Shame and the Vulnerable Self in Medical Contexts: The Compassionate Solution

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For evolutionary reasons, shame is one of our most powerful and important social emotions. It has a major impact on our experiences, ourselves, others and our relationships, and physiological state – including ones conducive to illness and vulnerability and recovery. This paper will explore the evolutionary origins of shame and reveals how and why it has powerful experiences. It will also discuss why the medical encounter is a very obvious arena for shame, because we are presenting our bodies as unattractive and undesirable, diseased, decayed and injured - with the various excretions that typically ignite disgust.

The origins of shame can be traced back to early mammals where the quality of social relationships could make a difference between life and death. The survival of uncared for infants and in some contexts, adults, was short. Humans are an evolved mammal with live birth and needs for considerable care early in life. We are also a species who evolved substantial capacities for caring for those diseased and injured [1]. Indeed, one of the major drivers of social intelligence over the last 2 million years has been the importance of social connectedness, relatedness and mutual sharing, caring and helping [2]. The central and autonomic nervous systems have been adapted to be highly regulated through social relationships [3], even including the methylation process of our genetic expressions [4]. There is now considerable evidence that caring, supportive and valuing relationships have profound impacts on a range of physiological systems including the immune, cardiovascular and neurophysiology systems. While in contrast - criticism, rejection, shame, social exclusion and marginalisation are major threats to humans, that can stimulate a cascade of physiological threat responses that undermine bodily healing and increase vulnerability to disease [3,5].

While the impact of distressed mental states such as depression and anxiety on recovery and relapse is increasingly understood, even in the cancers [6, 7], the intimate connection between social relating and a whole range of physiological processes that impact on illness, vulnerability, coping and recovery, including

engaging with medical services, is still under investigation [3, 5]. Relationships are not just psychologically powerful, in that they can provide a sense of support, hope and courage, but also are physiologically powerful and contribute healing and coping with the disease process [6, 7].

Need to feel valued and attractive in the eyes of others

The bottom line is then that human survival and prosperity have been highly dependent on the care and support of others. Hence, one of the important domains of human evolution is the capacity to monitor and respond to the way we feel other people think and feel about us; that is how we exist in the minds of others [8]. For a number of evolutionary reasons, humans are very sensitive to creating positive (or negative emotions) in the minds of others about the self. If we create positive impressions in others then we are more likely to be chosen as friends and employees and also more likely to be helped when in need. Signs of disease, injury and deformity are unattractive to potential sexual partners, unattractive to potential allies because they may signal that we will not be able to reciprocate, and disease signals potential infection, therefore, we are avoided on fear of contamination grounds. So there are many evolutionary reasons why individuals can be sensitive to the signals they are sending others in regard to their health status.

A second important evolutionary dimension is caring [9]. Originally and generally in other animals, distress signals, particularly those of disease, creates avoidance. Today, although humans still avoid indicators of disease and infection, from about 1 million years ago, the archaeological record shows that injured and ill people survived (only) because of the care they received [1] . Taking an interest in, and preparedness to help others, even with potential cost to oneself is therefore an important human adaptation [10]. However, considerable evidence suggests that care providers are discerning to whom they provide care for and will not dispense it equally. For example, we find it much more easy to be compassionate to people we like than people we don't, to people we know than people we don't know, to people with similar values to us than to people with different values[11]. Hauser and colleagues [12] highlighted the fact that we are

more interested in helping those who appear in positive rather than negative moods, seem appreciative rather than unappreciative, and are friendly rather than unfriendly. We also use concepts of deserve (especially when there are shortage of resources). For example, does a person with a drink problem deserve a liver transplant compared to a healthy living person? And if you are the person with the drink problem, and you know that these may well be thoughts in the mind of your clinician, how would you feel about that, and how honest will you be about your difficulty? The quality of the care we elicit from a potential caregiver is partly linked to the degree to which we can stimulate a caring motivation within them.

Shame

Shame can play a vital role in a whole range of experiences in the medical encounter. To understand shame, we can link it to the importance of creating positive impressions in the minds of others and fear of the opposite, becoming the 'undesired self' [13]. Although earlier models of shame had linked it to failing to meet standards or live up to ideals, using qualitative methods Lindsay-Hartz, and colleagues [14] found that:

> To our surprise we found that most of the participants rejected this formulation. Rather, when ashamed, participants talked about being who they did *not* want to be. That is, they experienced themselves as embodying an anti-ideal, rather than simply not being who they wanted to be. The participants said things like. "I am fat and ugly," not "I failed to be pretty;" or "I am bad and evil," not "I am not as good as I want to be." This difference in emphasis is not simply semantic. Participants insisted that the distinction was important...... (p. 277).

Shame requires that there is something actually "unattractive" about the person [8, 15, 16]. Illness, disease and injury are classic candidates.

We can also distinguish internal from external shame and their defences [8]. External shame is related to the experiences of threat arising from external sources; when we feel others are either looking down on us or see us as unattractive or unworthy in some way. Part of this can be linked to our own behaviour (doing something shameful), but also to the feelings that we will be

allocated 'group membership' to a group that has been stigmatised - referred to the stigma consciousness [17]. For example, people may be worried about being identified as obese, neurotic, homosexual and HIV positive. Stigma and stigma consciousness have common, but also variant cultural dynamics.

Shame can also be internalised and here we take a negative view of ourselves often powered by self-criticism. Commonly self-criticism anticipates a social audience, although over time that sense of how we exist for the other may fade and we are only left feeling negatively about ourselves. External and internal soon have a different pattern of attention, different offences in different coping behaviours.

Importantly, the self-conscious emotion of guilt is entirely different. The origins of shame are in competitive motivational systems and how animals and ourselves live within social hierarchies, where we have to compete for status belonging and 'caring resources'. Shame is focused on the self, its social judgement and reputation; emotions are typically threat-based one's of anxiety, anger, and disgust associated with hiding concealment, withdrawal, dissociation and sometimes aggression. Guilt, on the other hand, evolved within the caring motivational system. It is part of a harm avoidance mechanism (of those cared for). It focuses on the behaviour rather than the judgement of the self and the emotions that arise are ones of sadness, sorrow,remorse and urgency to repair harm. Empathy is very important for guilt, but less important for shame. So shame and guilt have very different evolutionary origins and mechanisms, ways of paying attention, differences of focus (self vs behaviour and consequence) different emotions, different defences and reparative motives. Shame and shaming are the basis for retributive justice, whereas guilt underpins restorative justice [18] for further discussion). These distinctions are important because some medical education practices and even the organisation of the health service itself, along with litigation, fail to understand these important differences. Thus they can overly rely on punitive shame-based consequences. While the fear of punishment (shame) can work to a degree, research suggests that it can also

stimulate unhelpful defences, including concealment, the evasion of responsibility, justification and defensive caring.

Shame and The Body

Bodily appearance and functions are clearly a source of shame [16]. Diseases themselves can be a serious cause for a sense of loss of attractiveness in one's own and others eyes and even of disgust, particularly when they are associated with excretions, vomiting, diarrhoea, and various forms of disfigurement. One can feel an acute lose of dignity with no personal blame (self-criticism) attached by either self or observer. Lazare [19] argues that suffering a disease can become an issue of shame and dignity.

> When patients discuss the importance of "dying with dignity" the indignities they refer to are the altered appearance (edema, emaciation, deformities, etc.), diminished awareness, incontinence, the need to be washed and fed, the need to ask or beg for medicine to relieve pain, the need to use a bed pan, and the perceived loss of meaningful social roles and social value. (p. 1654).

An awareness of one's body becoming miss-shapened, odd or unpleasant in texture and smell, with bodily emissions, and being a possible source of contagion to others, (not to mention the source of the disease itself e.g, HIV) speak to the emotional experiences that can operate in or close to shame in unique ways. As Lazare [19] argues, however, much shame in this area is caused by the reactions of others to the ill as much as by internalised values of the ill themselves. When it comes to suffering from a disease, the fear of `loss of one's dignity' can be a major source of concealment and even avoidance of potential help. Shame influences not only how we feel about a particular condition, but the degree to which we are prepared to seek help and expose ourselves. The medical television series of *Embarrassing Bodies* addresses these themes. In addition, we can be ashamed of how we may feel we are (not) coping, for example becoming tearful, depressed, withdrawing or having panic attacks – we can't muster the stiff upper lip. We can fear breaking down in the presence of the clinician. We can have secondary shame

too by being shamed by the consequences of treatment. For example, some treatments result in major changes in appearance, hair loss, and weight increases; treatments can interfere with sexual function (anti-depressant impotence); surgery can be very disfiguring. Indeed, sometimes the shaming side-effects stop people from continuing treatments – yet these dynamics are very rarely addressed in the clinic or taught. Lazare [19] how we label and discuss disorders can link to a cultural lexicon that has shame textures. For example, the way we talk about organ *failures, deficits or insufficiencies* clearly indicate that there is something about us that simply 'not up to the job'. The feeling of a woman who was unable to have children, can be riddled with shame of feeling that their body doesn't work as other women's do. The way in which we identify with our bodies as extensions of 'who we are' can be a source of internal shame [16].

The potential shame and stigma problems associated with mental illness are well recorded. But here again clinicians don't always help because of the language they use. So, for example, we describe people as having a personality disorder, suffering from hysteria, cognitive distortions, irrational beliefs and maladaptive thinking. There are many lay terms for shaming and stigmatising mental illness such as bonkers, crazy, mad, screw loose, basket case, losing one's marbles, a nutcase – and these are labels that people can internalise.

We should also note that there are a number of conditions where we rather contribute to our difficulties: obesity, smoking, drug addiction, poor exercise. Clinicians who take the attitude "well Mr Smith if you don't make more efforts to help yourself, how can we help you?", are making ham-fisted efforts to shame the patient into action, showing empathic failure to understand that these kinds of behaviours often have complex psychologies sitting underneath them. For example, some addiction problems relate to underlying unresolved trauma the patient maybe too fearful or ashamed to address; only rarely will shame increase willpower. Many need support groups in which they can feel connected and supported [6-7]. Lack of training in these dynamics can make some clinicians undermine understanding of the psychological processes underpinning unhelpful and unhealthy behaviour.

Shame in the clinician: One should keep in mind that because shame is about reputation and is very different to guilt, any analysis of shame in the medical encounter has to also consider shame in the clinician. Like other professions, people in medicine can be prone to both external and internal shame, with an uncertain sense of self, making it is easy for them to feel fearful or humiliated if their authority is undermined. They may have poor self-emotional insight and behave defensively, aggressively or dismissively in the face of possible criticism or patient conflict or colleague disagreements. Others can live in fear of the 'terror terror' and being shamed and taken to the General Medical Council. This is, I believe, a far more common anxiety in today's litigation environment; that is recognised and urgently needs attention, in support of the clinician's health, confidence and support.

Compassion

Importantly, the most powerful antidotes to shame include social validation, connection and compassion [9]. Importantly, compassion has been subject to scientific study, and so now clinicians need to know what it is rather than having some vague lay notion. Although compassion has been defined in many ways, a reasonably standard definition is "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it [9, 20, 21]. . This gives rise to two psychologies. The first is the ability to be sensitive and engage with suffering. The second is the preparedness and dedication to acquire the wisdom to work out what best to do.

Compassion should *not* be confused with love, because love is an attractor state (liking and enjoying closeness to) whereas we don't need to like or enjoy who we have compassion for. Rather compassion is rooted in courage and ethics. In the model I'm going to outline (and there are a number of other models) there are 6 competencies underpinning each of these psychologies; 12 in all. These are taken for the extensive literature on caring and are given in diagram 1 as an overview. They are interdependent, supporting each other, and not linear.

Diagram 1: the Competencies of compassion

Compassion: Motive and Competencies
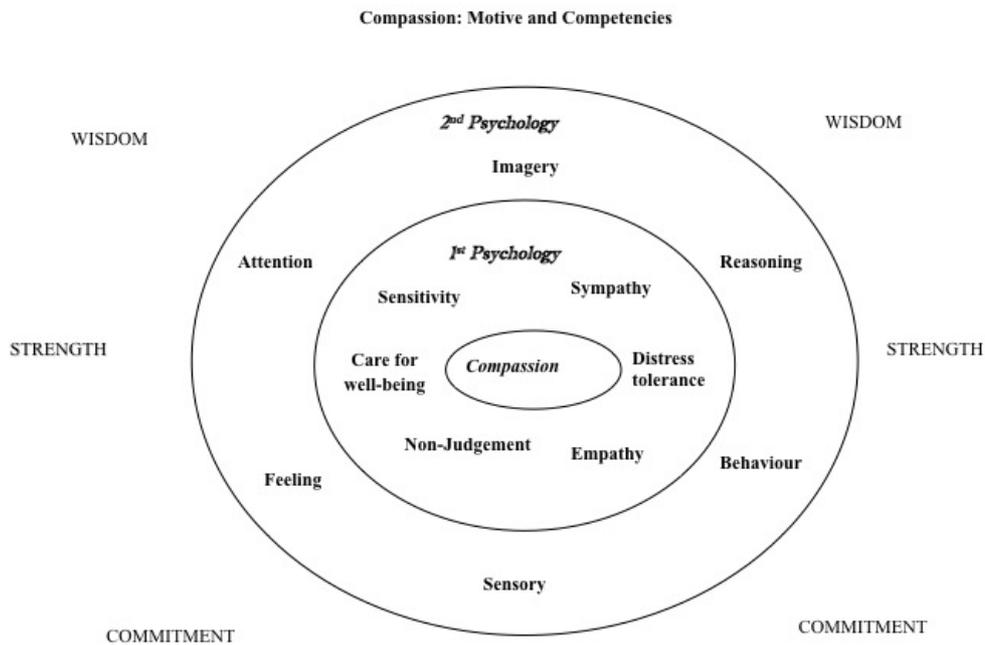
Adapted From P, Gilbert (2009). *The Compassionate Mind*. With kind permission Constable Robinson.

Engagement: To engage with suffering we need to, 1. be motivated to do so (intentionally open); 2. be attentionally sensitive and aware; 3. be emotionally engaged/moved with the suffering that we attend to (sympathy) rather than cold and indifferent; 4. be able to tolerate distress and suffering in self and others without dissociating, going into denial, minimization, or avoidance of distress; 5. be empathically attuned to the minds of self and others – able to understand theirs and our own motives, emotions, fears and needs; 6. be able to engage with suffering in an open and accepting way, rather than a critical or aggressive reaction to suffering.

Action With regard to the second psychology of compassion, there are also six competencies. 1.we are able to move our attention and bring into mind things that are going to be helpful; 2. use our imagination to stimulate compassionate physiological systems and intentions and imagine compassionate actions; we can run simulations of:

'if I do this - that may happen, but if I do that then something different may happen'; imagination allows us to work out things before putting them into action, which is an amazing advantage in evolutionary terms; 3. the ability to use our reasoning, wisdom and acquired knowledge/skills; think things through or know how to find the information we need. 4. we may know what to do, but may not do it because, for example, of anxieties. So taking action to act compassionately can sometimes require determination or courage, and the ability to over-rule automatic feelings such as anxiety or even disgust. 5. having sensory body awareness that allows us to beware of our physical states; how to breathe and use postures to stimulate physiological patterns conducive to compassion in the appropriate contexts. Finally, 6. our feelings of compassion are context dependent. For example, the emotions we have in A&E might be anxiety or urgency to resuscitate someone, whereas sitting quietly with a dying person would be quite different. What holds all these together is not feelings, but *intentionality* –that is compassion is rooted in motivation. Bringing these 12 competencies together, we can see compassion involves a sense of commitment, a sense of authority and strength, guided by wisdom [9, 20].

We can also see compassion as flow in the sense that there is the compassion we feel for others, our openness to the compassion from others and our capacity to be self-compassionate. Research suggests that these are mutually supportive. Although it is often said that one can't be compassionate to others unless one is compassionate to oneself; there is actually no evidence for this. Indeed, as a clinician who has worked with the medical defence union, I came across many doctors who were incredibly concerned for their patients, but were also perfectionistic self-critics and suffered anxiety and depression as a result. Others can be very 'self compassionate' but not terribly competitive to others.

We often say that clinicians need to be empathic, but that's only half the story, because what is crucial is that the patient picks up the *intentionality and compassionate competencies of the clinician*. So, for example, imagine I am seeing a consultant for cancer treatment. I will be consciously and unconsciously monitoring a range of intents, emotions and competencies in that clinician, picking up on - is: 1. s/he motivated to help me, 2. attentive (not distracted), 3. emotionally moved by my experience (not mechanical or indifferent – 'just another case'), 4. can tolerate any

distress as it arises in the consultation (my tears, terrors and of rage), 5. empathic to those feelings of say - why I behave as I do, and 6. not judging me, or telling me it is my own fault for smoking.

In addition, I pick up that my clinician has the competencies of the second psychology, is thinking about how best to help me, and has the skills and will act to help, etc. So our patients are monitoring a lot of information coming for the clinician. The way clinicians convey these complex sources information to the patient is extremely important for creating a sense of safeness and settling shame anxieties. For example, we know that facial expressions and voice tones and voice speeds are important conscious and unconscious stimuli, that have a major impact on people's physiological state. Clinicians who are sensitive to shame in their patients will ask them about it and look for it in order to sooth it.

Medicine is a very 'unnatural' and stressful occupation because one is constantly having one's own threat system stimulated both consciously and unconsciously,being confronted by the fragilities, injustices and sheer suffering of diseases, injuries and death, often in contexts of high time pressure and often feeling limited in what one can do. Compassionate mind training, therefore, would be a way clinicians could learn to *look after themselves* and practice holding their compassionate states, particularly one's parasympathetic tone in balance [9].

Fears, blocks and resistances
All motives have facilitators and inhibitors. Inhibitors are often related to fears, blocks and resistances [18]. As noted, shame is an obvious fear to reaching out for help when our bodies are diseased, decaying, failing and out of control. Some people value compassion, but are frightened of the feelings of compassion and the consequences of compassion; others don't fear it, but they resist it because they do not value it, or they see it as a weakness or unhelpful in some way. Fears of seeking help are an example. This can to be true for clinicians too, who might worry about seeking psychological help in case it implies they can't cope or are inadequate. Fear-based reasons for covering up difficulties, concealment, turning to the wine, and not obtaining or reaching out for help and support (in macho-self-sufficiency cultures) are not so uncommon.

In addition to fears are resistances. There are many in the higher reaches of business and politics who are *resistant* to compassion and its implications. There can be amisunderstanding of compassion. They think that compassion is not hard edged or results-focused enough, when in fact it's focused on ethics and courage. Within organisations, they can give lip service to the importance of compassion and mutual helping, but inhibit the processes by which this arises; such as interfering with people's support systems; overworking people; creating punitive bullying contexts. *Blocks* are often not due to fears or resistance, indeed the person may want to be more compassionate, but there is a contextual block. Examples include, time limitations, staff shortages, poor skills development and supervision, and bureaucracies. These are commonly noted reasons why clinicians don't feel they are being as compassionate and (time) attentive to their patients, as they would like to be [22]. These blocks to compassionate caring can be a source of stress to clinicians and even burnout. It is a mistake to believe that compassion fatigue is because we are constantly engaging in suffering –more commonly it's constantly battling to provide the service one wants to provide. There have obviously been some well-publicised cases of whole institutions failing in their capacity to provide compassionate healthcare (such as the Francis report and the Berwick report). Understanding the distinction between facilitators and inhibitors helps us recognise that there may be little point in putting a lot of facilitators in place if one is also creating inhibitors; and cost cutting accountancy driven health care, when taken too far, risks creating many (unintended) inhibitors – again as well-known high profile investigations have shown. Indeed, research after research shows that its quite easy to get good people to behave badly if you create certain contexts - being shamed is one [23].

Some few last thoughts

Humans are especially sensitive to how they exist in the minds of others. When we are injured, diseased, decayed and dying, or losing our functions we are highly vulnerable to feeling shame, marginalized and fearful. Sometimes we even avoid seeking medical help out of shame; sometimes respond aggressively, sometimes submissively and not sharing our fears and worries for fear of being seen as silly and neurotic. With the amazing technical advances of medicine, it is easy to forget the

human dynamic of how we feel safe with each other in times of immense pain invulnerability and plain ugliness.

Clinicians too are vulnerable to shame - perhaps increasingly so because modern society seems very intent on using shame and blame in very punitive ways. Medicine does not have a reputation for compassionate mutual supportive working, but more a macho self-sufficiency, being tough, and a stiff upper lip approach. The Schwartz rounds, which encourages clinicians to talk about their own feelings, recently introduced into the UK, is something new and novel. We must keep in mind that when people make errors in medicine the consequences can be very serious – and that threat is held by the clinician. So, we must wonder where doctors and other clinicians find opportunities to talk about their anxieties, rages, sensitivities, hopes and despairs, without feeling shame or 'should be able to cope better'? If we want to create a compassion focused service, then we need to first understand what compassion isn't. Second, show compassion for clinicians. Third, recognize the importance of social context and social relationships in the creation of compassion flow.

Compassion is more complicated than people may think. It is not (just) having time to listen or a bit of care here and there. There are scientific studies now on the nature of prosocial behavior, how it works in the brain - things that turn these on and turn off. In the model, I have offered there are at least 12 different competencies involved with developing compassion - each of these are trainable. The more compassion we develop for ourselves and others, the more we will be able to cope with the fragilities, vulnerabilities and terrors of living as vulnerable, easy to injure and infect, decaying, short-lived biological beings that we are.

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