Trace' was introduced (see Good Practice, point 9). Therapy contracts had to be re-negotiated to reflect this 'new world'.

Some liability insurers and referral sources, such as medical insurance companies and EAPs, provided permissions and requirements for practitioners to be able to work in the same room.

Good Practice, point 46 states 'We will give conscientious consideration to the law and how we fulfil any legal requirements concerning our work', so when legal responsibilities around Covid-19 emerged (for example making a health and safety risk assessment) practitioners, landlords of rented therapy rooms and organisations had to respond.

During this very challenging time, BACP published much useful information for members, which continues today and can be found at: www.bacp.co.uk/news/news-from-bacp/coronavirus/covid-19-resources.

Further information from BACP in regard to Covid-19 and in particular factors to consider, preparing to work face to face, carrying out risk assessments, mitigating risk, changes to your practice (such as sanitation and masks) re-contracting and contact tracing (should it apply) can be found at www.bacp.co.uk/news/news-from-bacp/coronavirus/deciding-how-to-work-with-clients.

In response to the pandemic (and lockdown), wanting to continue to honour their commitments to existing clients, many practitioners chose to take their practice online. Having found this way of working suited them (and their clients), some decided to continue online either wholly or as part of hybrid working.

Working online with a client is very different from working in the same room. The *Online and phone therapy (OPT) competence framework* provides much useful information about what is required (see www.bacp.co.uk/events-and-resources/ethics-and-standards/competences-and-curricula/online-and-phone-therapy). See also GPiA 040, 047, 124 and 125 at www.bacp.co.uk/gpia.

Providing online services can itself impact a practitioner's mental wellbeing both in positive and negative ways. For example, if a practitioner who works within an organisation can provide online therapy from home, this cuts down travel and frees up time for activities that might otherwise have to be squeezed in elsewhere.

However, this must be balanced with a sense of isolation that some feel. Working at a computer or on the phone for extended period takes its physical toll, which in turn can easily impact mental wellbeing (and hence safety).

'Zoom fatigue', that is feeling anxious, socially isolated, or emotionally exhausted due to lack of social connection, affected more than half of BACP members who responded to the Mindometer survey of 2021. This is in addition to the various aches and pains that can arise from sitting at a PC, laptop or being on the phone for long periods. Initially, these minor ailments might not seem too significant but as they accumulate, they can start to restrict other activities we both want and need to do and may affect our ability to sleep well.

'Online disinhibition' is a phenomenon which can arise during online therapy (and potentially supervision). This is when clients make rapid, uncensored disclosures of sensitive material about themselves or others. However sometimes, it might be what Suler (2004) describes as 'harsh criticisms, anger, hatred, even threats'. Both manifestations can be very stressful for practitioners. However, practitioners are not immune to online disinhibition themselves and might become aware that they have 'let slip' something they'd rather not have done, (which might weigh heavily on their mind).

Working online can impact on a practitioner's workload with working and non-working hours merging into one (see Good Practice in Action 109 Clinical Reflections for Practice: *Workload within the counselling professions* and Good Practice in Action 110 Fact Sheet: *Boundaries within the counselling professions*). The 24-hour society means that practitioners must set realistic expectations with clients and stick to boundaries otherwise they can find themselves 'just checking' texts and emails at times when they have supposedly 'stopped work for the day' (or even later in the evening which could adversely affect abilities to sleep well). More can be found on boundaries in Good Practice in Action 110 Fact Sheet: *Boundaries within the counselling professions* and Good Practice in Action 111 Clinical Reflections for Practice: *Boundary issues within the counselling professions*.

Working online requires different knowledge, skills and abilities to those needed when working in the same room, and the management of some client groups can be more complex than others. For example, working online with clients who have a mental health condition can take on extra significance and needs to be carefully considered (see Good Practice in Action 112). Good Practice in Action 125, *Working online in the counselling professions* cautions that with all clients, 'The impact of digital technology on the therapeutic relationship can alter dynamics and connections in unexpected ways; it is important, where possible, to consider carefully whether a particular approach is the right one for each individual client, and to revisit this consideration at intervals during the work.'

To work online competently may place extra demands if not managed well and can impact on both physical and mental wellbeing. This may have implications for the 'wellbeing' element of fitness to practise (see GPiAs 078 and 094, and practitioner self-care 088).

The *Online and phone therapy (OPT) competence framework* provides much useful information about what is required (see www.bacp.co.uk/events-and-resources/ethics-and-standards/competences-and-curricula/online-and-phone-therapy).

A member's perspective on working online and then returning to the therapy room can be found at www.bacp.co.uk/bacp-journals/private-practice/september-2020/articles/to-zoom-and-back.

The following vignettes describe scenarios where the physical and/or psychological safety of a counselling professional is put at risk. As you read them and the Observations on practice that follow, consider how well each counselling professional meets their ethical responsibilities as described in the *Ethical Framework for the Counselling Professions*. Although Good Practice points are dotted throughout, you are invited to think how others might also apply. A suite of Good Practice in Action (GPiA) resources is available at www.bacp.co.uk/gpia.

As self-care, workload and fitness to practise all impact safety, Good Practice in Action Fact Sheets: 078 *Fitness to practise in the counselling professions*, 088 *Self-care for the counselling professions*, 099 *Workloads and the counselling professions*, and 109 *Workload in the context of the counselling professions* would be useful to read.

This resource does not aim to give specific advice about safety but has been written to encourage members to think around this huge, multifaceted topic. Questions for reflection and discussion are provided to stimulate personal reflection, ethical thinking and discussion with your supervisor or colleagues. You may notice other ethical and practice issues that stand out and these might usefully form the basis of supplementary reflection.

1 Overview of vignettes

The vignettes that follow are fictional. Whilst work contexts may not match your own, it is hoped the underlying issues, challenges and dilemmas form enough basis for reflection and discussion for any counselling professional or anyone who uses counselling skills in their role.

Vignette one illustrates the practice of *Anna*, a psychotherapist. Working in a challenging clinical area, Anna's psychological safety is threatened. A change in the way she works could mean that her physical safety is at risk too.

Vignette two describes the work of *Darin*, a volunteer prison chaplain. Idrissa, his supervisor, has concerns for Darin's psychological and physical safety. However, Darin seems quite unaware of the dangers he may be putting himself in.

Vignette three provides a worrying account of *Fiona*, a coach. A badly managed break leads to a client's retaliation.

Vignette four *Mica*, a counsellor, is excited to have a new therapy room. But has she put as much thought into it as she might?

2 Vignettes

Vignette one – Anna

Anna, a psychotherapist, previously worked at an agency that supported people who had been raped, sexually assaulted or abused. When she qualified as a supervisor, she took on that role too.

Three months ago, the agency closed due to lack of funding. Although saddened by the closure of the service she had helped to grow, Anna felt relieved not to be doing this demanding work anymore. Despite feeling worn out and ground down, she had remained, not wanting to leave colleagues with more work to do. Now, she was pleased that the decision to leave had been taken out of her hands.

Almost immediately afterwards, Anna established a private practice. Her reputation as a well-respected, specialised psychotherapist and supervisor followed her, and her therapy and supervision practices rapidly grew. Ex-clients wishing to have further therapy tracked her down via the internet. Word of mouth spread, and other practitioners referred clients to her. Recently, people have contacted Anna to say that they really want to have therapy with her but due to the traumatic nature of what had happened to them, find it difficult to leave their homes to come to see her. During the Covid-19 lockdown, Anna provided text and email-based therapy to her existing clients and so, having some experience of working in this way, offered these as an alternative. Some clients have taken up this offer and Anna provides the service to them sometimes from her PC but at other times from her mobile phone. Other clients are not so keen on online working because the abuse they encountered was often via text message, social media or email messaging. Being sensitive to their needs, Anna offered to come to their homes and provide the therapy there.

After working in this way for a sustained period of time, the strain Anna previously experienced seems to be building once again.

She had imagined holding a mixed caseload, but instead her entire work seems to involve working with rape, sexual assault or abuse. Although Anna initially set a maximum number of contact hours to work each week, she regularly exceeds this.

Texts and emails from her new online clients began to arrive at all hours of the day. Chloe, Anna's partner, started to express her resentment one day saying 'I'm sick of hearing that phone pinging. I thought we were watching this film together. You said you weren't going to be looking at messages and sending replies so often. Anyway, what about that joint pain in your thumb. You can't keep taking so many of those strong painkillers – they're knocking you out. Switch the wretched thing off!'

Anna had promised Chloe that she wouldn't work evenings anymore so that they could spend more time together. But that plan had failed, partly due to the mobile phone 'pinging' all the time, but also because Anna had agreed to provide some clients with sessions during the evening, including seeing some clients in their own homes.

On top of all of this, Anna was starting to become pre-occupied with her clients, often wondering how they are and what they are doing. More worryingly, her dreams feature re-enactments of traumatic scenes. Sometimes she wakes up shouting at an imaginary attacker and has on occasion, hit out at Chloe, who has left their double bed to sleep on the settee. All of this is causing tension between the couple.

Anna has 1.5 hours supervision per month with Pam, who she has known for three years. She is always relieved to be there and as she recognises that her work is becoming a problem, plans to raise her concerns in her next supervision session.

Observations on practice

Anna's psychological and physical safety are very much in focus here (Good Practice, points 18, 91).

Working in a challenging and specialist area, she moved from an organisational to a private practice setting, perhaps losing valuable support and containment provided by agency colleagues (Good Practice, point 17). Now, Anna may feel psychologically (as well as physically) isolated in private practice (see Good practice in Action 004 Commonly Asked Questions: *Working in private practice*).

Her expertise and experience are valued by the profession and her reputation has led to a rapid growth in her private practice. There is little variation in her caseload, and she risks the possibility of vicarious and secondary traumatisation. Could this play out in her relationships with clients (putting her safety at further risk)?

Anna has agreed to provide therapy in clients' homes. Clients' requests for this may be for a variety of physical, psychological and social reasons. When working in a client's home, it is important to remember that whilst the venue changes, the role of the therapist does not. However, when away from our usual workplace and going from home to home, therapists may struggle with this idea. In their own home, a client might (quite innocently) offer their therapist a cup of tea and perhaps introduce family members. If they live alone, they may ask for assistance with minor domestic tasks, such as asking the therapist to take a tight lid off a jam jar. How to respond to these events well and maintain therapeutic boundaries requires prior consideration and the ability to sometimes think on your feet.

When providing therapy in a client's home, it is far harder to guarantee confidentiality and prevent interruption to sessions. Travel to and between client's houses, particularly in unfamiliar areas and where long distances might be involved, can be stressful (and may be dangerous, especially at night). By the nature of our work, we are usually alone in a room with a client. Has Anna taken all these factors into account and discussed this major change in working practice with her supervisor?

Even if the client is no physical risk to the practitioner, if the home is an unstable environment for the client, then the practitioner may be entering a dangerous situation. Having a thorough assessment process (including risk) is key.

Safety plans, maintaining back-up support (including the ability to contact the police quickly) are vital too. Whilst in the session someone may enter the room and threaten (or even assault) the client. If this is a child, young person or vulnerable adult, the practitioner is likely to be placed in a position of wanting to protect their client, which may put their own safety at risk.

When working in your own therapy space, escape routes will hopefully have been identified and escape rehearsed. Doors that are usually locked or unlocked can be checked to see if anything has changed but when working in a client's home, the situation is very different.

Practitioners providing therapy in the homes of clients will be aware that they might be entering a space over which they have very little control. Clients' home phones can ring, post and other deliveries may arrive at the front door. Dogs may bark (and sometimes have to be in the room). If childcare is an issue, crying babies may have to be attended to. The 'stuff' of domestic life may present a trip hazard in the form of toys, books, and any other discarded items that lie on the floor. Medical equipment lying around and disposables such as needles, may present a risk to safety from injury to infection. This may present a particular risk if the client (or someone else either in the household or who has visited) is a drug-user and has discarded needles, glass ampoules and other drug-taking paraphernalia.

For whatever reason, domestic hygiene may not be maintained. Practitioners who conduct sessions in familiar therapy rooms have been used to having (to varying degrees) control over their 'therapeutic space'. They have been able to take measures to reduce the risk of infection between client and practitioner as much as possible such as that caused by Covid-19 as explored above. For example, they can (in most cases) decide how far chairs are placed apart and whether windows are opened for ventilation. Doing this is much harder when working in a client's home. Windows might not open, a client may not want them open because they feel the cold or worry about fuel bills. For practical and other reasons, it may be unfeasible to move furniture about to ensure adequate spacing between practitioner and client.

Practitioners who work in their own rooms (or those allocated within an organisation) can sanitise 'touch points' but this is not possible in a client's home. Will Anna think through these important areas? As a simple measure, will she sanitise her hands after leaving a client's home?

Anna may come across requests from clients where 'home' is somewhere other than a domestic home. For example, this may be a residential care setting where the only reliable private space might seem to be the client's bedroom, which some practitioners may think is an unsuitable 'therapy space'.

Has Anna considered the places that may be called 'home' by clients? In the next vignette, a client refers to his prison cell as 'home'.

The views of several BACP members regarding some advantages and disadvantages of providing therapy in clients' 'homes' can be found at www.bacp.co.uk/media/3693/bacp-therapy-today-jun18.pdf.

Was Anna wise to have 'made space' for clients, particularly at night and when this might involve travelling alone and visiting clients in their homes? We can wonder about Anna's workload too (see Good Practice in Action 099 Fact Sheet *Workloads and the counselling professions* and 109 Clinical Reflections for Practice: *Workload in the context of the counselling professions*).

Anna's drastically disturbed sleep may impact her judgment, and by extension, her overall safety at work and elsewhere. We have committed to maintain our 'physical and psychological health at a level that enables us to work effectively with our clients' (Good Practice, point 18) and attend to 'care of self' (Good practice, point 91). Anna uses her mobile phone well into the evening, including to read and occasionally respond to client messages. Might this also be affecting her ability to sleep?

There may be expectations from clients (and sometimes practitioners) that the practitioner will respond instantly to answer-phone messages, texts and emails. Anna may find this stressful. Has Anna been clear about her boundaries in her contract, particularly those around out of session contact?

She seems to be suffering from a problem with her hand that Chloe attributes to her frequent mobile phone use. Anna is taking what Chloe considers to be a large number of 'strong painkillers', commenting that they are 'knocking you out'. We can wonder not only about injury but also the effect of these painkillers on Anna's fitness to practise.

Certainly, when working by phone, text or email, we have fewer clues as to what might be happening with our client.

There are no secondary communicative indicators such as body language. With texts and emails in particular, unless emojis are used, lack of intonation and ambiguously worded communications are open to interpretation, which might be stressful to a practitioner. Referring to the *Online and phone therapy competence framework* could help Anna.

Our secure base(s) helps us feel safe and secure. We can ask who (or what) provides this for Anna? It is hoped that supervision provides one secure base, but might she regard her professional body as another? Her partner Chloe may play a part too, even though their current relationship seems to be becoming increasingly compromised. There is no mention of Anna engaging in personal therapy (Good Practice, point 91c.).

Whilst Anna is 'relieved' to have supervision, we can be curious that she is only raising her difficulties now. Has she been honest with Pam (Good Practice, point 72)? If we assume Pam knows that Anna has left the agency and moved to private practice (plus the nature of the client-work she does) and that she will be providing therapy in clients' homes, has she been diligent enough in her consideration of Anna's safety? Is Anna having enough, frequent supervision to meet her needs (Good Practice, point 60)?

When providing supervision to a practitioner who works online, it is important that the supervisor also has experience of working online if they are to provide appropriate and effective supervision. Does Pam know about the *Supervision competence framework* (2021) as well as the *Online and phone therapy competence framework* with which she could map her existing competences and identify any areas for her own development?

Finally, in response to client need, Anna is making various changes to her working practices.

What she might consider to be 'reasonable adjustments' are beginning to impact negatively on her wellbeing, and there are concerns for her future safety once she starts home visits. For more information on 'reasonable adjustments' see Good Practice in Action 080: *Reasonable adjustment in the counselling professions*.

Questions for reflection and discussion

1. How do you monitor and manage the impact that work (and non-work) related stress has on your psychological and emotional safety at work?
2. Anna made what she might have considered 'reasonable adjustments' for clients. How do you balance making 'adjustments' for clients with your own needs?
3. Who (or what) provides you with a secure base(s), helping you to feel safe in your work? What might threaten this/these secure base(s)?

4. If you were Anna's supervisor, what would you see as your responsibilities regarding her safety?
5. Now that Anna will be working in clients' homes, what contracting issues might you want to discuss with her?
6. Has Anna thought about her competence for working remotely? Has she had training or is she just relying on her experience of working this way during the pandemic?

Vignette two – Darin and Idrissa

Darin is a member of BACP and recently also qualified as a chaplain. He has taken up a voluntary post with a charity that offers support to offenders in prison. His role as a chaplain at a very busy Category A male prison is very varied, supporting prisoners, staff, and visitors. On any day, he may be discussing spiritual matters, conducting religious services, be involved in telling a prisoner a loved one has died or listening to a prisoner's general concerns. He works alongside the full-time chaplain who is currently on long-term sick leave.

Darin's brother has occasionally voiced concerns that he might be attacked by a prisoner. Darin assures him there are panic buttons dotted around the wing. He has never heard one go off and cannot imagine a reason why he might press a button, but he is sure someone would come if he did. 'Why would any of the men want to harm me? I've done nothing to upset them' he asks his brother. 'Anyway, I'm a bloke. I'd be fine'.

Gary, a recently sentenced prisoner, asked for chaplaincy support. As Darin was on his way to meet Gary, a prison officer took him to one side and whispered, 'You wanna be careful of that 'un. He gets under 'yer skin if you know what I mean'. To Darin, this seemed an odd thing to say but more importantly it felt disrespectful of Gary. Darin politely thanked the officer and went on his way.

As with all the prisoners, Darin wanted to help Gary. He was very encouraged when recently, Gary expressed an interest in some of the major religions and wanted to explore this further with Darin. But he was convinced that some of the other prisoners would laugh at him if they knew about his new interest. He told Darin, 'Might be better to come to my cell, number 33. I've made it a "home away from home" if you know what I mean. Once the door's shut, we won't be overheard by them lot'. Agreeing that this might be best Darin enthusiastically replied 'I'd be very pleased to visit you in your "home away from home" this afternoon Gary. I'll look out some leaflets to bring. See you later'.

Darin has supervision, which is a requirement of the charity, but can only go after work (although the prison authority pays a small amount towards it). Darin had to find his own supervisor, and he and Idrissa meet monthly for one hour. They have had three supervision sessions so far.

Idrissa knows there is a high proportion of mental health problems, personality disorders and dual diagnoses among prison populations, and is beginning to feel concerned by what Darin tells him. Idrissa voices his concerns to Darin about his psychological and physical safety. However, Darin says he prefers 'not to judge another fellow human being' and in line with this, has chosen not to know why the men are in prison. He goes on to say, 'People come to me for help not to harm me – I'm a chaplain'. He aims to 'see beyond the crimes and the past'.

Darin tells Idrissa he has a good rapport with Gary (who often calls Darin 'Your Grace'). Apparently, Gary says he felt 'truly blessed' when he met Darin and describes him as 'an angel sent from above'. But today, Idrissa hears another side to the story. Darin tells him that Gary appears to have reversed his opinion of the chaplain and has been highly critical of him. Feeling very confused, Darin had asked Gary what he had done to upset him. Laughing, Gary had replied 'No worries mate ... just Gazza's little game' and had returned to his jokey persona. Twenty minutes later, Darin felt even more bewildered as Gary described his support as 'voodoo mumbo-jumbo'.

Observations on practice

- There are various questions relating to Darin's psychological and physical safety. In terms of competence, has Darin's counselling and chaplaincy training prepared him for this specialised and challenging work?
- What effect has his chaplaincy colleague being on sick leave had on Darin, or his workload?
- Because Gary fears he may be ridiculed by other prisoners, Darin considers that it is a 'reasonable adjustment' visit him alone in his cell (where they won't be overheard).
- Has the prison authority provided additional training, for example in de-escalation and breakaway techniques? There are likely to be rules about going unaccompanied into a prisoner's cell. Is Darin aware of these?
- Darin's supervisor knows that complex mental health issues, personality disorders and dual diagnoses are very common in the prison system but how much does Darin know about this?
- Does he have enough knowledge and experience of the powerful, unconscious or out-of-awareness relational dynamics that can occur between two people (especially in organisations such as a prison where a power-and-control model is likely to operate)?
- We can wonder what sense Darin makes of Gary's behaviour towards him and how he understands his own sense of confusion. Does Darin appreciate the attempts at manipulation that seem to be going on?

Having knowledge of these powerful dynamics is very important when we think about safety and ethical practice (Good Practice, points 13 and 14).

Whilst any theoretical model is incomplete and has imperfections, it might be useful for practitioners to think not only about their own theoretical model but perhaps look at what other models/frameworks of understanding might have to offer about relationship dynamics.

For example, in this kind of setting, having an understanding of concepts such as: transference (where feelings for one person are transferred onto another – often the therapist), splitting (also called black-and-white thinking or all-or-nothing thinking, where there is a failure to bring together positive and negative qualities of the self and others into a cohesive, realistic whole), or even projective identification (a relationship dynamic that can arise in the work of any counselling professional).

In this last dynamic, parts of the client's self are disowned.

But rather than simply being 'projected onto' (projection), they are 'forced into' the practitioner who begins to experience the disowned part and may even behave in accordance with it (often resulting in a self-fulfilling prophecy), which can sometimes lead them into unusual, unsafe and unethical behaviour. (This relationship dynamic in particular can feel very challenging and confusing to the recipient-practitioner.)

Can you see elements of these playing out within the vignette? What may this mean for Darin and his work with Gary? Does the fact that Darin is working in a role offering chaplaincy in a voluntary capacity have any impact on his ethical responsibilities or safety?

As you imagine the scene between Gary and Darin, what might Gary's non-verbal behaviour have told Darin about any possible risk? The 'Quick guide to lone working' contains examples of warning signs of violence and aggression, as well as appropriate ways to respond: www.bacp.co.uk/events-and-resources/ethics-and-standards/ethics-hub/lone-working-guide.

Questions for reflection and discussion

1. Thinking about your psychological and physical safety, how would you know whether you were working within your competence?
2. Are there any changes you might make to your working practices in relation to your physical and psychological safety? What other training might be useful?
3. Would you suggest that Darin discusses this dynamic with Gary? What might the implications be here for Darin's safety?
4. Are any ethical commitments in conflict here?
5. If you were Idrissa, what would you do next in your role as supervisor? What might you be saying to Darin regarding balancing 'reasonable adjustments' he makes with his own needs (in particular, needs for safety and wellbeing)?

Vignette three – Fiona

Fiona, a coach, works in private practice. She has been contacted by the owner of a small organisation who has concerns about Trupti, an employee with 'ongoing problems with co-workers'. The owner will pay for six coaching sessions and has persuaded Trupti this is the best way forward if she is to continue to work there.

Trupti arrives for her first session, throws herself into a chair and sobs 'Here I am. You can tell the boss I've come'. She goes on to say 'I try to be part of the crowd, but in the end, everyone lets me down. It's like I don't exist. I just feel so empty all the time'. The only time Trupti feels 'real' is when she cuts her arms. Trupti quickly changes direction to talk about Paula, a new colleague who she really likes. But she quickly moves to a past relationship with Mari. 'I really hoped she'd be a caring friend, but she turned her back on me too – I hate the bitch!' Fiona is surprised at the depth of Trupti's anger.

As the session approaches its end, Fiona asks Trupti if she would like to arrange a second appointment. 'Yes, definitely. You're fab!' enthuses Trupti. 'That's great. Let's put the next appointment in' replies Fiona.

As Trupti drives away something does not feel right for Fiona, but she cannot put her finger on it. As it is only their first meeting, she does not want to jump to conclusions so puts it out of her mind. Anyway, as Trupti has expressed difficulties in relationships with other people, Fiona is pleased she wishes to return.

Later the same day, Fiona notices a car like Trupti's drive quickly past her house. She does not attach much significance to this until the following day it happens again. This time, the car seems to be moving much more slowly (as if the driver is looking for an address). Catching sight of a yellow scarf around the driver's neck, Fiona remembers that Trupti wore something similar yesterday. But then Fiona remembers her house is on a main road through town so forgets about it.

Two sessions later, Trupti spoke about her childhood. Her mother was an alcoholic and when very drunk, used to get Trupti to help her to the toilet and into bed. When less drunk, she would shout at Trupti and threaten to throw her down the stairs.

Near the end of Trupti's next session, Fiona remembers to tell her she will not be working for the next two weeks. Her coaching practice has been very busy recently and she is pleased her partner has found a 'last-minute deal' for a holiday in Greece. Trupti asks 'Where are you going – anywhere nice?' and Fiona tells her. Feeling slightly guilty about leaving Trupti, Fiona remembers reading something about transitional objects. Picking up a shell, she hands it to Trupti and suggests she 'looks after it' over the break.

Trupti looks disappointed and asks instead if she could 'take a selfie' of her and Fiona using her mobile phone. She says if she is having a problem at work, she can quickly look at her mobile and remember the useful coping strategies they have discussed. 'It'll be like having you with me' enthuses Trupti. 'Selfie' taken the session finishes and Trupti leaves. Fiona realises she felt rushed into agreeing to the selfie but now must concentrate on getting packed for Greece.

Fiona returns from holiday refreshed. Logging on to her email account, she reads the following:

Hey buddy,

You know there's a certain porno site you've surfed recently? Well, I know it too. Kick back though! You're not the first for me.

When you visited the site, your browser saved my malware. My little baby knows where you hang out (especially those nasty backrooms).

But that's not all my friend – it gets stuff from your electronic mail. Yes, I've got access to your email account – your loved ones, buds, work-peeps, anyone else on your contact list. Sad isn't it.

Even sadder when I show them what you've been up to during the lonely, dark nights.

Yes. I've been very busy lately. I've even made a little gift for you. Click on the link and take a look. Would everyone like to see?

Yours (so truly and faithfully).

Your friend 'Satisfaction'

Fiona is horrified. She does not visit pornography sites but wonders whether 'Satisfaction' really has managed to get into her work and personal email address book. Clicking on the link, Fiona stares at an image of a woman's naked body.

Whilst relieved that the image is not hers, she is sickened to see a picture of her own head grafted on to it. Fiona knows there are several photographs of her on the internet, such as those on her practice website and professional directory entry so the 'head' must have been copied from one of these. But looking more closely at the macabre creation, Fiona notices one tiny detail – earrings. She has worn these earrings only once ... during her last session with Trupti!

Observations on practice

Fiona works very hard and is pleased her partner found a 'last minute deal' away. Whilst our psychological and physical safety are supported by self-care, how much does Fiona proactively think about this?

Trupti seems to have been coerced to come to coaching (otherwise her employment would be under threat). How might this have contributed to Trupti's vengefulness?

See Good Practice, point 25 for ensuring that clients are participating on a voluntary basis.

Even if Trupti had come willingly, was the referral to Fiona appropriate and should she have accepted it? At any stage, was referral to a more suitable counselling professional considered? Given that Fiona accepted this referral, is she working within her competence?

How much understanding of mental health conditions, attachment theory and other relevant areas does Fiona have? You can find more information on mental health in Good Practice in Action 112 Clinical Reflections for Practice: *Mental health in the context of the counselling professions*. There are clues throughout that Trupti may be exhibiting signs that suggest insecure attachment and even underlying difficulties that could affect her emotional stability and disturb her patterns of thinking or perceiving and result in impulsive behaviours. She is also self-harming.

Working with clients presenting the kind of issues Trupti does, can be very challenging, and safety, for both client and practitioner, can be a major consideration. Before agreeing to work with any client, it is important to carry out a full assessment to determine whether you are the right person to provide support for this particular individual, and to gauge risk (both for the client and themselves). Did Fiona make this assessment?

We agree we 'will endeavour to inform clients well in advance of any planned breaks' (Good Practice, point 40). This is important with any client but particularly so with clients who may have insecure attachments like Trupti.

Fiona gave news of her holiday in the closing minutes of the session; we can only imagine how distressed and abandoned Trupti felt. Was it more by luck, than good management, that Fiona remembered to tell her?

Practitioners from various modalities will have different ways of managing queries about breaks (and it may vary again between their clients). Fiona chose to tell Trupti the reason for her break and that she was going to Greece and so would be away from home.

She did not consider how important the maintenance of boundaries is, especially given what Trupti has told her of her own history and circumstances. What and how we tell clients of planned breaks, need to be carefully considered (see Good Practice in Action 132 Fact Sheet: *Breaks and endings in the counselling professions*).

Fiona wanted to use a transitional object, but does she fully understand their significance? By suggesting Trupti 'looks after' the shell, might Fiona have inadvertently re-activated Trupti's childhood trauma?

What about the 'selfie'? Fiona accepted Trupti's rationale, but Trupti used it to express her fury at being left. Might another client have posted it on their social media site, potentially impacting Fiona's professional reputation and that of the counselling professions (Good Practice, point 48). See also Good Practice in Action 040: *Social media, digital technology and the counselling professions* and Good Practice in Action 047: *Working online in the counselling professions*.

It is recommended you review your 'digital footprint' regularly by typing your name into various search engines and social media sites. We remember Trupti's initial impression of Fiona at the end of the first session. Given Trupti's relationship difficulties, Fiona may have felt pleased and possibly flattered by Trupti's comment, but did her reply fuel an adverse idealising transference? Fiona's 'fall from grace' seems almost inevitable.

Fiona experienced conflicting and confusing thoughts and feelings about Trupti. Whilst this is not unusual when working with any client, such processes can be particularly strong when working with clients who show behaviours suggestive of a personality disorder. Initially, Fiona was concerned by the suspected 'drive-bys' but quickly rationalised her response. Should Fiona have dismissed her thoughts and feelings so readily?

She agreed to Trupti's request for the 'selfie' but then briefly worried whether she had made the right decision. How much time does she give herself to consider client requests, and does she value reflective practice?

There is no mention that Fiona has discussed Trupti's case with a supervisor. Assuming she goes to supervision, why was her supervisor not flagging up concerns?

Having heard from 'Satisfaction', she suspects this to be Trupti. We can only imagine her anguish.

In the first instance, she would be advised to speak with her supervisor who would hopefully provide support, containment, guidance and help her think through what to do next. She might also contact her insurer who could maybe offer access to legal advice.

Fiona is worried about the security of her email address book and system (Good Practice, point 55a) further affecting her psychological safety. More about online safety can be found in Good Practice in Action 040: *Social media, digital technology and the counselling professions* and Good Practice in Action 047: *Working online in the counselling professions*.

Questions for reflection and discussion

1. Has a client asked to take a photograph of you? If so, how did you respond and what was your rationale? If not, what might be your response and rationale if it did happen?
2. If you had concerns that a client was repeatedly driving or walking past your place of practice, what would you do?
3. How much credibility do you place on initial (perhaps confusing) thoughts, feelings, imaginings and physical responses you might have about, and towards clients?
4. Thinking about your psychological and physical safety – how do you protect yourself online? Have you reviewed your 'digital footprint' recently?
5. Fiona might have wondered whether she should report this incident to the police. What are your thoughts about this?

Vignette four – Mica

Mica, a recently qualified counsellor, had been working from a rented therapy room. Financially, it was just not working as the rent kept going up and up. The building was a bit run down and there was often noise from the corridor. The only good thing about the building was that it had a ramp, which was helpful as Elizabeth, Mica's 80-year-old client, sometimes used it to get into the building when her knee joints felt painful. However, as money was running out, Mica had to look for an alternative venue. This was not proving to be an easy task.

Mica lives in a two-storey detached house with three bedrooms. The ground floor is completely open plan. Upstairs, she uses one room as her bedroom, the second as an office and the third, smaller room as a general dumping ground. She has a large mortgage that she struggles with.

A friend has suggested Mica tidy out this room, perhaps give it a new coat of paint and use it as a therapy room. Mica is very excited and sets about the project. Soon the room is almost ready and is furnished with two comfortable chairs and a small table on which there are tissues and a vase of flowers. As the walls are bare, she hurriedly brings in some pictures from other rooms. Not finding room elsewhere for her belongings, she boxes most of them up, stacking the boxes on the floor.

Mica is delighted with her new room; there is no rent to pay and living alone she will not be bothered by the noise of others. Currently, Elizabeth is Mica's only client. Mica has briefly wondered if the stairs might present a challenge to her but has decided that they will work something out between them. All Mica needs now is some more clients.

Mica does not have to wait long. Today she is seeing Billy who emailed asking for 'a quick free chat today if poss'. A friend has recommended Mica although Billy is unsure whether counselling is right for him and so would like to meet her to discuss.

Mica agrees and when Billy arrives, he follows her upstairs to her new therapy room. As they pass the bedroom, Billy says how comfortable Mica's kitten looks curled up on the bed. One day, he says, he would like to have a cat. 'Yes. That's Daisy's favourite spot' replies Mica. Once in her new therapy room, Billy asks Mica a lot about her training, how long she has been working and what types of issue she helps people with.

Whilst answering Billy's queries, Mica begins to feel troubled when she notices his eyes roaming around her body. Having rushed in from lunch with a friend, she has not changed her skirt (which is quite short and has a habit of riding up).

Mica is relieved when Billy asks to use the toilet but not having cleaned her upstairs bathroom recently, directs him downstairs to the toilet in the hallway, giving her the chance to adjust her skirt. Billy soon returns but five minutes later, says he is leaving 'to think about it'. Shutting the front door, Mica realises that whilst Billy had asked lots of questions, she knows almost nothing about him.

Later the same day, Mica is late for yoga. Reaching for the house keys that usually hang on a hook in the hallway, she finds they are not there. Thinking she must have left them in her jacket and short on time, Mica dashes out (she has a spare set under the plant pot outside her front door).

Back home after yoga, she goes into the downstairs toilet. Glancing at the window shelf she notices the small photo of Daisy is missing. Deciding it must have fallen behind the radiator, she decides to look for it later. Calling for Daisy to come for her tea, Mica inadvertently drops the latch on her front door.

Observations on practice

There are various areas of enquiry in this vignette.

Mica has recently qualified and gone into private practice. Whilst we are not aware of any problems before that time, has she developed enough competence to work in this context (Good Practice, points 13, 14)?

'A friend' recommended Mica and we do not know whether this is true or not. If Billy found Mica's details on a professional directory or her website, how might any profile picture/photograph or what he read, have influenced his choice?

What about Mica's method of arranging meetings? Before inviting Billy into her home, she gathered very little information. Whilst this may be influenced by modality, there are over-arching safety issues. If she had followed up his email with a phone call, might this have helped provide more direct (and indirect) information to her? Afterwards, she realised that all she really knew about him was his name and that he liked cats.

What information is it wise to collect before accepting a new client? Would you ask Billy who had recommended him (and what informs your decision)?

Sometimes, it is clinically appropriate (if we are able) to provide same day appointments to clients (particularly when risk is involved). Billy gave no reason for his urgent request and Mica did not enquire. Is this her usual practice or did she get caught up with using her 'new' room for the first time?

Billy wanted to meet for a 'quick free chat'. Some practitioners offer this facility in response to what seems (on the surface) a simple enough request from a client. However, like many simple things, it is packed with complexities, and whilst some of these are clinical, others have distinct implications for the safety of both parties.

Clients will have various conscious and unconscious responses to being in our home, even if this is in an ancillary building.

Working from home has advantages and disadvantages (Good Practice in Action 004 Commonly Asked Questions: *Working in private practice*). There is much to be considered in terms of safety (Good Practice, point 91a), threats to which do not always come from new clients. Could Mica set up a 'buddy system' by which she informs a colleague (or someone else) that she is seeing a new client, agreeing to ring/text when the session is over? This does rely on an agreed 'plan of action' in the event of no call/text. Lone worker devices and apps are also available (see www.suzyplamplugh.org/Pages/Category/lone-worker-directory).

Moving on now to Mica's therapy room. Might it have been advisable for her to invite a colleague or friend to 'test' it, not only in terms of client suitability, but also how safe or unsafe it might be to work in? For example, what personal information about Mica may the room unintentionally provide and how easily could Mica escape if she thought her physical safety was under threat? This could involve role-play of 'risk' scenarios.

The therapy room is upstairs and whilst this may be due to limitations of the downstairs space, when we go upstairs with someone, we enter a more intimate space. This might have all sorts of associations for clients, some of which could put our safety at risk. Also, might it have been safer if Mica followed Billy up the stairs? Her bedroom door was open and the bed visible, all adding to a potentially risky scenario.

Inside her therapy room, has she positioned the chairs to reduce the risk of being trapped (and might she fall over the boxes if she needed to escape)? Some of her personal belongings are still visible, possibly providing personal information that could eventually affect her psychological safety (similarly the hurriedly chosen pictures). Could any of these objects, including the vase, be used as a weapon?

Billy wanted to use the toilet and Mica directed him downstairs because she had not cleaned her upstairs bathroom recently. Like bedrooms, bathrooms house the intimacies of our lives. Do we put ourselves in an unsafe situation if we allow clients to see the more private elements of our lives?

Consequently, Billy visited the downstairs toilet, but Mica remained upstairs. Although affording him privacy and dignity, did she also give him the opportunity to wander round? As well as safety concerns, we might also think about the unintended self-disclosures made (see Good Practice in Action 117 Fact Sheet: *Practitioner self-disclosure in the counselling professions*). We can wonder what happened to the photograph of Daisy but also Mica's keys. Might spare keys placed under the plant pot be safe from a malicious client who wishes to return later unannounced?

Turning to clothing; Mica dashed in from lunch with a friend and regrets not changing her very short skirt. Leaving herself more time would have helped. What we wear when we are with clients matters, as our choice can elicit many different types of client responses and dynamics such as envy, hostility, sexual arousal, hate and erotic transference.

It seems that without thinking, Mica dropped the latch on her front door. When she realises, what might this inadvertent act tell her and how might she use it to help protect her future safety?

We can wonder what Mica might have learnt from this brief encounter with Billy and whether she plans to do anything differently in future. She may have wanted to discuss the matter with the police but may have had concerns about doing so (Good Practice in Action 014 Legal Resource: *Managing confidentiality within the counselling professions*).

Turning to Mica's existing client, Elizabeth. In her excitement to create a therapy room in her own home, Mica didn't seem to give much thought to how Elizabeth might manage the stairs (beyond that they will 'work something out between them').

Making a 'reasonable adjustment' springs to mind here (see Good Practice in Action 080: *Reasonable adjustment in the counselling professions*).

However, Mica has a living area downstairs, which is open plan and unlikely to be suitable for therapy. Mica could have a stair lift installed, although this would be expensive. Her private practice will not be providing much income, and she has a large mortgage to pay. Mica must balance her own needs with those of her client Elizabeth.

Whilst we have no information regarding supervision, there are many areas that Mica could usefully discuss with her supervisor.

Questions for reflection and discussion

1. If you work alone, what 'back-up' systems do you have that help protect your safety? Is there any equipment that you could afford that might increase your safety, for example lone worker or safety devices or apps?
2. If you work in a centre, what is the policy on lone-working? Does it feel adequate?
3. Would you consider providing therapy to clients in their own home? Would this be to any particular client group or anyone who wanted it? For you, what might be the pros and cons (including any issues of safety)?
4. If during a session with a client, you felt at physical risk, what would you do? If you needed to quickly exit the room, how easily might this happen?
5. What are your thoughts about offering face-to-face 'quick free chats'? What safety implications might there be for you (and your client)?
6. In what situations might you have to balance your commitment to making a 'reasonable adjustment' in response to a client's needs and your own needs?

3 Summary

The safety of counselling professionals is an immense and multi-faceted subject involving our psychological and physical wellbeing. How safe we feel in our work affects us both at a personal and professional level.

Whilst each counselling professional is responsible for their own safety, organisations also hold responsibility, whether the practitioner is employed or volunteers.

The dynamics of a therapeutic relationship can be complex and sometimes very intense. Our understanding of the work will depend on our modality; however, safety is paramount.

Threats to safety can arise from our own actions, for example, overwork, but also from our clients. Some threats are more clearly recognised than others, for example, physical intimidation. But we also know that there are less obviously identified threats, such as attempts at psychological manipulation.

Whether or not to discuss relational dynamics with a client is complex. Sometimes, it may be appropriate but at other times, could be dangerous and must be considered on a case-by-case basis. You are advised to discuss any concerns with your supervisor or trusted colleague. In an emergency situation, call the police.

Laying sound, professional foundations is key, as is having the competence, skills and knowledge to manage or avoid (as much as possible), hazardous situations. It is important we give ourselves enough time to think about and prepare for our work. Discussions with supervisors can play a significant role in our personal safety.

It is important we develop plans and procedures to keep ourselves safe both psychologically and physically wherever and however, we carry out our work.

Those working within organisations may be contractually bound by existing policies and procedures.

Dispenser's advice of almost 10 years ago still rings true today: 'In the current insecure and competitive job market, both qualified and new therapists may hesitate to identify or report risk issues. In hard economic times, organisations may deny the problem, locate it elsewhere, or argue that bringing the problem out into the open will jeopardise the organisation's own 'survival' (2014). Dispenser further urged therapists '...do not sweep your hunches, feelings and needs under the carpet. Recognise what ticks your boxes and safeguard your physical and psychological wellbeing' (2014).

As counselling professionals, we ask our clients to put their trust in us. For ourselves as individuals and as counselling professionals, it is important we can trust that we have done as much as we can to keep ourselves safe and well in the work we do. Part of taking care of ourselves and our clients sometimes involves us balancing the needs of others against our own. Supervisors can often prove an excellent source of support here.

About the author

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Further reading

More information about personal and online safety can be found at:

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www.staysafeonline.org/resources/online-safety-and-privacy#articles (accessed 6 November 2024).

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