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Review Article

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Shame is the Subtle Saboteur: Benefits to be Gained from Listening

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Abstract

Shame is a strong and unpleasant emotion, which often goes unrecognised. Those experiencing shame can feel unworthy of care, deserving of suffering, and damaged as a person. Sometimes confused with guilt, a related emotion, shame differs in its influence on behaviour. Yet, both can impact on the effectiveness of health care and both can be invoked during medical consultations

Keywords: Adulthood; Health care; Surgical specialities

Introduction

Shame is a distressing emotional state, which can arouse a personal sense of unworthiness and persistent low-esteem. Those experiencing shame, often feel undeserving of care and affection, and in healthcare situations, can sometimes sabotage plans for treatment.

This discussion concerns a woman who felt shamed and traumatised by a situation occurring in young adulthood, yet the impact of the event lingered throughout her remaining life. A short account of her circumstances illustrates ways that listening closely to her accounts of life events, encouraged a readiness to acknowledge and address the origins of her difficulties, resulting in happier more productive daily living.

Research demonstrates that shame can be invoked by treatment and care throughout medical and surgical specialities but prominently concerning mental ill-health impeding recovery from illness. Consequently, services might contribute to difficulties they intend to address. Over the past decade or more, concerns about the quality of treatment and care for mental ill-health, have gained prominence on health and social policy agendas. Increasingly, attention has been given to the experience of stigma and shame in maintaining mental ill-health and ways mental health services can contribute - through the organisation of treatment and care.

Stigma: Stigma has been defined as a mark or flaw linked to being a member of a group that isn't valued by society or culture and is considered to be the outward appearance of shame.

Shame: Shame also has social and cultural origins and consequences. It involves evaluating ourselves negatively as unattractive or undesirable to use psychotherapist, Paul Gilbert's phrase, 'being in the world as one does not wish to be' [1].

Shame can occur as oneself in relation to others. However, importantly, it can also occur as self-to-self making relief from distress almost impossible. Shame is different to guilt, although they are frequently viewed as the same [2]. While guilt encourages a person to address a situation, not always in helpful ways, shame will encourage hiding away.

Experienced simultaneously shame and guilt can deepen personal conflicts. Circumstances giving rise to distress may seem impossible to resolve. Consequently, shame can be emotionally corrosive, destroying a sense of pleasure in life and relationships. Shame also encourages isolation and negative ruminations perpetuating ill-health. As such, it is the saboteur of healthy relationships with oneself and others.

Adhering to treatment and care

Various researchers have noted that people receiving treatment and healthcare do sometimes fail to adhere to treatment plans or else neglect consultations because of shame, and this can occur throughout health care services and regardless of age or medical condition [3].

Nonetheless, compared with other treatment settings, those receiving treatment for mental ill-health may not always receive satisfactory levels of support from family members or social networks and sometimes this is because of personal fears of becoming stigmatised and shamed by association [4].

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Consequently, listening closely to accounts of those receiving treatment for mental ill- health is critical to accurately assessing and addressing circumstances concerning with feelings of shame contributing to continued mental ill-health [5]. People can also enter hospital or begin treatment already stigmatised and so vulnerable to feeling shame - influencing subsequent treatment and care processes with both human and service implications.

To illustrate:

Maria: A brief account: Maria (not her real name) was sixty-five years old and suffered low-mood and marked anxiety for much of her adult life. Over the years, she was prescribed a number of different anti-depressant medications along with several admissions to hospital but her circumstances remained unchanged. She would spend long periods in her house and generally neglect her physical and emotional health.

While not obviously alcohol dependant, she would regularly drink in order to dull her senses of being unworthy and something awful might happen to her common to feelings of anxiety. Maria, would miss appointments with her family doctor, giving the impression she was not committed to improving her circumstances. Missed appointments were often related to Maria's moods. Discussing events - without knowledge of Maria's trauma - concerning her ill-health. would activate shameful feelings, causing her to feel dread and anger towards others while hiding herself away in her home. She was eventually referred to primary care mental health services for a psychological assessment, with a view to psychotherapy.

Background and formulation

During early consultations, Maria spoke of an incident in her adolescence. This was a time of social stigma, and intolerance for single mothers - she became pregnant and gave birth to a daughter. Although the birth of her child was uneventful, Maria's behaviour was considered by family and others to be shameful and the child was subsequently adopted.

Such was Maria's family's shame, the child was never discussed and Maria had no knowledge of the circumstances surrounding or following her daughter's adoption. She hid the event away from the world and avoided all situations in which she might feel exposed and others would judge her negatively. Maria had no opportunities to grieve the loss of her daughter, although an image persisted in her mind. Maria's self-shame did not require the presence of judgemental others and lasted throughout her life, preventing her from grieving her losses and impacting on relationships. She spoke of the relief she felt from finally discussing events without feeling judged. Maria also recognised that she felt ready, after many years of hiding from her feelings, to acknowledge her distress and the events that contributed to her general sense of being wrong as a person. For perhaps the first time, after a long time, Maria felt a sense of hope that her life might improve.

Activities of daily living

Together, we organised a schedule of activities. This included attention to sleep, diet, recreation and regular but moderate exercise. She also agreed to follow our plan and not the way she was feeling on any given day.

Life began to change for Maria. She baked cakes and joined a group with similar interests and values – easing her sense of isolation caused through hiding her self away. Alcohol was no longer necessary to dull Maria's painful memories and feelings and she discussed the idea of a planned reduction of her antidepressant medication with her family doctor. – Maria was beginning to experience the smaller joys of daily living and a release from her self-imprisonment.

She spoke of the sense of relief from shame she experienced in the safe setting, provided by psychotherapy and planned for a life ahead, which did not involve mental health services and to address concerns appropriately, allowing her to resolve conflicts regarding her daughter.

A life without shame: For Maria, simply feeling ready to speak and being listened to, in safety and without fear of judgement, about an event in her life she considered shameful, allowed her to regain a sense of personal control, review, and plan for a more compassionate and enjoyable future. She could begin to grieve her losses and make decisions appropriately and sensitively, with the company and support of others of her choice.

What can we learn: Shame's function is to destroy pleasure and so maintain culturally and socially-defined group conformity for better or worse. Yet, social and cultural norms may not be explicitly defined and can change over time. This can impact on the effectiveness of the treatment and care of those experiencing mental ill-health Shame, can bring about strong non-acceptance of self and others, hindering the capacity for necessary compassion in relationships. While shame is, arguably, more evident in instances of mental ill-health including impacting on mental health professionals, It has relevance to all other areas and specialities of health care.

Consequently, stigma and shame, to some extent, are perhaps to be anticipated as a part of all health care. Yet research suggests, that activated shame is likely to motivate varied emotional states and behaviours e.g. self-concealment, resistance to treatments, and even hostility towards oneself and others.

Conclusion

Shame is a potent feeling and is manifestly concerned with ensuring social and cultural norms are followed closely. Even so, as with Maria, invoking shame, along with stigma, can prove psychologically overwhelming and so damaging to emotional health and well-being.

Nonetheless, as research and clinical work shows, our vigilance to the damaging effects of shame will be therapeutic to patients throughout specialities of health care, and services will likely be more effective.

References

1. Bromley JS and Cunningham SJ (2004) You don't bring me flowers anymore': an investigation into the experience of stigma by psychiatric in-patients. *Psychiatric Bulletin* 28: 371-374.
2. Gilbert P, Pehl J, Allan S (1995) The phenomenology of shame and guilt: an empirical investigation. *British Journal of Medical Psychology* 67: 23-36.

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3. Joaquin S (2020) Why Guilt and Shame are Functional for Mental Health. Positive Psychology. Why Shame and Guilt Are Functional For Mental Health.
4. Jones AC and Crossley DR (2008) In the mind of another' shame and acute psychiatric inpatient care: an exploratory study. A report on phase one: service users. J Psychiatr Ment Health Nurs 15: 749-757.
5. Jones A and Cutcliffe J (2009) Listening as a method of addressing psychological distress. J Nurs Manag 17: 352-358.

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