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OCCUPATIONAL HAZARDS FOR THERAPISTS

[1] Private practice

occupational hazards for therapists
loneliness of the therapist
sexual contact with a client

Summary

The article focuses on the occupational hazards faced by psychotherapists, discussing both sudden critical situations and the long-term effects associated with the profession. This topic has been little explored in professional literature, especially in Polish. The aim of the article is to discuss the most common risks that therapists may encounter, such as client suicide, therapist suicide, stalking, client violence, sexual relations with clients, and chronic occupational stress. The article begins by discussing situations that directly affect the therapist's professional and personal life. For example, client suicide evokes strong emotions such as shame, guilt, and regret, and stalking can lead to physical and emotional threats. Client violence is a real occupational hazard and may require preventive measures. A very difficult topic that requires attention is the potential risk of engaging in a sexual relationship with a current client. In the rest of the article, the author focuses on the long-term effects of therapeutic work, referred to as the "Big Four": burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization. Each of these phenomena is characterized by specific symptoms, affecting the therapist's functioning both at work and outside of it. In addition, the problem of professional loneliness, which may result from the nature of therapeutic work, is emphasized. There is asymmetry in the therapeutic relationship, in which the client's needs take precedence, which can lead to feelings of isolation. The article points to the need for further research and discussion on the issues presented.

Introduction

In the demanding and often exhausting daily work of psychotherapists (hereafter referred to as "therapists"—a gender-neutral term used for stylistic simplicity, with full respect for female practitioners), extraordinary situations may arise that can be classified as threatening to the profession. While a considerable body of literature addresses how therapists should prepare themselves methodologically to work with clients, there is a marked scarcity of publications on how to prepare for professionally threatening events—particularly in the Polish-language literature, where such resources are nearly nonexistent. This article aims to highlight the most common risks that may affect the professional and personal future of

a practicing therapist. Although the author cannot provide an exhaustive account due to the breadth of the subject matter, the intention is to introduce this topic into the professional discourse. For the purposes of this study, the author has adopted a classical framework of occupational threats [1], which includes: client suicide, physical assault, and sexual contact with a client. However, this framework has been expanded based on a literature review. The discussion first addresses the threats that exert the most overt impact on a therapist's life, such as: client suicide, therapist suicide, stalking, violence from clients, and sexual contact with a current client. Subsequently, it explores threats with cumulative and potentially latent effects, including: burnout, compassion fatigue, secondary traumatic stress, vicarious traumatization, and therapist loneliness. Due to the scope of the issue, the author refrains from offering specific procedural recommendations, as each subtopic merits dedicated attention.

Client suicide

There is a paucity of reliable studies detailing the prevalence of client suicide, despite it being a common source of concern among therapists. Since a study conducted in 1984 [2], it has been acknowledged that client suicide is perceived by therapists as the most stressful aspect of their work. The proportion of therapists who have experienced a client's suicide ranges from 20% to 50%. For example, a study from 2001 [1] found that 42.7% of therapists reported such an experience (n = 151; quantitative, survey-based research). No demographic, professional, or personal characteristics of therapists have been identified that would allow for predictive assessment of such events. On the client's side, a diagnosis of schizophrenia and personality disorder was associated with an increased risk of suicide, but it was not possible to determine which specific subtype of personality disorder was particularly implicated.

Following a client's suicide, therapists may experience intense grief, guilt, anger, shame, self-doubt—and sometimes even relief. Multiple factors influence the intensity and nature of the therapist's emotional response. A comprehensive review of clinicians' experiences following a client's suicide is provided in a publication from 2021 [3]; thus, a reiteration is unnecessary here. However, it is important to acknowledge the potential impact such an event can have on a therapist's professional and personal functioning.

Therapist suicide

It might be intuitively assumed that therapists—given their regular exposure to human crises, their possession of therapeutic tools, and their presumed greater insight into psychological mechanisms—would be less likely to choose suicide. However, such knowledge and skills do not always ensure optimal life functioning, though this

does not diminish their ability to assist others. Regrettably, the question of "why" remains unanswered, as the simplistic response—"because they are human too"—lacks sufficient explanatory power. There are unique factors that may increase suicide risk in this group, as well as numerous barriers to seeking help. After a therapist commits suicide, many people are left behind—including family, loved ones, patients, and fellow therapists—and this group is likely larger than in the case of a non-therapist's death. A thorough discussion of the issue, reflecting the current state of knowledge, is available in an article from 2022 [4]. It is worth noting that no new, rigorous studies on the subject have since emerged. At the time of writing this article, a search of the widely used APA PsycNet database (covering the years 1953–2024) yielded 143 records under the term "suicide of a psychotherapist"—none of which actually addressed a therapist's suicide. A search for "psychotherapist suicide" returned 195 records, of which one was a therapist's personal account of a colleague's death, and another concerned clients' reactions to a therapist's suicide.

Stalking

Stalking refers to intrusive and unwanted behaviors imposed by one individual upon another [5]. These behaviors may include persistent communication (via letters, phone calls, emails, or text messages); surveillance; following; approaching the person; and ordering goods or canceling services—purportedly on behalf of the victim. A 2023 textbook for beginning therapists [6] notes that "almost one in every five psychologists reported having been physically attacked by at least one client; more than 80% of the psychologists reported having been afraid that a client would attack them; more than one out of four had summoned the police or security personnel for protection from a client; and about 3% reported obtaining a weapon to protect themselves against a client". While adjustments must be made for American contextual factors, these findings underscore the potential occurrence of this threat. In a section addressing response strategies to threats or stalking, the authors offer 18 specific behavioral recommendations. Another publication [7] provides detailed legal and ethical considerations, real-life examples, and practical recommendations for managing such situations.

A British study on therapist stalking [8] revealed that 24% of therapists had experienced harassment by a current or former client—more than twice the general population average of 11.8% [9]. The most common behaviors included sending excessive emails or texts, silent phone calls, waiting outside the therapist's office, or following them. Other behaviors included sexual propositions, threats against the therapist's children, public confrontations, and threats of self-harm if the client's expectations were not met. The authors of the study suggested that these behaviors typically stemmed from attachment disturbances and categorized stalkers into three groups:

1. Clients with insecure attachment styles, unable to cope with the end of the therapeutic relationship—typically experiencing abandonment anxiety or narcissistic rage stemming from perceived rejection;
2. Eroticized transference, wherein the client could not distinguish their sexual feelings from the warmth of the therapeutic encounter;
3. Clients with personality disorders, demonstrating attachment disturbances in the context of transference.

The cited publication contains an in-depth discussion of the formation of attachment disorders, specific symptomatology, and key therapeutic considerations.

Client-perpetrated violence

In certain situations, therapists may find themselves trapped when clients begin to threaten, harass, or even stalk them. Legal and ethical standards permit the disclosure of confidential information concerning potentially dangerous clients, but only under relatively narrow conditions. As a result, therapists are often placed in a position where they must uphold the confidentiality of individuals who may pose a real (or perceived) threat to them. There is no universally accepted definition of what constitutes violence in the psychotherapeutic context, which contributes to variability in reporting rates. Guy and colleagues (1990) [10], in a quantitative survey study involving 340 therapists, found that 40% had been physically assaulted during their careers, while 49% reported having received serious verbal threats. In a subsequent study from 2001 [1] (n = 151, quantitative survey), 28% of therapists reported having been physically assaulted by a client at least once. Data from 2015 [11] indicated that three out of four therapists experienced some form of harassment during their professional careers; one in five reported being intimidated, and one in seven reported being stalked (n = 157, quantitative survey). A more recent European study from 2019 [12] (n = 917, quantitative survey) investigated therapists' experiences of client violence. Over half (51.3%) of the respondents reported having been either the direct target or a witness of client aggression or threats of violence directed at the therapist. Among this group, 27.7% experienced post-traumatic symptoms lasting more than four weeks, and 2.7% met criteria for full-blown PTSD. These findings suggest that therapists should be aware of the occupational risk posed by potential client violence.

There is no consistent evidence that specific personal characteristics of therapists are associated with being physically assaulted. Among clients who had attacked therapists, 60.7% were diagnosed with at least one personality disorder. Specific diagnoses included borderline (28.6%), paranoid (17.9%), narcissistic (13.4%), and dependent personality disorder (13.4%) [13] (n = 157, quantitative survey). Consequences for therapists included fear related to verbal threats or physical harm (29%), concern for the safety of family

members (17%), and fear for their own lives (7%) [10] (n = 750, quantitative survey). Therapist responses included refusal to continue treatment with certain clients (50%), discussing safety precautions with loved ones (30%), installing home security systems (13%), or purchasing a weapon (5%). Skovolot [14] refers to such experiences as *primary trauma,* distinguishing it from *secondary trauma*, which arises vicariously through clients' accounts of traumatic experiences. He defines it as a negative reaction originating from those one attempts to help, which may be particularly painful because it strikes at the "soft core" of the therapist and undermines the fundamental professional need to be helpful.

Sexual contact with current clients

The issue of sexual relations between therapists and their current clients is significant enough to warrant multiple dedicated publications and is not the primary focus of the present text. Sexual contact with current clients was a prominent area of empirical inquiry during the 1990s, yet in recent years, scholarly attention to this issue has diminished significantly. Consequently, the author must rely on older but still accessible studies. Notably, this topic remains virtually absent from Polish-language literature. It is critical to clearly distinguish between the experience of sexual attraction toward a client and the act of engaging in intimate relations with them. Preliminary findings suggest, for example, that therapists do not differ from other professionals in their general attitudes toward sexuality [15].

Psychotherapy creates a unique space in which emotions, thoughts, identity, and relational experiences can be deeply explored. The therapeutic alliance is among the strongest positive predictors of treatment outcomes [16]. However, when a close, empathetic connection transitions into sexual contact, the foundational ethical principles of psychotherapy are violated. The mutual experience of sexual feelings within the therapeutic dyad is relatively common and often evokes shame in both therapist and client [17]. Despite this, discussions among professionals regarding sexual feelings toward clients remain difficult, though they could help in recognizing, understanding, accepting, and managing such emotions. Barriers to these discussions include discomfort and a lack of safe environments [18]. Even when such conversations do occur, deeper sexual feelings are often disguised through more socially acceptable narratives involving "intimate emotions."

In a large national study from 1977 [19], based on a sample of 703 therapists (quantitative survey), 12.1% of male therapists and 2.6% of female therapists admitted to having had sexual contact with a current client or within three months after therapy's end. The sample included therapists from psychodynamic (185), behavioral (45), humanistic (48), cognitive (29), and eclectic (342) orientations. The study found no significant differences in frequency of such behavior across modalities. The credibility of these findings is supported by several factors: a) a relatively high response rate of 70%, which lends reliability to the sample; b) the improbability that respondents exaggerated such behaviors; and c) the self-report

nature of the data collection, suggesting that results may actually underestimate the true prevalence. At that time, both the American Psychological Association and the American Psychiatric Association explicitly prohibited such conduct.

Israeli researchers (1995) [20], in a comparative study of 535 psychologists and physicians, found that 3.4% of psychologists and 14.5% of physicians reported sexual contact with a client/patient (self-report survey). Pope (2001) [21], synthesizing U.S.-based studies, reported that 4.4% of therapists—7% of male therapists and 1.5% of female therapists—had sexual contact with a current client. However, the author did not describe the methodology used to combine the data, which limits interpretability. A substantial empirical review by Halter, Brown, and Stone (2007) [22] found that, despite cultural differences across countries, both the frequency and character of such incidents were strikingly similar [23].

Despite exhaustive efforts, the present author could not locate more recent statistical data. Publications by Celenza (2007) [24] and Capawan (2016) largely reiterate earlier findings. A 2020 publication confirms that most literature on therapist-client sexual relationships predates the year 2000, and newer data largely pertain only to physicians [25]. The only recent empirical study on this topic is from 2022 [26] (n = 786, quantitative survey), which found that 3% of therapists had established a sexual relationship with a current or former client. However, the study was limited to a sample of therapists from Flanders, Belgium, and did not differentiate between current and former clients—an important distinction in this context.

An alternative method for estimating the prevalence of intimate relationships between therapists and clients is by analyzing therapists' reports of clients disclosing prior sexual relationships with former therapists. Bouhoutsos (1983) [27] found that 45% of therapists had worked with clients who had been sexually involved with a previous therapist (n = 704, quantitative survey). Of these, 57% involved one client, 22% two, 12.7% three, and 9% four or more. Pope and Veter (1991) [28] reported that 50% of their clients had had similar experiences. In 2006, Israeli researchers [23] conducted a large-scale survey, distributing questionnaires to all registered members of the psychological, psychiatric, and clinical social work associations in Israel. They received 918 responses: psychologists (57%), psychiatrists (36%), and social workers (7%). These professionals reported treating 372 clients who had disclosed prior sexual contact with a therapist, suggesting that 29% had encountered such cases. One strength of this study was that it included only situations where the reporting therapist was the first professional consulted after the prior sexual relationship. However, the study did not differentiate between the professions of the offending or reporting therapists, limiting interpretability. Although therapist self-reports cannot determine what proportion engage in boundary violations with current clients, these data indicate a high probability that most psychotherapists will eventually encounter clients who report such experiences.

Importantly, boundary violations unrelated to sexuality are more common and may serve as precursors to sexual misconduct. This reflects a "slippery slope," wherein minor infractions initially perceived as harmless escalate into serious violations that compromise therapeutic integrity. Significant harm can occur even in cases where the culmination is nonsexual in nature [29].

It is difficult to identify an appropriate comparison group for therapists who engage in sexual contact with current clients, and the author does not seek to rationalize such conduct. However, clergy may serve as a relevant comparison group due to the relational nature of their professional roles. Richard Sipe, an expert on celibacy and therapist to thousands of clergy, estimated [30] that 50% of those surveyed had privately rejected the ideal of celibacy, normalizing behaviors inconsistent with that standard. The John Jay College of Criminal Justice for the U.S. Conference of Catholic Bishops [31] cites findings from Haywood and Green, who reviewed prevalence, victim characteristics, and recidivism among offending clergy. Depending on the study, prevalence rates ranged from 2–6% (for child abuse) to 20–40% (for sexual misconduct with adults). Among offenders, 56% abused one person, 27% abused two or three, 14% abused four to nine, and 3.4% abused ten or more. While the clergy abuse crisis is not the focus here, further discussion can be found in Weger's 2022 publications [32, 33].

Physicians may also be considered as a sample relevant for comparisons. In a 2007 review [22], 38–52% of healthcare professionals reported knowing colleagues who had sexual contact with patients. Only 22–26% of patients who experienced such contact reported it to another professional. One limitation of this study was its failure to specify the profession of the offending healthcare provider. A 2009 study [34] compared self-report surveys with disciplinary records and found that physicians admitted such behaviors ten times more often in surveys than were reported through official channels. In a 2020 German study [35] (n = 2,503, quantitative survey), 2.2% of women and 0.8% of men reported inappropriate sexual contact with a healthcare provider; one-third of these incidents occurred before age 18, and another third were non-consensual. Notably, these findings were based on patient self-report, not professional disclosure.

Sexual involvement between therapists and clients poses serious challenges in four key domains:

1. Ethical – violating the profession's ethical code and compromising the therapist's ability to provide effective care;
2. Moral – introducing internal conflicts within an already complex professional role;
3. Professional – damaging the public image of psychotherapy and reducing trust in the profession;
4. Theoretical – undermining the therapeutic process itself; the only theory that once legitimized such contact (McCartney's) [36] is now professionally obsolete.

A review of current ethical codes from psychotherapeutic associations operating in Poland confirms that all explicitly prohibit sexual relationships between therapists and

current clients. This prohibition is similarly upheld by the ethical standards of both the American Psychological Association and the American Psychiatric Association.

The "Big Four"

In a 2022 publication by Hersh [37], issued by the American Psychological Association and focused on the professional development of psychotherapists, four phenomena—burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization—are collectively referred to as the "Big Four." These represent cumulative and continually evolving experiences that, due to the nature of the profession, give rise to distinct sources and consequences of stress. Though frequently discussed together and at times used interchangeably, these phenomena must be considered separate constructs. They are not diagnostic categories, nor are they synonymous with depression, anxiety, or everyday stress. Rather, they are characterized by unique constellations of therapeutic, professional, and personal circumstances. Importantly, the Big Four may affect highly qualified, hardworking, committed, and well-intentioned therapists who:

1. Become emotionally depleted, socially isolated, and gradually experience a reduced sense of professional fulfillment due to a mismatch between workplace demands and their personal resources (professional burnout);
2. Become increasingly negative, cynical, stressed, and overaroused in response to repeated exposure to client suffering and erosion of interpersonal boundaries (compassion fatigue);
3. Develop trauma-like symptoms as a consequence of exposure to clients' traumatic material (secondary traumatic stress);
4. Internalize clients' suffering, trauma, or despair into their own worldview, resulting in a shift in their cognitive and emotional schemas (vicarious traumatization).

Professional burnout

The phenomenon of professional burnout has been extensively documented in the literature, and thus a comprehensive review is unnecessary here. A commonly cited definition [38] conceptualizes burnout as a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors at work. Its core dimensions include: 1) overwhelming exhaustion; 2) cynicism and detachment from work; 3) a sense of inefficacy and lack of accomplishment. Psychotherapy is widely recognized as a high-stress occupation, and therapists are considered particularly vulnerable to burnout [39]. A review of 40 studies involving various measurement tools found that the average burnout rate among psychologists is approximately 55% (n = 8,808) [40]. However, a notable limitation of this review was the lack of differentiation between psychological specialties; it included psychotherapists alongside correctional and sports psychologists, among others.

Most research on burnout is quantitative. However, one notable qualitative study [41] provides valuable insights by identifying three central themes:

1. **Professional identity crisis** – "Maybe I just don't have what it takes?" This theme captures the erosion of professional identity and self-confidence resulting from burnout. Therapists described deep feelings of inadequacy, shame, self-criticism, and imposter syndrome. Their internal dialogue became harshly self-critical, affecting their perceived professional integrity. Striving to be seen as "good enough," therapists withdrew from relationships and concealed their struggles for fear of being "exposed" as unfit to practice. Many had internalized unrealistic professional ideals that "good therapists" should be invulnerable, consistently available, energetic, infinitely empathetic, and stoic in the face of occupational stress.
2. **Embodiment of burnout** – "Constantly running in the red" (an allusion to phone battery depletion – author's note) Despite mounting exhaustion, therapists described "pushing through" until physical symptoms became unavoidable. These included chronic fatigue, disrupted sleep, and vague somatic complaints such as pain, kidney issues, back problems, or frequent minor infections. The physical toll was perceived as a "bodily burden." Many did not recognize these as signs of burnout and felt compelled to suppress their discomfort to meet client needs—aligned with their professional ideals. They often felt guilty for rescheduling or relieved when clients cancelled, allowing rest without shame. Burnout transformed work into something to endure rather than enjoy.
3. **Balancing** – "Being real". The therapists in this study had survived burnout and continued practicing. They described recovery not as a cure, but as a process of regaining balance through normalization, acknowledgment, and practical changes. The journey was highly individual, involving peer support, selective client engagement, regular breaks, authenticity, and validating one's emotional sensitivity. Many highlighted a shift in their internal dialogue toward greater self-compassion. Supervision was not always helpful; some therapists idealized their supervisors and concealed their distress. Most noted that burnout had not been addressed in their formal psychotherapy training.

A 2019 article [38] offers extensive insights into the effects of burnout on both professional and personal life and suggests strategies for prevention.

Compassion fatigue

The term compassion fatigue was first introduced by Joinson in 1992 [42], referring to a "reduced capacity to feel compassion for those we serve and care for." This phenomenon may arise from prolonged absorption of others' suffering and anxiety. Hersh [37] describes it as the "paradox of compassion fatigue", where "the very nature of our work can produce the antithesis of the very nature of our work". Unlike burnout, compassion

fatigue centers on the emotional exchange between therapist and client. The issue is not empathy itself, but what happens to the therapist when they internalize the client's deep suffering and traumatic narratives. Instead of bearing witness, the therapist begins to absorb the client's emotional pain, risking over-identification. Following exposure to clients' traumatic material, therapists may:

- continue to feel empathy without necessarily experiencing anxiety;
- feel compassion for the client, understanding what they are going through, without becoming overly involved;
- experience and express compassion with the intent to alleviate the client's pain;
- become emotionally overwhelmed and suffer personally—i.e., develop compassion fatigue.

Compassion fatigue results from more than just the therapist-client dynamic. It is influenced by the therapist's personal history, sensory sensitivity, sense of responsibility and justice, and the depth of emotional immersion. Also relevant is the strength of the therapist's desire for positive outcomes. Emotional intelligence, emotion regulation, and adaptive coping strategies serve as important protective factors.

Secondary traumatic stress

Being a witness to a traumatic event is a well-documented risk factor for developing post-traumatic stress disorder (PTSD). Working with traumatized clients exposes therapists to the risk of developing symptoms of secondary traumatic stress (STS). The most common symptom is the intrusion of distressing thoughts about the client and their trauma. STS has been conceptualized as the transmission of PTSD from client to therapist [43], potentially resulting in symptoms such as intrusive thoughts, avoidance, negative mood and cognition, and hyperarousal. Therapists with unresolved personal trauma may be more susceptible to "absorbing" the client's traumatic material. The client's state of arousal can activate the therapist's own arousal system, increasing vulnerability to STS.

Vicarious trauma

Vicarious trauma develops over time in therapists working with traumatized individuals and involves gradual disruptions in the therapist's sense of self, others, and the world. Core cognitive schemas related to safety, intimacy, respect, and control may be altered. Like anyone, therapists seek to make meaning of past, present, and future experiences—yet exposure to clients' trauma can distort this meaning-making process. The author has previously explored this phenomenon in detail [44].

The therapist's loneliness

One widely accepted definition of loneliness involves a discrepancy between desired and actual social relationships. This discrepancy leads to a negative experience of loneliness and/or anxiety, often accompanied by feelings of social isolation—even when one is physically surrounded by others [45]. Importantly, loneliness does not necessarily equate to being alone, nor does being alone always result in loneliness.

It may be surprising to consider that therapists often feel lonely—after all, they are constantly interacting with people. However, therapeutic relationships are inherently unidirectional, designed to meet the client's needs, not the therapist's. In this sense, it is a one-sided or skewed relationship, which can be deeply isolating. While rarely explored in academic literature, some authors (e.g., Yuval et al., 2001 [46]) have touched upon loneliness in public practice settings. More often, however, therapists themselves discuss the topic on personal blogs or websites. Drawing on these sources [47–49], as well as the author's own clinical experience, several key domains of therapist loneliness can be identified:

1. **Loneliness in private practice.** Many therapists choose private practice for its autonomy and flexibility. However, such settings often lack opportunities for collegial interaction and a sense of professional belonging. The absence of feedback or informal guidance can intensify self-doubt. Private practice is typically more condensed, with fewer natural breaks compared to, for instance, group work.
2. **Work conditions.** With the exception of group therapy, therapists work alone, continuously self-monitoring. Even within multidisciplinary teams or supervision frameworks, the therapist is ultimately alone with the client in the consulting room. Loneliness may be compounded by clients' projections—viewing the therapist as invisible, as a need-gratifying object, or as someone to envy or resist [50]. The irony of psychotherapy lies in the emotionally intense intimacy of sessions—followed by the solitude that ensues once the client leaves the room.
3. **Loneliness within the therapeutic relationship.** Certain client psychopathologies contribute to therapist loneliness. Narcissistic clients may evoke feelings of therapeutic incompetence; schizoid clients may elicit emptiness or hopelessness; and borderline clients may provoke identity diffusion or a sensation of "torturing" the patient through therapeutic boundaries [51]. Such pathologies can obstruct genuine connection. Therapists may emotionally distance themselves, particularly when striving to quickly reduce symptoms, leading to feelings of isolation, helplessness, or even unworthiness. Regardless of the client's presence, therapists must also confront and manage their countertransference.
4. **The presence of "The Gang Beneath the Couch".** As Redl aptly noted [52], the therapist is never truly alone in the therapy room. There may be invisible presences—such as a peer group (real or imagined) or an entire family system—affecting the session.

This can leave therapists feeling powerless and isolated amid the unseen "crowd," unable to connect with the client's true self.

5. **Loneliness in contact with the child**. A child therapist may experience loneliness in a special way. Among the reasons for this are the need to form an alliance with the child against their family and to deal with the family's interference in their work, as well as the very nature of working with children and the attempt to "protect the child within oneself" – which is one of the reasons for choosing to work as a child therapist [51].
6. **Emotional burden**. The therapist cannot tell their loved ones "what's going on at work," and supervision does not take place every day. Although they could be understood substantively and emotionally by another therapist, this is difficult if they respect their colleague's private time and space. After all, everyone wants to recharge their batteries, even if only before returning home – rather than focus on someone else in the same profession. Containing the experience until a convenient opportunity arises causes it to become blurred and "overwritten" by new experiences.
7. **Choice of social circle**. Due to the intense closeness experienced in relationships with clients and the caliber of problems they encounter, many therapists become reluctant to engage in ordinary social interactions, which they find superficial and sterile or even trivial. Such contact can even be perceived as tiring. Therapists explain this to themselves as a search for "good" and "deep" relationships – but to what extent is it actually an inability to remain in "ordinary relationships"? The professional ability to listen (which cannot be turned off) automatically triggers, in many people, a desire to satisfy their hunger to "be heard," and the therapist must actively seek attention (with what effectiveness?). Often, the last thing they can count on is that someone will listen to them and take an interest in their experiences and views. It happens that when they try to talk about their professional experiences in an anonymous way, their interlocutors automatically identify with the clients, and "abandon" the therapist personally. Loneliness can also be fostered by the attitude of other people towards the profession – they attribute to therapists the ability to "read minds" or are afraid of contact with other people's suffering.
8. **Difficult boundaries between work and rest**. Many therapists fight heroically for free time for themselves in order to be able to "regulate" themselves. However, even so, among their loved ones or acquaintances, there will always be someone who wants to consult or talk about their issues, knowing that they are talking to a therapist. When a therapist sets boundaries, they are perceived as unfriendly or even unprofessional, which can be painful. It's a bit like the experience of a doctor who is approached by a former patient in a restaurant who wants to show them their operated knee.
9. **Ethical principles**. They suggest avoiding private contact with former and current patients whenever possible. This is certainly possible in large urban areas, but in smaller towns, multiple relationships are inevitable and uncomfortable. What can a therapist

do when, for example, they are chosen to be in a class trio together with a patient? Or when, invited to a gathering with friends, they recognize a person they know from a professional relationship? Ethical awareness cannot disappear after office hours. In presenting the above information, the author is painfully aware that they have not exhausted the subject.

Each of the risks presented should be explored in more detail in the future. It is also necessary to develop recommendations on how to address and prevent them. There are certainly other risks that have not been included in this publication, such as how novice therapists experience "disappearing" patients. However, the author hopes to initiate a discourse on the existence of real threats associated with this fantastic profession, which may allow for the normalization of the experiences of many practitioners. Research in this area is essential and currently lacking in Poland.

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