Exposing Shame and Its Effect on Clinical Nursing Education

Mary Ellen Bond, MSN

ABSTRACT

Shame is identified as a universal dynamic in education. Brain-based learning theory suggests negative emotions like shame have a powerfully detrimental effect on learning. Shame theory may explain why students have difficulty identifying with professional nursing culture. Yet shame has neither been directly described nor referred to in the context of clinical nursing education. Accordingly, the aim of this article is to raise awareness among nurse educators about shame and its potential effect on students' ability to learn in clinical nursing education. This article examines shame in its many manifestations; the power to shame inherent in the clinical context; the consequences of shame on students' ability to learn; and, finally, the knowledge, skills, and attitudes needed by nurse educators to heal and prevent shaming in clinical nursing education.

> What will happen to us as we become aware of this powerful force that has done so much to bring us into the present?
>
> ~ Nathanson (1992, p. 32)

The powerful force to which Nathanson (1992) refers is shame. Although shame is ubiquitous in North American culture, discussing it is considered taboo (Kaufman, 1985). Certainly shame has not been described or referred to in the context of clinical nursing education; yet, according to Kaufman, shame is a universal dynamic in education. That nurses and nursing students are vulnerable to shame is evidenced in the nursing literature, which describes nurses as members of an oppressed group (Daiski, 2004; DeMarco, 2003; Dunn, 2003; Freshwater, 2000; Griffin, 2004; Harden, 1996; Roberts, 1983, 2000) who, because of feelings of low self-esteem and powerlessness, may engage in aggressive behaviors toward each other (Daiski, 2004; Dunn, 2003; Griffin, 2004; Randle, 2003).

Long before I became aware of oppressed group behaviors and horizontal violence, I experienced both phenomena within nursing, but it was many years before I recognized the connection between these phenomena and shame. Thus, the foundation for this article is grounded in my own experiences as a nursing student, an entry-level RN, and a nursing instructor. My personal history provided the impetus to learn more about shame and its effect on one's ability to learn in the clinical practicum area. Using the story of the shame I felt in my clinical nursing education as a springboard, I wrote this article to raise awareness among nurse educators about shame and its potential effect on students' ability to learn in clinical nursing education.

A PERSONAL DISCOVERY OF SHAME

My nursing education began in 1980, when I enrolled in an undergraduate nursing program at a Canadian university. Although successful academically, I struggled with clinical learning. I was expected to apply what I read in my nursing textbooks to real-life hospital situations, but regardless of how much I studied, I attended every practicum session feeling anxious and unprepared. In the clinical setting, where I cared for real patients, I was a nervous

Received: March 28, 2006

Accepted: June 27, 2007

Ms. Bond is Nurse Educator, College of the Rockies, Cranbrook, British Columbia, Canada.

The author thanks her sister, Susan Bond, as well as her nursing colleagues, Joan Bray, Sandi Hendrickson, Heather Hepworth, and Norma Sherret, for their valuable input regarding the Table.

Address correspondence to Mary Ellen Bond, MSN, 2700 College Way, Box 8500, Cranbrook, British Columbia, Canada V1C 5L7; e-mail: bond@cotr.bc.ca.

wreck as my instructors quizzed me on patient conditions and expected me to perform skills I had never done before.

My academic strengths enabled me to complete my nursing degree, but I was no more comfortable in the clinical area upon graduation than I had been when I began my studies. My clinical learning experiences in year one had been painful, humiliating, and difficult; by year four, things had not improved. In fact, I felt more like a failure than ever because at that point, I was expected to have the skills, knowledge, and confidence to function as a novice practitioner.

After graduation, I was hired as a staff RN on a medical unit of an acute care hospital. The transition from nursing student to nurse was difficult, largely because of the head nurse on the floor who seemed to dog my every footstep and question my every move. The fact that I had won academic scholarships throughout my undergraduate years and had achieved an "A" standing on my RN examinations did not seem important. The head nurse was "not to be fooled" by my apparent success as a student. She seemed bent on exposing what she regarded as my incompetence. My response was a strong urge to hide from her, thus reducing opportunities for exposure. This relationship was the norm until I was no longer the least experienced nurse on the unit. When a new graduate was hired, the head nurse's regime of intimidation focused on the newcomer, and repeated itself with all new nursing staff.

I survived my initiation as an acute care nurse, and then turned to nursing education. In 1988, I began teaching in a diploma nursing program and soon after began to observe a pattern in my students. They were often high-achieving, intelligent, hard-working individuals who nevertheless seemed to suffer from low self-esteem. Recalling my own time as a nursing student, I noted that they too appeared to be highly anxious during clinical practicum. Thus, early in my teaching career, I developed an interest in understanding the relationship between nursing students and self-esteem. I wanted to understand why so many smart and capable individuals (who were, for the most part, women) seemed to suffer from low self-esteem and perfectionism. I wanted to understand the effect of these traits on the students' ability to learn and to gain insight into how my relationship with students helped or hindered their learning, particularly in the clinical area where student anxiety was greatest. While researching the psychological literature on self-esteem, I discovered a link between low self-esteem and shame (Jordon, 1989).

According to Jordon (1989), shame results from a loss of self-respect or self-esteem. Jordon suggested that shame is "a felt sense of unworthiness to be in connection, a deep sense of unlovability, with the ongoing awareness of how very much one wants to connect with others" (p. 6). Shame causes a feeling of exposure, with the result that one feels compelled to pull away from shame-making situations. Reading this, I began to make a connection between shame and the usual methods used in nursing education to evaluate student performance: direct question asking in the clinical area, return demonstrations in laboratory situations (particularly for the purposes of testing), and observing students performing clinical skills in the initial learning stages of those skills. Learning that performance expectations amplify shame (Kaufman, 1989), I further reflected on the clinical context and considered other common and potentially shaming practices in nursing education: correcting a student in front of patients, staff, or peers; ignoring a student; becoming impatient with a student; displaying verbal or nonverbal contempt in response to student lack of knowledge or skill; taking over for a student performing a skill; or refusing to provide help to a student. I recalled experiences from my clinical learning when I felt what I was now recognizing as shame. Feeling shame, I also identified occasions when I likely had shamed my students. With this insight, I felt compelled to learn more about shame and the potential for shaming in clinical nursing education.

An extensive literature review revealed no research on the role of shame in clinical nursing education. I was able to locate only one study specific to shame in the context of nursing: a philosophical inquiry into shame as experienced by two fictional women in health-related situations (Connolly, 1995). In another nursing study, Ehrmin's (2001) investigation of alcoholism, shame emerged as a predominant theme, although the original focus of the research was not shame. In clinical nursing education literature, studies addressing student anxiety and the student-instructor relationship failed to describe shame (Benor & Leviyof, 1997; Gignac-Caille & Oermann, 2001; Jones & Johnston, 1997; Oermann, 1998; Shipton, 2002). This failure to identify the role of shame in nursing education represents a significant gap in nursing knowledge. Although I do not believe nurse educators intend to shame their students, I believe shaming practices do occur and that they seriously undermine effective teaching and learning. Clinical nursing education will improve significantly when nurse educators recognize shaming practices and manifestations of shame; understand the power to shame inherent in the clinical context; acknowledge the consequences of shame on students' ability to learn; and possess the knowledge, skill, and attitudes to heal shame and prevent shaming.

RECOGNIZING SHAME AND ITS MANIFESTATIONS

Jacoby (1994) linked the origin of *shame* with the Indo-Germanic root *kam/kem*, meaning *to cover oneself*. This relates to the concept of *aidos*, which is the Greek word for shame and also the word which designates the genitalia (Kilborne, 2002), obliquely referred to as *private parts* (Jacoby, 1994). Shame emerges in Greek literature as an experience of "being seen, inappropriately, by the wrong people, in the wrong condition" (Kilborne, 2002, p. 38). According to Kilborne, shamed individuals struggled to regain their honor; failing to do so, they were driven to suicide. Wurmser (1981) reinforced the point when he said

that shame can strike one dead. Hartling, Rosen, Walker, and Jordon (2004) noted:

> The literal meaning of the word is consistent with the individual responses associated with shame (e.g. feeling exposed, avoiding eye contact, wanting to hide or withdraw). (p. 105)

Figuratively, and at times literally, to feel shame, or to be shamed, is to be dealt a mortal blow. Shame theories further elucidate its meaning.

Healthy development includes relationships with important others where human needs for touch, identification, power, nurturing, and affirmation are met (Kaufman, 1996). A developmental theory of shame puts forth that shame is activated when those we respect and admire fail to meet these basic relational needs (Erikson, 1950; Goldberg, 1991; Jacoby, 1994; Kaufman, 1996). This theory could apply to those nursing students who, because their primary interpersonal needs were not met in childhood, are shame prone and experience low self-esteem.

According to a psychoanalytic theory of shame, shame arises when individuals believe they have not lived up to their own standards, leading to the perception that the whole self is a failure (Andrews, Qian, & Valentine, 2002; Gilbert, 1998; Gilbert & Andrews, 1998; Jacoby, 1994; Kaufman, 1996; Morrison, 1989, 1998; Nathanson, 1992; Wurmser, 1981). Morrison (1989) wrote that shame shares a relationship with "narcissistic grandiosity" and a "desire for perfection" combined with "the sense of the self as flawed, inadequate and inferior" (p. 62). The outcome is to "become narcissistically vulnerable and preoccupied or, alternately, defensive, self-sufficient, haughty or arrogant" (p. 62). Clinical instructors who do not recognize manifestations of shame in their students may misinterpret these behaviors and then may react negatively toward the students in response to them.

In shame, perfection is sought; one is either perfect or a total failure, one does not experience anything in between.

Nathanson (1992) is known for what he calls the compass of shame, which describes four patterns of possible responses to shame: shameful withdrawal (from others); masochistic submission (where self is attacked and shame is accepted by depreciating self in relation to others); narcissistic avoidance of shame (distracting attention from the shame experience by focusing on something positive); and the rage of wounded pride (where others are attacked to deflect shame by decreasing the self-esteem of others). Applying Nathanson's compass of shame from psychoanalytic theory to clinical nursing education illuminates some typical student behaviors.

Students who hide from, rather than seek out, their instructor depict what Nathanson referred to as shameful withdrawal from others. In shame, perfection is sought; one is either perfect or a total failure, one does not experience anything in between. This reflects what Nathanson described as masochistic submission, such as when students see themselves as total failures if a mistake is made. In narcissistic avoidance of shame—the third needle of Nathanson's compass—students refuse to be accountable for their actions or to accept responsibility for their mistakes. The fourth needle, the rage of wounded pride, can be seen in students who cannot accept negative feedback and become defensive and blame others for their difficulties.

Tomkins (1962, 1963), creator of the affect theory of shame, believed shame to be one of several inborn affects. According to Tomkins, reactions to shame either enable or disable one's ability to be interested in the world. Affect theory states that one feels shame when one desires to continue an activity or association that brings interest or joy but is blocked from doing so. In addition, Tomkins thought the shame response, which includes blushing and lowered eyes and head, is itself a further stimulus to shame. The affect theory can be seen at work when an initially enthusiastic nursing student is undertaking a newly learned task, albeit in a slow or clumsy manner, and is stopped by the instructor, who then completes the task. The student feels shame and may be less willing to attempt new procedures in the future.

A social-relational theory of shame says shame is related to how others see and judge us and arises when there is a threat to the social bond. For that reason, Scheff (2000) proposed that shame is the premier social emotion. According to Lewis (1971), every person fears social disconnection, and shame is a physical or mental response to the threat of disconnection. Jordon (1989) believed the need for connection and emotional joining is a primary human need that, when not met, leads to shame.

Despite its apparent universality, recognizing shame is not easily done. Lewis's (1971) analysis of verbatim transcripts of hundreds of psychotherapy sessions revealed an interesting paradox: a prevalence of shame among patients, yet a corresponding lack of awareness that shame was the emotion in play. She suggested that shame is difficult to recognize because most shame states are not experienced in consciousness but are either unconscious or misnamed. However, she noted that identifying shame by name appears to be an important aspect of understanding and managing it.

Scheff (2000) noted there is a slipperiness surrounding the concept of shame and observes that many researchers who have made important contributions to shame knowledge have nonetheless failed to name or define the emotion. Lynd (1958), who developed a social and psychological conceptualization of shame, stated that shame, although prevalent in her study, was hard to identify because it was so deeply hidden. Kaufman (1985) declared that although our society is shame based, the shame is hidden and the shame about shame keeps recognition or acknowledgement of shame under

strict taboo. Jordon (1989) said that because shame silences, those who are shamed do not speak about it. In addition, the difficulty of distinguishing individual emotions, for example shame and guilt, makes discussions specific to shame unlikely (Andrews, 1998). However, understanding that shame is a member of a group of related emotions, and how guilt and anxiety relate to shame, may help in its recognition.

Work by Scheff (2000) and others reflects shame as a member of a large family of emotions that involve reactions to rejection or feelings of failure or inadequacy and includes humiliation, embarrassment, and related feelings of shyness. Although the terms *shame* and *humiliation* tend to be used interchangeably in the literature (Hartling et al., 2004), humiliation differs from shame in that "in shame the focus is on the self, while in humiliation the focus is on harm done by others" (Gilbert, 1997, p. 133). Hartling et al. (2004) noted that in this way, humiliation can be used as a power-over strategy by a dominant group or individual to control a subordinate. In the context of the instructor-student relationship, the instructor, who holds the balance of power, is more likely to humiliate the student, rather than the other way around. Hence, it is important that nursing instructors understand shame and humiliation to refrain from humiliating students. Kaufman (1996) described embarrassment as "shame before an audience" and shyness as "shame either in the presence of or at the prospect of approaching strangers" (p. 23).

Guilt can be considered the twin of shame because it is the emotion most commonly associated with shame. Some would say guilt and shame are identical twins; for example, Tomkins (1962) thought shame and guilt are not distinguished from each other at the level of affect, and Kaufman (1989) thought one can feel shame about actions as well as guilty about the self. However, most shame theorists think guilt is a fraternal twin to shame because guilt is about what one did or failed to do, whereas shame is about the self (Jacoby, 1994; Lynd, 1958; Morrison, 1989; Nathanson, 1992).

Jacoby (1994) considered that anxiety plays a major role in shame. He thought of anxiety as the master emotion from which guilt and shame are derived. Jacoby stated that if one is anxious, it is the anxiety that brings on such shameful events as blushing, shaking, and inhibited speech. Anxiety impairs the ability to attune oneself to the requirements of a situation by forcing one to observe one's self continually. Kaufman (1989) described this as dividing one from others and one's self. Lewis (as cited in Gilbert, 1998) stated:

> Anxiety appears central to the shame experience—episodes of shame have an almost panic-like quality to them, where one loses the capacity for rational thinking. We are aware of the scrutiny of the other and become intensely and rapidly aroused. We experience intense anxiety, feel our minds going blank, feel rooted to the spot, wish the ground would open and we could slip out of sight or flee. (p. 6)

POTENTIAL FOR SHAME: THE CLINICAL CONTEXT

Student anxiety during the clinical learning experience is well documented (Beck, Hackett, Srivastava, McKim, & Rockwell, 1997; Beck & Srivastava, 1991; Burnstein, 1995; Jones & Johnston, 1997; Kim, 2003; Oermann, 1998; Oermann & Standfest, 1997; Shipton, 2002). Study results show that the degree of stress experienced by students is influenced significantly by the teacher, whose approach can facilitate or inhibit learning in clinical nursing education (Oermann, 1998; Oermann & Standfest, 1997). The most anxiety-producing clinical experiences include being observed by instructors, asking questions of faculty, and being evaluated by faculty (Kim, 2003). Oermann and Standfest (1997) concluded that clinical faculty should recognize the inherently stressful nature of clinical practice for students and that a trusting and caring relationship with the clinical teacher is critical for effective learning to occur.

Studies of students' perceptions of the most effective clinical nursing teachers reveal clinical competency as the most important characteristic of effective instructors (Benor & Leviyof, 1997; Gignac-Caille & Oermann, 2001). Good interpersonal relationships and a warm personality (Gignac-Caille & Oermann, 2001), as well as a sense of humor (Hayden-Miles, 2002), were also highly rated.

In a qualitative study by Hayden-Miles (2002), the importance of building a trusting relationship with one's clinical instructor emerged as a strong theme in each student narrative. However, it was noted that this did not always happen. A contrasting theme to teacher-as-partner was teacher-as-despot, where narratives described experiences in which students had no relationship with their instructor. In the teacher-as-despot situation, instructors were seen as holding absolute power over their subordinate students. Instructors controlled students by meting out punishment when students did not meet their expectations, and this in turn destroyed students' trust in their teachers. In spite of the caring and holistic values on which the philosophy of the program was based, it was noted that students and instructors often related to each other in adversarial ways. Students wanted to be treated like the adults they were; instead, they were treated in an authoritarian manner as though they were children. Instructor openness was identified as a positive trait. Because open instructors did not intimidate them, students felt comfortable in approaching these instructors to ask questions. A stern instructor had the opposite effect: students felt intimidated and frightened and, consequently, did not ask questions. Students in this study reported learning little or nothing from instructors who related to them in this manner.

It is clear that clinically skilled, helpful, and supportive nursing faculty will ameliorate the stressful environment that is the clinical classroom. When nursing faculty act otherwise, the consequences for learning can be severe.

CONSEQUENCES OF SHAME IN CLINICAL NURSING EDUCATION

Kaufman (1985) believed the need to identify is a fundamental human process that occurs developmentally through relationships and nurturing. Kaufman discusses the alienating effects of shame and the shame-inducing process, which he calls "breaking the interpersonal bridge" (p. 11), the bond that ties two individuals together through mutual understanding, growth, and change. When this bridge is broken, shame is generated.

The process of professional socialization requires just such an interpersonal bridge between nursing student and instructor. Professional socialization—a coupled process whereby students acquire knowledge and skills, and internalize the values and norms denotative of the profession (Jacox, 1978)—has been identified as a key area of learning in clinical nursing education (Beck & Srivastava, 1991; Benor & Leviyof, 1997; Campbell, Larrivee, Field, Day, & Reutter, 1994; Gillespie, 2002; Jackson & Mannix, 2001; Magnussen & Amundson, 2003). That professional socialization is a coupled process emphasizes the importance of a social-relational connection between instructor and student if students are to learn professional norms and values.

Shame has the potential to interfere with the socialization process in nursing. When Beck and Srivastava (1991) contemplated the problems nursing has in defining itself and developing its image, they noted that students who complete their nursing education do not feel prepared to practice nursing. The reason most often given is that these students are not prepared to handle the realities of nursing, in part because they are not fully socialized into the profession (Beck & Srivastava, 1991; Hamill, 1995). It follows that anything that interferes with a sense of connection, such as shame, has the potential to interfere with students' socialization in nursing, thus leaving students unprepared to practice. Indeed, Kaufman's (1985) description of the interpersonal bridge demonstrates what Gillespie (2002) referred to when she described the student-teacher connection in clinical nursing education.

In research by Gillespie (2002), a connected student-teacher relationship (characterized by caring, knowing and trusting, respect, and mutuality) emerged as a strongly positive influence on nursing students' clinical learning experiences. Students who connected relationally with their instructors developed organization skills, communication skills, and clinical nursing judgement. Their skill acquisition enabled them to recognize and respond to patients' needs with ever-increasing effectiveness. In contrast, the predominant role of teachers with whom students experienced a lack of connection was that of evaluator (Gillespie, 2002). Students described "the nonconnected teacher's tendency to 'grill' them with questions, offer only 'negative feedback', to 'constantly critique', and 'watch them like a hawk'" (Gillespie, 2002, p. 572).

These were the teacher behaviors in my undergraduate nursing program that led to my feelings of incompetence and insecurity, feelings I would now describe as shame. Gillespie's findings that in nonconnected student-teacher relationships, the students' focus within their clinical learning experience was on the teacher, rather than on learning, describes my experience as a student in clinical nursing education. Like me, the students of nonconnected teachers were preoccupied with "pleasing the teacher" and "getting it right"; thus, Gillespie (2002) concluded, this "tended to narrow their vision of a nurse to one which doing and empirical knowing predominated and, thus, limited their learning and professional socialization" (p. 572). Shame-inducing behaviors are the antithesis to behaviors that promote student confidence and, thus, optimal learning (Campbell et al., 1994; Magnussen & Amundson, 2003). As a further consequence, by causing a break in the interpersonal bridge, shame disrupts socialization into nursing identity and culture. Indeed, shame may completely interfere with students' ability to learn in clinical nursing education.

Brain-based learning theory puts forth that learning is impaired when feelings of self-doubt, insecurity, and lack of confidence predominate (Weiss, 2000). In situations of high stress in which shame and anxiety are likely emotions—situations such as those encountered by nursing students in the clinical environment—there is a psychophysiological response in which information is directed to the amygdala, which is a site of emotion but not learning, bypassing the thalamus whose job it is to send information to the frontal lobes where planning, problem solving, and other higher order thinking occurs (Lyons, 2003). In this information pathway, when negative affects such as shame and fear are present, one is able to memorize isolated facts but unable to access the complex thinking and creative processes (Caine & Caine, 1997) associated with the frontal lobes. When shame is present, the shame is detected in the amygdala, even before we recognize what it is we are reacting to or feeling (LeDoux, 1996). Thus, the experience of shaming can alter the learning pathways such that learning, memory, and thinking are impaired (Lyons, 2003).

In contrast, positive emotions, such as those associated with a safe learning environment, drive attention, which in turn drives both learning and memory. Higher order thinking (i.e., the thinking involved in synthesizing factual information and storing it into long-term memory) occurs in the hippocampus of the brain (Greenspan & Benderly, 1997) in circumstances in which the learner feels a sense of control (Caine & Caine, 1997). Principles of brain-compatible instruction state that learning should take place in a nonthreatening environment, thus enabling students to think rationally and creatively (Sylwester, 2000).

That the clinical nursing arena is perceived by nursing students as stressful has been demonstrated; therefore, the onus is on clinical nursing instructors to be supportive and respectful in their relationship with students so that learning is possible. If clinical nursing instructors represent another source of stress for

TABLE
Faculty Behaviors

Disconnecting Behavior	Connecting Behavior
• Reprimanding student for not seeking out, or avoiding, the instructor.	• Promote relationship by empathizing with, rather than punishing, student's strategy of disconnection (Hartling et al., 2000). • Recognize student behaviors that are manifestations of shame (e.g., fear of exposure); seen as hiding (Kaufman, 1996).
• Comparing students or groups of students (i.e., fostering competitiveness by focusing on one student—negatively or positively—at the exclusion of the others).	• Emphasize cooperation over competition. • Name relational competence as it is demonstrated by student (i.e., empathy, empowering others, contributing as a team member to the work of the student clinical group and the agency staff).
• Correcting student in front of patients, staff, or peers.	• Discuss with students ahead of time how and when they want to receive feedback. • Always give feedback out of earshot of others. • Have students describe what they will do when with a patient (e.g., prior to engaging with a patient, students describe principles of catheter insertion and steps they will take to accomplish the task). By doing so, potential mistakes can be identified and possibly prevented.
• Hovering around students as they perform basic nursing care and skills the student is able to perform independently (i.e., indicating lack of trust in students' abilities).	• Offer to work with students to provide patient care.
• Intensely questioning students about specific diagnoses, laboratory values, pathophysiology. Increasing the intensity of the questions regardless of the students' ability to answer (i.e., making the students feel stupid).	• Ask the group a question and prompt all members of the group to contribute a perspective. • If one-on-one, pose questions in a nonthreatening way that stimulates thinking and learning by building on students' current knowledge.
• Failing to meet relational needs of student. • Healthy professional socialization includes relationships with important others where human needs for identification, power, nurturing, and affirmation are met (Kaufman, 1996). • For a student, shame is activated when the instructor, who is respected and admired, fails to meet these basic needs (Kaufman, 1996).	• Demonstrate belief that a supportive, trusting instructor-student relationship is vitally important to student learning by consistently treating students with warmth, empathy, and respect. • Ask students to think over their expectations of the clinical instructor. • Meet with students to learn expectations and give feedback about what is realistic and possible within the clinical context and instructor-student relationship (e.g., unrealistic for instructor to work one-on-one with each student all of the time, realistic to accompany students until they feel comfortable performing the skill or when students request instructor presence).
• Taking over if students perform the newly learned task correctly, albeit in a slow and clumsy manner (in situations where patient safety is not compromised).	• Support students by allowing them to finish the task. When the task is complete, ask students to describe what they did well and felt good about and what they would do differently the next time. • Add own observations and prompt students to journal experience. • Encourage students to note in journal specific feelings of pride generated by accomplishing tasks, as well as capacity to identify own areas for improvement.
• Interacting with students in an authoritative and stern manner.	• Maintain a warm and open manner with students. • Characterize interactions with empathy and appropriate humor.

nursing students in an already stressful environment, brain-based learning theory suggests a link between such a relationship and feelings of shame and anxiety, resulting in psychological and physiological processes that negatively affect one's ability to learn. Beck et al. (1997) posed the questions:

TABLE (Continued)

Faculty Behaviors

Disconnecting Behavior	Connecting Behavior
• Criticizing, scrutinizing and interrogating students in an environment that is universally described as stressful. • Impairing students' ability to learn by contributing to students' feelings of self-doubt and insecurity and lack of confidence (Weiss, 2002).	• Act to ameliorate the pressure students may feel in a demanding, hectic, often understaffed clinical environment. • Create a strong relational connection by acting as a buffer, mentor and sounding board for the students, thereby enhancing the students' ability to learn while supporting the students' professional socialization.
• Listening superficially to students (i.e., failing to respond to students in ways that reflect students have been listened to and heard).	• Respond to students with attention and concern (i.e., listen actively). • Demonstrate authenticity by being fully present and engaged with the students (Hartling et al., 2000).
• Emphasizing having "power over" students.	• Use power responsibly by creating opportunities for students to explore options and make choices (Kaufman & Raphael, 1991). • Help students identify salience in situations and determine priorities accordingly. • Move toward mutuality where power is shared (Hartling et al., 2000).
• Interpreting students' anxiety (i.e., expression of fear) as student weakness, lack of intelligence, or unpreparedness.	• Help students to cope with negative affect. • Understand affect is primarily experienced on the face (Kaufman, 1996). • Recognize students' expressions of distress, shame, or fear and reflect feeling to students. Facilitate students' awareness of and ability to cope with feelings.
• Including element of randomness during psychomotor skills testing (i.e., students do not know which specific psychomotor skill they will be asked to perform for a grade in the Patient Simulation Center prior to being asked).	• Have students choose from a number of designated skills which one they will prepare for and then perform for a grade. • Create opportunities for feelings of power and competence by giving choices.
• Expecting students to find answer(s) on their own.	• Partner with students to find answer. • Model how one finds answers, strengthening relationship with students at the same time.

> How do we as faculty balance the need to ensure client safety by evaluating the competency of students and yet provide an atmosphere for learning which fosters in the student self-confidence, independence and accountability for deficits with respect to cognitive, psychomotor and attitudinal competency? How can we best break that cycle of anxiety, stress, lack of self-confidence and self-esteem, which not only affects the individual student and his/her relationship with faculty but which, as we glean from this study, also affects the student-client relationship? (p. 185)

PREVENTING AND HEALING SHAME

Shame can be healed within empathic relationships in a climate of respect (Ahmed, Harris, Braithwaite, & Braithwaite, 2001; Bradshaw, 1988; Connolly, 1995; Ehrmin, 2001; Goldberg, 1991; Jordon, 1989; Kaufman, 1996; Satterly, 2001; Shenk & Zehr, 2001). According to Jordon (1989), we experience a loss of empathic attunement in shame because the experience of shame leaves one feeling disconnected and disempowered. Shame is a powerful obstacle to connection, but an empathic, relational approach can significantly alter the experience of shame. Any relationship with the potential for shame would be immunized against shame by such an approach. In the context of clinical nursing education, a student-instructor relationship founded on mutual empathy and respect, such as is put forth in the Stone Center's relational-cultural theory (Jordon & Walker, 2004), would provide a vaccination against shame.

Relational-cultural theory (Jordon & Walker, 2004) puts forth that connection forms the foundation of human growth and development. A prevailing lack of connection results when people important in our lives fail to respond in ways that reflect we have been listened to and heard. Conversely, when we can express our feelings and have them responded to with attention and concern, we feel val-

idated and relationally competent. This fosters our self-esteem, as well as the self-esteem of the important other. The cultural aspect of relational-cultural theory recognizes the importance of the cultural context in relationships, that "indeed, relationships may both represent and reproduce the cultures in which they are embedded" (Jordon & Walker, 2004, p. 3).

For nurse educators, this involves recognizing and understanding the impact of the student's culture on the student-instructor relationship, including such factors as upbringing, education level, gender, and age; the instructor's own culture, including upbringing, education, relational skills, values, clinical experience, and expertise; and how these cultures interact with and are influenced by the nursing culture, the medical culture, and the cultures of the hospital within which the clinical learning is situated and the educational institution from which the curriculum is derived (Hartling et al., 2004). The complexities of the situation described, compounded by the often chaotic circumstances of the clinical education context—which can include patients with multiple medical and nursing needs residing in often understaffed wards—make up the challenging, and at times overwhelming, conditions that face the clinical instructor whose job it is to ameliorate, not add to, the students' felt stress and anxiety. With the potential for shame and humiliation so great, the nursing instructor must channel "best relational practices" (Hartling et al., 2004, p. 104) and direct them toward creation of a safe and supportive learning environment for students. The practices which serve to connect nursing instructor with student include listening and responding, mutual empathy, authenticity, movement toward mutuality, and humor. The consistent implementation of these practices creates the potential to eliminate power-over; fear-based teaching situations where shame and humiliation interfere with, if not completely stifle, students' ability to learn in clinical nursing education (**Table**).

CONCLUSION

Although clinical nursing education literature does not recognize shame by name, the consequences of shame on students' ability to learn has been documented. This article opened with a quotation from Nathanson (1992), asking what will happen when we become aware of the powerful force that shame has exerted in bringing us into the present. In response, I say that when nurse educators—in fact, when all nurses—recognize shame and understand the detrimental effect of shaming behaviors on student learning and professional socialization, the shaming practices of the past will cease to be a part of nursing's future. Whether the context is nursing education or new graduate orientation, it is hoped that exposure of shame and its effect in nursing will mark a beginning to putting an end to shaming as a common, if previously unrecognized, teaching and socializing technique. Shaming is a practice that is the antithesis of establishing trusting relationships with our students, colleagues, and patients. And truly, isn't that what nursing is all about?

REFERENCES

Ahmed, E., Harris, N., Braithwaite, J., & Braithwaite, V. (2001). *Shame management through reintegration*. Cambridge, UK: Cambridge University Press.

Andrews, B. (1998). Methodological and definitional issues in shame research. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 39-54). New York: Oxford University Press.

Andrews, B., Qian, M., & Valentine, J.D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology, 41,* 29-42.

Beck, D.L., Hackett, M.B., Srivastava, R., McKim, E., & Rockwell, B. (1997). Perceived level and sources of stress in university professional schools. *Journal of Nursing Education, 36,* 180-186.

Beck, D.L., & Srivastava, R. (1991). Perceived level and sources of stress in baccalaureate nursing students. *Journal of Nursing Education, 30,* 127-133.

Benor, D.E., & Leviyof, I. (1997). The development of students' perceptions of effective teaching: The ideal, best, and poorest clinical teacher in nursing. *Journal of Nursing Education, 36,* 206-211.

Bradshaw, J. (1988). *Healing the shame that binds you*. Deerfield Beach, FL: Health Communications.

Burnstein, C. (1995). *Nursing students' perceptions regarding effective interventions used by nurse educators in assisting students to cope with anxiety during the clinical learning experience.* Unpublished master's thesis, University of British Columbia, Vancouver, British Columbia, Canada.

Caine, R.N., & Caine, G. (1997). *Unleashing the power of perceptual change: The potential of brain-based teaching.* Alexandria, VA: Association for Supervision and Curriculum Development.

Campbell, I.E., Larrivee, L., Field, P.A., Day, R.A., & Reutter, L. (1994). Learning to nurse in the clinical setting. *Journal of Advanced Nursing, 20,* 1125-1131.

Connolly, M. (1995). *Shame and women: A nursing perspective.* Unpublished doctoral dissertation, University of Colorado, Denver.

Daiski, I. (2004). Changing nurses' dis-empowering relationship patterns. *Journal of Advanced Nursing, 48,* 43-50.

DeMarco, R. (2003). Negative behaviors in nursing. *American Journal of Nursing, 103*(3), 113, 115-116.

Dunn, H. (2003). Horizontal violence among nurses in the operating room. *AORN Journal, 78,* 977-988.

Ehrmin, J.T. (2001). Unresolved feelings of guilt and shame in the maternal role with substance-dependent African American women. *Journal of Nursing Scholarship, 33,* 47-52.

Erikson, E.H. (1950). *Childhood and society*. New York: W.W. Norton.

Freshwater, D. (2000). Crosscurrents: Against cultural narration in nursing. *Journal of Advanced Nursing, 32,* 481-484.

Gignac-Caille, A.M., & Oermann, M.H. (2001). Student and faculty perceptions of effective clinical instructors in ADN programs. *Journal of Nursing Education, 40,* 347-353.

Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology, 70*(Pt. 2), 113-147.

Gilbert, P. (1998). What is shame? Some core issues and controversies. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 3-38). New York: Oxford University Press.

Gilbert, P., & Andrews, B. (Eds.). (1998). *Shame: Interpersonal behavior, psychopathology, and culture.* New York: Oxford University Press.

Gillespie, M. (2002). Student-teacher connection in clinical nursing education. *Journal of Advanced Nursing, 37,* 566-576.
Goldberg, C. (1991). *Understanding shame.* Northvale, NJ: Jason Aronson.
Greenspan, S.I., & Benderly, B.L. (1997). *The growth of the mind and the endangered origins of intelligence.* Reading, MA: Addison-Wesley.
Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *The Journal of Continuing Education in Nursing, 35,* 257-263.
Hamill, C. (1995). The phenomenon of stress as perceived by Project 2000 student nurses: A case study. *Journal of Advanced Nursing, 21,* 528-536.
Harden, J. (1996). Enlightenment, empowerment and emancipation: The case for critical pedagogy in nurse education. *Nurse Education Today, 16,* 32-37.
Hartling, L., Rosen, W., Walker, M., & Jordon, J. (2004). Shame and humiliation: From isolation to relational transformation. In J. Jordon, M. Walker, & L. Hartling (Eds.), *The complexity of connection: Writings from the Stone Center's Jean Baker Miller Training Institute* (pp. 103-128). New York: The Guilford Press.
Hayden-Miles, M. (2002). Humor in clinical nursing education. *Journal of Nursing Education, 41,* 420-424.
Jackson, D., & Mannix, J. (2001). Clinical nurses as teachers: Insights from students of nursing in their first semester of study. *Journal of Clinical Nursing, 10,* 270-277.
Jacoby, M. (1994). *Shame and the origins of self-esteem: A Jungian approach* (D. Whitcher, Trans.). London, UK: Routledge.
Jacox, A. (1978). Professional socialization of nurses. In N. Chaska (Ed.), *The nursing profession: Views through the mist* (pp. 10-20). New York: McGraw-Hill.
Jones, M.C., & Johnston, D.W. (1997). Distress, stress and coping in first-year student nurses. *Journal of Advanced Nursing, 26,* 475-482.
Jordon, J. (1989). *Relational development: Therapeutic implications of empathy and shame (Work in Progress No. 39)*. Wellesley, MA: The Stone Center Working Paper Series.
Jordon, J., & Walker, M. (2004). Introduction. In J. Jordon, M. Walker, & L. Hartling (Eds.), *The complexity of connection: Writings from the Stone Center's Jean Baker Miller Training Institute.* New York: The Guilford Press.
Kaufman, G. (1985). *Shame: The power of caring* (2nd revised ed.). Cambridge, MA: Schenkman.
Kaufman, G. (1989). *The psychology of shame: Theory and treatment of shame-based disorders.* New York: Springer.
Kaufman, G. (1996). *The psychology of shame: Theory and treatment of shame-based syndromes* (2nd ed.). New York: Springer.
Kaufman, G., & Raphael, L. (1991). *Dynamics of power: Fighting shame and building self-esteem* (Rev. ed.). Rochester, VT: Schenkman.
Kilborne, B. (2002). *Disappearing persons: Shame and appearance.* Albany: State University of New York Press.
Kim, K.H. (2003). Baccalaureate nursing students' experiences of anxiety producing situations in the clinical setting. *Contemporary Nurse, 14,* 145-155.
LeDoux, J. (1996). *The emotional brain: The mysterious underpinnings of emotional life.* New York: Touchstone.
Lewis, H.B. (1971). *Shame and guilt in neurosis.* New York: International Universities Press, Inc.
Lynd, H.M. (1958). *On shame and the search for identity*. London, UK: Routledge & Kegan Paul.
Lyons, C.A. (2003). *Teaching struggling readers: How to use brain-based research to maximize learning.* Portsmouth, NH: Heinemann.
Magnussen, L., & Amundson, M.J. (2003). Undergraduate nursing student experience. *Nursing & Health Sciences, 5,* 261-267.
Morrison, A.P. (1989). *Shame: The underside of narcissism.* Hillsdale, NJ: The Analytic Press.
Morrison, A.P. (1998). *The culture of shame.* Northvale, NJ: Jason Aronson.
Nathanson, D.L. (1992). *Shame and pride: Affect, sex, and the birth of the self.* New York: W.W. Norton.
Oermann, M.H. (1998). Differences in clinical experiences of ADN and BSN students. *Journal of Nursing Education, 37,* 197-201.
Oermann, M.H., & Standfest, K.M. (1997). Differences in stress and challenge in clinical practice among ADN and BSN students in varying clinical courses. *Journal of Nursing Education, 36,* 228-233.
Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing, 43,* 395-401.
Roberts, S.J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science, 5*(4), 21-30.
Roberts, S.J. (2000). Development of a positive professional identity: Liberating oneself from the oppressor within. *Advances in Nursing Science, 22*(4), 71-82.
Satterly, L. (2001). Guilt, shame, and religious and spiritual pain. *Holistic Nursing Practice, 15*(2), 30-39.
Scheff, T.J. (2000). Shame and the social bond: A sociological theory. *Sociological Theory, 18,* 84-99.
Shenk, B.T., & Zehr, H. (2001). Restorative justice and substance abuse: The path ahead. *Youth & Society, 33,* 314-328.
Shipton, S.P. (2002). The process of seeking stress-care: Coping as experienced by senior baccalaureate nursing students in response to appraised clinical stress. *Journal of Nursing Education, 41,* 243-256.
Sylwester, R. (2000). Unconscious emotions, conscious feelings. *Educational Leadership, 58*(3), 20-24.
Tomkins, S.S. (1962). *Affect, imagery, consciousness: The positive affects* (Vol. 1). New York: Springer.
Tomkins, S.S. (1963). *Affect, imagery, consciousness: The negative affects* (Vol. 2). New York: Springer.
Weiss, R.P. (2000). Brain-based learning. *Training and Development, 54*(7), 20-24.
Wurmser, L. (1981). *The mask of shame.* Baltimore, MD: The Johns Hopkins University Press.