Special Article

Shame and Humiliation in the Medical Encounter

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Patients are at high risk for experiencing shame and humiliation in any medical encounter. This is because they commonly perceive diseases as defects, inadequacies, or shortcomings; while the visit to the hospital and the doctor's office requires physical and psychological exposure. Patients respond to the suffering of shame and humiliation by avoiding the physician, withholding information, complaining, and suing. Physicians may also experience shame and humiliation in medical encounters resulting in their counterhumiliation of patients and dissatisfaction with medical practice. A heightened awareness of these issues can help physicians diminish the shame experience in their patients and in themselves.

Twelve clinical strategies for the management of shame and humiliation in patients are discussed.

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The aim of this article is to examine the proposition that patients' experiences of shame or humiliation are important but neglected aspects of medical encounters. This is evident if one thinks of patients as persons who fear they have defects of body or mind, whose self-esteem can be undermined if this fear is validated, yet who have to expose their bodies and thoughts to strangers (physicians) to receive the desired help. Many patients and physicians agree with this proposition. Yet, the subject of shame and humiliation in medical encounters is rarely discussed, studied, or written about. Only one article in the medical literature during the past 20 years has the word "shame" or "humiliation" in the title. Highly regarded books on the doctor-patient relationship and interpersonal aspects of patient care do not even index the subject.

Distinguished physicians such as Hippocrates,8 Osler,19 Shattuck,20 and Peabody,22 as well as contemporary clinician/scholars,3,14 have emphasized the qualities of caring, sympathetic attention, interest, positive regard, politeness, sensitivity, and trustworthiness, dignity, decorum, and respect in dealing with patients, but have not mentioned the potentiality for shaming or humiliating them. Psychiatrists, psychologists, and sociologists have only begun systematic explorations of shame or humiliation during the past three decades, but not in medical settings.15,20

I will first discuss the definition, phenomenology, and general psychology of shame and humiliation, and then attempt to show the relevance of these effects to the medical encounter.

DEFINITION AND PHENOMENOLOGY OF SHAME

Shame and humiliation refer to painful feelings caused by the lowering of one's pride, self-respect, or self-concept. Although shame and humiliation are often used interchangeably, there are differences in their use: shame may refer to distress concerning the state of the self that the person regards as no good, not good enough, or defective; humiliation, in contrast, refers to a temporary status of the self, an alteration, usually caused by someone else, that the person regards as lowering or debasing.26,27

A list of over 150 words and phrases related to these affective experiences can be assembled. They include expressions that emphasize visual exposure (blemished, exposed, naked, red-faced, scarred, shamefaced, stigmatized); the subjective experience of being reduced in size (belittled, diminished, humbled, put down, slighted, taken down a peg); overall deficiencies (degraded, dehumanized, devalued, dishonored, and insignificant); the perception of being attacked (insulted, mocked, ridiculed, scorned, vilified); and avoidance responses (disappearing from the face of the earth, hiding one's face in shame, hiding under the rug, sinking into the ground). Vulgar expressions that are used to humiliate others refer to hidden parts of the lower gastrointestinal tract, excrement, and male and female genitalia.

With the experience of shame or its allied effects, we feel or believe that we do not measure up to ideals or standards that we have set for ourselves. We become aware that we are not the kind of persons we think we are, wish to be, or need to be. This standard against which we judge ourselves is actively discussed in psychodynamic circles, where it has been referred to as the self, ideal self, self concept, self representation, ego ideal, and ego identity. Various theorists, beginning with Erik Erikson, have attempted to understand the development and dynamics of the self concept and its relationship to shame and humiliation.17,28,36

The self concept may seem a vague, elusive, or irrelevant concept for many of us much of the time. Its significance becomes clear only when it is in jeopardy: when a photograph of ourselves startles us (do I really look like that?), when our best efforts disappoint us, when those whom we believed thought well of us betray us, when our bodies fail us because of age and disease, when our reputation is under attack.

Although shame and guilt are often confused, they represent two distinct experiences. With shame, the antecedent event is the sudden awareness of a deficiency of the self, a goal not reached. With guilt, the antecedent event is an act committed, a boundary transgressed leading to a sense of badness. Shame shields the self against further exposure; guilt regulates the wish to exert aggressive power. With shame the response is to hide or disappear. With guilt, the response is to make restitution. With shame the other person is the origin of scorn, contempt, or ridicule. With guilt, the other person is injured, suffering, or hurt. Shame is about the whole self, often calling into question one's total identity. Guilt is usually about one aspect of the self that may be considered as separate from other aspects of the self. Finally, a person can be ashamed not only of himself, but feel shame for those close to him—a child, parent, or friend. It is less common to feel another's guilt. Much of the difficulty in separating shame from guilt results from the frequency with which these two experiences occur together. For instance, a person who commits a transgression may feel guilty over how he has hurt others and ashamed of how he is perceived by others.17,36,39

The acute shame reaction is usually of sudden onset and

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Shame and Humiliation—Lazare 1653
short duration. Sometimes there is a delay before the person realizes what is happening. There may be a sense of receiving an unexpected blow, a jolt, or a sting. Accompanying autonomic reactions may include blushing, fainting, sweating, burning, freezing, and a sense of weakness. On a cognitive level there is a painful awareness of oneself as defeated, deficient, exposed, a failure, inadequate, wanting, worthless, and wounded. The deficiency seems pervasive. The very essense of the self feels wrong. The person feels alone and estranged from the world; there seems no way to redress the situation. He or she wants to sink through the floor, disappear, or cease to exist.15,17,19·21

Many shame experiences are of a milder variety with reduced intensity of emotions and cognitions.

THE DETERMINANTS OF SHAME

For the purpose of exposition, I propose that any experience of shame can be understood as resulting from the interaction of three factors: (1) the shame-inducing event; (2) the vulnerability of the subject; and (3) the social context, which includes the roles of the people involved. These factors are a part of any given shame experience, and their contributions are usually additive or complementary. Yet, any one may be so powerful in a particular situation that it alone can dominate the experience.

The Shame-Inducing Event

The importance of the shame-inducing event can be illustrated by those occurrences that are shameful or humiliating to most people, irrespective of personality and context. Examples include betrayal by one’s spouse, being fired from one’s job, being accused of a crime, being sexually abused, or raped.

In the medical setting, patients may experience physical or psychologic 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, i.e., student, teacher, physician, parent, sexual partner, and breadwinner. Treatments and their side effects may be potential sources of further shame and humiliation: mastectomies, the loss of hair, and impotence are examples. For some patients in certain clinical situations, death is preferable to disfiguring treatment.

When patients discuss the importance of “dying with dignity,” the indignities they refer to are altered appearance (edema, emaciation, deformities, etc), diminished awareness, incontinence, the need to be washed and fed, the need to ask or beg for medicine to relieve pain, the need to use a bed pan, and the perceived loss of meaningful social roles and social value.

As if the humiliation of disease, treatment, and dying were not enough, there are medical and lay terms assigned to various conditions that may be intrinsically shaming: hypertension, heart failure, coronary insufficiency, failed back, lazy eye, mongolian idiocy, and incompetent cervix.

In addition to the physical and psychologic limitations caused by the disease, patients may also feel stigmatized; that is, they are socially discredited or branded, anticipating unfavorable reactions by others.1 I suggest that diseases that are stigmatizing may be categorized according to the following: (1) offend others through their sight, odor, contagion, and the possibility of physical violence (eg, leprosy, other dermatologic conditions, gross body deformities, contagious diseases, mental disorder, epilepsy); (2) are associated with low social station or poor living condi-

tions (eg, tuberculosis, lice, and gross dental neglect); (3) involve sexual or excretory organs (eg, venereal disease, cancer of the rectum); (4) are believed to be caused by behaviors that are perceived by others as weak, stupid, immoral, or manifestations of personal failure (alcoholism, mental disorders, obesity, venereal disease, and acquired immunodeficiency syndrome). With our current knowledge about the prevention of disease, many individuals who become ill feel ashamed over their failure to behave in a prudent manner—by overeating, smoking, or failing to exercise. Similarly, patients who develop diseases that are believed, at least by the lay public, to be caused by stress or personality defects may feel a sense of inadequacy or personal failure. Such diseases include peptic ulcer, ulcerative colitis, rheumatoid arthritis, asthma, migraine headache, cancer, coronary artery disease, and essential hypertension.

There are exceptions to the principles described above. To some individuals, peptic ulcer or myocardial infarction is a badge of courage, evidence of hard work and success. In earlier times, tuberculosis was associated with sensitivity and creativity.4 The stigma of epilepsy, tuberculosis, mental illness, and cancer has diminished over time as more is known about the cause and as treatment has become more effective.

The Vulnerability to Shame

Attempts have been made to categorize issues over which people may be vulnerable to shame.15,18 These include the need to be loved and taken care of, not rejected; to be strong and powerful, not weak; to succeed or win, not fail or lose; to be clean and tidy, not messy and disgusting; to be good, not bad; to be whole and complete in physical and mental makeup, not defective; to be in control of bodily functions and feelings, not incontinent and out of control. A multitude of day-to-day issues involving self-esteem may be subsumed under these categories. The vulnerability to one or a combination of these issues varies from person to person, and the wide range of issues over which a person may be vulnerable makes it difficult to predict how that person will respond to a particular event. For example, an individual arriving 30 minutes late for an appointment because of automobile failure may feel a social misfit. Another may feel like an inept automobile mechanic. A third may feel no impact on his or her self-esteem.

In the medical setting, it is evident from clinical experience that the self-esteem of people may be associated with their physical attractiveness, strength, dexterity, intellectual acuity, sight, hearing, or other physical or psychologic attributes. One can make no ironclad assumptions in advance that a given patient will or will not be humiliated over a given symptom or disease. Adolescents, in general, are more prone to shame than people in other age groups. This may be attributed to the rapid changes that are occurring in their bodies and identities. Physicians, many of whom enter the profession to conquer, master, or control disease, and who are expected to know more about disease and its prevention than lay people, may be particularly shamed by their own disease.2 This may explain, in part, the belief that physicians delay seeking help for their own symptoms.

The Social Context of Shame

The last factor necessary for the experience of shame is the social context. This includes the nature of the relationship to the person or people perceived as doing the shaming, the nature of the communication, and the nature of the social event. The more the person matters to the

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subject and the more public the exposure, the more intense the shaming experience. The perceived humiliating communication may take the form of a facial expression, a gesture, a verbal intonation, innuendo, an explicit criticism, a scathing attack, or a complex symbolic act such as tarring and feathering or standing to “face the music” and be “drummed out of the corps.”

A person may experience shame and humiliation alone, but this is apt to be less powerful than in the interpersonal realm. In solitary shame, the person may consciously anticipate exposure and ridicule at a later time or completely internalize the shame dynamic so that the exposure takes place internally (“how stupid of me to misplace my keys!” or “wait until they realize what a fool I have been!”).

In the medical setting, the shame-inducing event (the perceived disease) and the individual vulnerability ultimately interact with a social context once the patient seeks professional help. Patients who visit urban hospitals for the first time often brave unfamiliar traffic, search frantically for parking space in high-price lots, and make their way through a labyrinth of buildings, passing busy and seemingly indifferent hospital employees as they search for the doctor’s office. In the elevator, they hear white-suited house officers openly discuss patients. They hope they do not meet any acquaintances who may ask: “What are you doing here?” These patients may understandably feel bewildered, harassed, exposed, insignificant, and incompetent. They are not quite sure at that moment, what preoccupies them most, their disease, their insufficiency, or arriving late. In the waiting room, privacy is further eroded. Patients are noticed by other patients and are labeled as people who belong in this office or clinic—oncology, hypertension, arthritis, psychiatry. They may be acutely aware of telephone communications in the waiting room in which other patients’ names are mentioned within earshot of strangers. Eventually they are acknowledged by the secretary or other office personnel.

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. In normal socialization, we learn that such behaviors are shameful, except in the medical setting. On admission to the hospital, there is the giving up of everyday clothes, valuables, freedom, and privacy. For certain diagnostic and treatment procedures, there is the further surrender of glasses, dentures, and hearing aids. In providing detailed histories, patients may be expected to describe their perspectives on their illness. This includes previous attempts to find lay and professional help, use of home remedies, theories about the cause and pathophysiology of the disease, fears as to what is wrong with them, the reason for deciding to come for help at this time, goals of treatment, and desired methods of treatment. In anticipating such an inquiry, many patients fear they will be laughed at or criticized for their ideas about the nature of the disease, for causing or aggravating the disease, for waiting too long before seeking medical attention, or coming too early with such trivial complaints and so wasting the doctor’s time. Patients may be further humiliated by the physicians’ pursuit of historical data about the possibility of diseases such as acquired immunodeficiency syndrome and venereal diseases. Physicians, in communicating the diagnosis to the patient, may become the messengers who carry the news of the humiliating event: that the patient has coronary insufficiency, heart failure, alcoholism, or syphilis.

The significance of the social context of shame in medical settings includes other settings and personnel. Emergency room visits are particularly humiliating since patients are apt to be frightened, and privacy is often inadequate, particularly as patients wait unattended in corridors for their roentgenograms, or sit or walk about in “Johnnies” flapping open at the rear. Finally, there is the significance of communications to friends and relatives. Who shall know and what shall they know? A physician friend of mine was hospitalized for several days with low-back pain. The most distressing experience of the hospitalization was an unexpected visit by one of his patients. This led to intense shame over not being strong and in control. Confidentiality and privacy is most often a matter of protection from exposure to the shame that others know what one personally regards as an inadequacy.

**REACTIONS TO SHAME**

There are a wide variety of reactions to and defenses against shame.16,17,19-21 Some are adaptive and others are maladaptive. A common reaction to a minor affront is for the shame response to both appear and disappear within seconds. Laughter may serve as a relief. Much of what we call anxious laughter, in my opinion, is an adaptive response to minor embarrassments or shameful events. Humor can be a powerful healer of humiliation. When the affront is perceived as more meaningful, the person may assume the hiding responses of diminished spontaneity, increased protective ness, lying, or the avoidance of social situations in which the person might be found vulnerable. One “hides one’s face in shame.” The hiding response can have an adaptive function. Shame, here, acts as an emotional wall or boundary around a person serving as a protection against violations, assaults, or incursions against the self. A breach of this boundary signals the person to maintain distance, move away, hide, and protect himself. A common maladaptive hiding response seems to shame-prone individuals is the unnecessary distancing from others, thereby depriving themselves of normal intimacy. The most extreme maladaptive hiding response is suicide. Angry responses include displacing the humiliation onto someone lower in the pecking order and counterhumiliating the person who inflicted the injury. The quality of the anger (referred to as humiliated rage) is quite distinctive. Such anger usually is enduring and unforgiving, leading to long-lasting grudges and revenge seeking. In former times, duels were fought to settle such humiliations by restoring honor. A constructive response to shame would be the strengthening of vulnerable parts of the self (“no one will ever again call me weak, uneducated, or unsuccessful”). Finally, our fear of shame supports behaviors that are part of our ideals. We behave in ways that make us feel proud and honorable and avoid behaviors that make us feel shamed and humiliated. Some exhausting quests for perfection may represent maladaptive or neurotic variations of the attempt to strengthen defects in ourselves, so as to totally avoid any shameful or humiliating experiences.44,45

Patients who feel ashamed of their illness may use one of several hiding maneuvers. Some avoid going to the doctor or keeping a return appointment. They assure themselves that they will make an appointment when their weight or blood pressure return to normal or when they can appear more presentable. Others may seek care away from their community, avoid telling friends or relatives about their illness, and/or refuse to receive visitors. Still others lie to their physicians or withhold information that they think will put them in a bad light such as self treatment based on idiosyncratic health belief theories. The most radical hiding response is the patient’s denial of illness.

The most common response during the interview to a
perceived embarrassment or insult at the hands of the physician is for the patient to become subdued and withdrawn. The patient usually expresses anger indirectly by criticizing support staff, demanding more information, changing doctors, complaining about the medical profession as a whole, speaking to the patient care representative, or suing. It is uncommon for patients to tell their physicians directly that they feel shamed and humiliated.

I believe that most patients who are angry at their physician or at the medical profession are responding to perceived experiences of shame and humiliation. The specific complaints are not that the doctor makes mistakes, misses the diagnosis, causes too much pain, or charges too much. The complaints are that "the doctor has no compassion for me;" the doctor is "too busy for me;" the doctor treats me like a piece of meat." "the doctor is sexist," "the doctor insults my intelligence," "the doctor thinks my problem is all in my head." Underlying these complaints, I contend, are the emotions of shame and humiliation.

SHAME AND HUMILIATION IN THE PHYSICIAN

The physician, like any other person, has a self-concept or standards that he strives to maintain. In the professional realm this may include qualities such as intelligence, dexterity, honesty, reliability, dignity, integrity, devotion, and compassion. As with other people, some of these may be vulnerable to attack.

There are at least four circumstances that can lead to shame and humiliation in any physician. The first is the failure to successfully diagnose the disorder. The second is the performance of a therapeutic procedure that does not satisfy one's own or one's colleagues' standards. The third is the experience of disrespectful behavior by the patient or the patient's family: coming late, being unclean, demanding an unreasonable amount of information, claiming to have the treatment or fee, expressing a lack of confidence, requesting a consultation from another physician, or threatening to sue. The fourth is the physician's feelings of being shamed or humiliated through an empathic identification with the patient. For example, the perceived humiliation of a patient with rapidly deteriorating Alzheimer's disease, particularly someone similar to the physician in age and social background, often elicits such an empathic identification.

There are physicians who are particularly shame-prone over their need to see themselves as perfect and in complete control in their practice of medicine. These needs (and vulnerabilities) may be a part of the personality style of some who enter medical school. They are certainly reinforced by recurrent threats of and real humiliations during medical school and residency training. This shame-prone state of some physicians can have adaptive functions: the doctor works long hours with diligence and dedication to maintain the highest standards of practice. On the other hand, there are problems; such physicians may be prone to unwittingly humiliate patients, students, and house officers. They may be unable to accept criticism or hostility from patients. They may be unable to acknowledge mistakes or apologize. They may have difficulty learning from others. They may be unable to relax and enjoy other aspects of their lives.

I recently observed a state of persistent shame and subsequent demoralization in many psychologically sound, recently trained, primary care physicians. This emotional state is a result of their difficulty maintaining their standards of care in practice settings where cost containment seems to be the first priority. Their specific concern is having inadequate time to evaluate and treat their patients. Some describe being shamed and otherwise penalized by colleagues and employers for spending more time than is allotted. Their distress is considerable. This problem appears to be growing with no solution in sight.

THERAPEUTIC IMPLICATIONS

To optimally manage shame and humiliation in medical encounters, physicians should assume that any disease (and treatment) can be a shame-inducing event which then interacts with a patient's individual vulnerabilities. With this heightened awareness, physicians can then use their skills to manage the social context of the medical encounter. In this role, physicians attend to three interrelated tasks: (1) diminishing the patient's shame and humiliation; (2) avoiding exacerbating the patient's shame and humiliation; and (3) recognizing and managing their own shame and humiliation.

To accomplish these goals, physicians should attempt to develop relationships in which the patient allows them to come inside the protective boundaries erected to avoid shame. Ideally, patients should come to believe that their exposure to physical and emotional weaknesses will be respected and cherished. From this perspective, there are common elements in patients' relationship to their physicians and to those they love. Patients' lonely anguish over their illnesses and the physicians' socially defined roles as nonjudgmental healers make such relationships both possible and desirable. The betrayal of such a trust, once achieved, will lead to humiliation, usually beyond repair.

What follows are several observations and suggestions on the management of shame based on discussions with patients and experienced clinicians.

The Ambience of the Hospital and Office

Physicians have the ability to influence patients' experiences in the hospital and office including the admission procedure, emergency attendance, roentgenograms, and blood drawing. Patients commonly feel frightened, de-personalized, and dehumanized, and that their presence and needs are an imposition on the complex bureaucracy, rather than the reason for the preeminent of the bureaucracy. The goal is to create an atmosphere in which patients feel welcome, cared for, and respected.

Waiting for the Physician and Interruptions in the Interview

It is important for physicians to see patients with minimal delay. Long waits for physicians after the designated appointment time or interruptions during the visit devalue the importance of patients' time and worries. Patients usually make their appointments weeks in advance and then think about them often. Their entire sense of well-being may depend on the outcome of the clinical interview. From this perspective, the clinical visit is more important to patients than to physicians. A simple apology for significant lateness or unavoidable interruptions acknowledges that the delay or interruption is the doctor's problem or a result of unavoidable circumstances and not an indication of the patient's lesser status.

The Use of Surnames

Physicians seeing adult patients for the first time should refer to them by their proper titles and last names. Patients should be the ones to initiate changes. Calling new patients by their first names forces a level of intimacy to which the patient has not agreed. It also assigns to patients a lesser status, since they are generally not expected to refer to their physician by his or her first name. Asking patients...
how they would like to be addressed puts the burden on them to anticipate what the physician wants to hear.

Supporting the Patients' Identity

Patients may attempt to maintain their identity and self-esteem in medical settings by bringing personal possessions, such as photographs, to the bedside and by sharing personal stories. Physicians should understand and support these efforts.

Attention to Privacy

Physicians communicate respect and dignity by attending to the privacy of patients' body parts, verbal disclosures, and records. Such behavior make an important impact on patients.

The Physician's Self-Exposure

Self-exposure on the part of physicians, carefully thought out, can help diminish the patients' shame and humiliation. ("I broke my leg skiing. The recuperation can be dreadful, having to ask people for help all the time"). There are at least three pitfalls in the use of self-exposure. First, patients may feel the physician is burdening them with his or her own problems. Second, patients may experience the physician as superior and condescending, since they have already solved similar problems. Third, patients may experience the physician as offering insincere support ("I know how you feel").

Shaming the Patient

Patients often behave in ways they anticipate will win the respect and praise of their physicians. Physicians' deliberate use of shame and humiliation, however, to motivate patients to behave in ways that promote health will usually fail. ("How do you expect me to help you when you continue to smoke?") Patients are apt to respond by not returning and changing their physician. Exceptions to this rule are those patients whose physician has treated them over long periods of time and with whom they have created strong and caring bonds. Shaming someone can be expected to induce behavioral change only when the person who is the object of the shame cannot leave the situation, e.g., the Marine in boot camp, the drug addict in a secure treatment setting, or the child at home.

Acknowledging the Patient's Shame and Humiliation

When physicians suspect that shame and humiliation are important aspects of the patient's experience, they should avoid direct comments about these emotions ("it must be humiliating to have this disease"). Such comments are experienced as intrusive and humiliating. Instead, physicians should engage patients by empathically commenting on their psychological distress without referring specifically to shame and humiliation. For example: "it is not easy to come and see a doctor," or "this disease can place enormous stress on a person," or "what does this illness mean to you?" Such comments or questions invite patients to ultimately share more specific aspects of the stress, including feelings of shame and humiliation. In general, labeling these emotions helps dissipate some of the mystery, ignorance, and fear that surround them.

Validating and Praising the Patient

It is often helpful to support patients on their decisions to see the doctor ("it was wise of you to come today; pigmentation of the skin like you have could be quite a source of worry"). Such a response diminishes the patients' concerns that their worries are trivial or foolish and that they are wasting the doctor's time. It may be equally helpful to praise patients on the management of their disease. In the lonely struggle with chronic and/or deteriorating disease, patients often feel that they are failures. Their families may feel helpless, discouraged, and angry. The physician may be the only one who can see courage and heroism in the patient's behavior.

Clarifying the Patient's Perspective on the Problem

Physicians may be able to diminish patients' shame and humiliation by eliciting and responding to their perspective on their illness; the patients' definition of the problem, including their theories about the nature of the illness; their goals of treatment; and their requests for particular methods of treatment. It is common for physicians to discover through this inquiry a set of unrealistic beliefs that support shameful but unrealistic views of the disease: that patients are to blame for the disease, that the infectious disease is contagious, that they are morally or physically weak, or that the disease is a source of stigma. Such an inquiry affords the physician the opportunity to discuss and refute these shameful beliefs and to provide alternative explanatory models.

The Use of Support Groups

Certain patients and families of patients with humiliating conditions make good use of therapeutic or support groups made up of people with similar disorders. The obese, alcoholics, families of alcoholics, families of brain-injured patients, women who have undergone radical mastectomy, families whose infants died of sudden infant death syndrome, infertile couples, and families of the mentally ill have all organized self-help groups.

The Management of Patients Who Fail to Accept Medical Advice

With patients who are obese, who smoke, or who engage in other behaviors that obviously impair health, the physician runs the risk of humiliating these patients with lectures or confrontations during each visit. One solution to this problem is to educate such patients during the first visit and then assure them that this will be the last such "lecture" unless the patient initiates the discussion. Another method of responding to such diseases is to encourage the patient to define the problem: "Are there any other problems that you would like me to help you work on?" Patients who acknowledge their own problems are more apt to maintain their dignity than those who are confronted with their weaknesses.

Physicians' Management of Their Own Shame and Humiliation

One of the most difficult but important tasks for physicians in the clinical encounter is the recognition and management of their own shame and humiliation. A clue to this situation is the physician's anger at the patient, his/her inadvertent humiliation of the patient, or his/her wish not to see the patient again. By attending to any of these signals, physicians can explore whether they feel shamed or humiliated by the patient. They can then analyze the dynamics of the relationship and plan a therapeutic response. For example, a frustrated and embarrassed physician whose patient is not responding to treatment asks the patient: "Are you sure you are taking the medications I have prescribed?" The patient, feeling insulted that his integrity has been questioned, says: "I do not think we are getting anywhere. Perhaps I should consult with another doctor." The physician, further humiliated by the patient's request,
can continue the downhill spiral of counter humiliation by encouraging the patient to leave. Alternatively, the physician can return to the critical juncture and address the insult: “I did not mean to offend you by my question about your taking the medicine. I was just attempting to be as thorough as possible. This has been frustrating to both of us.” The patient would, in all probability, accept the apology and the interview would continue. In another example, a 55-year-old woman consults a physician for “high blood pressure.” He performs the proper examinations, confirms the diagnosis, and recommends that the patient lose weight, lower her salt intake, take antihypertensive medications, and return in three weeks. The patient returns in five weeks and informs the physician that she is a religious woman and that God has told her that she does not need to lose weight, lower her salt intake, or take pills. The physician, feeling humiliated that his carefully thought-out recommendations were not heeded, humiliates the woman and her religious beliefs by saying: “Did your God tell you who your next doctor will be?” Had the physician been aware of his feelings and response, he could have made one of many nonhumiliating responses, such as: “Is there some way in which you would like to help?” After all, the patient did return.

Physicians can also gain some mastery over their humiliation by creating an atmosphere among their peers where these feelings can be openly discussed instead of being avoided for fear they would be perceived as weak or unprofessional. Such discussions and labeling of emotions diminish the psychologic need for counter humiliation on the part of physicians and provide profound insights into the suffering of patients.

The Neglect of the Concept of Shame

In conclusion, it is well worth considering why the significance of shame and humiliation in medical encounters has been ignored. I shall offer three possible explanations. First, even as physicians treat patients with the greatest sensitivity, respect, and decorum, it has not been part of the medical tradition to inquire as to the subjective experience of the patient. Second, in our concerns as physicians to do no harm, it is difficult for us to contemplate how we inevitably contribute to the shame experience in patients. Finally, neither patients nor physicians like to acknowledge or discuss their own shame and humiliation. It is shameful and humiliating to admit that one has been shamed and humiliated.

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References