

Filling the feedback gap: the unrecognised roles of shame and guilt in the feedback cycle

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I was halfway through a recent feedback session with Dr W, a first-year resident on our in-patient service, when things began to unravel. His eyes, heavy and focused on the floor, suggested inner turmoil in response to what I felt was constructive, albeit challenging, feedback. He shifted uncomfortably in his chair and was visibly disturbed. Things escalated at the conclusion of our conversation: 'I appreciate everything you told me but I just don't think I'm good enough to get through residency. I have too many deficiencies, I feel like an impostor, and honestly, I'm thinking about quitting.'

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I recognised that Dr W was experiencing a damaging *shame response*, but I was caught off guard. Over the prior week, I had successfully navigated the first two phases of the feedback cycle described by van de Ridder *et al.*¹ in this edition of the journal: I had laid out expectations and instructions (phase A) and observed and inter-

preted Dr. W's performance based on a generally held standard (phase B). I was now in the midst of communicating the feedback to him (phase C), while assessing his response (phase D), particularly his emotions. My efforts to provide meaningful feedback had obviously gone astray, but where in the cycle had they failed and what variables had influenced this ineffective outcome?

In their meta-review published in this edition of the journal, van de Ridder *et al.*¹ provide insight into these questions. Their analysis identified 33 variables that influence the feedback process, effect or both. They mapped the variables to the four phases of the feedback cycle and analysed their influence on future phases and the overall feedback effect. The results provide new and exciting information about the factors that influence the feedback cycle and highlight major gaps in the feedback literature.

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While the analysis yields robust findings about variables that influence the processes used to collect feedback (phases A and B), it reveals a relative paucity of information about the variables that influence the communication and reception of the feedback (phases

C and D). The authors conclude that feedback effectiveness is lowered if it is perceived as threatening to self-esteem,¹ but the relative lack of data about phases C and D preclude a deeper understanding of this powerful finding. Thus, although the study provides compelling information about how to best gather and prepare meaningful feedback, it identifies a critical gap in our understanding about how to effectively communicate it and ensure that it is received in a constructive manner.

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To begin addressing this gap, we might examine the roles played by shame and guilt in the feedback process. Feedback leads to shame when the recipient receives it and adopts a negative evaluation of his or her *self*, as opposed to the behaviour or action under scrutiny.^{2,3} As a result, shamed individuals feel small, inferior and exposed and may see themselves as defective and unworthy.² Guilt, on the other hand, is the tendency to respond to difficult feedback by focusing on the action or behaviour rather than the *self*.⁴ People who experience guilt are able to say: 'This *thing* I did was bad, but *I* am not bad.' Although there is still a negative affective reaction with guilt, it does not generalise to the

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self and thus does not lead to damaging self-assessments.⁵ The resident to whom I provided feedback interpreted it at the self-level, and viewed himself as deficient and not good enough (a shame response), rather than as a capable learner who was struggling with typical challenges for a first-year resident (a guilt response).

Guilt is the tendency to respond to difficult feedback by focusing on the action or behaviour rather than the self

Distinguishing between shame and guilt is critically important because they lead to different outcomes with significant implications for learning. Shame leads to a desire to withdraw or hide, deny responsibility, and ignore the problem at hand.^{2,3,6} Guilt, by contrast, stimulates reparative action and attempts to grow from the situation and prevent the behaviour from happening again.^{3,6} Applied to learning, shame has the potential to promote detachment from critical learning processes, whereas guilt has the potential to stimulate engagement, the latter of which should be a primary end goal of the feedback process.

How, then, is shame implicated in the communication of feedback?

When communicating feedback (phase C)¹, even the most well-intentioned teachers can induce shame by generalising the feedback to the learner's self, rather than his or her actions. Feedback that focuses on the learner's self has been shown to decrease in its effectiveness and lead to damaging outcomes including avoidance behaviour, decreased self-efficacy, and an increased desire to quit,⁷⁻¹⁰ all of which are consistent with a shame response. To avoid this out-

come and steer a learner towards a more constructive response, teachers should focus on *specific actions that the learner can change*, rather than core, unchangeable facets of his or her personality.⁷

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Feedback that is communicated in a humiliating manner may also induce shame in the recipient.¹¹ Humiliation, or the act of putting another in a lowered, debased position, is disturbingly prevalent in medical education.¹² A learner who experiences shame in response to humiliating feedback believes that the treatment is justified, accurate and deserved.¹³ As a result, he may adopt a negative view of himself by believing in the message that humiliation sends: that he is inherently deficient. This concept appears to be highlighted, in a juxtaposed fashion, by van de Ridder *et al.* in their conclusion that feedback provided in an encouraging manner leads to enhanced effectiveness.¹

How does shame influence the reception of feedback?

In my session with Dr W, I communicated the feedback in an action-focused and non-humiliating way and yet as he received it (phase D)¹, he experienced shame. This suggests the presence of additional factors that influence the feedback recipient's tendency to experience shame. The psychology literature makes associations between susceptibility to shame and underlying depression,⁵ anxiety¹⁴ and past shaming events.^{15,16} Further research is needed to elucidate how these and other factors, through

their potential to induce shame and effects on self-esteem, moderate the manner in which feedback is received. This research may provide deeper insight into the related findings by van Ridder *et al* that feedback threatening the learner's self-esteem leads to decreased overall effectiveness.

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The degree to which learners are prepared to navigate the challenges of learning clinical medicine is an additional factor that may influence how they receive and respond to feedback. Dr W, in reflecting on his reasons for experiencing shame, admitted: 'I was totally unprepared for how difficult residency would be, how much I would struggle, and how exposed I would feel.' Clinical training is a time of intense scrutiny and the necessary 'unearthing' of weaknesses, bad habits and knowledge deficits. As such, it may present serious challenges for learners who are not prepared for such a high degree of exposure and criticism, especially those who achieved high academic success in the classroom and those who strive for perfection. As a result, they may be predisposed to damaging self-assessments and high levels of shame susceptibility following *normal and expected* facets of learning,¹⁷ including the routine and necessary communication of constructive feedback, exposure of weaknesses, and occurrence of medical error. Further research is needed to determine how preparation for adversity (including the presence or absence of coping skills) influences a learner's response to these events.

Clinical learning may present serious challenges for learners who are not prepared for such a high degree of exposure and criticism

How can feedback-induced shame be avoided?

The recognition of a shame response in Dr W provided me the opportunity to open up to him about my own struggles in learning medicine (which continue today), my growing comfort with my own imperfection, and the motivation they both give me to improve every day. In doing so, I attempted to utilise *normalisation* and to model *vulnerability*, both of which may help guide learners away from shame responses.^{18,19} Teachers and institutions might also positively influence the manner in which learners respond to difficult feedback by helping them set realistic standards for performance and by preparing them for the expected challenges inherent in the clinical learning process. Preparation should occur early and often, beginning prior to matriculation into medical school, and should continue throughout the clinical years. Finally, institutions are called upon to eradicate humiliating treatment and provide faculty development on shame-free approaches to teaching in order to optimise the manner in which difficult feedback is communicated.^{20,21}

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Dr W's story reminds us that as we seek greater understanding about the forces that guide our attempts to build competent and skilful

learners, we must pay equal attention to those that build compassionate, resilient human beings. The meta-review by van de Ridder *et al.*¹ provides vital insight into the variables that influence the feedback cycle, one of the primary vehicles through which this building occurs. It also identifies a critical gap in the feedback literature with reference to the lack of data about forces that influence how feedback is communicated and received. Future inquiry is needed to address this gap and the roles played by shame and guilt in the feedback process. Better understanding these *fundamental* and *normal* human emotions will allow us to harness feedback to improve not only performance, but also well-being, engagement, and resilience.

Disclaimer

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Improving patient outcomes through supervision and simulation

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Health professional education programmes are under constant pressure to train caregivers in fundamental skills even as the opportunities to practise those skills change dynamically. Consider, for example, the rate of operative deliveries in the USA. Caesarean deliveries increased from 22.7% of all deliveries in 1990 to 32.8% in 2011.¹ In view of the associated risk for maternal morbidity, the American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine have strongly recommended operative vaginal delivery (e.g. forceps- and vacuum-assisted) as an intervention to reduce primary caesarean delivery. Unfortunately, operative vaginal delivery rates have declined as caesarean delivery rates have increased,² yielding a

situation in which many graduates do not feel competent to perform a forceps-assisted vaginal delivery.³ As operative deliveries comprise nearly half of births, and in recognition of the need to decrease caesarean delivery rates, expertise and training in vacuum- and forceps-assisted vaginal delivery need to be at the forefront of our resident education programmes even as these practices have become less common.

Operative vaginal delivery rates have declined as caesarean rates have increased and many graduates do not feel competent in forceps-assisted vaginal delivery

In their paper, published in this issue, Aiken *et al.*⁴ recognise the need for physician learners to build a solid foundation of supervised experience prior to performing operative deliveries independently. An increase in operative deliveries performed under direct supervision prior to operating without direct supervision was shown to decrease the occurrence of procedure-related

complications and adverse events.⁴ Increasing the number of procedures performed under direct supervision is arguably a standard towards which all residency training programmes should strive, but achieving that standard is not without its challenges. In addition to the decline in opportunities to be involved in certain procedures, the more general restriction on resident work hours and associated limitations in hands-on training contribute further to the issue.^{5,6} How can these challenges of time, exposure and experience be overcome? The answer, as proposed by Aiken *et al.*⁴ and others, may lie in simulation.

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Although simulation may seem to be a relatively new phenomenon, especially given its growing prominence across medical disciplines, the history of simulation in obstetrics dates back to the childbirth

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