

Stigma and Shame: Conceptualisations and Views Concerning Service Use and Health Care Provision: A Literature Review and Commentary

*Alun Charles Jones**

Betsi Cadwaladr University Health Board, The Department of Psychological Therapies, Swn-Y-Coed, Grove Road, Wrexham, L111 1DY, North East Wales, UK

**Corresponding author: Alun Charles Jones, Betsi Cadwaladr University Health Board, The Department of Psychological Therapies, Swn-Y-Coed, Grove Road, Wrexham, L111 1DY, North East Wales, UK. Email: alun.jones4@wales.nhs.uk*

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Abstract

Aims

Being aware of the way's stigma and shame effect individuals and groups of people could contribute to improving the quality of care provided to people using health services. This paper explores situations that might provoke stigma and shame in people receiving or providing health care.

Background

Internationally, there are concerns for aspects of health care available to people who use health services. There is literature, which suggests that treatment, care and hospital admission can be stigmatising and shame provoking and so non-therapeutic.

Data-Sources

The following data sources were explored; CINHAL, PSYCHOLOGICAL LITERATURE, MEDLINE and EMBASE Key words included stigma and shame. Inclusion criteria concerned English language texts.

Review Methods

This paper reviews literature concerning stigma, shame and health care provision and service use generally. The discussion provides a commentary concerning the potentially harmful effects of stigma and shame aroused because of health care provision and service use.

Results

This discussion concludes by suggesting that we will gain a better understanding of difficulties encountered by people, experiencing illness, by expanding our awareness of potentially stigmatising and shame provoking situations. By understanding ways that shame impacts on health professionals, more effective team working may also be possible leading to more enhanced morale and better communication.

Conclusion

By knowing more about situations, which provoke stigma and shame, we may become more able to plan and deliver health services considerately and cost effectively. A moral imperative for health professionals is to understand ways that health provision might invoke stigma and shame responses in different situations, impeding recovery and perpetuating distress...

Keywords: Health Provision Words 4470; Literature Review; Stigma; Shame; Service Use.

What is Already Known about this Topic?

- Stigma can have a negative impact on the health and well-being of individuals and groups of people.
- Shame is considered closely related to stigma and its relation to other emotional states is incompletely understood.
- Stigma and shame can influence the outcomes of health service use and provision.

What this Paper Adds

- This paper provides a literature review with commentary concerning stigma and shame, service use and health care provision.
- Shame should be considered as potentially influencing all human interactions. Stigma and shame can negatively influence health service use and provision.
- Stigma and shame can arise from and because of the nature of health professionals' work particularly in instances where professional practice is inadequately thought out.

Introduction

The Review

This paper is concerned with a review of the literature and accompanying commentary concerning how stigma and shame can impact on individuals and groups of people including families.

A better understanding of ways the twin concepts interrelate and impact on health service use and provision could contribute to improving the quality and cost effectiveness of care health care across a range of health care services. Examples of ways that stigma and shame impact negatively on health provision are documented throughout the international literature concerning health and social care.

Davis for example, recently suggested that shame related to adult literacy is a major contributor to people failing to access health services because of a desire to conceal difficulties.

Murray [1] similarly proposed that stigma is a salient factor when accurately identifying depression in the elderly. since undesirable associations with weakness and failing are associated with depression in elderly persons, symptoms are often not reported to health and related professionals.

Aims

The aims of this review paper are therefore to explore the way stigma and shame influence health service use and provision. The purpose of the discussion is to illustrate ways that unaddressed stigma and shame can reduce the effectiveness of health interventions.

Search Methods

The following data-bases were explored for the purpose of this paper: All EBM reviews, BRITISH NURSING INDEX, CINAHL, PSYCH INFO and MEDLINE and EMBASE. Key words included stigma and shame. Inclusion criteria concerned English language texts up to 2008.

This paper offers a literature review with accompanying commentary concerning what is currently known about stigma, shame and health care provision internationally.

Search Outcomes

All papers considered appropriate to this paper concerned the concepts of stigma and shame and their relation to health and well-being particularly with regards to health service use and health care provision.

Quality Appraisal

Papers were assessed according to their relevance to stigma and shame and health service use together with health service provision.

Data Abstraction

Given the extent to that stigma and shame are discussed in the health science literature a wide range of papers related to physical and mental health have been included in the review, including research studies and discussion papers concerning stigma and shame and their influence on health and well-being.

Stigma

Stigma is a social concept, in which potentially damaging social associations are attributed to a person or group of people [2] suggested that the term stigma was originally intended to refer to an enduring mark on the skin, often used to indicate that a person was of lower moral standing. However, he also asserts that stigma now typically refers to any person or group of people that display traits which are different to the normal.

The sociologist Erving Goffman first formally identified the potentially harmful consequence of stigma in the early 1960s and asserted that to be stigmatised leads to disqualification from full social acceptance [3].

Stigma, Felt and Enacted

By way of example, with the injurious characteristics of stigma in mind, [4] explored the experiences of patients diagnosed as having lung cancer and proposed that the negative evaluation of stigma may be either felt, enacted or both;

- A felt negative evaluation refers to a fear of being discriminated against because of unacceptability or a perceived inferiority.
- An enacted negative evaluation relates to actual discrimination contributing to strong psychological and social disadvantages. Interactions with friends and family members can all suffer with work-life negatively influenced and self-image impaired.

These researchers found that as a result of felt negative evaluation, people sometimes conceal symptoms of illness. Others reported enacted negative evaluations in the form of unhelpful changes in communications with family, friends and health professionals.

Some people resisted being stigmatised, blamed or self-blaming because of their illness, suggesting that stigma does not necessarily impact negatively in all instances. However, concerns were voiced about gaining access to services and sensitive support. Because of stigmatising associations with smoking and lung cancer, people in the study felt apart from those with other types of illness [5] discuss stigma in relation to being different from the general population.

Referring to Goffman's Work, the Authors Defined Stigma as Follows

Stigma comes from a Greek word, which describes signs that indicate something out of the ordinary or bad about the person [3]. Stigmatizing is a process in which a social meaning is attached to behaviours and individuals [3] described three types of stigma. The first is physical deformities. The second is because of character blemishes, which may include traits such as weak will, dishonesty, addiction or mental illness. The third type of stigma is tribal, because of race or religion. Tribal can be passed on through familial lines with all members of a family or group being equally stigmatized [5].

Stigma by Affiliation

Earlier, Gray [6] writing with regards to the families of children with high functioning autism, referred to a `courtesy stigma`. This is also an occurrence first identified by Goffman, in which people are labelled by their affiliation to others who are stigmatized.

Courtesy stigma stigmatizes relatives because of family links with a stigmatised individual. On the other hand, family members might receive equally negative responses if they refused involvement to their stigmatized kin.

Family units might therefore exist in what [7] early on described as a `double bind`. Essentially a disqualifying transaction this is a cannot-win, in which individuals are judged negatively regardless of their conduct. Yet because of emotional circumstances they are unable to remove themselves from developmentally harmful situations.

Stigma Trajectory

Various authors describe stigma trajectories associated with specific circumstances [8] discussing the implications of stigma on people with HIV describes stigma as a social construct, impacting on the quality of life of individuals who are HIV positive. Stigma, however, is unique to everyone's circumstances and changes throughout the progression of the illness trajectory [9] by way of further illustration, conceptualize stigma along a social trajectory in which five interrelated components unite.

They authors describe a stigma pathway, which is as follows:

- Human differences. are defined and labelled.
- Dominant social and cultural beliefs connect individuals or groups of people to unfavourable characteristics and negative stereotypes.
- Discrete categories disconnect individuals and/or groups of people.
- Those labelled, experience a loss of status and are discriminated against in ways that lead to inequalities.
- Social and cultural stereotypes separate labelled individuals or groups into distinct categories with corresponding censure.

Challenges to Conceptualisation of Stigma

[9] nonetheless, suggest that conceptualisations of stigma vary considerably, and research is by and large conducted by none stigmatised groups of people. Researchers therefore conceptualise stigma in different ways. Citing the work of other social researchers, (Oliver, 1992; Kleinman et al 1995; Sayce 1998), the authors argue that there are two main challenges to the stigma concept.

The first is that many social scientists who do not belong to stigmatized groups, and who study stigma, do so from the vantage point of theories that are uninformed by the experiences of the people they study. Secondly, the authors also propose, stigma is typically viewed something that resides in or functions as a mark on a person(s).

Stigma, therefore, refers to labels that others assign to person(s). The term stigma focuses on the people who are the recipients of these behaviours. The authors suggest that the term discrimination might be more appropriate because it encompasses those who reject and exclude individuals or groups because of characteristics.

Stigma and Shame

Despite different conceptualisations stigma is in addition, considered by some authors to be the outward sign of shame [10]. Shame is a universal, adaptive and common emotional response to exposure of easily-hurt aspects of the self, although some people are more vulnerable to it than others [11].

An Everyday Definition of Shame Is Provided by The Encarta English Dictionary:

- Shame is a negative emotion that encompasses feelings of dishonour, unworthiness and embarrassment.

- Santy (2007) nevertheless, refers to a healthy shame`, which is an adaptive emotion designed to moderate behaviour.

Santy (2007) Believes that:

- Shame, in limited quantities and small doses-has facilitated civilized conduct and made both individuals and cultures behave more appropriately. Shame... keeps us in touch with reality, and reminds us of our limitations, faults, and humanity (Santy, 2007 p.1)

The effects of shame might best be thought of as complex and multi-dimensional. Its arousal can be socially and culturally determined [12] for Example, has indicated:

- Shame can therefore be regarded as a physical sensation that occurs as a response in a socio-cultural context. It is often culturally or socially determined in that cultures or societies establish norms that if transgressed by an individual may be accompanied by feelings of shame.
- The response to the feeling of shame is also culturally and socially influenced. There are expectations of how an individual should express shame. Shame is always linked to the self in relationship with others [12].
- Shame encompasses feelings of being wrong as a person. It can occur either as self-to-self (in one's own mind), self-to-other (in the mind of another) or both [13].

Shameful Bleeding

- Buchman et al (2002, p. 669) [14] referred to Talmudic sages as declaring that `shaming another in public is like shedding blood`. The authors argued that the pain of shame and humiliation can be experienced as greater than that of a physical injury. Gilbert (2003) [15] concurs, believing that such is the fear of being shamed that in certain circumstances individuals will risk physical injury or death to escape it.
- Gilbert (2003) [15] also suggested that shame can bring about social non-acceptance and therefore, strong discord in social relationships. Shame is consequently linked to social threat systems and aspects are related to the need to hold an image of oneself in another's mind as attractive [15]. Shame is also a deep-rooted emotion and durably correlated with individual dignity.

Shame and Psychopathology

- Tangney et al, [16] have referred to shame as feeling as though the whole of the self is exposed and negatively evaluated even without the presence of critical other with regards to relationships with others, the harmful effects of shame along with stigma have been reported on internationally by researchers.
- Stigma and shame are identified as playing key roles in sexual addictions [17], depressive illness [18], psychological recovery following suicide attempts [11], aggressiveness in childhood development [19], sexual orientation [20] and the onset of anxiety disorders [21].
- Shame has also been linked to concerns about identity and gender [22], narcissistic disturbances [23], HIV and AIDS (Fortenberry *et al*, 2002), personal appearance [24], eating

disorders (Morady *et al*, 2005) and TB-HIV [25], mental illness [26] and children with nocturnal enuresis [27].

- With regards cultural influences, [28] have written about ways in which shame can be strongly linked to self-realisation and face-saving cultures. This list is by no means exhaustive and merely indicates the extent to which shame permeates human existence and can influence day-to-day-life and illness trajectories.

Conceptualising Shame

Tangney, in partnership with other researchers, has devised a shame assessment measure, Test of Self-Conscious Affect (TOSCA) [29]. Tangney has also carried out influential research concerning the psychopathology of shame and the effects on health and well-being. (For further examples see, [30,31]).

Subsequently, shame has been linked to feelings of anger, blaming others and a reduced capacity to trust [32]. Shame-proneness is also thought linked to attachment styles established in early life yet enduring into adulthood [33].

Thematic throughout all the health science literature is the idea that because shame is unified with other strong emotions it is difficult to separate from other discomforting states of mind [30]. As such a complete definition has seemingly eluded researchers.

Moreover, conceptual melding has contributed to a lack of clarity and an absence of any helpful operational definition by which to interrogate research data and fieldwork reports. To illustrate, it is reported that shame is sometimes mistaken for guilt, embarrassment or humiliation, although all may be interrelated (Sabini and Silver, 1997).

Tangney [34] linked shame proneness with difficulties in empathizing. While Karen [35] made interesting observations, connecting shame to narcissistic leanings and a strong sense of personal deficiency leading to difficulties in relating to others genuinely. Shame may therefore underpin perfectionist and achievement cultures and its destructive effects could be particularly evident at times of difficulties or perceived failing.

An Evolutionary View of Shame

Shame is considered one of the principal survival emotions. Webb (2000) held that the anthropologist Charles Darwin was the first to make a scientific study of shame linking its occurrence to deference Gilbert writing with McGuire [36]. concurred and proposed that the evolutionary development of shame is concerned with an ability to detect and avoid social threats.

Various authors consider shame to be a submissive defence against attacks from a dominant other (s). For example, citing the work of Keltner and Harker [37] and Macdonald and Morley (2001),

Gilbert [15] argued that shame can trigger autonomic defenses related to escape, submission, assuaged rage and the suppression of emotional distress. Hook and Andrews [38] for example found that mental health service users undertaking psychological therapy did not report symptoms or experiences because of shame proneness.

They assert that non-disclosure of symptoms can result in poor therapeutic outcomes and so a longer experience of mental ill-health. These authors also propose that recognizing shame proneness and encouraging openness about shame will bring about better health related behaviors.

Claesson, Birgegard and Sohlberg, [39] suggested, that even though there is consensus in the literature regarding the subjective experience of shame, there are disagreements about its purpose. The authors refer to [40] to assert that anthropological perspectives define shame as culturally defined, rather than evolutionary, and its arousal conditional on social and cultural norms and values.

Notwithstanding, there is agreement throughout the literature that shame is primarily an adaptive human mechanism and has survival value. Shame is considered a higher order emotion, related to an ability to discern how one is viewed by another [41].

Evidently shame is a composite emotion and is manifestly concerned with continued existence. Even so an inherent paradox exists in that under some circumstances, the literature strongly suggests that invoking shame can prove psychologically overwhelming and as such, damaging to human health and welfare [39,42] argued that the main function of shame is to destroy inappropriate pleasure.

A sense of well-being arguably related to providing treatment and care and recovery from of illness might therefore be negatively influenced by feelings of shame and have far reaching effects to individuals and their families but also to the cost of health care delivery [11].

Consequently, a moral imperative for health professionals is to better understand how approaches to health provision might invoke shame responses in different situations impeding recovery and perpetuating distress.

Stigma, Shame and Health Care Provision

Damaging effects of stigma and shame are documented throughout the spectrum of health science literature internationally [43,44,45]. It is thought, stigma can influence, negatively, the course of illness along with the potential for recovery.

In addition, stigma and shame can be provoked by the transaction of giving and receiving health care causing individuals to disguise suffering [46].

Research has also shown that shame can be aroused in both frank and subtle ways and has a powerful destructive effect on individuals and groups [47]. Shame might cause individuals to withdraw from situations, fail to get their needs met and experience an accompanying sense of identity change [48]. In such circumstances, health service delivery is compromised, often with loss of effectiveness and cost implications.

Moreover, because of unsuspected attitudes, treatment and care provision to people with certain types of health problems may be unsuccessful, even harmful, in terms of stigmatizing individuals and families with accompanying shame.

The emotional impact on families may be immense and far-reaching. The literature concerning stigma suggests difficulties of living because of experiencing accompanying shame, might also be passed on from one generation to another disadvantaging groups of people and placing a further responsibility on health resources [49].

Invoking shame, to varied extent, is perhaps therefore to be anticipated as a part of health care provision, some nursing or treatment processes (Harper and Hoopes, 1990). However, when shame is activated in those seeking help for illness, the emotion is likely to motivate self-concealment or result in hostility towards oneself or/and others. (Retzinger, 1998).

In such circumstances, health service delivery could be compromised, with an accompanying loss of personal dignity, professional effectiveness and service provision cost-effectiveness [4].

In an early paper Lazare [50] indicated that in all medical encounters there is potential for individuals to be shamed because illness implies defects or inadequacy. Hospital visits (and health service use more generally) typically require the scrutiny of another and personal exposure, with potential to arouse feelings of shame.

Lazare [50] suggested that in response to shame related feelings patients will withhold information, fail to keep appointments, complain *or* take legal action against the providers of health services.

Importantly, this author suggested that medical practitioners can also experience feelings of shame because of difficulties with providing health care, resulting in them counter shaming those in their care as a corresponding psychological defence.

Influences of Stigma, Shame on Healthcare Professionals

Later Davidoff [51] citing Lazare argued that medical practitioners can be shame-prone because of tendencies to perfectionism, which arguably forms a part of the personality of individuals attracted to medical practice. In addition, the author implied that a desire to attain perfection is both implicit and explicit in selection criteria for medical training.

Medical practitioners, however, are by no means alone in their experiences of shame. Post [52] for example, conducted descriptive a research study with perioperative nurses and found that in value conflict situations nurses experience strong feelings of shame with corresponding negative influences on professional practice.

Even earlier, Ardnt (1994) conducted a qualitative research study concerning nurses' experiences with medication errors. The researchers discussed the shame nurses experience and are made to experience because of organisational concern with personal and professional failings. This researcher proposed that diminishing a fear of being shamed can contribute to more openness and so promote critical learning from professional errors.

Other research studies which identify shame as being provoked by providing nursing care, include a study of district nurses [53], and groups of mental health nurses' work and relative status [54], as well as hospice nurses' clinical reports during work discussions [55].

Darovic [56] in a later discussion went as far as to suggest that, in certain circumstances, the organization of nursing can serve to mobilize shame as a social defense mechanism in both clinical work and educational settings.

The author argued that within nursing teams, colleagues and managers can stigmatize others or use shaming strategies to exert influence and control over others, because of unhealthy competition and/or shortfalls in service resources and provision.

Darovic [56] argued also that shame has the potential to impede an ability to care for one and others as well as erode team spirit and moral values together with harming professional identity.

Shame and Professional Care

The literature suggests that shame can be overlooked by healthcare professionals with damaging consequences. Svedlund [57] for example, discussed how women following a myocardial infarction along with family members experience shame because of an enforced dependency on professionals. A later Finnish research study, exploring cooperative team meetings in two psychiatric inpatient units, illustrated ways that shame formed a core narrative of all meetings studied (Vuokila-Oikkonen *et al*, 2003).

Following an analysis of video recordings over eleven team meetings, the researchers suggested that in instances where service users and their relatives attempted to speak about the shame aroused by their experiences, health professionals either changed the topic of conversation, offered explanations about the experience or asked questions so avoiding an uncomfortable subject matter. The researchers suggest that failure to address issues of shame resulting in service users feeling alone and isolated.

Stigma, Shame and Mental Health Services

Investigations concerning the experience of service users suggest, most prominently psychiatric hospital admission is viewed negatively and that hospital settings are stigmatising and shame provoking (DoH, 2002). Such concerns have led to the development of initiatives to reduce stigma and its effects on people with mental illness.

Corrigan and Watson [58] remind us that while it is generally accepted that wider society often endorses stigmatising views concerning mental illness, occurrences may not be confined to the general public. Professional groups, including mental health professionals, can subscribe to negative stereotypes about mental illness with accompanying harmful influences on health care effectiveness and recovery.

According to Thornicroft [2] in certain instances mental health professionals can be stigmatised in both felt and enacted ways, with accompanying feelings of shame, because of affiliations to stigmatised groups of people.

This may cause individuals to withdraw or hide away with an accompanying sense of reduced professional standing. Thornicroft [2] suggested that situations can also occur in which those providing care can believe that there is a difference between themselves and those whom they provide treatment and care.

This occurrence arises from a need to cope psychologically with emotionally demanding work. However, in circumstances where a mental health professional becomes ill, he or she can be distanced by other mental health professionals as a form of psychological protection. In such instances, unaddressed stigma and shame lead to empathic failures in the organisation and delivery of health care.

Research with people who have accessed mental health services along with professionals demonstrates ways the both groups experience shame [59,60,61]. The investigators found that mental health professionals were stigmatised because of their affiliation to vulnerable groups of people.

In addition, because of their professional roles entailing negotiating challenging aspects of relationships, mental health professionals experienced moral distress. Mental health professionals in the study spoke of ways they avoided shame invoking situations such as the desire to wear uniforms so they would not contrast with other hospital staff.

Some Examples of Shame Avoidance Behaviours

Barker [62] suggested five illustrations of how shame might manifest in unhelpful ways in various social situations.

They are as follows;

- Attacking or striking out at others.
- Seeking personal power and perfection,
- Diverting blame onto others,
- Being overly nice or self-sacrificing with others
- Withdrawing from or avoiding shame provoking situations.

The behaviours proposed by Barker (2007) reflect concerns throughout the health sciences literature. It seems self-evident that where such behaviours feature in health care settings the potential benefits of health services are likely to be compromised. The author also asserted that while listed behaviours may bring temporary relief from shame, in the long term they are unlikely to prove effective with possible harmful affects on others.

Combating Shame

Gilbert [63] perhaps the most prominent contributors to the literature concerning shame in the United Kingdom, has developed a model of therapy designed to combat anti-social or self-attacking behaviours arising because of psychological difficulties related to shame. Gilbert has named the approach Compassionate Mind Training (CMT).

The approach is designed to help people who are highly shame-prone, self critical and self-aggressive Writing with Procter (2006) Gilbert [64] describes a situation in which a person experiencing all the destructive effects of shame can feel the world is threatening and overwhelming resulting in self-condemnation.

Gilbert and Procter [13] suggest that in some circumstances it may be possible to encourage a more compassionate stance towards oneself and others so reducing vulnerability by a process of self-soothing.

Gilbert and Procter [13] described several key abilities, which can, they suggest, can be fostered in others.

They are as follows:

- A desire to care for the well-being of another
- Distress/sensitivity recognition
- Sympathy
- Distress tolerance
- Empathy
- Non-judgement
- Warmth (Gilbert and Procter, 2006 p.358)

The authors suggested that developing such abilities will increase the likelihood of to recognize and process distress in oneself and others so reducing the potential to deny or overlook difficulties. In addition, individuals will be more likely to be emotionally moved by distress and be better able to tolerate painful feelings so reducing the potential to avoid challenging situations or judge oneself and others negatively.

The approach clearly synthesises other therapeutic approaches, perhaps most notably those embedded in humanistic psychology. However, the authors indicate that it does not seek to target specific core beliefs, as is the case in some models of psychotherapy, such as Cognitive Behavioural Therapy. It is devised as an attempt to change the global orientation towards oneself and others i.e. to change an attacking or defensive attitude to one of care and compassion.

Gilbert and Procter [13] also describe a biopsychology rationale underpinning CMT. Gilbert in association with other researchers (See for example [64,13] carried out research studies related to assuaging self-criticisms and self-attacking behaviours and has found the methods described to be effective in enhancing self-compassion.

Gilbert and Procter [13] do not indicate the potential for the approach to provide organising frameworks for professionals practice. Despite this, much like recovery approaches to mental illness, further research might illustrate ways that CMT could usefully apply to professional groups in view of the literature concerning occupationally aroused shame.

Discussion

Stigma and shame have endured throughout time and cultures. The literature suggests that stigma and corresponding shame have strong potential to damage the health and well-being of individuals and groups of people, including families.

Health care services should therefore be cautious so as not to contribute to stigmatizing or shaming situations that impact on service users and their families or health professionals.

Limiting the effects of shame is likely to reduce a sense of stigma which is some literature suggests will be compellingly therapeutic. The preventative value in terms of psychological health could benefit all concerned with service use and provision

Implications for Research

Qualitative research has a critical role to play in developing our knowledge of the effects of stigma and shame across cultures. By knowing more about situations, which provoke stigma with accompanying feelings of shame, we may become better able to plan and deliver health services considerately and cost effectively. We may become better informed about ways people fail to get their health needs met because of shame.

Pragmatic solutions to difficult problems might, in some circumstances, be possible. We might also develop a better social and cultural awareness of the complexities in relation to ways shame is aroused in individuals and groups of people, including service providers and health professionals.

Knowing more about the interplays of shame invoking interactions between health professionals and service users is likely to prove helpful to organising health care delivery. The complexity of human dynamics and provision of health care might be more sensitively managed.

Implications for Professional Practice

If we are to effectively reduce the potential to unknowingly shame others in professional situations, it seems sensible that all professionals recognise and examine moral principles influencing the course of their work. About human service organisations it seems clear from some literature reviewed in this paper that the values of those who make up the administration and provide services can differ considerably from those who use services.

Differences in values held by and between professional groups and service users, could lead to reduced quality of service provision. Given the apparent the potential for divergence and misunderstandings between healthcare professionals and service users, along with the evident potential to arouse feeling of shame, it is vital that variations in values are recognised and managed.

Failures in empathy, discrimination, stigmatising, shaming and counter- shaming might all be prevented or at least diminished. Being aware of differences may help all involved with service provision and uptake to identify common ground and shared values while respecting diversity.

The literature shows that people will conceal health and related problems because of shame. Training and on-going education might be organised with values clarification and appraisal prominently in mind with a potential to reduce shame proneness and diminish stigma. These ideas of course extend to service users as well as providers.

Conclusion

Stigma and shame are concepts which give rise for concern throughout health sciences literature and across cultures. They are socially and culturally constructed concepts and are potentially harmful to psychological health and well-being.

Helping professional service providers to become more aware of situations, which provoke feelings of shame in service users and health professionals alike, including their families, may bring benefits. More thoughtful service planning, professional preparation and ongoing education might be possible leading to beneficial changes to the way treatment and healthcare more generally is organised.

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