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A Conceptualization of Shame and its Remedies in Healthcare

Dominic Mangino | *Guest Contributor*

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As a patient-centered healthcare model has been adopted, there has been an increase in the literature describing shame in the clinical setting. Much of it has focused largely on social stigmas relating to specific afflictions: HIV, AIDS, lung cancer, addiction, and various mental health disorders. Somewhat neglected in these accounts is a comprehensive account of shame itself. This is not to say the various therapeutic suggestions and proposed solutions are ineffective. Rather it is to suggest that a more fundamental conceptual basis is missing or being presumed within the various solutions already proposed. A framework is necessary for providing a cohesive context in which a discussion regarding shame, its importance to healthcare, and its remedies may take place. In the rest of the paper, I present a notion of shame adopted from the work of Eleonore Stump to help illustrate conceptually the link between seeking medical care, illness, and feelings of shame. I then argue that any attempt to combat shame must attempt to defeat one of shame's two necessary conditions, which involve being deficient in or accepting as binding some objective standard of human attractiveness.

The Concept of Shame

Eleonore Stump discusses the topic in her work dealing with the problem of suffering.[1] She believes it is helpful to investigate shame alongside guilt, as they are similar in their logical structures and are sometimes confused. First, it is important to note both are a response to an action or state of being. Second, they both relate to things desired by the one who is experiencing shame or guilt. According to Stump,

> it is helpful to think about the difference between shame and guilt in terms of the things desired and the penalties feared in each condition. The response on the part of real or imagined others that is anticipated with anxiety by a person feeling guilt is anger, and the penalty anticipated with anxiety is punishment of one sort or another. But shame is not like this. The response that is anticipated by a person feeling shame is more nearly rejection than anger, and the penalty dreaded is ostracism or abandonment.[2]

If desire is at the root of shame, it is natural

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to inquire as to *what* is being desired. Answering this question adequately requires one to follow the logic back to the fundamental and most basic object of desire. For Stump this is *love*, understood as: (1) the desire for goods for the beloved, and (2) the desire for union with the beloved.[3] Guilt is correlative with the desire for goods and shame is correlative with the desire for union.[4]

> A shamed person and a guilty person each anticipates a repudiation, on the part of real or imagined other, of both the desires of love. . . . A guilty person . . .is anxious about things others may impose on him that are not for his good, at least not in his own view. By contrast, the shamed person anticipating rejection and abandonment . . . is anxious about marginalization or isolation; his anxiety is directed towards a distance, an absence of union, forced on him by others with whom he himself desires some kind of closeness.[5]

A 10 year old who disobeys his parents by not completing his homework when it is a well-established condition for playtime will feel guilt. The child knows (or believes) that his action will result in revocation of his playtime (contrary to his good) and frustrated parents (anger). On the other hand a 14-year-old child may feel shame when his parents find out he has been skipping school. He is not primarily concerned with the revocation of any particular good by the discovery, but he may feel anxiety about the prospect of rejection or abandonment by his parents. It is easy to see why the child in the first scenario may feel guilt.[6] It is less clear in the second scenario.

Elaborating two necessary conditions of shame will help explain why there is shame in the second scenario. The first condition requires the individual to believe himself to be deficient in a standard that is deemed an objective measure of human attractiveness by a particular community. Let us call this the *deficiency criterion*. Second, the individual must accept the objective measure as ultimate and binding for himself. Let us call this the *acceptance criterion*.[7] In the second scenario the child has identified and internalized as binding both obedience and studiousness as the objective measures of attractiveness set by his parents. By falling short of both, the child sees himself as a failure and worthy of abandonment in some sense. It is not necessary for the parents to actually abandon the child for the child to feel truly isolated. The abandonment deemed appropriate by the child can *in itself be* enough to isolate him. For instance it can temporarily lead to self-loathing and a type of willed loneliness.[8]

There are three species of shame in persons: (1) One may be worthy of shame who does not feel shame, (2) one may be worthy of shame and feel shame, and lastly, (3) one may be undeserving of shame and feel shame.[9] All three varieties are likely present in the healthcare setting, although the third will be the focus of this paper. Focusing only on the third species of shame limits the discussion to only those individuals for whom shame is an objectively bad state of being in nearly every sense. In doing this, I assume that illness *qua illness* is underserving of shame, and thus believe that all patients *qua patient* are also underserving of shame. I do not rule out the possibility that sick persons can be deserving of shame in other respects, but think it beyond the scope of medicine to make that determination. This assumption also seems consistent with the medical professions' commitment to caring (i.e., not abandoning) equally for all patients regardless of their past actions.[10] Focusing only on those undeserving of shame also avoids complicating factors involved with the other species of shame that fall beyond the scope of this paper: for instance, if individuals are truly deficient in sound objective measures of human attractiveness, feelings of shame *might* be good in some sense.[11]

Although the social stigmas related to certain diseases, such as lung cancer, are likely sufficient to bring about feelings of shame, I contend that there is a much more prevalent source of shame in healthcare. Analyzing the phenomenon of illness within the American cultural context will demonstrate how one who seeks medical attention may in many cases feel shame because of some commonly held values.

Values and the Nature of Illness

Productivity, efficiency, and autonomy are prevalent values in American culture.[12] The American obsession with productivity and efficiency has appeared frequently in the news, and the value Americans place on autonomy may be reflected by the fact that more than 90% of people who received physician-assisted suicide in Oregon cited "loss of autonomy" as one of their primary concerns.[13] Autonomy has further gained prominence as a central principle of contemporary biomedical ethics.[14]

The source of these values is worthy of discussion, but their existence as important things for which humans strive (sometimes inordinately) is clear. This makes it plausible that many see these values as the objective criteria by which human attractiveness is measured. If this is the case, there are important implications for healthcare. The following discussion on the nature of illness will show how a sick individual who seeks medical care will likely fail to live up to these criteria.

Edmund Pellegrino notes four goods in which sick persons are deficient to some degree. These are (1) the freedom to act, (2) the freedom to make choices, (3) freedom from the power of others, and (4) one's self-image.[15] He argues that the experience of a deficiency in these criteria constitutes an assault on that which differentiates human life from other forms of existence.[16] It is easy to see how an inability to act will harm the ability to be productive. One may argue that this is a narrow understanding of productivity only accounting for physically laborious activities. However, this is a misplaced objection, for even if one was still productive in other ways (i.e., writing, thinking, etc.) bodily integrity to some degree remains a necessary condition to carry out these or any human actions. To the extent faculties pertaining to an act are damaged, production resulting from that act will be hindered. This applies *mutatis mutandis* for efficiency.

Autonomy is hindered by deficiencies in choice making and freedom from the power of others. According to Beauchamp and Childress in their seminal work *Principles of Biomedical Ethics,* autonomy at a minimum requires self-rule free from both controlling interference by others and limitations that prevent meaningful choice (i.e., inadequate understanding).[17] Acute or chronic illness hinders the individual's ability to act as stated above, and often times places an individual in a condition where he is incapable of healing himself due to inadequate knowledge, which then requires him to seek out the help of another.[18] Any illness for which one seeks help from a medical professional requires, at the very least, the authorization of a stranger to probe the secret places of mind, body, or soul.[19] This is the momentary surrendering of oneself to another for the purpose of one's own good, and demonstrates a clear loss of autonomy to some degree. Moreover the inherent power imbalances between the patient and healthcare provider (the one to whom one is surrendering) can exacerbate this tension and lead to feelings of domination if the covenantal relationship between the clinicians and patient is not properly safeguarded. These aspects need not lead to feelings of shame, but they very well may.

The above discussion demonstrates how prominent American values—like productivity, efficiency, and autonomy—and the nature of illness interact strongly to predispose the sick towards feelings of shame. Any individual who accepts the values of productivity, efficiency, and autonomy as objective measures of human attractiveness and does not have a belief overriding these values is likely to experience shame whenever he is ill and seeks medical attention. This is because a sick person seeking medical attention is inherently deficient in those values to some degree, and the acceptance of the values as ultimate fulfills both the deficiency and acceptance criteria.

Combating Shame

In combating shame it seems there are two general approaches. The first requires a restoration or defeat of the deficiency the individual embodies.[20] This in healthcare is the medical means taken to restore bodily integrity. However, this approach is dependent on the technologies and procedures available at any given moment, which makes it materially limited. Material limitation and the more psychospiritual nature of shame seem to demand another approach. Rather than attempting to combat another's deficiency directly, one could assist a person in rejecting as ultimate the values in which he is deficient—in this case the values of productivity, efficiency, and autonomy.[21] This happens in two ways: (1) by reordering one's objective measures of human attractiveness and by (2) celebrating the life of the shamed individual.[22]

The first way is obvious—by not accepting the criteria denoting himself deficient in some respect, his ability to be shamed by it is removed. Further, since this discussion concerns people who *feel* shame but are *undeserving* of it, the problem of denying a sound objective measure of human attractiveness (i.e., one deserving of shame) is avoided. The "mode of action" for celebrating one's life is less apparent, but becomes clear after considering the kinds of things we celebrate. We celebrate things that are lovely, desirable, or dignified in some way. Therefore, when we celebrate a person's life, we acknowledge something lovely or dignified about him or her. This acknowledgement communicates some desire for union with that person and defeats the chief anxiety at the base of shame—the fear of abandonment.[23]

There are at least two ways to celebrate another's life, which correspond with two varieties of the term "dignity" commonly employed in ordinary language.[24] First, one can celebrate another's attributed dignity, the dignity we attribute to another's life in virtue of having certain qualities. [25] We do this by celebrating another's admirable traits, actions, and talents. For instance, a hospital staff might celebrate the harmonica skills of a patient by hosting a "mini-concert" in his room. Gathering together to celebrate the patient's talents clearly communicates to him that he is lovely in some way and that others desire union with him, and thus shame may be defeated.[26] Celebrating one's life in this way may often times be easy, however this is not always the case.

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Imagine a "locked-in" patient who may still be fully aware of everything around him but lacks the ability to respond in any way. Further, imagine that very little is known about the patient before his locked-in state—for instance, there is no knowledge of his past career, hobbies, or talents. How might this person's life be celebrated? How can a healthcare team show him he is desired by others? In this kind of case, it is not possible to celebrate the excellent qualities of the patient, so one needs to celebrate something more fundamental and inherently lovely about him—his intrinsic dignity. This is the kind of dignity an individual has simply by virtue of being the kind of thing he or she is.[27] It is more difficult to defeat shame in this way, for it is not always easy to communicate to another that he or she is desired and dignified simply for existing. One way may be to simply tell the patient she is desired and dignified. Another might be to devote time to a patient beyond what is professionally expected, perhaps by reading a book aloud to him. Further discussion on how to practically celebrate another's intrinsic dignity in a way that aptly communicates that others desire union with him is warranted. Such a discussion would benefit by examining how early Christians operationalized their understanding of *imago Dei*—the theological concept that all persons are created in the image of God.[28] The *imago Dei* clearly has important ramifications regarding one's intrinsic dignity. For instance, how could one not recognize the inherent worthwhileness of caring for an elderly patient with dementia who struggles to eat, speak, and move, if he or she is made in the image and likeness of God? How might this concept motivate use to make advanced care planning decisions and mobilize resources for our loved ones? Further work needs to be done to spell out the implications of the *imago Dei* for combating shame.

Conclusion

A crucial point must be made regarding the defeat of shame in healthcare: its defeat does not preclude or necessarily defeat other forms of suffering. Shame—the fear of abandonment and isolation caused by ones deficiency and acceptance of some criteria—is only one type of suffering. It is an acutely existential and debilitating form of suffering; however, there are no doubt other forms to which the sick are subject: physical pain and suffering, the encountering of one's finitude, and permanent or temporary loss of things held dearly, among other things. These other forms of suffering must be absorbed into a larger context if they are to become intelligible, however this is beyond the problem to be dealt with in this paper.

I have proposed that a fleshed-out concept of shame is necessary to combat it in the healthcare setting. In the account offered shame is the real or imagined

abandonment of oneself or others caused by a deficiency in some objective measure of human attractiveness held to be ultimate by an individual. I then showed that common American values predispose any sick individual who seeks medical care towards feelings of shame if he is not committed to other overriding values. I argued shame could be defeated by remedying the deficiency one has, or by shifting the values one accepts as the objective measures of human attractiveness. One way to do the latter is to celebrate the life of the shamed individual, which communicates to him that others desire union with him. I further argued this is done by celebrating the attributed and intrinsic dignity of the patient. Recognizing challenges in practically celebrating another's intrinsic dignity, I called for further discussion on how this may be done. Laying the conceptual groundwork for the defeat of shame is necessary but insufficient for the defeat of shame in healthcare, so it is my hope that this discussion leads to concrete efforts to improve the lives of patients.

1 Stump's account was selected for this paper because: (1) she engages critically and builds on influential discussions of shame by notable figures like, Ruth Benedict, Martha Nussbaum, Douglas Cairns, and Moshe Halbertal, and (2) her discussion of shame is a constitutive part of her overall theodicy, which is one of the strongest and most analytically presented theodicy accounts on offer. Although she is not directly engaged with bioethics, her analytically sound theodicy and shame's large role in that account can provide many insights to bioethicists tackling shame in healthcare.

2 Eleonore Stump, *Wandering in Darkness: Narrative and the Problem of Suffering* (Oxford: Clarendon Press, 2010), 143–144.

3 Ibid., 85–107. This is the two-desire account of love that Stump takes from Aquinas, which is able to encompass the two distinct features of love. Feature 1 is that we love others for their particular characteristics. Feature 2 is that our love for others remains constant despite changes in those particular characteristics. Other accounts like the responsiveness, volitional, and relational models are unable to adequately explain these two features. For a longer discussion see Stump's discussion in chapter 5, "The Nature of Love."

4 Ibid., 144.

5 Ibid., 144.

6 One might object that love itself is a good when desired. This is intuitive, but I believe the "good" one desires when she says "I desire love" is one of union rather than of some good in the ordinary sense.

7 Ibid., 148.

8 Ibid., 143–148.

9 Ibid., 141. A truly shamed person is one who is worthy of being abandoned (in some sense) by others as opposed to one who only feels shame and only believes he is worthy of being abandoned.

10 Ofer Merin, Sara Goldberg, and Avraham Steinberg, "Treating Terrorists and Victims: A Moral Dilemma," *The Lancet* 385, no. 9975 (2015): 1289.

11 Within the delineation there is the implicit notion that there are sound and unsound objective measures of human attractiveness. It follows that if an individual is deficient in one of these sound measures he or she may benefit from the feeling of shame, which serves as a catalyst for change or reform. This notion of sound and unsound objective measures derives from an understanding of truth in which propositions correspond rightly with reality. It is henceforth assumed there are sound and unsound objective measures of human attractiveness, and that those in the category with which we are concerned are not deficient in them.

12 The definitions in this paper assume common and broad notions of productivity, efficiency, and autonomy. Productivity is the ability to produce goods or services. Efficiency is just a measure of how well one produces. Lastly, autonomy is the ability to be self-determining.

13 Melissa Gregg, "The Productivity Obsession," *The Atlantic*, November 13, 2015, https://www.theatlantic.com/business/archive/2015/11/be-more-productive/415821/; Jill Lepore, "Not So Fast," *The New Yorker*, October 5, 2009, https://www.newyorker.com/magazine/2009/10/12/not-so-fast; Lydia Dishman, "The Dark History of Our Obsession with Productivity," *Fast Company*, September 12, 2018, https://www.fastcompany.com/90230330/how-our-obsession-with-productivity-evolved; Center for Health Statistics Public Health Division, "Oregon Death with Dignity Act: 2018 Data Summary" (2019), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf.

14 Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th ed. (New York: Oxford University Press, 2013).

15 Edmund Pellegrino, "The Humanistic Basis of Professional Ethics," in *The Philosophy of Medicine Reborn: A Pellegrino Reader*, ed. H. Tristram Engelhardt, Jr. and Fabrice Jotterand (Notre Dame: Notre Dame Press, 2008), 95–97.

16 Ibid., 95.

17 Beauchamp and Childress, *Principles of Biomedical Ethics*, 101.

18 Edmund Pellegrino, "The Humanistic Basis of Professional Ethics," 94.

19 Edmund Pellegrino, "The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic," in *The Philosophy of Medicine Reborn*, ed. Engelhardt and Jotterand, 101–126.

20 This would be the preferred method for one who is truly worthy of being shamed one way or the other. This is the case with moral and character deficiencies, for the shame would catalyze a positive change in an individual assuming that the objective measures of human attractiveness that individual accepts are sound.

21 I take it for granted that these concepts, as valuable as they may be, are not appropriate as ultimate values by which one should judge herself. One reason for this is that these values and capacities seem to be largely instrumental in character rather than ends to be pursued for their own sake, thus they do not seem to be the proper kind of values by which one should be shamed.

22 Stump, *Wandering in Darkness*, 146–47.

23 Ibid., 147.

24 For a discussion of the three varieties of the term "dignity" used in ordinary language see: Daniel P. Sulmasy, "The Varieties of Human Dignity: A Logical and Conceptual Analysis," *Medicine, Health Care and Philosophy* 16, no. 4 (2013): 937–44.

25 Ibid., 938.

26 Important to note this defeat might only be temporary. Celebrating one's life is an antidote to shame, but like many remedies it is unlikely to permanently cure the patient from feelings of shame.

27 Ibid., 938–939.

28 Gary B. Ferngren, *Medicine and Health Care in Early Christianity* (Baltimore: Johns Hopkins University Press, 2009), 97–112.