Shame-Sensitive Practice and COVID-19

Evidence and recommendations from *Scenes of Shame and Stigma in COVID-19.*

Scenes of Shame and Stigma in COVID-19 is a UKRI-AHRC Covid Rapid Response Grant led by Professor Luna Dolezal, with Dr Arthur Rose and Dr Fred Cooper as co-investigators. It is a sister project to Shame and Medicine, housed at the Wellcome Centre for Cultures and Environments of Health at the University of Exeter.

Document Purpose: this briefing is for internal information only, to support and inform policymakers, leaders, and practitioners in developing shame-sensitive responses to the epidemiological, social, and psychological challenges of Covid-19. It is not intended for any public use. The observations below are the product of early-stage analysis by the researchers to draw out rapid recommendations in a time-sensitive context.

Executive Summary

Shame is a negative emotion with serious consequences for mental, relational, and physical health. It results from the stigmatisation of particular bodies, behaviours, and identities; is more likely to be experienced in situations of perceived vulnerability or inadequacy, e.g. within healthcare settings or during the receipt of welfare; and is frequently the product of public health initiatives aimed at effecting behavioural change.

In every context, the use or presence of shame damages engagement and outcomes. Shamed individuals or groups avoid diagnostic, curative, or prophylactic processes, lose trust in medical expertise or public health messaging, are or feel unable to share the burden of illness with vital support networks, and can be subject to complicated emotional, psychological and physiological processes which further widen existing social and health inequalities.

The Covid-19 pandemic has introduced new scenes of shame and shaming, and broadened or amplified others. The urgent imperative to attain or manage rapid shifts in public behaviour is a fertile environment for shame, whether as an implicit facet of public health messaging, or an unplanned-for side-effect through haste, lack of care, or insufficient support in developing shame-sensitive responses. This briefing provides a quick and accessible framework for policymakers to think critically about how shame works in a range of contexts, and how it can be proactively avoided and reduced. It makes the following recommendations, summarised here in brief:

- **Reject shame as a behavioural tool of any kind in policymaking or practice.** An institutional commitment to shame-sensitive practice can be an effective starting point for sustained cultural change.
- **Build attentiveness to shame into institutional expertise and cultures, through the development of shared tools and resources.** Create and systematise nuanced and collaborative understandings of how shame is produced and experienced.
- **Use these tools and competencies to conduct frequent and challenging reviews and audits** on work of any description which has the potential to generate, spread, or exacerbate shame.
- **Engage and collaborate with excluded communities and publics** to promote shame-conscious health-seeking or risk-averse behaviour, and support them proactively to do so.

Understanding Shame

Shame is a negative emotion which people experience when they feel they have been seen and judged to be flawed in some crucial way by others, or when some aspect of their self is perceived to be inadequate, damaged, inappropriate or immoral. Variants of shame include a wide array of negative self-conscious experiences such as embarrassment, humiliation, chagrin, mortification, feelings of defectiveness, heightened self-consciousness or low self-worth.

Shame itself is a potent source of shame. Admitting to the experience can be difficult, and usually requires some pre-existing level of trust. Despite often being hidden and unspoken, it is a powerful force in personal experience and interpersonal encounters. People go out of their way to avoid shame, even when avoidance can be self-defeating or destructive; for many, escaping shame can feel like a life-saving measure.

The fear of being shamed is heightened for people with stigmatized identities or attributes, who live with daily experiences of 'stigmatising shaming.' These can include addiction, minority status, lower socio-economic status, lack of literacy, obesity, chronic illness, loneliness, or disability.

Chronic shame can lead to avoidance behaviours such as substance abuse, social withdrawal, self-harm, and suicide. It also causes prolonged stress in the body which has a clear physiological effect on the immune and cardiovascular systems. This can lead to or exacerbate ill-health, because of chronically elevated PIC and cortisol levels.

Healthcare Settings and Clinical Encounters

Shame and embarrassment are common experiences for patients in healthcare settings. It is common for patients to fear being judged and/or shamed by health professionals, since such encounters are frequently accompanied by the exposure of their vulnerabilities and physical bodies, along with their (perceived) flaws, inadequacies, faults or frailties.

Experiencing or anticipating shame around clinical encounters can add to the burden of illness in a variety of ways. Shame can lead to avoidance or procrastination in seeking medical attention, even when serious symptoms are experienced. It can lead to the concealment of a diagnosis from family or friends, or the failure to disclose important details of health status, situation or identity in a clinical encounter. It can lead to the avoidance of screening for infectious illness (such as HIV, Hepatitis C, or Covid-19), as well as failure to take up or complete the course of a prescribed treatment. Attentiveness to shame in healthcare contexts has been shown to increase both patient engagement and clinical outcomes.

Shame and Covid-19

The Covid-19 pandemic has been a key context for the emergence of new populations for public shaming, in the form of groups or individuals perceived to be transmitting the virus, breaking social distancing guidelines, or ignoring public health directives. These include people unable to wear face masks, young people making use of public spaces, and commuters who have little choice but to be mobile, often in conditions where effective distancing is impossible. Uneven economic rescue packages have widened populations which are frequently made to feel shame, by increasing material poverty and reliance on food banks or universal credit.

Covid-19 has also worsened the experiences of populations who were already subject to persistent shaming, whether through racialized concerns over 'contamination' and global mobility, or stigmatising narratives on Covid-19 and overweight bodies. Frequently, experiences of shaming are intersectional, cutting deeper where people with long experiences of being publicly shamed become tangled in newer dynamics of viral shaming.

Clinical encounters already carry an elevated potential for shame, and these factors complicate and exacerbate that potential still further. Access to other public services is also routinely shamed. Both are taking place in the context of heightened anxieties over services, space, and who is entitled to use them; public resources vital to health - from parks to food banks to GP appointments - seem fraught and finite, with shame attached to perceived misuse. Medical and non-medical initiatives and interventions which fail to reckon with shame in their design and execution risk excluding individuals and groups who are already likely to be marginalised.

Because of the considerable leverage it has in conditioning behaviour, shame has been a frequent component of public health messaging, historically and throughout the Covid-19 pandemic. In some cases, initiatives rely directly on shame to achieve their outcomes; in others, shame is the secondary product of a particular emphasis or representation. All forms of shaming in Covid-19 public health work, whether intended or otherwise, are potentially harmful. They erode trust in institutions and experts, frame decision-making in terms which ignore vital social, cultural, economic, and relational contexts, and have deleterious long-term consequences for health.

Recommendations for Shame-Sensitive Practice

Reject shame as a behavioural tool of any kind in policymaking or practice. Not all shaming is accidental, and many initiatives and encounters still rely on shame as the inherent emotional driver of the change they set out to promote. An institutional commitment to shame-sensitive practice can be an effective starting point for sustained cultural change. This involves vulnerability, and requires critical reflection on past and future practice.

Build attentiveness to shame into institutional expertise and cultures, through the development of shared tools and resources. Create and systematise nuanced and collaborative understandings of how shame is produced and experienced. Collective accountability for shame-sensitive or shame-reducing practice begins with mutually-agreed goals and frames of reference; this could take the form of an institutional code of conduct, or a shame-proofing toolkit.

Use these tools and competencies to conduct frequent and challenging reviews and audits on work of any description which has the potential to generate, spread, or exacerbate shame. Does this initiative represent people, choices or behaviour in ways which could cause shame? Does it reflect on how shame might be present, and seek to minimise it in every possible way?

Engage and collaborate with excluded communities and publics to promote shame-conscious health-seeking or risk-averse behaviour, and support them proactively to do so, including by fostering supportive networks and relationship-based practice. Shifting emphasis away from individual decision-making – and understanding that this approach creates shame – makes space for attention to the collective determinants of health, trust, dignity and equity.

Thank you for your time and attention. We are happy to discuss any aspect of this work, provide resources, and collaborate on further action. Please direct enquiries to f.cooper@exeter.ac.uk.

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