

Professional Guilt

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“Did you ever feel that you failed to give a patient proper care? Or that you hadn’t handled a staff problem effectively? The complexities of modern nursing make it especially easy for such feelings to develop.”

Robert W. Hyde and Norma E. Goggon (1958)

Abstract

It is normal throughout life’s professional journey to be left with little harbingers of guilt. We all try to do our best every day, but become aware in retrospect that our best may not be good enough when we realise that something has been left undone or forgotten, or that we could not give a certain matter the consideration that it required. This paper will explore professional guilt, and how guilt feelings of guilt can be channelled into a force for good.

Introduction

Possibly the best way to introduce professional guilt is to read the words of Grohol.

It’s amazing how quickly guilt can kick in for the smallest, most meaningless things in our lives. Guilt is an emotional warning sign that most people learn through their normal childhood social development. Its purpose is to let us know when we’ve done something wrong, to help us develop a better sense of our behavior and how it affects ourselves and others.” Grohol.(Grohol, 2007, no page given)

This indicates where guilt may come from, but how does it link to professionals, especially those working in nursing and midwifery? Our profession involves working with people every day and meeting different challenges. Because we are human we do not always achieve the (high) standards that we set ourselves. Sometimes the source of guilt is very small, such as not remembering to do something until you are off duty. On the other hand, it might be that despite working hard all shift/day, you go home feeling you have not done the best you would have liked to have done; for example, when time driven, we might not have given a particular person the extra time that he or she really needed.

It is likely that we will all know of more serious episodes that we can bring to mind, even after years have passed. I have many – some not so serious in retrospect, but which were disturbing at the time. For example, as a senior student midwife I had spent several days with a young 15 year old mother who was desperate to keep her baby despite knowing that Social Services were coming to take her baby away. After the baby had gone, the mother berated me for not telling her that Social Services were on their way. She was angry that I had not given

her time to prepare for the visit and to enjoy the first and last few minutes that she and the baby could be together.

What is guilt?

Collins English Dictionary (2014) defines guilt as follows:

1. The sense of right and wrong that governs a person's thoughts and actions.
2. Regulation of one's actions in conformity to this sense.
3. A supposed universal faculty of moral insight, conscientiousness; diligence.
4. A feeling of guilt or anxiety.

All of these could be explored in relation to professional guilt. Existential psychology tends to consider guilt under five categories. Corso (2016, no page given) defines them as follows:

1. Guilt for something you did.
2. Guilt for something you did not do, but want to.
3. Guilt for something you think you did.
4. Guilt that you did not do enough to help someone.
5. Guilt that you're doing better than someone else.

As with the first grouping, I find 2 and 4 very similar and could apply them to my professional life, although I know from my colleagues in palliative care that 5 can be applicable among their staff, especially in children's hospices. There are many more definitions that could be used but most deal with being a criminal or are wrapped up in religious doctrines, neither of which fit here.

In looking for an underpinning approach to how we understand guilt, we might consider a variety of psychological and psychoanalytic frameworks. If we look (for example) at those involved in exploring existential philosophy, the works of Heidegger, Husserl, Dostoevsky, Kafka, Camus, Kierkegaard, Nietzsche, Sartre offer an understanding of relevant life experiences. Later, others including Otto Rank, Karl Jaspers and Ludwig Binswanger proposed the principles in the practice of psychotherapy. More recently still we read of the work of Viktor Frankl, R.D. Laing, Rollo May and Irvin Yalom, who look at the practical use of these concepts.

Existential Psychology

The existential approach follows a specific philosophical method of enquiry involving description, understanding and exploration of the person's reality, known as phenomenology. It challenges and confronts life's experiences and our limitations, and how we investigate them or explore them. It looks at the person's lived experiences and how they are revealed, and at coping mechanisms and assumptions.

Corso (2016) talks about experiencing guilt and anxiety by saying we should not permit it to cripple us with worries and questions but manage it. Corso (2016, p. 4) states: "Heidegger's philosophy tells that if we listen to the voice of our conscience warning us that we are falling short, that we have slipped into inauthentic living again, we can wake up and return to ourselves. But authentic living entails taking stock of our limitations and responding to it. Hence, guilt throws us back into anxiety..." Previously Tillich (2000) also described how

existential psychotherapy can be seen as a reliable method of confronting our concerns to bring about a positive outcome. So, one way of looking at guilt is by using the existential approach in which a philosophical method can help deal with many challenges in life.

Cognitive Dissonance

One of the concepts that psychology gives us is cognitive dissonance, where we consider a state of uneasiness/discomfort caused by holding two opposite attitudes or beliefs about the situation. This is not the same as Milgram's research, where he considered obedience as being socialised to obey. Crigger and Meek (2007) suggest cognitive dissonance creates tension when a person has to handle what can be done with what they consider should be done. Previously, Festinger (1957) described it as a person trying to create harmony in their thinking. So are we trying to rationalise our thoughts when they become tangled as a result of a difficult situation which we could not resolve? Therefore, are we justifying personal behaviour which falls short of desirable behaviour? According to Festinger (1957), nurses must be prepared to deal with many conflicts of competing beliefs, which could lead to a high level of dissonance, in order to avoid harm. They must find a way to diminish or reduce this mismatch. So can we use these concepts to help us move forward?

Self-Evaluations

The concept of self is one recognised by the western world, not by all communities. Are we in the west more likely to feel this type of guilt? If we look at self-esteem we know theoretically that it refers to the extent to which it parallels our values. Therefore, we know our own acceptable standards and can see if we fall short. When this happens, our self-examination can be praise or be harsh and very negative where failure occurs. Some people feel this may lead to self-reproach, but professional guilt does not work in that way. If it did, none of us would be able to continue our careers. Psychologists call our ability to continue working a self-protective system whereby we learn to construct a balancing mechanism so that we do not drown in retrospective analysis. A French psychologist, Emile Coué, back in the 1920, described a concept similar to the protective system; he called it self-affirmation. The theory of self-affirmation is that you tell yourself positive things about yourself, making sure that they become part of you, so when you are threatened by negative thoughts you can reaffirm yourself, thereby neutralising your negative thoughts. Sherman and Hartson (2011) wrote in the *Handbook of Self-Enhancement and Self-Protection* (Chapter 6: Reconciling Self-Protection with Self-Improvement Self-Affirmation Theory) that "Self-affirmation may be considered as one process that operates as part of a psychological immune system that is engaged when individuals experience self-threats" (Gilbert et al., 1998, p.131). They continue by saying they feel for many people, and this is an in-built process which could be taught through an understanding of mindfulness. Should we teach mindfulness?

My Own Professional Guilt

Hyde and Coggon (1958) recognised the guilt that resides in nurses. Nursing was considered a fertile field for retrospection in relation to job satisfaction and giving good patient care. Professional guilt comes in many forms: from the simple everyday happenings, such as not going back to a patient having made a promise that you would be back, to knowing that you have not done a good day's work, despite doing as much as was humanly possible. Most staff will be aware of these all too frequent occurrences, but this paper will explore the more significant aspects of guilt.

My training began in the mid-1960s, when I had no understanding of guilt, possibly due to the fact that we worked 48 hours per week; apart from a day off we were always on the ward. On the wards you knew your level of reporting: first years reported to second years and so on, upward along the chain of seniority, until you became a staff nurse, but even then you were safeguarded as a junior staff nurse because you reported to a senior staff nurse who by this rank had years of experience. This develops safeguarding.

Not until I started my training as a midwife did I realise how easy it was to feel guilt, even if there was little that you could have done. My first experience of guilt was when I was a new student midwife with less than one month's experience and I was working on a postnatal ward. Sister called me to take a father to the nursery to see his babies. I took this young man to the nursery and showed him his daughters. He was ecstatic, and after he had cooed over them, I asked if he would like to see his son. It was a four-bedded nursery; the girls were on one side and the boy on the other. He looked at me bewildered; he knew that his wife had expected twins, but during her caesarean section we discovered she had triplets. I did not know if he had not been told or it had not registered. He appeared not to be able to take it in. In the office, Sister sat him down and asked me to get a glass of cold water for him, so off I went. On my return, all hell had broken loose in the office. I waited a few minutes, only to see the father coming out on a stretcher. He had had a heart attack and he died two hours later. Everybody wanted to talk about it but nobody wanted to know how I felt, or that I knew the happiness for the family was short lived and now shattered. So how does one come to terms with this episode?

My first stillbirth was not long after this episode. The baby died as I was delivering him. After the delivery was complete I was asked if I would like to be relieved, but I felt that it would be more difficult for both me and the mother, whom I had known over a period of days. We were both shocked and tearful, even if this was not professional. Following the warning of the mother, I was given tea. I was also given time to say how I felt and to go over the episode with the departmental head of the delivery suite. It was good to have this time. I was asked if I wanted to go home or stay. Before they gave me the option they had already discovered that one of my group was around if I went off duty. So there was care in the system, which I feel has now been lost: we appear not to be so nurturing of our students or newly trained staff. A professional journey is filled with unexpected incidents and mine is no more unusual than that of any other profession.

Research

Because it is a very delicate subject, it would appear that few researchers wish to conduct research in this area. The first paper I found was the Hyde and Coggan paper (1958), who interviewed nurses to elicit their feelings and how they related to guilt. They discovered that nurses do often overtly express guilt as it is not seen to be professional to acknowledge this feeling. These comments were supported by a paper written in 1975 by Jones, who was exploring why degree nurses stayed or dropped out of their courses. One of the reasons cited was guilt. Are we surprised and would it not be similar today?

The next work I found was that of Kasman et al. (2003). They undertook qualitative research which looked at everyday emotions and experiences which trigger off certain feelings. Their participants were trainees in medical and paediatric hospital settings. The research looked at how training experiences affect the professional behaviour of physicians. The final number

who participate was small (ten); this was because they used two open-ended semi-structured interviews, non-participant observations and self-reporting tasks. From the first interview and the self-reporting exercise, 475 experiences were coded and out of 17 categories guilt was ranked 7. Some of the reasons cited for guilt were 'Guilt was very frequently for lack of control or knowledge and perceived responsibility for poor outcomes' (Kasman, 2003, p. 734). In their discussion they cite difficult emotions being associated with uncertainty, powerlessness, a lack of respect, differing values to their own and overwhelming patient suffering. This would correlate with the comments of palliative care staff. One of their conclusions is that training/education can help with how a person manages emotional responses; it is hoped this would then reduce depression and burnout. Cunningham and Wilson (2003, p. 2) looked at shame and guilt in medical practice. They commented: "Guilt, however, implies an understanding of where they judge failure sits on its relevant axis of right or wrong, good or bad, and of the values and beliefs that placed it there." This finding was noted in the research conducted by Kasman et al. (2003), who were looking at trainees' emotions and found that difficult outcomes resulted in guilt.

Six years on, Alum Jones (2009) explored how palliative care staff managed their life when working in these settings. Staff repeatedly said they had feelings of guilt in relation to the people they are caring for. Their work has emotional complexities in relation to the many different types of patients they deal with. He feels it is an essential area in which clinical supervision should play a substantial role, and this should include observation of work life balances. I would have to say this sits well with my work with these staff in that some find it is only an area they can work in for a short period of their career, whilst others find a way of de-stressing themselves so that this type of guilt does not override them. We need to offer all staff who work in emotional areas (which would include A&E, ITU and Neonatal ITUs) care support and emotional care.

A research paper by Kaya et al (2012) explores these issues. Data was collected using a cross sectional study with 1002 participants who were mixed gender, age and schooling. They used Personal Information Forms and Guilt-Shame Scale. One aspect they considered was how nurses and midwives are socialised into their profession. They discovered that it was a difficult area, as acknowledging guilt and shame in practice was not easy to consider. The literature review considered the work of Bond (2009) who examined the need for shame and guilt to be identified during education so that problems could be addressed and resolved. Kaya et al (2012) recommended many changes in education.

Reflection

Possibly the way that most professionals would consider any aspect of professional guilt could be solved is by reflection. How does it work? It is usually defined as a technique for turning experience into learning or a way for staff to become self-reliant and solve problems. Kolb (1975) said that reflection is central to the process of turning experience into learning. Whereas Boyd and Fales (1983) suggested that it was more complex. They described it thus: "The process of reflection is the core difference, whether a person repeats the same experience several times between becoming proficient in one behaviour, or learns from experience in such a way that he or she is cognitively or effectively changed" (no page number). Later, both Rogers (1986) and Reid (1993) extended our understanding of what was required in the process by saying it required an incorporation of both feelings and intellect which reviews experiences in practice in order to describe, analyse and evaluate the situation in order to inform future behaviours.

Possibly today's professionals would endorse the definition by Burns and Bulman (2000) who described: 'Reflection on experience is a pathway that is worth pursuing for its lead in the right direction: toward an education where nurses learn to understand the meaning of their experiences, toward a profession that values its practical expertise, towards a research tradition that has a language that adequately expresses nursing work and finally towards a discipline whose knowledge is not only embedded in nursing practice but can be expressed in new and transformed ways' (Burns & Bulman, 2000, p. 22).

Educationalists have taken on the role of enabling an understanding of reflective practice, but in the early days it was handled very gently, as it was a new concept to many. Boud and Walker (1998) criticised reflection as being easily turned into a process involving "checklists which students work through in a mechanical fashion without regard to their own uncertainties, questions and meanings" (p.193). Finlay (2008) says "the problem with reflective practice is that it is hard to do and equally hard to teach. It is even harder to do and teach effectively. Provide adequate support, time, resources, opportunities and tools for reflection. Bearing in mind the potentially stressful and ethically challenging nature of reflection, it is important that students are given plenty of time and are well supported when they engage reflection. They need to feel safe and to have access to others who are effective at reflecting and on whom they can model." Interestingly, Rees (2007) found that those who were responsible for mentoring reflection often found it too difficult, and were unable to be supportive.

A few found reflection a disturbing process since they were left with guilt about what happened as it never seemed to be good things that were reflected upon but unfortunate events. Possibly this was due to the forcing of an action plan at the conclusion and it is easier to write about change than to say we did it correctly. Students found they would obtain a good grade if the situation had had negative aspects, as it was easy to discuss.

Many reflections are not seen or may be cursorily looked at in the yearly staff review. Some staff are not being helped to move on, if they have been part of a difficult situation. Midwifery is more fortunate; we did meet with our supervisor each year and our portfolio was with her/him before our meeting, so if you had a good supervisor, things were discussed. Jayatileke and Mackie (2013) say that the reflective model is irrelevant. They considered reflective articles written between 1970 and 2011; thirteen were selected and their conclusion was that reflection does improve practice. They said "high quality papers identify improvements in knowledge and understanding, increasing self-awareness and engagement in reflection and improved opportunities through specialist training and continuous professional development" (2013, p. 312).

Mindfulness

Do we need to consider the use of mindfulness? Although a reasonably new term, it has its origins in ancient Greek, in many religions especially Buddhism and more recently in Gestalt and humanistic psychologies. The present practice is said to be based on Jon Kabat-Zinn's (1990) stress reduction programme at the University of Massachusetts Medical Center, which was developed to help people with chronic physical pain and disease. This is possibly why it has been developed as part of cognitive therapies such as those offered by Professor Mark Williams in the Oxford Mindfulness Centre, in the course of about eight weeks. The practice of mindfulness is said to concentrate on the grey matter in the brain, which covers the

memory processes and emotion regulation, thus becoming a called-on process. This helps the person to be equipped to tackle different situations positively.

In 2010 Halliwell compiled the Mindfulness Report for the Mental Health Foundation. This covered all aspects of mindfulness, including research with regard to its usefulness through surveying GPs. It concluded that the use of mindfulness has positive results for many people. So could it be successfully used with professionals to help feelings of guilt? **Do we need to be careful and not just jump on the 'band wagon'?**

Conclusion

Kaya et.al. (2012, p634) wrote: "Nursing and midwifery can help prevent shame and its negative consequences whilst still encouraging a healthy sense of right, wrong, and guilt when necessary." Being able to look at guilt, share it, accept it and realise that one is still accepted by others as a valued person, often helps resolve it. Or when the nurse/midwife is able to recognise that perhaps her/his guilt is tied up with something outside their control, they can be helped so they do not drown.

On a positive note, Schaumburg and Flynn (2012) reported that "Guilt-prone people tend to carry a strong sense of responsibility to others, and that responsibility makes other people see them as leaders". This work is supported by Krakovsky (2012) who commented: "When thinking about what traits are important for leaders to possess, there tends to be a focus on what people do well. But we know that people make mistakes and mess up, and it's important to look at how people respond to those mistakes because that's a clue to who they are". **Therefore there is a possibility that professional guilt may lead to better leadership.**

References

- Body, E. & Fales, A. (1983) Reflective learning: key to learning from experience, *Journal of Human Psychology*, 23(2): 99-117
- Bond, M. E. (2009) Exposing shame and its effect on clinical nursing education. *Journal of Nursing Education* 48, 132-140
- Boud, D. and Walker, D. (1998) Promoting reflection in professional courses: the challenge of context. *Studies in Higher Education*, 23(2), 191-206.
- Burns, S. & Bulman, C. (2000) *Reflective Practice in Nursing*, 2Ed, London, Blackwell Science
- Collins English Dictionary (2014) 12th edition, Published 23rd October 2014, ISBN 9780007522743.
- Corso, T. M. (2016) On the basic assumptions of Existential Psychotherapy. <http://www.existentialpsychotherapyandcounselling.bacp.co.uk/?p=757/Article-On-Existential-Psychotherapy>. Accessed on the 31st January 2016
- Crigger, N. & Meek, V. (2007) Toward a theory of Self- Reconciliation following mistakes in Nursing practice, *Journal of Nursing Scholarship*, Second Quarter 2007; 39,2;p177183 ProQuest Hospital Collection.

- Cunningham, W, & Wilson, H. (2003) Shame, guilt and the medical practitioner, *The New Zealand Medical Journal*, 10 October 2003, Vol.116 No. 1183/629. P.1-5
- English National Board (1991) *Ten Key Characteristics of the ENB Higher Award*. London, English National Board ENB. Adding up the past APL/APEL: guidelines for good practice. London, ENB
- Festinger, L. (1957) *Theory of cognitive dissonance*. Palo Alto, CA: Stanford University Press
- Finlay, L. (2008) Reflecting on 'Reflective practice. PBPL paper 52, A discussion paper prepared for PBPL CETL www.open.ac.uk/pbpl Accessed on the 31st January 2016
- Gilbert, D., Pinel, E, Wilson, T., Blumberg, S., & Wheatley, T., (1998). Immune neglect: A source of durability bias in affective forecasting. *Journal of Personality and Social Psychology* 75, p.617–638
- Grohol, J. (2007). 5 Tips for Dealing with Guilt. Psych Central. Retrieved on January 25, 2016, from <http://psychcentral.com/blog/archives/2007/11/27/5-tips-for-dealing-with-guilt/> Accessed on the 31st January 2016
- Halliwell, E. (2010) *Mindfulness Report*, London: Mental Health Foundation
- Hyde, R. W. & Goggon, N. E. (1958) When nurses have guilt feelings? *The American Journal of Nursing*. Volume 58: p.231.
- James, H. (1884) *The Art of Fiction* Originally published in *Longman's Magazine* (1884-09-04) and reprinted in *Partial Portraits* (1888)
- Jayatilleke, N. & Mackie, A. (2013) Reflection as part of continuous professional development for public health professionals: a literature review. *Journal of Public Health* 2013;35:308-12.
- Johns, C. (2000) *Becoming a Reflective Practitioner: A Reflective and Holistic Approach to Clinical Nursing, Practice Development and Clinical Supervision*. Oxford, Blackwell Publishing.
- Johns, C. (2006) *Engaging reflection in practice: A narrative approach*. Oxford, UK: Blackwell Publishing.
- Johns, C. (2007) *Reflective practice, effective practice, Reflections on Nursing*. Oxford, UK: Blackwell Publishing.
- Jones, A. (2009) Returning meaning to palliative care staff, *European Journal of Palliative Care*, Vol. 16 (4) p.161
- Jones, W. (1975) Why associate degree nursing students persist? *Nursing Research*. New York *American Journal of Nursing* Vol.24. p.57-9

- Kabat-Zinn, J.(1990) Full Catastrophe Living: How to Cope with Stress, Pain and Illness Using Mindfulness Meditation. Delacorte,
- Kaya, N.,Asti, T., Turan,N., Karabay, B., Emiir, E.,(2012) The feelings and shame experienced by nursing and midwifery students. Nurse Education Today. Vol. 32, p630-635.
- Kasman, D. L.; Fryer-Edwards, K.; Braddock, C.H. (2003) Educating for Professionalism: Trainees'Emotional Experiences on IM and Pediatrics Inpatient Wards. Academic Medicine, VOL.78. No.7. p.730 741)
- Kolb, D. A. (1984). Experiential learning: Experience as the source of learning and development (Vol. 1). Englewood Cliffs, New Jersey: Prentice-Hall.
- Krkovsky, M. (2012) Why feelings of guilt may signal leadership potential. <https://www.gsb.stanford.edu/insights/why-feelings-guilt-may-signal-leadership-potential> Accessed on the 31st January 2016
- NHS Choices (2014) Your health, your choices Media last reviewed: 21/09/2014 <http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-wellbeing.aspx> Accessed on the 31st January 2016
- Rees, K. L., 2007. The lived experience of final year student nurses of learning through reflective processes. Doctorate Thesis (Doctorate). Bournemouth University.
- Reid, B. (1993) But we're doing it already. Nurse Education To-day, 13 305-9
- Rogers, C. (1986) Freedom to Learn, New York, Ginn Press.
- Sherman, D. Hartson, K. (2011) Chapter 6. Reconciling Self-Protection with Self-Improvement Self-Affirmation Theory, in Mark D. Alicke and Constantine Sedikides.(2011) Handbook of Self-Enhancement and Self-Protection, New York, The Guilford Press.
- Schaumberg, R. &Flynn, F. (2012) Uneasy lies the head that wears the crown: The link between guilt-proneness and leadership. Journal of Personality and Social Psychology. August 2012, Vol. 103, Issue 2, Pages 327-342
- Tillich, P. (2000) The Courage to Be. 2Ed. New Haven, Yale University, 2000 (1st ed. 1952)
- UKCC. (1994) The Future of Professional Practice, London, UKCC