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## Shame and using mental health services: Connection and validation or alienation and objectification?

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The aim of this paper is to explore how current mental health services risk exacerbating the very emotional problems they are supposed to be helping with. This is not a new idea and there have been many critiques over the past few decades of the ways in which mental health services can be experienced by their users as causing further distress and a sense of powerlessness. However, we want to explore a relatively neglected aspect of this argument and that is the issue of shame – an aspect of the difficulties that many people *bring* to mental health services, and yet unfortunately a not infrequent response to *using* mental health services.

Firstly I will talk about the relevance of shame to psychological difficulties. I will then discuss the importance of understanding shame as something which often takes place *between* people and will outline the social conditions which seem important for repairing shame. Then, referring briefly to some of our own research data, I will note how the experiences of mental health service users suggest that the right kind of conditions for repairing shame cannot be guaranteed within services and consider why this might be.

People don't often talk about mental health services as there to help people manage and repair feelings of shame. However, we would argue that this is in fact a major part of what they are tasked to do. The shame-like feelings illustrated on the slide (3) are the issues that many bring to mental health services which might, for example, be labelled as:

- 'depression' (I feel worthless) or

- 'eating disorder' (I binge to cope with feelings, feel ashamed of bingeing); or
- 'post-traumatic stress disorder' (I couldn't cope...with a particular traumatic event)
- or here 'social anxiety',
- or clients may struggle with feelings of shame *about* their difficulties and ways of behaving & the possibility that they are 'going mad'.

In fact an increasing body of research suggests that feelings of shame are a major component of many of the psychological difficulties for which people seek help and are sometimes central to these difficulties. Phenomena such as hearing voices and paranoia have also been suggested to sometimes be ways of coping with or defending against a sense of shame.

There is debate about the kinds of feelings that are best captured by the label 'shame'. Clinical theorists have sometimes viewed shame as negative self-evaluation (e.g. Tangney; M. Lewis). However, we would suggest it may often be more appropriate to conceive of shame as a social rather than an intrapsychic phenomenon. Many theorists have pointed to the way in which experiences of shame often involve a painful awareness of how one is or *might* be devalued in the eyes of the other, including a generalised other (e.g. Goffman; Erikson; Satre; Scheff; Gilbert). They have emphasised feelings of rejection, isolation, alienation, exposure, threat to social status and *relative* powerlessness before another in experiences of shame. There is now plenty of empirical data to support these views that shame reflects problematic social relations or the perception of these. As such shame is a useful concept for thinking how being positioned as of less value in some way can be internalised.

An interpersonal conception of shame also suggests that *repair* of shame is played out between people, as much as privately, and the social context is likely to be vital in determining how individuals manage and repair feelings of shame. Feelings of shame can exacerbate problems in relating to others, as when we are ashamed we sometimes deal with this by withdrawing or hiding or sometimes even attacking others whom we perceive to be critical. Therefore it is not surprising that recent qualitative research with clinical and

non-clinical groups, has suggested that relationships can be crucial in repairing feelings of shame. What seems to be helpful is:

- a sense of meaningful connection with others
- articulating and acknowledging feelings of shame to yourself and others, rather than denying or ignoring shame
- However, for this to be helpful there needs to be a sense of acceptance from others such that you and your experiences are validated – in other words there is a sense that we are accepted *despite* the source of shame or supported in resisting the idea that we have anything to be ashamed of. This might include being helped to -
- normalise shameful experiences and feelings as something that has happened to others too, and make sense of how the experience has arisen from a particular context
- And finally a sense of empowerment seems important. To repair shame means to accept that you have the right to redefine your own experiences and self and that you feel empowered to do this in that you have some sense of control over your identity and some ability to effect changes in relations with others that might previously have been shaming & humiliating.

So repairing shame is often not just a matter of changing negative self-evaluations but making a shift in how we relate to the world around us and arriving at a different sense of our position in relation to others. This suggests that our environment and interactions with others are crucial and therefore we need to look at the social environment provided by mental health services and how well this facilitates repair of shame.

Clearly mental health services vary hugely and cover a wide range of practices and we need to be sceptical of broad generalisations. However, we would argue that there are some reasons to believe that mental health services are often not best placed to facilitate repair of shame. Firstly, there are now numerous critiques of mental health services based on service-user and practitioner accounts, which suggest that it is not uncommon for service-users to experience services as disempowering, degrading, blaming and in other ways

shaming. Secondly, within most societies the very act of using mental health services risks one of the most stigmatising and shaming identities. These factors combined do not seem conducive to the sense of connection, acceptance & validation necessary for dealing with shame.

Our recent research on the experience of managing the potential for shame in accessing mental health services provided further data on ways in which services can exacerbate a sense of shame. We interviewed 22 service-users across a range of ages who had accessed various UK National Health Service inpatient and outpatient mental health services via a child and adolescent mental health service, two community mental health teams for older adults and a service-user advocacy group. The focus of the semi-structured interviews was on how the participants managed the potential for shame and stigma that can arise from using mental health services and from experiencing difficulties that are often viewed negatively. This included discussion of the disclosure of psychological difficulties to others, the response to this by others and how participants dealt with this.

We found that for several of the participants a sense of shame or stigma arose not just when interacting with the wider community, but within their interactions with MH services staff. One of the themes identified via a qualitative thematic analysis was 'being diminished by staff' which included sub-themes of negative judgements, alienation & rejection, restriction of autonomy (which in Western societies is often experienced as demeaning) and a sense of having personal shortcomings or private experiences exposed without consent.

This slide (8) gives some flavour of these aspects of the data:

Instead of empowerment or a sense of acceptance Choe, one of the teenage participants, felt humiliated by the sense of scrutiny and criticism. Bob, an older participant, also talked about the staff's power over him and others - 'their word was law'. Instead of real relationships which might give him a sense of connection, Frank felt with some staff 'like a number', while Michelle felt like 'a face on medication'.

However, some did say how important the validation & acceptance of some staff was for countering their negative views of themselves and their difficulties. For example Bob also valued staff in one service 'treating me like a person – not like an inferiority complex' 'they

accept me for what I am or as I am'. It's worth noting though, that it was not unusual for participants to explain that they had been worried that they would *not* be seen in a positive light by staff. Gabrielle, one of the teenage service users expected to be looked at 'like dirt or somink' & very much valued the way she was made to feel welcome instead. It was as if the staff were assumed to have a certain power to judge, although some might choose not to use this....

The last part of this presentation considers why there is such a potential for mental health services to diminish, humiliate and shame people, instead of offering the validation and acceptance that Bob, Gabrielle and others experienced with some staff.

There are likely to be many factors including the social control function of psychiatry; the position of judgement this places staff within; the large-scale of many services; the difficulty we noted earlier of coping with extreme distress and the way in which acute negative emotions such as shame can make it difficult to manage relations with others without attacking or withdrawing. Several of our participants noted that they had not been the easiest of people to deal with when they were more acutely distressed. Also, in Western societies there is a taboo on acknowledging and talking about feeling ashamed, inferior, incapable or less than autonomous and independent, which makes it difficult for staff to address these issues.

However, we are going to focus on one further issue the medicalisation of extremes of distress and problematic behaviour, because we would argue that there are several reasons why a medical framework produces conditions at odds with those necessary for the repair of shame. In particular, the centrality of the process of diagnosis, can make it more likely that a certain kind of relationship is produced between service user and professional within which shame can be exacerbated rather than repaired.

On this slide (11), drawing on previous critiques of diagnostic practices, we have noted how these practices are problematic *because* they are diametrically opposed to the conditions necessary for repairing shame. Firstly, a medical approach can objectify the problem and discuss it with the aim of mapping the general form of the experience to a universal diagnostic category, rather than exploring in some depth the personal meaning of the experiences. In this way more personal disclosure can be inhibited and the scene is set for

avoidance of articulating and acknowledging painful feelings of shame, which is often so important for repairing shame. Hence distance is maintained and there is an avoidance of meaningful connection between the professional and service user, for example where one participant talked about staff “*sitting there with their clipboards*” and other participants ‘*felt like a number*’ or ‘*a face on medication*’. The research on repairing shame noted earlier suggests that connection with others, so that it is possible to articulate painful feelings, is often crucial for repairing shame.

Research has also suggested the importance of being able to make sense of feelings of shame as having arisen within a particular context and also as being something *normal*, given challenging or abnormal circumstances – something that others might feel too, rather than further evidence of *ab*normality. However, instead, the practice of diagnosis aims to identify aspects of behaviour and subjectivity which are abnormal and the process also actively *de*contextualises service-users’ experiences, constructing these as a symptom of illness rather than as a product of circumstances and life experiences.

The aim of the process of diagnosis is applying professional understandings or categories to clients’ experiences, rather than facilitating clients’ own understandings of their feelings. All our participants talked in some way about the importance of being able to make sense of their difficulties. However the medical approach is an ‘expert knows best’ approach which maintains professional control over the process of recovery. This is likely to be at odds with the sense of empowerment that enables individuals to repair shame by redefining their own identity and bringing about changes in their living circumstances.

And of course, in addition to the way in which diagnostic practices shape the relationships between service users and professionals, the diagnoses being applied are often perceived very negatively by the general public, as anything other than validating and affirming.

Some participants spoke explicitly about disliking the process of diagnosis, seeing this as a form of critical judgement and about feeling diminished by the diagnostic label. However, it is important to note that some participants said that a diagnosis could be helpful and even validating in seeming to absolve them of blame for their difficulties. Such variation in service-users’ views is not surprising given that some diagnoses are generally perceived far more negatively than others by the general public, and also, for a number of our

participants a diagnosis seemed preferable to the alternatives they perceived of being seen by those around them as a malingerer or someone who behaved badly or was difficult or simply couldn't cope.

Therefore we are not suggesting that any health professional who uses a diagnostic term is shaming, denigrating or humiliating service users or that service users will necessarily feel diminished by diagnostic labels, though many do. Instead we are suggesting that the way in which mental health services are structured around the central activity of diagnosis sets the scene for relationships between professionals and service-users which are less than helpful in facilitating recovery from shame. We would argue that relationships between staff and service-users that are indeed respectful, accepting and valuing develop *in spite of* rather than because of the medicalisation of mental health services.

## **Summary and conclusions**

If we think about some of the core problems that service users are experiencing, such as shame, then it draws our attention to a different set of needs than being 'treated' for a 'mental illness'. This includes relationships in which people can connect with others and feel accepted and empowered rather than diminished.

In a society where diagnoses may be perceived as necessary to account for certain kinds of behaviour and troubling experience, some service users may find diagnosis reassuring. However, the way in which diagnostic practices structure helping relationships can be problematic for repairing shame in that this sets the scene for helping relationships which are less likely to facilitate connection, disclosure and empowerment and are more likely to proceed as if the difficulty is an individual deficit.

The Division of Clinical Psychology has recently issued a position statement on diagnosis which clearly states the need for a paradigm shift and highlights the inherent problems of a 'disease' model for understanding psychological difficulties. This, along with the international resistance to DSM-5, the latest version of the American psychiatric classification manual provides support for alternative and more valuing ways of understanding and responding to psychological distress. However, the backlash against this



position statement, both within the UK press and within the pages of the 'Psychologist' (the monthly publication of the BPS), suggest that there is some way yet to go.