

Learned Helplessness as it Applies to Clinical Education

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Commentary

Teaching a clinical skill in a healthcare laboratory requires more preparation time than teaching a theoretical skill in a lecture hall. In developing countries, concepts such “firm” consistency, or “touching a rubber band stretched tightly over your fingers” may or may not translate easily into teaching tactile sensitivity. As teachers of clinical skills we tried to explain the feeling in the students’ native language in a previous semester to no avail. We later noticed during the first few clinical sessions, as the students acted as patients for each other, they experienced an “aha” moment when the dental probe was pushed exuberantly into their gingival sulci by their classmate. People all over the world have experienced “learned helplessness” at some time. Many of us can remember a time we said, “no matter what I try it does not work”, and throwing our hands up while we abandoned the task at hand.

In behavioral theory, Seligman [1] conceptualized and coined the term “learned helplessness” as prior learning of an activity resulting in a negative or a “no win” outcome. He theorized that this type of learning taints any future action as being unwarranted for the attainment of even highly desired outcomes. People may remain believing that regardless of what they do - nothing will change. Then they may act passively and may not progress [2]. The learner does not become self-directed in their learning if we continue giving them the “right answers” as if they were still in school and have to be correct to get a good grade. In that manner, we are not letting them learn that to be wrong is not “wrong”. Making mistakes with support from the instructor to try again will empower the student to depart from the old ways of learning. In dentistry, articles have been written discussing this theory as a possible underlying problem in our dental hygiene patients even after they have tried taking our suggestions [3]. As Nuvvala [3] said, we need to build the patients self-esteem by giving them alternative choices and not allowing learned helplessness from their schooling days to interfere. Using a toothbrush to stimulate the gums is not what they were taught growing up! Toothbrushes were for brushing the teeth. Discussions about the length of time passing before neglect shows as pain or bleeding, may not address the reality they have experienced in the three or six months before their next visit; just a slight increase in bleeding upon brushing. We need to gain the patient’s trust in us regarding the passage of time for the toothbrush applied at the gum line not being utilized to see the implications of disease. We then need to work together over time to regroup and arrest the disease and promote a semblance of health.

This same theory applies to progression and learning in the clinical simulation laboratories within developing countries. Educators are called upon to motivate students to learn new concepts when the actual fact of rote learning to attain mediocrity has been instilled. At that time of learning, nothing may have been done to stimulate lateral thinking and other ways to solve problems. There are many reasons for such an occurrence, one being the large sized classes of students, the

minimal wages paid to teachers, and the political state of the government to name a few.

Students in some developing countries may think that rising to the challenging occasion will once again result in a no win outcome. Not only that, any effort expended in extending ones capabilities without an unforeseeable reward may seem useless and a wastage of time [4]. From Chaput’s [4] paper, learning environments where negative outcomes such as a failure is awarded without chances of a rewrite of the test will be seen as unchangeable. Being correct the first time is paramount to progression. Students’ lateral thinking is curtailed and students do not achieve the objectives set. This state of human behavior is difficult to watch and even more difficult to overcome as a clinical educator. Rewards for motivation may be viewed as “playing favorites” when one student is verbally rewarded and others are not. We are even seeing this in developed countries where routine rewards while growing up are resulting in another form of learned helplessness, that of “only” getting verbal praise in some instances, rather than a monetary (or equivalent physical) reward. This has been called “a sense of entitlement” or a right to benefits in many conversations about student attitudes.

What can we do about such an issue? If anyone has an answer, it would be valuable on the educational materials market. Our education experts are doing research into various kinds of teaching methods, technology is developing rapidly to address the educational needs of the new types of learning styles, and these are meeting with success in the developing world [5]. There are various techniques such as encouraging risk takers who are normally silent when questions are asked as they fear ridicule from their class fellows. We are told to try and make students feel comfortable and safe in answering questions even if the answer is wrong. That works well in classroom theory, but how would one judge the learning of tactile sensitivity? We need to remember that success builds success and failure builds failure according to Hermann [5]- so also with clinical teaching. In newly developing countries, some of the basic concepts remain uncovered in student’s minds. Without these concepts, higher education has to regress to the older methods of teaching, like lectures, to rapidly instill the basics before moving onto enhanced methodology.

So what is your problem? Teach the basics via basic methods of reading, writing and lecturing.

Ah, there is the rub. The reading and writing has regressed to being of little interest due to learned helplessness and so, teaching reverts to a circular definition of students not willing to read unless it is entertaining! How does one entertain when teaching periodontal concepts or immunology and microbiology? These particular subjects do not lend themselves easily to the “newer” methods of teaching.

What has shown success in the simulation laboratory recently is the use of analogy, as per personal experience. There may not be a moniker or a specified method that can be researched using this technique.

However, a good example that can be shared is the concept of how teeth and gingiva are related to each other. An easily accessed item in a developing country is the hibiscus flower [6]. As garden books present showy images of beautiful flowers, these hibiscus flowers have pretty petals (if you can get a white hibiscus). That whiteness can be related to pretty teeth and the calyx can be related to the surrounding gingiva. The stem accordingly, can be called the nutrient channel as well as the attachment for the whole calyx itself. Practicing dental periodontal pocket probing around the calyx mimics the dentoforms we use in dental teaching laboratories [7]. Learning on a dentoform comes close to simulating the movement of the probe, but the plastic teeth do not have gingival sulci that would stop the probe from advancing to the screw that holds the tooth in place.

Similarly, we conveyed the idea that cutting too deeply inwards toward the seed of the mango can simulate texture. When a mango is sliced the conventional way, cutting in too far towards the large seed causes a part of the fibers to remain attached to the “fruity” treat of the mango slice. Palpating the area of attached fiber with one’s index finger can relay the texture and consistency of oral sub mucous fibrosis [8]. In a patient with this type of lesion, the buccal mucosa which is normally rather fleshy and spongy becomes fibrotic and tough to pressure from palpation or to the side of a probe.

No complaints from the flower, fruit, and none from the dentoforms. But look out student partner practice in clinic, here we come!

The first incidence of student centered clinical practice allows the student the opportunity to experience the outcome of jamming the

probe into the sulcus rather than the gentle, exploratory movements suggested in the laboratory to feel the rubbery stop when periodontal fibers are engaged. Empathetic and considerate gentle practice on each other after that type of learning translates simply to the old adage of “do unto others as you would have them do unto you”.

This commentary was written as it seemed to have worked in this single group of students. It would be advantageous if such a learning method could be tested with a scientific experiment involving the study group and a control group. As clinical teachers, even a small observational report like this can mean a great deal and may be tested individually.

References

1. Seligman MEP (1975) Helplessness: On Depression, Development, and Death. W.H. Freeman and Company, San Francisco, USA.
2. Miller A (2015) Avoiding learned helplessness. Edutopia, USA.
3. Nuvvala S (2016) Learned helplessness. *Contemp Clin Dent* 7: 426–427.
4. Saintonge CDM (1998) The helpless learner: a pilot study in clinical students. *Med Teach* 20: 583-586.
5. Hermann E (2014) Learned Helplessness in the Classroom. ESL globe, NC State University, USA.
6. <https://www.sunset.com/garden/new-sunset-western-garden-book>
7. <https://www.columbiadentoform.com/>
8. Wollina U, Verma S, Mukram A, Patil K (2015) Oral submucous fibrosis: an update. *Clin Cosmet Investig Dermatol* 8: 193–204.