Shame-Sensitive Public Health and COVID-19

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Shame has been an endemic consequence of medical, political, and public responses to the COVID-19 pandemic in the WHO European Region. International public health literatures generally demonstrate an informed handle on the ill-effects of stigma, developed in part through visible interventions on global challenges such as obesity, mental illness, and sexually transmitted diseases *(1-3)*. Stigma is also an emerging theme in international work on the social and behavioural dimensions of COVID-19. What these literatures – and, subsequently, policymakers in the region – presently lack is an integrated and coherent understanding of shame and how it is related to experiences of stigma, and also how shame can occur independently of stigma events and stigmatization. Shame can be usefully defined as the lived and subjective emotional, psychological, and physiological correlate or response to situational or systemic judgement, degradation or exclusion *(4)*. Unlike stigma, shame has an ambivalent status in public health. Although policymakers rarely set out to use shame as an overt tool for behavioural change, it can often be the unspoken affective driver around which particular messages or interventions revolve. Even more commonly, a lack of attentiveness to shame in policy design can lead to secondary or inadvertent shaming in the populations being targeted, with serious consequences for immediate uptake and engagement, and health-seeking behaviour in the longer term *(5)*.

In this report, we demonstrate how attentiveness to shame, and the active cultivation of shame-sensitive practice, aligns with a series of WHO and UN priorities. We assemble a working definition of shame from the best available research in the WHO European Region, set out evidence on the consequences of shame for social and relational health outcomes, explore how experiences of shame are framed and conditioned by their cultural context, and assess the present and future dimensions of shame in the context of the COVID-19 pandemic. We then offer a practical and adaptable toolkit to assist policymakers in short- and medium-term decision-making on urgent and emerging issues, such as vaccine hesitancy and vaccine passports. Finally, we make a wider case for the acknowledgement of shame as a key determinant of health.

Shame

Shame is a negative emotion with serious consequences for mental, relational, and physical health. It arises when people feel that 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, and low self-worth *(6)*. Shame itself is a potent source of shame. Admitting to the experience can be difficult, and usually requires pre-existing bonds of trust. Despite frequently 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 patterns of avoidance are self-defeating or destructive; for many, escaping shame can feel like a life-saving measure *(7)*.

The fear of being shamed is heightened for people with stigmatised identities or attributes, who live with daily experiences of 'stigmatising shaming.' These can include addiction, minority status, and experiences of poverty, 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, with a clear physiological effect on the immune and cardiovascular systems. This can lead to or exacerbate ill-health, through the chronic elevation of cortisol levels *(8)*.

Shame, medicine, and public health

Shame and embarrassment are common experiences for patients in healthcare settings, and can easily result from public health messaging which reduces health to the product of individual failure, behaviour, or choice. In some cases, public health initiatives rely directly on shame to achieve their outcomes; in others, shame is the secondary product of a particular emphasis or representation. 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 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 testing for infectious illness (such as HIV, Hepatitis C, or COVID-19), as well as failure to take up or complete courses of treatment. Conversely, attentiveness to shame in healthcare contexts and public health messaging can increase both patient engagement and clinical outcomes *(9)*.

Cultural contexts of shame

Although some variant of shame is felt in almost every human society, the ways in which shame is experienced and responded to – as well as the spectrum of actions, feelings, experiences and behaviours that are considered to be shameful – are conditioned by specific personal, cultural and historical contexts. Moving beyond outdated and simplistic theorisations of nation-level 'shame cultures', recent research on shame and culture calls for a closer attentiveness to how shame is produced and experienced in real-world relationships and situations *(10)*. Broad cultural ideologies and practices around shame can help to frame and situate it as a lived experience, but culture has to be understood as complex, local, and in a perpetual state of redefinition and reproduction. The landmark WHO report *Culture Matters* offers a useful definition which highlights 'lifestyles, ways of living together, value systems, traditions and belief', and stresses that national, religious, or ethnic affiliations are only part of the picture *(11)*.

Global research on shame across cultures further emphasises that the English word 'shame' does not translate cleanly into other languages, with proximal words for shame carrying

diverse weights and meanings which frequently escape outside observers. Work – such as the present report – which speaks to the problem of shame in multiple cultural contexts can only offer a loose overview of shared public health challenges. The ways that 'shame' is thought, spoken, and felt will always differ by cultural context, if only fractionally *(12)*. Further, each member state in the WHO European Region encompasses multiple porous and shifting cultures with different relationships to shame *(13)*. What might be shameful in one context, culture, or environment may not be in another, and the ways and sites in which shame is experienced will also differ. Bodily shame, for example, differs extensively according to the kinds of bodies that are valued or devalued in any given context. Literatures on shame which originate in countries which benefit from extensive existing research, therefore, can only take member states so far. Attempts to prevent or alleviate shame should always be attentive to the national cultural contexts in which it occurs.

Layered through these differences, each cultural framing of shame has been shaped and produced, at least in part, by unique histories of shame as a behavioural tool in political rhetoric and public health messaging *(14)*. These histories contribute to differences in how shame around health and illness is felt, but they also create institutional cultures which can either support or obstruct shame-sensitive practice. Some health systems in the region are more attentive to shame, and more receptive to adopting principles for shame-sensitive public health than others. In part, this is a matter of how useful shame is considered to be as a device for effecting behavioural change, and a product of different institutional cultures in medicine and health policy. Policymakers reluctant to abandon shame require good evidence

on its short- and long-term harms, and effective scaffolding to transition from interventions which rely on shame to interventions which work proactively against it.

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 different kinds of state welfare.

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 deepest where people and groups with long experiences of being publicly shamed become tangled in newer dynamics of viral shaming *(15)*.

Within the WHO European Region, emerging literatures on shame and COVID-19 have identified multiple sites of shame and practices of shaming, and have connected pandemic shame with a host of negative health outcomes. Early in the crisis, videos of Italian mayors

condemning the behaviour of citizens gained international attention, with 'little public consideration for whether such stigmatization… [was] proportionate or effective.' In the Netherlands, calls for COVID-19 patients with bad prognoses to make space in hospitals for patients with better chances of survival shifted blame for poor outcomes onto those who refused *(16)*. Research in Croatia has underlined the complex emotions and behaviours that surround shame in healthcare workers overwhelmed by the pandemic, and work in the UK has explored how such workers have been shamed as 'super-spreaders' or purveyors of false information *(7, 17)*. Additional research in the UK context has taken sight at public health messaging around obesity, arguing that attempts to raise awareness about the correlation between excess weight and COVID-19 morbidity and mortality have placed an unnecessary burden of stigma on the people they target. Messaging on losing weight to ease the burden on health services misrepresents complicated challenges around exercise and healthy eating as matters of simple choice, implicating individuals in entrenched systemic problems beyond their capacity to influence *(5, 18)*. Finally, qualitative research into experiences of shame in multiple cultures – including Germany – has explored feelings of shame over catching or spreading the virus. This latter study reflects a widespread ambivalence over shame in public health, addressing the emotion as a negative aspect of the pandemic, but simultaneously suggesting that it can also have positive effects, such as increased mask-wearing or compliance with public health regulations *(15)*.

We differ from this position in our contention that all forms of shaming, including those in service to public health objectives, 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 can have considerable deleterious long-term consequences for health and health outcomes. An ongoing failure to address shame in the context of COVID-19 will also be a contributing factor in the complex and wide-reaching legacies of the pandemic for social and relational health, legacies which may not become fully apparent even in the short or medium term. In being shamed, whether by politicians, public health initiatives, or other members of the public, individuals and populations can become shame-prone, more sensitive to future instances of shame, and less likely to engage fully in health systems or health-seeking behaviour. In attaching most forcefully to groups who have long experiences of being lower down social hierarchies, pandemic shame should also be considered as a significant vector for, and component of, entrenched health inequalities across the Region. Although this context for future policymaking may seem daunting, the long-term effects of shame are neither inevitable nor irreversible. We therefore suggest four brief recommendations for shame-sensitive public health building on principles for shame-sensitive practice developed by Gibson and Dolezal *(18)*. Intended to be neither definitive nor universal, these recommendations are offered as a starting point for policymakers interested in adopting evidence-based principles on avoiding or mitigating shame in their own practice and the institutions they work within.

Four recommendations for shame-sensitive practice

1. **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.

2. **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.

3. **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?

4. **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.

Futures

The idea of 'post-COVID' recovery is misleading, implying a distinct and verifiable end point; this is profoundly unlikely, if not impossible *(20)*. While it might be impractical to think about clean endings, the complex health legacies of the pandemic – and our political and public health responses to it – bear urgent consideration.

For many, shame over viral transmission or poor pandemic citizenship might have been something painfully new; for others, prior encounters with shame framed and conditioned the ways that pandemic shame could be experienced and felt. In either case, the deep or shallow marks left by shame work against vital determinants of health. They compromise positive and protective feelings of relational embeddedness, and stoke mistrust in social and medical systems. They contribute to feelings of isolation and alienation, whether incremental or acute; in extreme cases, they can ignite a lifelong relationship with shame which severely curtails the possibility for security, connection, or social and political engagement. Already undergoing painful processes of collective trauma and grief, a population subjected to shame is a population with a weakened capacity to stay well.

In a pandemic which has witnessed shame emerge as both an additional burden and a barrier to good public health, we renew calls for shame to be widely explored and acknowledged as a key determinant of health *(9)*. Shame is an indispensable theoretical tool for understanding public behaviour in the pandemic; the processes by which health inequalities result in uneven viral outcomes; and the ways that adverse social, emotional, and relational experiences can threaten collective health in the longer term.

With careful attention to shame in future public health work, some of the adverse consequences of COVID-19 for health in the Region can be reversed.

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Scenes of Shame and Stigma in Covid-19

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