

DISMANTLING OUR SOCIETY'S SHAME MACHINES

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This issue of *JLGH* contains a number of timely reports, including a fine review about medicine's great imitator, syphilis; an update on the use of buprenorphine with questions about many of the "edicts" we encounter when prescribing medical assisted therapy (MAT); and an overview of efforts to detoxify Lancaster housing. I am also excited to introduce two new columns, a health care innovation series by PC Nguyen and a book review series by Dr. Cherise Hamblin, who in her inaugural review offers a compelling commentary on *Medical Apartheid*.

I encourage you to spend time with each of these articles. In several of them, the authors ask us to engage an aspect of our history in which shame played a key role in policy, and within each is an opportunity to ask ourselves hard questions about where we've been and where we're headed as a society.

Challenging health-related questions are everywhere we turn. Decisions by our elected and appointed leaders suddenly have a direct bearing on our public health. Shame is increasingly used to influence others. I am struck by the level of vitriol and spite that has permeated the conversation within public forums. From political discourse in the wake of Supreme Court Justice Clarence Thomas's recent opinions, to social media posts about masking and vaccinations, there seems to be an ever-escalating degree of overt vilification. Yet, if there is anything positive that can be said about the rising temperature within the public space, it's this: such discourse has made possible an open conversation about shame itself.

In her new book, *The Shame Machine*, Cathy O'Neil begins by exploring the personal assault she has faced from doctors and others regarding her weight, then quickly moves to the broader medical system and our culture as a whole. She puts forth a cogent argument, that attempts at shaming represent an evolution in relationship dynamics that does more harm than good, missing the intended target and instead inhibiting the kind of change we might hope to facilitate.¹

Shame can be a valuable tool when used appropri-

ately, such as when we subtly instruct small children not to pee in the reservoir or teens not to steal candy from toddlers. In the same way that pain can protect our bodies, shame can protect our society, especially when transgressors can move smoothly through the stages of shame, from feeling hurt to denial, from acceptance to transcendence. If an individual can reach the last, O'Neil argues, they may experience peace and relief, and shift focus toward their community.

But lately shame as a tool is more than a covert means to correct. We do more than insinuate, we adjudicate and eviscerate, even ridicule. Sadly, those who lack choice and the power to change may become stuck in a cycle of pain and withdrawal.

Shame assaults are everywhere. We shame those who have not been vaccinated, whose weight is outside the "normal" range, who may have ended their pregnancy or require treatment for chronic disease. And while it may sometimes be intended as protective, O'Neil argues, the literature suggests that inflicting shame is no more productive than inflicting corporal punishment.

In a series of elegant trials, shame was determined to be associated with adaptive mechanisms consistent with withdrawal, self-neglect, and self-harm.² In opposition, patients less inclined toward feelings of shame were more likely to engage in self-reflection and actions that help move them toward self-correction. Thus, the intentional use of shame as a motivational tool may have unintentional and inappropriate effects.

There is a suggestion, born perhaps of our land-of-opportunity mythos, that we all have limitless resources and therefore opportunities at our disposal, the proposition that all problems are the consequences of poor choices. Yet, few of us have as much agency as we would like, and it becomes too easy to get stuck within any stage of the shame cycle.

Many of our medical policies perpetuate shame-cycling. We endlessly drug test those on MAT, we limit access to emergency contraception and other means to empowerment, and we needlessly delay access to life-sustaining treatments through an out-of-control

prior-authorizations process. Further, we use stigma, one of shame's close cousins, as a way of communicating these strategies to other transgressors, thus keeping those who have been shamed trapped within their cycles of limited autonomy ... and this can lead to a perpetual state.

Chronic shame can consume us with doubt about our own worth, leaving us – leaving our patients – with no energy to overcome the odds. A 2001 study of women in Alcoholics Anonymous found that people struggling with addiction who had higher levels of shame were more likely to relapse.³

Once shame-cycling begins, it may continue with only a look, an offhanded phrase, a tone. Patricia DeYoung, in her book *Understanding and Treating Chronic Shame*, describes “the experience of one's sense-of-self disintegrating in relation to a dysregulating other,” where the dysregulating other is “a person who fails to provide the emotional connection, responsiveness, and understanding that another person needs in order to be well and whole.”⁴ Thus, shame can be perpetrated – and perpetuated – without intent.

It's no wonder current victims are disproportionately poor and powerless. Yet we in the medical community may be well positioned to consider shame's power because we have proximity and are not triggered by it. Having committed ourselves to becoming agents of assistance, we can be available to suggest steps to better a patient's situation without judgment.

Shame, in O'Neil's epic, is the tool of the oppressor. Thus, we can honor our mission to shelter those patients who are most vulnerable by asking ourselves if those we see through the lens of shame have a viable choice, and more importantly, the power to make a difference.

Once we realize that shame occurs when we stigmatize, perhaps without meaning to – when we associate any patient's disease with a behavioral characteristic, such as when we inform patients with arthritis they would feel better if they just lost weight – we can then make efforts to *not stigmatize*. Instead, we can look through the lens of shame at each encounter, asking ourselves if those in our presence are being inappropriately compared, made to conflate, made to conform. O'Neil concludes this argument with the suggestion that we reserve judgment and approach every patient encounter by showing empathy.

As far as I know, there is as yet no readily available clinical calculator for discerning a person's risk for shame. The PTSD risk calculator may come close, but it subsumes that one can point to a time and space

during which a transgression or trauma was endured. Shame, as O'Neil suggests, is often the result of an insidious series of insults and microaggressions, any one of which is merely a strand of straw within the proverbial camel's burden.

O'Neil thus posits a “dignity roadmap”: look for shame and, when we recognize it, analyze its origin and extend respect. Giving people the benefit of the doubt, O'Neil suggests, gives them the opportunity to be trustworthy. Absolution frees us all; by offering forgiveness, Nelson Mandela said, we “liberate the soul and remove fear.”

On an individual level, if we can recognize when we may be perpetuating shame in those we treat, we can instead reserve judgment and allow patients safety and space. More importantly, though, we might consider that *everyone* we encounter in our clinics and health care settings is at some risk for feeling shame, and thus it seems most prudent to continue to demonstrate empathy, extend trust, and build pride within them.

When we recognize that all patients have needs and desires, we can make efforts to limit the shame we impose. Why shouldn't we give one another the benefit of the doubt and offer trust?

On the wider level, O'Neil suggests, we can work to give every member of our community a voice, a choice, and the power to make the changes that can better their lives. Within our own system, we can re-examine policy, and recognize that guidelines that punish patients have limited or no utility and should be eliminated. For example, patients miss appointments for all kinds of reasons; dismissing individuals from care probably does not fix a patient-centered problem.

We may further ask ourselves: Why isn't every primary care provider credentialed to prescribe MAT? Why do we limit the capacity to prescribe buprenorphine at all when its availability makes patients safer? Why do we have policies in place that limit access to hepatitis C therapy? Why do we prescribe dieting as a means to weight reduction when studies are underwhelming that such strategies result in sustained weight change at all?⁵

After you have read the pages within, please engage. Think about how we can use what these authors offer as an opportunity to confer dignity, to extend the benefit of the doubt. Let's further develop the awareness we all know intuitively, that people do not suffer of their own volition. Finally, let's take steps toward dismantling our society's shame machines.

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JLGH SUMMER 2022 RECAP

Q&A for Extended Learning

The last issue of *The Journal of Lancaster General Hospital* offered scientific reports and columns covering a range of topics – from emergency contraceptives, to fetal demise due to SARS-CoV-2 infection, to simplified rules for pneumococcal vaccination. Review the questions and answers below to see how much you remember from the Summer issue. Need a refresher? All issues of JLGH are available online at JLGH.org.

Q What is the over-the-counter agent used for emergency contraception, and how soon after unprotected intercourse does it need to be taken to be effective?

A Levonorgestrel should be taken as soon as possible within 72 hours of unprotected sex since its efficacy decreases with time. Note that it is ineffective if the patient has already ovulated.

Q What method of complement 4d (C4d) staining is most conclusive in confirming the presence of SARS-CoV-2 viral antigens in the placenta of a SARS-CoV-2 positive pregnant patient?

A In situ hybridization (ISH) staining proved to be more conclusive than C4d immunostaining in the Lancaster General Health Pathology report looking at two cases presented to Women & Babies Hospital triage. Not only did ISH staining confirm the presence of antigens, but it added evidence to the possibility of vertical transmission of the infection.

Q What are the first three steps in treating hypertriglyceridemia in patients, and what is the most effective lifestyle modification to help these patients reduce their triglyceride levels?

A The first steps are to rule out secondary causes, optimize blood sugar control, and optimize therapeutic lifestyle changes. Weight loss has been shown to be the most effective lifestyle change, with up to a 70% reduction in triglycerides in some patients, although dietary modifications and physical activity can also help.

**Q What is pneumomediastinum?
What is its main presenting symptom?**

A Pneumomediastinum is a rare condition in which air is present in the mediastinum; it is most common in young patients. Its main presenting symptom is typically chest pain that often radiates into the neck or back.

Q How long after receiving a 13-valent pneumococcal conjugate vaccine (PCV13) should a 68-year-old patient receive PPSV23? Will any additional shots be necessary?

A A 68-year-old patient should receive PPSV23 at least one year after PCV13. No additional shots are then necessary, as the PPSV23 completes the vaccination series.