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Farley, S orcid.org/0000-0003-0782-4750 and Manger, J (2016) Emotion sharing: implications for trainee doctor well-being. Medical Education, 50 (8). pp. 798-800. ISSN 0308-0110

https://doi.org/10.1111/medu.13114

Emotion Sharing: Implications for trainee doctor well-being

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In this issue, de Vries and colleagues use Goffman's dramaturgical framework[1] to insightfully examine how and why medical trainees share their work-related emotional experiences. A recent trend of medical curricula has been the implementation of mentoring programs designed to promote student well-being. The authors investigated this context to determine whether group mentoring promoted emotion sharing, they found that rather than sharing during mentoring sessions, participants preferred to share informally with peers in the same department who were 'going through the same thing at the same time'. Participants also expressed a preference for sharing with fellow professionals, rather than support networks outside the medical community. The study prompts a number of questions, including how does emotion sharing influence well-being? and how can emotion sharing be fostered in an educational context which emphasises skills, knowledge and competence? We will address both questions in the following commentary.

Experimental, diary and questionnaire studies on emotion sharing, defined as a process which entails 'a description of the emotional event in a socially-shared language by the person who experienced it to another'[2] (p. 65) have demonstrated that approximately 90% of emotional events are shared socially[3, 4, 5], while approximately 60% of events are shared on the same day[6]. Of particular interest is how sharing negative emotions influences well-being. A well-held societal belief is that sharing a negative emotional experience dissolves the impact of that experience, however Rimé[2] rejects this idea as an oversimplification of the recovery process. Empirical evidence has failed to find a link between emotion sharing and emotional recovery[7], yet paradoxically people who share their emotions find it subjectively beneficial[8].

To explain this paradox, Nils and Rimé[9] developed and tested a theoretical model on the effects of emotion sharing. The model is based upon the perspective that negative

emotions arise when the meaning of an event clashes with an individual's expectations[9]. Components of this experience are stored in long-term memory and can be re-evoked by various cognitions regarding the episode (for example, goals blocked by the episode or disconfirmed models, schemas, expectations). Therefore, the theory predicts that emotional recovery requires cognitive work centred on encouraging the narrator to give up frustrated goals, reorganise their motives and re-create meaning. However, when emotions are shared narrators rarely want (or receive) a cognitive response, as a primary motive for emotion sharing is to receive socio-affective responses (for example, social support, validation, comfort) from listeners[10]. Thus emotion sharing tends to elicit a socio-affective response which aids relationship development between the pair and provides the narrator with a sense of relief. Nonetheless, if the social sharing does not involve cognitive work, this relief is temporary and the emotional recovery incomplete[9]. This explains why social sharing is subjectively beneficial, but also why venting alone cannot promote recovery. Experimental testing of the model provided empirical support[9] and previous studies fit with the propositions[11], yet the question remains of how these findings can be applied.

The stresses of medical school are well recognised and varied[12] but increasingly as curricula move towards earlier clinical exposure, students experience distressing situations at a stage when they are less equipped to deal with them.

Medical students transitioning into the workplace environment are exposed to varied stressors. Initially, there is often a sense of uselessness as they feel they do not possess the required skills to contribute to patient care[13]. For many, the clinical attachment will provide their first experience of death or human suffering. Dyrbye et al describe how many feel underprepared for subsequent conversations with patients and families surrounding dying and consequently develop anxiety about these interactions[14].

Additionally, they may be subject to bullying or harassment from senior figures, either directly or indirectly, for example, by witnessing the belittling of a junior doctor by their consultant[13].

Emotion sharing with peers in the immediate aftermath of a distressing event allows medical students to evoke a socio-affective response from the listener which can alleviate the initial distress and strengthen peer relationships. However, a socio-emotional response may not fully facilitate emotional recovery. This requires cognitive work following on from the emotional event. This raises the question; could mentoring models such as that described by de Vries and colleagues provide the platform for emotional recovery?

Whilst it is well documented that mentoring in medical schools can improve student well-being and provide psychosocial support[15, 16], there remains a lack of qualitative data to provide understanding into how this (and other aspects of the mentoring relationship) are achieved[17].

Kalen et al. sought feedback through individual interviews with students enrolled in a combined group and individual mentoring programme[18]. They offer an insight into the nature of the mentor-mentee relationship and how mentees perceived this influenced their personal and professional development. Students felt that mentors listened and were able to offer advice[18]. A key characteristic of the mentor should be that they are more experienced than their mentee[19], an asset that is unlikely to be true of fellow medical students on placement. This allows them not only to listen but to provide guidance and offer coping strategies, an experience which can be enhanced by disclosing their own encounters[20].

Kalen found that whilst there was a tendency to share emotions in one-to-one meetings, group sessions provided the opportunity to share experiences and thoughts with peers in a non-judgemental setting. The confirmation of students' thoughts by peers or sometimes the offer of alternative opinions provides an atmosphere of reflection[18]. This implies that, whilst students may not open up emotionally about an experience, group mentoring can provide reassurance that others have similar viewpoints or have been faced with similar ordeals.

Whereas rotating through hospital placements often results in the separation of medical students from their friends and colleagues[14], mentoring programmes provide continuity and hence a familiar environment to share experiences and seek guidance thereby aiding emotional healing. They can provide an outlet for discussion in a setting where trainees often do not seek help and may act as venue for the type of cognitive work which facilitates recovery from negative emotional encounters.

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