

Shame, Stigma & Medicine Workshop

Neil Lecture Theatre,
Long Room Hub,
Trinity College Dublin.
October 16, 2015

9.30-9.50 *Registration*

9.50-10.00 *Introduction* Barry Lyons & Luna Dolezal

10.00-11.30 *Session 1*

Brendan Kelly	<i>'One Flew East, One Flew West': Stigma, Shame and Psychiatry</i>
Katherine Browne	<i>Plastic Surgery and Shame</i>
Danielle Griffiths & Alex Mullock	<i>The Surgical Other: Using Shame to Legitimise Cosmetic Surgery</i>

11.30-12.00 *Coffee*

12.00-13.00 *Session 2*

Paul Snelling	<i>Shame as a Public Health Intervention</i>
Rebecca Brown	<i>Equating 'Healthy' and 'Unhealthy' Behaviour with 'Good' and 'Bad' Behaviour: Moralising and Public Health Promotion</i>

13.00-14.00 *Lunch*

14.00-15.30 *Session 3*

Janice McLaughlin	<i>The Medical Reshaping of Disabled Bodies as a Response to Stigma and a Route to Normality</i>
Matt Phillips	<i>'The Concealed Blossom': Sexual Health, Shame and Stigma</i>
Sheelagh McGuinness	<i>The Experience of Women in Northern Ireland Travelling to England to Access Abortion Care</i>

15.30-16.00 *Coffee*

16.00-17.00 *Session 4*

Luna Dolezal	<i>Embarrassing Bodies: Shame in the Clinical Encounter</i>
Barry Lyons	<i>Blame, Shame and Accountability</i>

Speakers:

Prof. Brendan Kelly	<i>Dept of Psychiatry, University College Dublin</i>
Dr. Katherine Browne	<i>Dept. of History, Trinity College Dublin; SpR in Plastic Surgery</i>
Dr. Danielle Griffiths & Dr. Alex Mullock	<i>Centre for Social Ethics & Policy, University of Manchester</i>
Dr. Paul Snelling	<i>Institute of Health and Society, University of Worcester</i>
Dr. Rebecca Brown	<i>Health Services Research Unit, University of Aberdeen</i>
Prof. Janice McLaughlin	<i>School of Geography, Politics and Sociology, Newcastle University</i>
Dr. Sheelagh McGuinness	<i>School of Law, University of Bristol</i>
Dr. Matthew Phillips	<i>Tameside and Glossop Centre for Sexual Health, Stockport NHS Foundation Trust</i>
Dr. Luna Dolezal	<i>Irish Research Council / Marie Curie Postdoctoral Fellow Department of Philosophy, Durham University and Trinity Long Room Hub, Trinity College Dublin</i>
Dr. Barry Lyons,	<i>Bioethics, School of Medicine, Trinity College Dublin</i>

'One Flew East, One Flew West': Stigma, Shame and Psychiatry

Professor Brendan Kelly

Department of Adult Psychiatry, University College Dublin

A stigma is a perceived mark of shame or discredit. Shame is a painful feeling of distress or humiliation owing to consciousness of wrong or foolish behaviour. Neither stigma nor shame can be experienced (or, arguably, exist) without self-awareness, the very quality that is altered in many psychiatric disorders and states of psychological distress. Forty years ago, in 1975, the movie *One Flew Over The Cuckoo's Nest* (Fantasy Films) addressed certain stigmas associated with mental disorder (chiefly through its bracing, direct approach to the issues) but also created other, arguably more enduring, forms of stigma. Four decades later, in 2014, a remarkable Irish film *Patrick's Day* (Ignition Film Productions) did something similar: addressing certain forms of stigma through its openness and clarity, but perpetuating other forms, most notably in relation to institutional living, violence and electro-convulsive therapy (ECT). Why? The stigma and shame associated with psychiatry co-exist with strong societal rhetoric about community-based care and equally strong, somewhat contradictory pressures to 'psychiatrize' a broad range of awkward social issues. The use of psychiatry as an instrument for the attempted resolution of both psychiatric and non-psychiatric matters has a long history in Ireland and elsewhere. At the level of society, then, the stigma and the shame commonly associated with psychiatry is a distinctly moveable feast, dependent on changing political need. But at the level of the individual, stigma and shame retain their iniquitous, formative powers in shaping mental disorders and their outcomes.

Shame as a Public Health Intervention

Dr Paul Snelling

Institute of Health and Society, University of Worcester

The bioethicist Daniel Callahan has recently argued for ‘stigmatisation lite’ as a way to reduce the incidence of obesity. ‘The force of being shamed and beat upon socially’ worked for him when he stopped smoking, and a positive application of social pressure has been influential in behaviour change related to, for example, the reduction of drink driving, so why can’t we shame people into losing weight? Criticism of the paper was swift and multifaceted, but it turned out that he didn’t intend to stigmatise the obese at all – only to use social pressure (if that is possible) on the not-yet-obese or just a little overweight. Nevertheless his paper provides an opportunity to re-evaluate the use of stigma and shame as interventions in public health policy.

Public health policy is an enterprise which outwardly promotes personal choice, but encouraging and facilitating decision making based on capitulating to social conformity seems at odds with respecting personal autonomy. Health professionals spend a good deal of time and energy trying to increase self-esteem in stigmatised groups, and so a suggestion that we deliberately increase stigma, lite or otherwise, seems odd. Public health policy which aimed to increase stigma might be acceptable if it worked, but Callahan offered no evidence that it would.

But the rejection of stigma and shame as public health tools to reduce obesity does not necessarily reject the use of social emotions in public health policy. Differences between guilt and shame are discussed and I argue that in some circumstances fostering guilt for direct harms to others may be ethically acceptable. Television anti-smoking campaigns are used as examples it is tentatively concluded that Callahan’s ill-received paper promoting obesity shame should not obscure the possibility of using social emotions in public health policy elsewhere.

Equating 'healthy' and 'unhealthy' behaviour with 'good' and 'bad' behaviour: moralising and public health promotion

Dr Rebecca Brown

Health Services Research Unit, University of Aberdeen

Those attempting to promote public health are increasingly focusing on strategies targeted at changing 'lifestyle' behaviours. The main targets are physical activity, diet and smoking, since overweight and obesity, along with being a smoker, are significant risk factors for a host of non-communicable diseases including various forms of cancer, type II diabetes, and heart and respiratory diseases. Much of these efforts have focused on information provision and education in an attempt to make people better informed about the effects of lifestyles on health and to motivate them to adopt healthier habits.

Whilst the aim of improving the health outcomes of a population are laudable, the project of encouraging healthy lifestyles has directed focus toward an idealised, 'optimum' state of living, where one consumes *precisely* the right number of calories per day, whilst exercising for the recommended time, refraining from smoking, alcohol consumption and other enjoyable activities. As a result, public health promotion has rendered a wide variety of common behaviours not only 'unhealthy' but 'unacceptable' as well. A more worrying, further effect, is for those engaging in such behaviours - the sedentary, over-eaters, heavy drinkers and committed smokers - to be considered 'bad' themselves: the valence of the unhealthy behaviour is extended to the person as a whole, now considered weak-willed, ignorant, lazy and selfish.

I will argue that, where such moralising is either an intended or unintended consequence of public health promotion strategies, efforts must be made to counter it. A moderate view of the responsibility of states to remain neutral with regard to the life projects citizens pursue will be undermined by interventions which stigmatise legal and commonplace 'unhealthy' behaviours. Whilst public health ethics often focuses on the intrusiveness of the *tools* of health promotion interventions, I suggest that the *effects* are equally as important: for instance, although a major concern of public health ethicists is typically the preservation of freedom those subject to health promotion strategies, many (apparently) freedom-respecting interventions could have powerful and harmful consequences through more subtle influences on social norms, which we should be equally attentive to.

The Medical Reshaping of Disabled Bodies as a Response to Stigma and a Route to Normality

Professor Janice McLaughlin

School of Geography, Politics and Sociology, Newcastle University

Disabled bodies can be locations of stigma and shame through the ways in which social interactions identify the body as different from the norm. One solution to this is the reshaping of the body via medical intervention to appear closer to social norms of how a body should look and function. This presentation will examine how disabled young people whose lives have been marked by a range of medical intervention think about and approach the different ways in which their bodies have been and are subject to a range of medical practices. The ideas explored draw on narrative qualitative interviews and visual practices carried out with seventeen disabled young people in a project funded by the Economic and Social Research Council that took place between 2011 and 2012 in the North East of England. The findings discussed here focus on how medical and societal responses to bodily difference become part of the stories disabled young people tell about their bodies, and influence the way they work with the body as something which remains 'unfinished' and therefore both fixable and flawed. Our conclusion is that a narrative of an unfinished body is produced, as young people manage their bodies as something that is integral to their emerging identity, but also as a potential threat due to the apparent distance that remains between it and normal ways of being.

'The Concealed Blossom': Sexual Health, Shame and Stigma

Dr. Matthew Phillips

Tameside and Glossop Centre for Sexual Health, Stockport NHS Foundation Trust

Sex- we all do it (or hope to do it), at a frequency which may or may not be to our satisfaction. Why is sexual health so embarrassing? Is it the physicality of the sex act that makes us blush, or is it the unmasking of our innermost desires that provokes our nervous chuckles? The stigma of sexual health, especially when things go awry, comes from many directions. The acquisition of an infection may show that you are having sex (with someone you shouldn't be), that you make poor judgements in our risk averse society, or perhaps your standards are too low because nice people don't get infections. We cannot engage with sexual health in the same way we engage with other health paradigms because sex is normally a voluntary and controlled act as opposed to breathing or ageing for example. But does this mean we must feel shame in connection to this most basic human function? This piece will explore the multifactorial contribution to stigma and shame connected to sexual health and unpick some of the issues that contribute to the propagation of this state of affairs.

Embarrassing Bodies: Shame in the Clinical Encounter

Dr. Luna Dolezal

Irish Research Council / Marie Curie Postdoctoral Fellow

Department of Philosophy, Durham University and Trinity Long Room Hub, Trinity College Dublin

When broaching the question of shame in medicine in the present day, it is impossible, especially in a UK context, to not think of the Channel 4 television series *Embarrassing Bodies*. This compelling and popular TV Series has aired on Channel 4 since 2007 and its main objective is to aid people who have a wide range of illnesses and bodily conditions that they are ‘too embarrassed’ to show to their doctor. What *Embarrassing Bodies* has made explicit through the confessional formula of reality television is that shame about the body and illness is a powerful force when considering the effectiveness of medical treatment. The overwhelming popularity and success of this TV series makes evident the fact that shame, embarrassment and other self-conscious emotions often prevent individuals from seeking medical attention, from following through with medical treatments, and from accurately narrating and disclosing symptoms and histories.

This paper will examine medical shame in the context of clinical encounters, using *Embarrassing Bodies* as illustrative of some of the shame dynamics that occur within in medical treatment. Although there is a paucity of literature about the significance and effect of shame in the doctor-patient relationship, recent research has demonstrated that shame is a significant force in the clinical encounter. In this paper I will expand on the insights of Aaron Lazare’s ground breaking 1987 article ‘Shame and Humiliation in the Medical Encounter’ where it is argued that patients often see their diseases and ailments as defects, inadequacies or personal shortcomings and that visits to doctors and medical professionals involve potentially humiliating physical and psychological exposure. Building on Lazare’s findings, I will argue that shame, particularly body shame, can have a powerful impact on the medical encounter and must be carefully considered as a component of the doctor-patient interaction. In doing so, I will outline a phenomenology of body shame, looking closely at how the experience of shame about the body impacts on experience and intersubjective relations. I will then examine how body shame can be highlighted or exacerbated within the medical encounter. I will conclude with some reflection about both the positive and negative potential for shame in medicine, using *Embarrassing Bodies* as illustrative.

Blame, Shame and Accountability

Dr. Barry Lyons

Bioethics, School of Medicine, Trinity College Dublin

Do No Harm, Henry Marsh's memoir of his life as a neurosurgeon, contains some reflections on events that did not go well. In describing a case where the surgical intervention resulted in harmful consequences for the patient, he contends that "most doctors feel a deep sense of shame when their patients suffer or die as a consequence of their actions". Although probably true, this empirical claim is made in the absence of any substantive quantitative data. In fact, despite the pervasive and potentially harmful repercussions of shame when experienced by healthcare professionals (e.g. withdrawal, defensive practice, hostility towards patients and colleagues, and lack of empathy), its prevalence and consequences remain particularly under-examined. Analysis is also made difficult by the tendency to employ alternative terms such as embarrassment or humiliation in personal accounts. Following Lewis's conceptualisation of shame theory as including particular emotions that threaten identity and/or social bonds, other notions such as feeling 'incompetent', 'inadequate' or 'stupid' might also be considered as shame variants in the context of 'expected perfection' within medical practice. By thus broadening the language of shame it is possible to identify a number of different thematic triggers of shame acting through the processes of internal blame and negative self-evaluation or external scrutiny and public accountability. These might be labelled as:

1. Inadequacy shame
2. Error shame
3. Outcome shame
4. Accountability shame
5. Moral shame
6. Public shame

While such division risks oversimplifying complex experiences, outlining a range of contexts within which the operation and consequences of clinician shame might take place could allow for a more focused and fruitful exploration of any data. Extant research provides some evidence of the potentially damaging nature of shame on personal and professional relationships, and thus it seems pertinent to medical practice that the phenomenon of clinician shame becomes the subject of further conceptual and empirical investigation.