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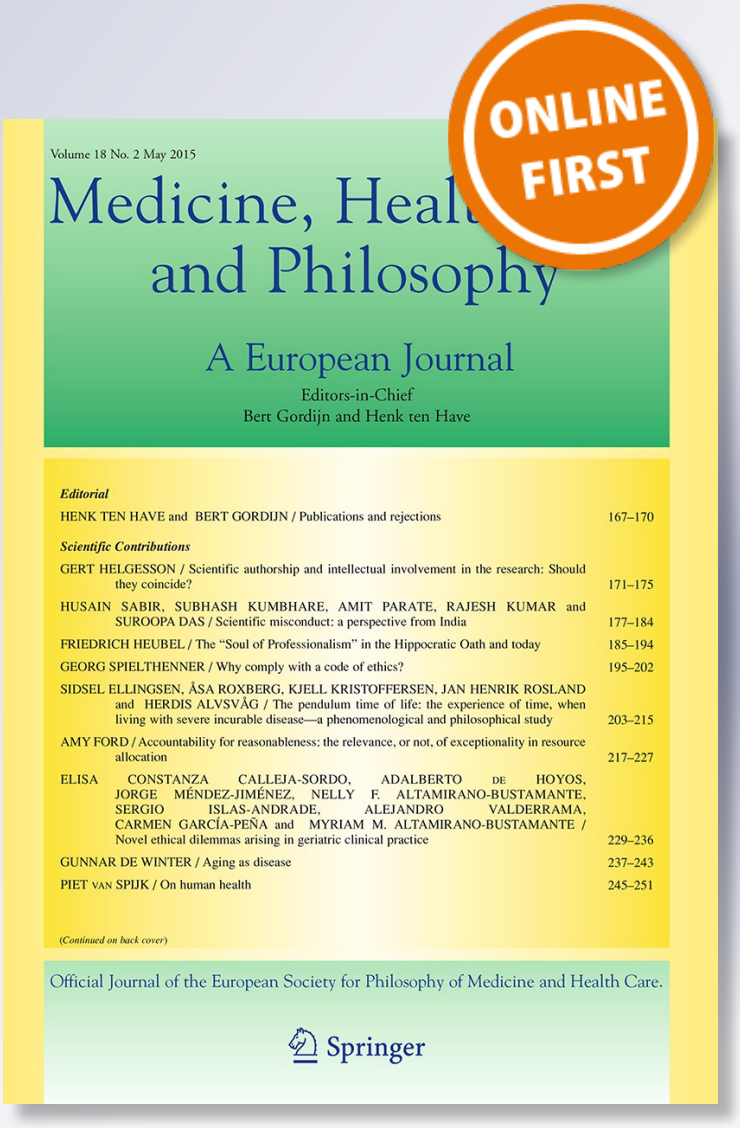

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SCIENTIFIC CONTRIBUTION

The phenomenology of shame in the clinical encounter

Luna Dolezal[1]

Abstract This article examines the phenomenology of body shame in the context of the clinical encounter, using the television program 'Embarrassing Bodies' as illustrative. I will expand on the insights of Aaron Lazare's 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. I will start by outlining a phenomenology of shame in order to understand more clearly the effect shame about the body can have in terms of one's personal experience and, furthermore, one's interpersonal dynamics. I will then examine shame in the clinical encounter, linking body shame to the cultural stigma attached to illness, dysfunction and bodily frailty. I will furthermore explore how shame can be exacerbated or even incited by physicians through judgment and as a result of the power imbalance inherent to the physician-patient dynamic, compounded by the contemporary tendency to moralise about 'lifestyle' illnesses. Lastly, I will provide some reflections for how health care workers might approach patient shame in clinical practice.

Keywords Shame · Body shame · Clinical encounter · Stigma · Embarrassing Bodies

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Introduction

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 their doctor. It is arguable that the popularity of *Embarrassing Bodies* arises from the voyeuristic appeal of the show where intimate parts of the body are graphically displayed in order to show bodily conditions that are most often kept private and hidden from view, such as genital warts, piles, hemorrhoids, rashes, tumors, verrucae, abbesses and countless other conditions. However, beyond the potential visually explicit, voyeuristic appeal, anecdotal evidence, the only kind presently available, indicates that the show's popularity is a result of the tangible effect it has had in terms of de-stigmatizing certain bodily conditions and illnesses. By making public aspects of healthcare that had previously been personally shameful and secret, *Embarrassing Bodies* has encouraged viewers to feel more comfortable approaching healthcare professionals. Watching others confront and dispel their medical shame on television seems to be significantly cathartic and compelling. As one doctor remarks, it makes "people feel that these things can be openly discussed, that it's OK to go to your doctor, and that you'll be treated with respect."[1]

The show is award-winning and has had widespread popularity both nationally and internationally. It is the most watched television program on Channel 4 and its accompanying internet platform has had a tangible impact in

[1] Quoted in: Benedictus (2011).

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terms of national healthcare in the UK. In 2011, the Embarrassing Bodies website, which features an autism test, an STI checker and several other diagnostic tools, had over 100 million page views and Channel 4 boasts that it saves the NHS £283,000 a month as a result of this online resource.[2]

What *Embarrassing Bodies* makes 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. There are numerous testimonies from patients and doctors reporting that after watching the program individuals were more likely to feel comfortable seeking out medical treatment or identified a health concern that they had previously not been aware of.[3] In fact, what *Embarrassing Bodies* seems to demonstrate is that, within the clinical context, acknowledging and openly talking about shame and embarrassment can have a very tangible positive impact in terms of patient experience and concomitant 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.

However, even in the era of *Embarrassing Bodies*, very few people are discussing the dynamics of shame in medical practice. Within the face-to-face drama of the clinical encounter, shame is often the "elephant in the room," to use Davidoff's formulation.[4] Although it is ubiquitous and ever present, it is something so big and disturbing that we "don't even see it" or do our very best to avoid it.[5] Shame in medical practice often remains unspoken, hidden or repressed. This is reflected in the paucity of literature on the role that shame plays in medicine and clinical care. In fact, since Aaron Lazare's ground-breaking 1987 article 'Shame and Humiliation in the Medical Encounter,' where he argues 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,[6] there have only been a handful of articles, blog postings and editorials addressing shame as a force to be considered within the clinical encounter or within medical treatment.

As such, my aim in this article is to explicitly describe the phenomenology of the experience of body shame and to explore its consequences within the clinical encounter. I will start by outlining a phenomenology of shame in order to understand more clearly the effect shame about the body can have in terms of one's personal experience and, furthermore, one's interpersonal dynamics. I will then examine shame in the clinical encounter, linking body shame to the cultural stigma attached to illness, dysfunction and bodily frailty. I will explore how shame can be exacerbated or even incited by physicians through judgment and as a result of the power imbalance inherent to the physician-patient dynamic, compounded by the contemporary tendency to moralise about 'lifestyle' illnesses. Lastly, I will turn again to consider *Embarrassing Bodies*, providing some reflections for how health care workers might approach patient shame in clinical practice.

A note on terminology: In this article both the terms shame and embarrassment are used. In particular, the term 'embarrassment' is used with reference to the TV series *Embarrassing Bodies*. Due to the large body of literature addressing the differences between shame and embarrassment, it is worth commenting briefly on terminology here. There is an on-going debate within empirical psychology and other disciplines regarding whether shame and embarrassment are distinct emotions or simply variations of the same emotion. Many empirical studies have been carried out in the attempt to meaningfully distinguish them. To summarize, key differences postulated between shame and embarrassment are related to: intensity; a moral component; the presence of an actual or imagined audience; a contagious element; an element of surprise; injury to one's self; and frequency of occurrence.[7] Although there are often overlapping features between experiences of embarrassment and shame, for the purposes of this article, my focus will be on shame, which, when compared to embarrassment, is arguably a more intense and devastating experience which, furthermore, is not easily trivialized, forgotten or made light of.[8] In fact, the TV series *Embarrassing Bodies*, I would suggest, would be more aptly entitled 'Shameful Bodies' as the participants are usually not merely embarrassed, but in fact, deeply ashamed of their bodies and ailments.

[2] "Embarrassing Bodies Series Saves Nhs £280 k in a Month," http://www.channel4.com/info/press/news/embarrassing-bodies-series-saves-nhs-280k-in-a-month. (Accessed 6 June 2015).

[3] Wiseman (2010).

[4] Davidoff (2002).

[5] Ibid., 623.

[6] Lazare (1987).

[7] For example, see: Sabini et al. (2001), Babock and Sabini (1990), Keltner and Buswell (1996), Tangney et al. (1996) and Miller and Tangney (1994).

[8] In this way, embarrassment can be consider to be a 'mild' or 'less intense' form of shame, and there are several thinkers who argue to this effect. See: Kaufman (1993, 24). See also: Crozier (1990, 39–40), and Lewis (1995, 210).

Shame and the body: a phenomenology

Shame, in general, arises when one is concerned with how one is seen and judged by others. It is a 'self-conscious' emotion, in that the object of shame is oneself. Furthermore, shame involves an awareness of how one perceives that other people view the self. We feel ashamed when we are perceived by others (whether they are present or imagined) as doing, or being, something that we consider inadequate, inappropriate, untoward, deviant or immoral. Shame is a difficult and even devastating emotion. It goes to the core of an individual and their identity, making them feel exposed, inferior and deficient. Shame threatens social bonds and one's feelings of belonging and acceptance. When faced with shame, common reactions including 'hiding,' 'escaping,' 'disappearing from view' and 'shrinking into the floor.'[9]

Despite the paucity of writing on shame in the medical encounter, it has long been acknowledged that patients often regard their illnesses as personal shortcomings, or arising from personal inadequacies and, as a result, shame about illness and the body is a common experience. In this way, falling ill and exposing one's illness is often a potent source of shame. In fact, the links between the body, shame and exposure of the self have a long cultural and conceptual history. Shame is etymologically and historically connected with the body and nakedness, particularly the desire to conceal one's nakedness. In the biblical story *Genesis*, after the fall, Adam and Eve become aware of their naked state and cover themselves because they become ashamed of their nudity. In this story, the very origin of humanity is intimately linked with shame about the body. In English, the word 'shame' comes from a pre-Teutonic word meaning 'to cover' where 'covering oneself' is considered the natural expression of shame.[10] In Ancient Greek, *aidoia* (αἰδοῖον), a derivative of *aidōs*, is a standard Greek word for the genitals,[11] again connoting the reaction of wishing to hide or conceal oneself.[12] In addition, the German word for shame, *Scham*, also refers to the genitals as does the Danish word for labia, *skamloeber*, which literally translates to the lips of shame.[13]

According to the philosopher Max Scheler, nakedness has been traditionally associated with shame and we seek to cover our sexual organs because they are symbolic of our animality, mortality and vulnerability. In Western culture, humans have traditionally celebrated their transcendence, not their flesh, and the animal nature of human life has been shunned and repressed. As such, shame about the body is particularly powerful in that it disrupts our illusion of transcendence—the notion that we are more than *merely* animals—and reveals our undeniable and imperfect corporeality. The body symbolizes our vulnerability, neediness and ultimate lack of control over our own mortality. Hence it is not surprising that the body, especially when it falls ill or fails us, is a powerful source and site of shame.

Shame about the body is often referred to as 'body shame.' Body shame can be understood to be shame that arises as a result of some aspect of the body or bodily management, perhaps appearance, bodily functions or comportment.[14] It is shame that is centred on the body, where the subject believes their body to be undesirable, inadequate or unattractive, falling short of social depictions of the 'normal', the ideal or the socially acceptable body.[15] Indeed, the body, as Stephen Pattison notes in his recent work *Saving Face: Enfacement, Shame, Theology*, and "its appearance and functions are an important locus for shame."[16] Although body shame can be straightforwardly about some aspect of the physical body, such as one's appearance, it also encompasses shame about less obviously physical aspects of body presentation, such behaviour, comportment, bodily functions and illness. Body shame encompasses a wide range of embodied conditions and experiences, such as ageing, perceived unattractiveness, disfigurement, race, disability, cancer, incontinence, skin disorders, among many others.

Body shame is a particularly powerful and potent form of shame. Not only is the body the part of ourselves that is immediately observable to others, the body is also the seat of personhood and that which makes meaningful subjective experience possible. The body is the ground of the self, as consciousness is necessarily embodied.[17] In fact, no thoroughgoing demarcation can be made between the subject and the body. In experiences of body shame, some part of the body or one's bodily functioning is brought into awareness and is regarded (and judged) by the self or others. Body shame involves exposure and visibility; one is seen by oneself or by others (whose views and judgements one shares) to be failing or flawed in some crucial way.

As a result, self-consciousness is key in experiences of shame about the body. The individual feels exposed and this leads to a paralyzing inner scrutiny, a moment of extreme self-consciousness. As the clinical psychologist Gershen Kaufman describes it: "to feel shame is to feel

[9] Dickerson et al. (2004, 1196).

[10] See the 'shame' entry in the Oxford English Dictionary. Also see: Klein (1967, 1430).

[11] Liddell and Scott (1889, 19).

[12] Williams (1993, 78).

[13] Zahavi (2014, 216).

[14] For example, see: Gilbert and Miles (2002).

[15] See: Dolezal (2015). The ideas in the paragraphs which follow here are discussed at length in chapters 1, 2 and 4 of this monograph.

[16] Pattison (2013, 62).

[17] See: Merleau-Ponty (2012).

seen in a painfully diminished sense."[18] In experiences of body shame, this occurs on two levels. Firstly, as body shame is about some aspect of the body or comportment, part of the body becomes conspicuous or *shameful* and attention is drawn to it. Consider, for example, Michelle, a 23-year-old woman who suffered from chronic shame about the shape of her nose before undergoing rhinoplasty. Michelle describes how her attention was continuously drawn to her nose, distracting her from other activities and disrupting the 'flow' of her social situations. She comments on her experience:

> It was like, my nose would just get really, sort of, *hot* and I'd be like, I've got to get to a mirror… My boyfriend and I would be having a meal out and I wouldn't be thinking, y'know, about enjoying myself. I'd be worrying, does my nose look huge in this light.[19]

Second, compounding the feeling of being *seen* that arises as a result of shame about a physical feature or function, the shame experience itself also involves a whole slew of involuntary physiological reactions which also bring awareness to the physical body.

Shame, like all other affective experiences, occurs through the body. Although it can have a clear cognitive dimension, shame, for the most part, is an embodied response. It overwhelms us physically. The physical symptoms that can arise in a shame experience are varied, as they arise from both sympathetic and parasympathetic responses in the body.[20] Erving Goffman, in his extensive writing about shame and embarrassment, offers a list of possible shame symptoms and responses:

> [B]lushing, fumbling, stuttering, an unusually low- or high-pitched voice, sweating, blanching, blinking, tremor of the hands, hesitating or vacillating movement … there may be a lowering of the eyes, bowing of the head, putting the hands behind the back, nervous fingering of the clothing or twisting of the fingers together, and stammering … There are also symptoms of a subjective kind: constriction of the diaphragm, a feeling of wobbliness, consciousness of strained and unnatural gestures, a dazed sensation, dryness of mouth, and tenseness of muscles.[21]

This list is not intended to be a complete catalogue of shame symptoms, but rather demonstrates that, although shame is *always* expressed through the body, it is difficult to describe a paradigmatic shame response; the symptoms and responses are numerous and varied, depending on a variety of factors. However, what is clear is that a shame experience is never merely cognitive, but instead manifests through corporeal expressions which draw attention to the physical body.

What is particularly interesting about shame is that these symptoms, as outward displays of shame, are themselves taboo. Revealing that one is experiencing shame, through blushing, trembling, stuttering, etc., is *itself* shameful.[22] As a result, shame symptoms provoke a shame spiral or "loop,"[23] in which, when shame arises it incites more shame (about the shame). Shame, as such, is referred to as an iterated emotion in that its occurrence leads to an intensification or multiplication of itself.[24] What we might consider to be "second-order"[25] shame results from shame itself being a source of shameful anxiety. As a result, shame is an emotion that is often fastidiously avoided and if that is not possible, it is to be scrupulously ignored and unacknowledged.

However, shame cannot always be avoided or ignored, and it sometimes intrudes into interpersonal encounters and interactions with disruptive consequences. Body shame can disrupt 'flow'—whether it is an individual's flow in an activity, or the 'flow' of a social encounter—and cause attention to be turned to the body, as in the example of Michelle cited above.[26] Gershen Kaufman terms this disruptive experience due to shame "binding."[27] Binding arises as a result of perceived exposure and visibility, and it involves a disturbance of smooth activity because some physical feature has brought attention to the body. In addition, the physical symptoms of shame, themselves shameful, affect a further disruption: "The binding effects of exposure, of feeling *seen*, acutely disturb the smooth functioning of the self…. Exposure can interrupt movement, bind speech and make eye contact intolerable. Shame paralyzes the self."[28] In the experience of binding, there is the desire to conceal oneself, to shrink away from others and the situation.

[18] Kaufman (1993, 17).

[19] Quoted in: Gimlin (2006, 707).

[20] Miller (1996, 17).

[21] Goffman (1967, 97).

[22] The shamefulness of shame can vary for certain groups. For example, it is suggested by Aneta Stepien that shame is particularly shameful for men. As a result they are much more likely to repress, hide or deny shame, perhaps bypassing it for other emotions or experiences such as depression or anger. See: Stepian (2014).

[23] Scheff (2000, 90).

[24] Lewis (1971). See also: Kaufman (1993, 4, 20).

[25] Lee and Wheeler (1996, 7).

[26] Thomas Fuchs makes a similar point arguing that an individual undergoes, what he terms, a 'corporealization,' where the spontaneous performance of the body is ruptured in experiences of guilt and shame. See: Fuchs (2003).

[27] Kaufman (1993, 18).

[28] Ibid., 18, 19–20.

Concomitant with the exposure and self-consciousness that are characteristic of shame, is the experience of an extremely negative affect within the subject which is directed towards one's own estimation of oneself. The psychologist Silvan Tomkins writes that as a result of the "inner torment" of shame, one feels "naked, defeated, alienated, lacking in dignity or worth."[29] Gershan Kaufman echoes this sentiment, describing shame as a "wound made from the inside by an unseen hand" which leads us to feel "fundamentally deficient as individuals, diseased, defective."[30] To experience shame, Kaufman argues, is "to experience the very essence or heart of the self as wanting. Shame is inevitably alienating, isolating and deeply disturbing."[31]

In addition, the negative affect of shame does not just impinge on the individual. Body shame has a peculiar 'contagious' character. In social relations, all the participants in a particular situation may experience feelings of embarrassment or shame when one person is overcome with the feeling themselves.[32] Shame cannot, therefore, be considered an experience with consequences limited to an individual subject. Instead, it has a social dimension, in that it changes the character of a situation in which it has occurred and, in addition, can 'infect' others: what would otherwise have been a smooth social encounter becomes infused with awkwardness and uncertainty about social cues and roles. To avoid the discomfort that arises in instances of shame, people go out of their way to avoid shame (or even mention past instances of shame),[33] even when this avoidance means harming or hurting the self.

Beyond remaining silent or being scrupulously avoided, shame can also be an "unidentified" or "hidden" emotion which does not enter conscious awareness but is nonetheless frequently present.[34] As shame is such a painful and disruptive experience, there is an intrinsic connection between shame and the mechanism of denial.[35] Although the experience remains available to consciousness, the person experiencing it is not able to, or perhaps simply will not, identify it as shame. In these cases, shame is 'bypassed' and other affects, such as anger, guilt, depression or doubt, take over. When shame is replaced with another emotion, or when it is unacknowledged or hidden, it goes "underground."[36] As, Lashbrook explains: "Shame (and its various manifestations) despite its ubiquity, is subtle and hard to detect because its painful nature leads to the need to repress it."[37] Hence, shame commonly leads to avoidance and to silence.

The stigma of illness and shame in the clinical encounter

This tendency to avoid body shame and potentially shameful exposure is of particular relevance when considering the dynamics of the clinical encounter where the metaphoric and literal exposure of the physical body is the centrepiece around which the drama of the clinic revolves. Exposure of the body is, as noted above, inherently shameful in our cultural context and it is not at all surprising there is stigma attached to instances of disease and illness, where the body is not only exposed and vulnerable but also cast as failing or deficient. As Lazare notes:

> In the medical setting, patients may experience physical or psychologic [sic] limitations as defects, inadequacies, or shortcomings that assault various treasured images of the self: youth, beauty, strength, stamina, dexterity, self control, independence and mental competence … This sense of inadequacy further jeopardizes social roles that give meaning and self-respect to patients' lives.[38]

Consider the reaction of the author Jenny Diski to a terminal cancer diagnosis, as very recently recounted in her essay 'Diagnosis' in the *London Review of Books*:

> The future flashed before my eyes in all its pre-ordained banality. Embarrassment, at first, to the exclusion of all other feelings. But embarrassment curled at the edges with a weariness, the sort that comes over you when you are set on track by something outside your control … the flood of embarrassment, much more powerful than alarm or fear, that engulfed and mortified me at finding myself set firmly on that particular well-travelled road.[39]

That embarrassment and shame arise for Diski before fear or alarm in the face of a terminal diagnosis and the threat of imminent death is testimony to how powerful shame, and the concomitant fear of social stigma and loss of self-respect that comes with illness, can be.

What Diski's testimony alludes to is that body shame in illness, in this case about cancer, is not straightforwardly about physical frailty and vulnerability, but can also have a

[29] Tomkins (1963, 118).

[30] Kaufman (1993, 5, 18).

[31] Ibid., 18.

[32] See, for example: Goffman (1959, 12).

[33] See: Miller (1996, 4–5).

[34] Lewis (1971, 203). And Lee and Wheeler (1996, 2).

[35] Lewis (1971, 196).

[36] Scheff (2004, 231).

[37] Lashbrook (2000, 754).

[38] Lazare (1987, 1654).

[39] Diski (2014, 7).

moral component. In fact, body shame is often intimately linked to socio-cultural mores and norms around what is 'good' or 'bad' in terms of one's character and behaviour. In this way, the potential for body shame in the clinical encounter is often connected to one's perceived responsibility, or blameworthiness, for an illness due to personality traits or health-related behaviours. In fact, human beings have a long history of linking illness and bodily conditions with negative personal attributes and, furthermore, doing so in order to moralize about certain social groups. For instance, in Victorian times, acne and skin blemishes were considered to be the result of moral failure and frequently associated with sexual deviancy. For the Victorians, physical beauty was thought to derive from pure inner qualities, such as morality and spirituality.[40] Hence, social and moral worth were conflated with the physical appearance of the body.

This logic extends to health and illness, where a "characterological predisposition," to use Susan Sontag's term, can be utilized to explain why one has fallen ill. Writing about the stigma of cancer, Sontag argues that "cancer is regarded as a disease to which the psychically defeated, the inexpressive, the repressed—especially those who have repressed anger or sexual feelings—are particularly prone."[41] In short, in the case of cancer, the illness has historically been seen to arise from one's own personal failing, and, as a result, can be regarded as justly deserved: a form of divine punishment or karmic retribution. In this vein, cancer has been characterized as a "curse," a "punishment" and a source of "embarrassment," rather than as a straightforward physical disease for which the diseased individual is not blameworthy.[42]

Furthermore, as Sontag notes, the shame of cancer is compounded by its propensity to attack intimate and embarrassing parts of the body, particularly those related to reproductive and excretory functions, such as the colon, bladder, rectum, breast, cervix, prostate and testicles.[43] Sontag concludes, "the metaphoric trappings that deform the experience of having cancer have very real consequences: they inhibit people from seeking treatment early enough, or form making a greater effort to get competent treatment."[44] What Sontag illustrates very clearly in her account of metaphor and illness is that when the body fails or falters as a result of some physical ailment, and when this is compounded by a negative moralizing cultural landscape, or the judgement of a health care professional, there are real consequences in terms of one's experience of oneself and one's concomitant medical treatment. As the illness in question is seen to be a negative and defining feature of the self, the body bears or *is* your moral failing.

The consequences of feeling ashamed and even responsible for one's illness are not trivial. In fact, it is reported in empirical work that patients who are concerned with feeling judged or shamed by their physician for their health-related behaviour avoid clinical settings.[45] This is clearly a concern in the case of sexually transmitted diseases, such as AIDS, which Sontag discusses at length. The "unsafe" behaviour that produces AIDS, "is judged to be more than just weakness. It is indulgence, delinquency…[AIDS] is a calamity one brings on oneself."[46] In our cultural context which values autonomy, discipline and self-restraint, illnesses associated with alcoholism, addiction, sexual activity or overeating are strongly stigmatized, and afflicted individuals are made to feel ashamed of their supposed lack of self-control and weak will.

This is, of course, exacerbated in our contemporary medical culture that increasingly defines health and illness in terms of risk factors that are controllable by individual's behaviour and their capacity to make "wise choices."[47] The overarching sentiment being that everyone is capable of modifying and controlling their behaviour and lifestyle and, hence, responsible for their own risk factors.[48] What this all points to is an increased tendency in contemporary medicine to moralize about illness and the causes of illness, shifting the onus onto the individual who is responsible for achieving and maintaining his or her own health through (increasingly commercialised) practices involving diet, exercise, digital 'wearables,' and other disciplinary lifestyle choices and practices.[49] It seems clear that the more responsible an individual feels for their illness, especially if they perceive it to have arisen from a lack of self-control, the more potential for shame and avoidance.

Hence, although we might distinguish medical shame as having two distinct components, namely, shame about the body and shame that results from judgement,[50] what we find in experience is that these two components of shame are intimately related within the medical context, and it is often difficult to meaningfully separate them. Indeed, the shame of being judged for a health-risk behaviour, such as

[40] Brumberg (1997, 64, 70).

[41] Sontag (1989, 100).

[42] Ibid., 102.

[43] Ibid., 17.

[44] Ibid., 102.

[45] Consedine et al. (2007, 440).

[46] Sontag (1989, 113–14).

[47] On responsibility for one's own health behaviour and risk-factors in the case of obesity, see for example: Lupton (2013).

[48] Tomlinson (2012).

[49] For example see: Metzl and Kirkland (2010).

[50] For example, the distinction between 'bodily embarrassment' and 'judgement concern' is argued for by Consedine et al. in their study to explore why people do not always seek out medical attention. However, they conclude these elements of medical shame interact in several significant ways. See: Consedine et al. (2007).

smoking, has considerable more traction when this is linked to an existing illness, rather than a hypothetical one. The inherent shame that the vulnerability of the body in illness can provoke, as discussed above, is strongly compounded and exacerbated by judgement, cultural stigma and moralizing. As shame itself is shameful, this compounded shame can lead to avoidance behaviours, where individuals do not always seek out medical examinations and treatments even when they have concern about serious symptoms, and practitioners have long been alert to this fact.[51]

Of course, avoidance of medical attention in the context of illnesses such as cancer and HIV, which historically carry high levels of stigma, can have very grave consequences including serious illness or even death. However, this willingness to risk one's health, and even life, as a result of shame demonstrates just how powerful a force shame can be. Rousseau in *The Confessions* characterises the power of shame thusly: "I did not fear punishment, but I dreaded shame: I dreaded it more than death, more than the crime, more than all the world. I would have buried, hid myself in the centre of the earth: invincible shame bore down every other sentiment."[52] Potential threats to social bonds, and hence the potential to not be recognized within one's social group, through shame experiences, are cause for significant distress. As Gehert Piers notes, "behind the feeling of shame stands not the fear of hatred but the fear of *contempt* which, on an even deeper level of the unconscious, spells fear of *abandonment*, the death by emotional starvation."[53] The fear of being ostracized is likened to *death* by some thinkers. This association is by no means arbitrary, nor extreme; there are very high stakes involved when breaching social norms and when one's sense of belonging, acceptance and recognition are compromised.

Goffman's seminal work on shame, *Stigma: Notes on a Spoiled Identity*, opens with a letter to the agony aunt Miss Lonelyhearts. Written by a sixteen-year-old girl born without a nose, the letter recounts how she is completely ostracized from social life as a result of her bodily defect. Even her parents find it difficult to accept her. She ends the letter desperately asking if suicide is her only option.[54] As Jane Megan Northrop notes, in cases of stigma and the breaching of societal norms, "social death and actual death are imminently convergent."[55] Lazare makes a similar point: "For some patients in certain clinical situations, death is preferable to disfiguring treatment."[56] As a result, avoiding potential instances of shame, through ignoring illness, avoiding treatment or concealing symptoms, can feel like a life-saving measure. In short, fear of shame and its concomitant social stigma leads to avoidance and to silence.[57]

Preliminary empirical results corroborate this finding, where in Harris and Darby's recent, and arguably unique, study on shame in physician-patient interactions, they found that in a study of over nine-hundred adults, over fifty per cent reported that shame had been a component of an interaction with a physician.[58] Furthermore, over forty-five per cent of those individuals, reported that they "stopped seeing the physician, and/or lied to the physician" as a result of shame.[59] These numbers may well be low, as the study does not take into account those who avoided seeking medical attention altogether. Furthermore, relying on testimony in empirical work is particularly difficult when dealing with shame and embarrassment. In general, shame and embarrassment are more difficult to talk about than other experiences such as anger or sadness. It is well documented that not only do individuals avoid shame, they even avoid mentioning past instances of shame. Furthermore, subjects participating in an empirical study may not explicitly be conscious of a shame experience because shame is often bypassed or repressed. Acknowledging shame, or just talking about shame, is itself potentially shameful for both parties within an interaction. As a result, it is not clear that a subject's report of his or her own shame or embarrassment experiences within a clinical setting will be accurate.[60]

However, it is clear from Harris and Darby's study, and from ample anecdotal evidence, that the medical encounter is unavoidably "emotion laden,"[61] and that shame is frequently, if not inevitably, a feature of the clinical encounter due of the inherent vulnerability of the body coupled with the stigma that is often attached to illness. This shame is compounded in the clinical context through the necessity for physical and personal exposure. As Lazare notes, "Once in the examining room, patients must reveal personal information often about their weaknesses, expose their bodies, place themselves in undignified postures, and accept handling of their bodies including intrusions into orifices."[62] In fact, it is acknowledged that medical procedures that are intimate in nature or that involve

[51] Ibid., 440.

[52] Rousseau (1996, 82).

[53] Piers (1953, 16). As quoted in: Probyn (2005, 3). Emphasis in original.

[54] Goffman (1990, 7).

[55] Northrop (2012, 105).

[56] Lazare (1987, 1654).

[57] Davidoff (2002, 623).

[58] Harris and Darby (2009, 327).

[59] Ibid., 328.

[60] See, for example: Keltner and Buswell (1996, 168).

[61] Malterud and Hollnagel (2007, 69).

[62] Lazare (1987, 1655).

reproductive or excretory functions are a source of anxiety and shame.[63] Indeed, there is literature that demonstrates that areas of health that involve private and socially sensitive parts of the body or bodily functions are a clear source of embarrassment and shame and can act as a "barrier" to seeking medical assistant, even when there is concern about serious symptoms.[64]

Furthermore, due to the structures of power between doctors and patients, which result in an imbalance of authority in the consultation space, medical professionals are in a prime position to exacerbate shame connected to health-related behaviours and their concomitant illnesses. Within the consultation space doctors may take up the role of the "oppressor" through unintentional (or perhaps sometimes intentional) intimidation.[65] The power-dynamics in the consultation space are such that the medic is the authority figure, with privileged knowledge, training, expertise and, as a result, power. Quite simply, patients are not allowed to claim equal authority within the rhetorical space of the consultation room.[66] As such, patient testimony regarding emotional states, like shame or embarrassment, or concerns about social stigma are often dismissed as irrelevant (to the medical matter at hand).[67] Resulting from this inherent imbalance in power, patients can feel helpless, vulnerable and infantilised.

It should be noted that there is some argument that in the case of illnesses that are clearly linked with lifestyle choices, like obesity or lung cancer, shaming can motivate positive change and be efficacious in terms of treatment and prevention.[68] However, it is clear that this sort of judgement and shaming within the clinical encounter must be managed carefully, if attempted at all. Of concern is the preliminary research that suggests that shame itself can have negative physiological and health outcomes. In a study of HIV-positive patients, shame and perceived threats to one's social bonds clearly correlated with disease progression and mortality.[69] Encouraging doctors to exacerbate shame, as a treatment or prevention strategy, may in fact lead to further negative health outcomes.

Beyond exacerbating existing shame, it is also the case the medical professionals are in a prime position to incite shame in the first instance. This is particularly worrying in the context of commercial aesthetic medical procedures where cosmetic surgeons can cultivate profound anxieties and shame in their clients in order to encourage further procedures.[70] Feminist theorist, Susan Bordo cites this telling example:

> Writing for *New York* magazine, 28-year-old, 5-foot 6-inch, and 118-pound Lily Burana describes how a series of interviews with plastic surgeons—the majority of whom had recommended rhinoplasty, lip augmentation, implants, liposuction and eyelid work—changed her perception of herself from 'a hardy young sapling that could do with some pruning … to a gnarled thing that begs to be torn down to the root and rebuilt limb by limb.[71]

The lopsided power relation between the (usually male) doctor and the (usually female) patient is augmented to the extent that it is difficult, if not impossible, for women (who are already vulnerable) to resist the advice (or shame) of their doctors.[72] The discrepancy in power in the doctor-patient relationship, as Leder points out, means that it is "not a matter of reciprocal exchange of intentions, so much as one body submitting to the intentions of another."[73] Jane Megan Northrop, in her study of body shame and cosmetic surgery, recounts a further telling example about one of her interviewees who, in the context of her doctor's clinic was unable to resist the shame-inducing medical gaze: "In their domain the surgeon and his receptionist left her little choice by to accept their version of her. In their presence she felt acutely shamed…. Away from their gaze she was able to amend her sense of self and dispel their imposed shame by recounting the event to a girlfriend."[74] In short, the inherent vulnerability of a patient in the clinical setting can result in a greater susceptibility to shame.

Conclusion: *Embarrassing Bodies* and confessing shame

Within the clinical setting, the dynamics of shame are complex and multifaceted. As discussed above, the phenomenology of body shame results in a fear of exposure and a desire to conceal oneself. This can lead to many potentially harmful behaviours such as dishonesty within the clinical encounter, avoidance of seeking medical attention, not following through with medical treatment, and even negative health outcomes as a result of the shame

[63] Consedine et al. (2007, 440).

[64] Ibid., 440–441.

[65] Malterud and Hollnagel (2007, 69).

[66] Ibid., 72.

[67] Carel and Kidd (2014).

[68] For example: Harris and Darby (2009, 328).

[69] Dickerson et al. (2004, 1209–10).

[70] For an extended discussion of shame in the context of cosmetic surgery, see: chapter 6 of Dolezal (2015).

[71] Bordo (2009, 28).

[72] Cosmetic surgery is a highly gendered practice. While over 90 % of cosmetic surgery patients are female, 8 out of 9 cosmetic surgeons are male. See: Dolezal (2015, 125–26).

[73] Leder (1990, 98).

[74] Northrop (2012, 178).

itself. Furthermore, shame may be compounded when there is a sense that one may be responsible for one's own illness. Due to the inherent imbalance of power in the clinical context, medical professionals are in a prime position to exacerbate or incite shame through judgement, moralizing or merely insensitivity to a patient's experience. However, in this conclusion I want to discuss how clinicians are also in a prime position to alleviate shame, and that this can be a very powerful and tangible force within medical practice.

Considering again the example of *Embarrassing Bodies*, what this TV series demonstrates is the tangible effect that acknowledging and talking about shame can have within a clinical context. As noted in the Introduction, by making public aspects of healthcare and the body that had previously been personally shameful and secret, *Embarrassing Bodies* has encouraged viewers to feel more comfortable approaching healthcare professionals, diffusing the stigma of certain bodily conditions. In fact, there are numerous testimonies from patients and doctors reporting that after watching the program individuals were more likely to seek out medical treatment. In addition, the program had helped others identify a health concern that they had previously not been aware of.[75] What the format of *Embarrassing Bodies* seems to demonstrate, and further research is needed to verify these suggestions, is that, within the clinical context, the acknowledgement of body shame along with the advice and attentions of a sympathetic medical expert legitimates what might otherwise feel like a shameful and solitary preoccupation, and this can have a very tangible positive impact in terms of patient experience and concomitant medical treatment.

The confessional formula of this reality show is testimony to how making shame public can diffuse, or even perhaps eliminate, the negative impact of shame. This insight is acknowledged in the work of clinical psychologists where it is argued that the "only way to resolve shame is to talk about it."[76] Acknowledging and publically confessing one's shame has a cathartic effect, it dampens its negative affect and shifts the experience towards one of validation and recognition. However, revealing and acknowledging shame must occur within a receptive and safe context otherwise the impact can be negative (shame is exacerbated or intensified) rather than positive (shame is diffused). What *Embarrassing Bodies* makes evident is that when clinicians acknowledge body shame, and its significance on an individual's experience, while avoiding judgment, alongside treating the medical problem in question, it can be a profoundly therapeutic experience. As one patient remarked after a televised *Embarrassing Bodies* consultation, "That was so fantastic…. He gave me the confidence to go back to my doctor. And yes, it's an embarrassing problem, but when you finally talk about it you feel so much better."[77] What this patient's testimony demonstrates is that due to a clinician's inherent expertise and legitimacy, they can reframe a shameful secret or preoccupation into a medical problem that requires expert intervention. Rather than seeing an illness as a personal and individual failing, it becomes part of a universal diagnosis that can be dealt with medically and 'objectively'. Exposing the body is no longer a cause of shameful preoccupation; the fear of exposure in shame can be trumped wholesale through the relief of recognition.

Hence, within the clinical encounter there is potent potential to alleviate shame and this can have clear consequences in terms of medical care. Through *Embarrassing Bodies*'s format it is evident that when patients are reassured that their shame will be acknowledge, taken seriously and handled with care and respect, they are more likely to seek medical attention, disclose personal information and follow through with medical treatment. As a result, it seems that training clinicians to be alert to the dynamics of shame within clinical encounters can have a tangible impact on patient care. In fact, in the context of clinical encounters, training health practitioners to identify the potential for shame, whether it is as a result of body vulnerability, judgement or cultural stigma, and give them concrete guidelines for how to diffuse that shame, could have significant benefits in terms of both individual and public health outcomes.

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[75] Wiseman (2010).

[76] Brown (2010, 25).

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