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Reflecting on professional self-disclosure and supportive relationships with foster carers during the COVID-19 pandemic

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Abstract

Professional self-disclosure can be defined as a clinician revealing personal information about themselves to the person they are caring for. This article provides reflections from clinicians working in child and adolescent mental health services (CAMHS) and their navigation of professional self-disclosure during the coronavirus disease 2019 pandemic. The reflections focus on the use of self-disclosure in supportive relationships with foster carers. Drawing on the authors' practice experiences as clinicians in specialist CAMHS settings, the article considers changes in the way that self-disclosure was approached following the shift to remote care delivery during the pandemic. The authors suggest that remote working involves a potentially increased scope for inappropriate use of self-disclosure and outline the implications for mental health nurses working with foster carers.

Keywords

child and adolescent mental health, child health, coronavirus, COVID-19, mental health, mental health therapies, therapeutic relationships

National Lockdowns and social distancing regulations were introduced in the UK as public health measures to limit the spread of coronavirus disease 2019 (COVID-19). They radically changed people's everyday home and work routines and disrupted the lives of children through school closures and a lack of social development opportunities. However, there were some positive effects of the social distancing measures, such as some parents and carers being able to dedicate more attention to their children. Moreover, it has been acknowledged that the lockdown periods and increased parental attention sometimes led to children experiencing a reduction in daily stress and sensory exposure (Bruining et al 2021).

Despite these benefits, the COVID-19 pandemic exacerbated inequalities and everyday challenges experienced by vulnerable and marginalised populations that were already disadvantaged, such as children residing in foster care. The pandemic led to extraordinary challenges for such vulnerable groups. Foster care placements broke down due to the additional strain created by limited respite opportunities and compromised access to external support provided by social care services, extended family and support networks. This led to some foster carers questioning whether they could continue to maintain long-term placements (Johnson 2020).

During the COVID-19 pandemic, the authors also recognised how mental health professionals' practice was compromised by the additional burdens that services were subject to. These included the rapid transition from in-person consultations to new ways of working, such as online and telephone-based care delivery, and the need to adapt to those changes and master new digital technologies (Burn and Mudholkar 2020, Feijt et al 2020, Bentham et al 2021). Issues with connectivity and access to suitable technology were also significant barriers to care, as were the obstacles some children and families experienced with online engagement, such as challenges with children's attention span and the lack of private spaces to conduct online consultations (Feijt et al 2020, Racine et al 2020, Archard et al 2021, 2022).

This article addresses the issue of professional self-disclosure when mental health professionals are providing therapeutic support to foster carers and how this may have changed during the COVID-19 pandemic. The authors reflect on how the act of self-disclosure was altered by the remote care necessary during the pandemic. Specifically, these reflections relate to clinical work in specialist child and adolescent mental health service (CAMHS) teams that manage the care of children and young people living in alternative out-of-home care, as well as other groups, such as adopted children and unaccompanied asylum seekers, considered to have a high level of mental health need.

Key points

- Navigating professional self-disclosure in work with foster carers in specialist child and adolescent mental health services (CAMHS) settings altered considerably during the COVID-19 pandemic
- Information about a clinician's personal circumstances can be inadvertently revealed in remote and online care delivery
- During remote working, nurses may feel pressured to disclose excessive or minimal amounts of personal information or may disclose this information inappropriately
- Principles from relational psychoanalysis may assist clinicians to navigate self-disclosure in practice, especially when working online
- CAMHS clinicians require practice guidance and training in personal and professional boundaries when navigating the issue of professional self-disclosure

Professional self-disclosure

Professional self-disclosure can be broadly defined as the clinician verbally revealing personal information about themselves to the person or people they are caring for (Warrender 2020). Professional self-disclosure can be beneficial in the development of therapeutic relationships by fostering rapport and encouraging candid disclosures. However, there are also potential risks in terms of the confusion of personal and professional boundaries.

The ways in which mental health nursing has been influenced by various therapeutic traditions means there are likely to be varied views on what level of professional self-disclosure may be regarded as appropriate. A common expectation among clinicians is that any disclosures should be made in the service of the patient rather than to meet the clinician's needs. The 'textbook' position on revealing personal information is that it can be a potentially harmful and a potentially beneficial act (Wright 2021). This, however, depends on the context and modality in which the clinician is practising (Gibson 2012). For example, person-centred and cognitive behavioural therapies are often associated with greater openness towards revealing personal information as a way of modelling personal openness, normalising challenges and communicating coping strategies (Ziv-Beiman 2013). Conversely, within psychodynamic therapies, self-disclosure traditionally tends to be regarded more cautiously because it is associated with relinquishing therapeutic neutrality and the complication of transference dynamics (Borenzweig 1981).

The use of self-disclosure by clinicians is context-contingent in that its use depends largely on circumstances. Day-to-day disclosures are often rooted in basic transparency and likely to be inconsequential. For example, a nurse may inform a patient or carer that they have to reschedule a visit because they must attend a training course. In other situations, personal information might be revealed. For example, a nurse may disclose to a patient that they have had issues with their own mental health in an attempt to build rapport or to encourage the patient to speak more freely. However, this type of disclosure can compromise personal and professional boundaries (Reamer 2001, Warrender 2020).

Self-disclosure can be a complicated issue for nurses to navigate in practice and to speak about openly with colleagues (Warrender 2020). This is because some nurses may adopt a rigid stance, stating that personal information should never be disclosed to a patient. However, by refusing to disclose, nurses may miss opportunities to develop rapport and establish therapeutic relationships.

Some clinicians may want to self-disclose and believe they are distancing themselves from patients by not doing so. Others may also believe that by not engaging in self-disclosure they are following the expectations of colleagues. However, the way in which nurses and other mental health professionals approach self-disclosure with patients is not just influenced by their relationship with colleagues or service users. Other factors in the practice environment are also relevant, such as the specific role they are engaged in, which might involve direct therapy, care coordination or monitoring the administration of medicines, as well as the wider organisational culture and the clinician's training and personal background (Knight 2012, Archard 2021).

Professional self-disclosure with foster carers

Specialist mental health teams serving children who are looked-after and living in foster or residential care tend to work closely with local authority children's services. These teams and services tend to be focused on children's adverse early life experiences and impaired attachment and links between these factors and mental health issues. It is essential that foster carers feel valued and involved in decision-making because the daily care they provide is crucial in developing children's positive relationships and emotional health (Rao et al 2010, Deuchar and Majumder 2021).

With respect to the issue of professional self-disclosure and working relationships between clinicians working in CAMHS and carers and parents, foster carers can be viewed as occupying a unique position. They are part of the professional network around a child, with access to supervision and training, and having been assessed and recruited for their suitability. Yet they also have a parental role. Foster carers are paid carers, unlike adoptive or biological parents, but they are also part of a child or young person's family, even if only

for a circumscribed period. As Callaghan et al (2015) stated, the foster carer's working life 'spans the domestic and the public sphere – being a foster carer is both a job and a relationship'.

Owing to the foster carer occupying a unique position that extends across domestic, professional and public spheres, the clinician working with them may reveal more about themselves in some ways but not in others. Potentially, they are more likely to view a foster carer as a professional peer. They may be more forthcoming in revealing personal information about themselves than they would, for instance, with an adoptive or biological parent. Still, they may not reveal as much about themselves or have as informal conversations with a foster carer as they would have with colleagues in other mental health teams or children's services, because of having a more distant professional relationship without the same level of collegiality as they would, for instance, have with a child's social worker. And yet, the foster carer may know more personal information about a clinician than a social worker, albeit much is dependent on the work being carried out, the strength of the relationship and how much the foster carer enquires about the clinician's life outside of work. For example, the authors' experience has been that a clinician would likely reveal very little about themselves in a one-off clinical consultation, and more, intentionally or not, during the facilitation of a training course or group-based psychoeducation for parents and carers. They would most probably reveal more still when engaged as a case holding clinician with a foster child and family over a long period involving regular review appointments and telephone calls with carers.

Professional self-disclosure during COVID-19

At the time of writing, in-person appointments were becoming routine again following the shift in COVID-19 status from pandemic to endemic. However, under the COVID-19 social distancing regulations, much of the work undertaken by CAMHS with foster carers and children in foster families took place via the phone and videoconferencing. In-person appointments were only undertaken when clinically necessary and even these were sometimes held outdoors to reduce the risk of disease transmission.

Early in the pandemic, the authors noticed how they and other clinicians sometimes revealed more about themselves than they would have otherwise to maintain trust in professional relationships, particularly regarding reasons around availability for appointments and consultations. Sometimes, this involved explaining how working patterns had to be entirely remote due to having to shield another member of one's household or being unable to complete a face-to-face appointment owing to one's own children showing symptoms associated with COVID-19. Similarly, there may be a need to clarify that an extended leave period or period spent working remotely was not for vacation but rather to see extended family members who were unwell and lived abroad, and to take sufficient time to adhere to quarantine measures.

At times during the COVID-19 pandemic, some of the authors had to take on various roles such as urgent mental healthcare provision or consultation work aimed at reducing a backlog of cases. In such scenarios there is usually less need for extensive disclosures. Nevertheless, even in the type of one-off contacts with foster carers involved in clearing a backlog of cases, there can still be issues around disclosure. For example, during a challenging consultation a frustrated foster carer might ask a clinician if they have children of their own.

During the pandemic the authors came to recognise that boundaries for appropriate online clinical working had changed (Eppel et al 2020, Crowe et al 2021). For example, a psychotherapist in private practice might have had a dedicated office consulting room at home that they could use for online conversations, but for many clinicians this was not the case, which changed the nature of the therapeutic space. For example, a recently qualified or trainee mental health nurse may have been living in shared accommodation where noise or lack of space affected them just as much as the children and families they were attempting to support.

Engagement in providing care online inevitably involves implicit forms of self-disclosure. Choices are made about whether one uses a background filter or not, what objects are left visible at home and if one opts to work from home rather than at the office or clinic. All these things reveal something personal about what one wishes – and does not wish – to reveal to children, parents and carers. These implicit forms of self-disclosure may even be used in a conscious, deliberate way at times. For example, a clinician may engage in a good deal of stage management in terms of the objects that appear behind them, that is, books, artwork and décor, which will convey something about their taste, personality, cultural identity and social background.

In an ideal world, of course, one takes time with this. But, in the case of the pandemic, this was not always possible – the personal would intrude into the therapeutic space, for example a clinician's children running into the spare bedroom 'office' during a consultation. Similarly, having to respond in real time to juggling different personal and professional roles and responsibilities, one may not realise what is seen via the computer camera, making washing or clothes visible to a carer, for example.

The gendered nature of these scenarios became apparent, in that it was often female clinicians with children who were forced to balance their work commitments with taking responsibility for children who might be unwell themselves. These attempts to balance work and home life could lead to foster carers being frustrated when appointments had to be cancelled or rearranged at the last minute.

While any such cancellations were usually out of the clinicians' control, there were also occasions when clinicians would 'act out', for example reminding carers that they were receiving specialist support and that they could look for alternatives if they did not feel the support was helping them. These types of ruptures in

therapeutic relationships during the pandemic were often resolved, sometimes by the clinician apologising directly. However, such circumstances also had an effect on how clinicians working in CAMHS viewed their caregiving responsibilities, and some clinicians decided to reduce their hours or leave their post because the work-life balance was unsustainable.

Ordinary decency and relational psychoanalysis

How should this use of self and these practices of self-disclosure be conceptualised? Using the terminology of Clarke (2013), they may be described as acts of 'ordinary decency'; ethical practices that reflect 'everyday ways of being' and a recognition of reciprocity and mutuality in helping relationships (Alexander and Charles 2009). Another way of viewing them is in terms of how they correspond with a relational psychoanalytic standpoint – namely, that it is not necessarily true that a lack of self-disclosure on the part of a therapist will lead to patients being more candid about their own thoughts and feelings (Renik 1999, Gediman 2006, Siebold 2011, Newberger 2015, Campos 2020). For example, a nurse working with a foster carer might choose not to disclose how COVID-19 pandemic restrictions have affected them, but not doing so may risk giving the foster carer the misleading impression that the nurse is not experiencing the same challenges as everyone else. This demonstrates the relational psychoanalytic view that in avoiding the disclosure of personal information, the clinician is inevitably still revealing something about themselves and not maintaining a position of hypothetical professional neutrality.

Moreover, sharing personal information can sometimes be more useful than not sharing anything at all. If a clinician regards the therapeutic relationship as co-constructed with the patient and approaches it with some personal warmth, an ethos of mutual trust and understanding can be strengthened. By revealing personal information to the client, the clinician can facilitate a sense of safety by demonstrating that it is not unhealthy to be curious about each other's experiences, especially given that most people avoid speaking about uncomfortable topics (Wachtel 1993, Campos 2020).

Epistemic trust is defined as a person's willingness to accept information from another as trustworthy and relevant and is developed via mentalising the client, a relational skill that includes self-disclosure of the clinician's thoughts and feelings (Fonagy and Allison 2014). Epistemic trust is believed to be an important part of creating a therapeutic alliance (Auchincloss 2016). Nurturing epistemic trust using self-disclosure can assist in reducing defensiveness between the clinician and the patient in the therapeutic relationship.

Support with navigating professional self-disclosure

When navigating the issue of professional self-disclosure in working relationships with foster carers, clinicians working in CAMHS need access to support and meaningful frameworks in the form of practice guidance and training in personal and professional boundaries. Staff support in the form of supervision or reflective practice groups is also crucial. Box 1 shows some of the prompts that clinicians might use to reflect on their use of self-disclosure with foster carers.

Box 1. Prompts that clinicians might use to reflect on their use of self-disclosure with foster carers

- Am I more inclined to disclose personal information as a clinician in certain scenarios rather than others?
- How does my approach to the issue of professional self-disclosure connect to my clinical training and personal identity?
- What influence has working online had on what I am willing to reveal or have revealed about myself, deliberately or not?
- In what ways am I concerned about what my colleagues and/or other professionals would think about how I approach the use of self-disclosure?
- How much have I thought about the use of professional self-disclosure in my work?
- In what situations might self-disclosure be more useful in work with foster carers than others and why?
- In what situations might self-disclosure be less beneficial in work with foster carers than others and why?
- When I choose not to self-disclose, or refuse to answer a personal question from a carer, what am I revealing about myself?
- How might I seek support for navigating the issue of self-disclosure at work and what support might be most beneficial?

Such supports and guidance need to be based on the understanding that more 'closed' and 'open' stances towards answering personal questions by parents and carers can be viewed as being linked with anxieties about the maintenance of a particular professional identity (Archard 2021). It may be said that for some clinicians being 'professional' is regarded as synonymous with emotional distance from service users and a natural reluctance to disclose anything personal about oneself. On this basis, insights from relational psychoanalysis may be helpful to incorporate as prompts for reflection because they place an onus on the clinician asking themselves why they may be more inclined to disclose in certain scenarios rather than others.

This includes considering how the clinician is positioning themselves in regard to the carer they are seeking to help, what this may say about the pressures they are under, as well as the response a carer may be consciously or unconsciously seeking to elicit from them when asking questions of a personal nature.

The authors also experienced how home working during the COVID-19 pandemic left clinicians in a predicament regarding clinical decision-making. There was an absence of opportunities for discussions with colleagues in which clinicians could share their views or talk through clinical challenges, as they might when sharing an office. Like other examples of unethical practice, the inappropriate use of self-disclosure is more likely to take place in organisations where ethical practice is not discussed (Warrender 2020, Archard 2021). With much more time spent in office and clinic locations following the pandemic, time should be set aside for such conversations. Also, the importance of staff support, which was emphasised during the pandemic, should continue to be advocated even as services begin to return to pre-pandemic practices.

There are other avenues that warrant exploration regarding professional self-disclosure, such as what types of information are disclosed to parents and carers compared with that disclosed to children and young people. There is a delicate balance between protecting children and not acting paternalistically in deciding what they should and should not be allowed to know about the clinician with whom they are working. These issues can be linked to debates about the agency of children and assumptions made about information they are able to manage and process (Terr 2008).

Conclusion

The navigation of professional self-disclosure in work with foster carers in specialist CAMHS settings underwent significant changes during the COVID-19 pandemic. In the altered therapeutic space of remote and online care delivery, information about a clinician's circumstances, such as whether they have children or the aesthetics of their personal space, can be inadvertently revealed. Additionally, during remote working, nurses may feel undue pressure to disclose excessive or minimal amounts of personal information, or disclose this information inappropriately. In this context, principles from relational psychoanalysis may be particularly valuable in considering how clinicians working with foster carers and children can navigate self-disclosure in practice, especially when working online.

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