Scenes of Shame and Stigma in COVID-19.

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Summary of the research

The COVID-19 pandemic has witnessed a proliferation of scenes and experiences of shame, particularly around catching and transmitting the virus, behaving in ways deemed to be irresponsible, stupid, or selfish, and placing healthcare systems and resources under undue strain. Although – and, indeed, because – shame is a predictable historical aspect of pandemics, many of these instances of shame have been avoidable. While people in crisis often look for scapegoats, interventions by the UK government have caused, heightened, and made unnecessary room for shame, when public health (both viral and non-viral) would have been better served by attempts to confront, mitigate, and prevent it. Rather than sensitise different publics to the ill-effects of shaming, pandemic healthcare policies, rhetoric, and communication have contributed to the conditions in which shame and shaming occur, relying on divisive and blaming languages which deflect shame from political responsibilities and structural harms.

Shame is a negative emotion with serious consequences for mental, relational, and physical health. It results from the stigmatisation of particular bodies, behaviours, and identities; is more likely to be experienced in situations of perceived vulnerability or inadequacy; and is frequently the product of public health initiatives aimed at effecting behavioural change. Shamed individuals or groups avoid diagnostic, curative, or preventative processes, lose trust in medical expertise or public health messaging, are or feel unable to share the burden of illness with vital support networks, and can be subject to complicated emotional, psychological and physiological processes which further widen existing social and health inequalities.

Policy recommendations

- Reject shame as a behavioural tool of any kind. Not all shaming is accidental, and many initiatives and encounters still rely on shame to create behavioural change. Refusing to knowingly use shame is a crucial first step, requiring vulnerability and critical thinking about past and future practice.
- Build attentiveness to shame into institutional expertise and cultures. Create a shared collaborative understanding of how shame is experienced and produced. Even in contexts or encounters where shame might seem inevitable, shame-sensitive approaches can still lead to improved outcomes.
- Use this competency to conduct audits on any work which has the potential to generate, spread, or exacerbate shame. Does this initiative represent people, choices or behaviour in ways which could cause shame? Does it reflect on how shame might be present, and seek to minimise it in every possible way?
- Engage and collaborate with communities and publics to promote shame-conscious health-seeking behaviour, and support them proactively to do so. Shifting emphasis away from individual ‘choices’ makes vital space for attention to the collective and structural determinants of health.

Case Study: Obesity. Following the hospitalisation of Boris Johnson and his statement that 'I was too fat', public health messaging on obesity emphasised individual choices (i.e. making simple food swaps) with no acknowledgment of the complex relational and structural contexts of weight gain (particularly in a pandemic). It therefore attributed responsibility (including for burdening a chronically under-resourced health service) on individual bodies and behaviour, in ways that were experienced as shaming.

Key findings

Shame in the COVID-19 pandemic has emerged – or has been allowed to emerge – in ways which, if not always entirely predictable, have largely followed the logics of existing patterns and histories of shame and the conditions which cause it. We have therefore seen shame emerge in contexts which are simultaneously new and not new; for example, around overweight or 'foreign' bodies; around work in healthcare, or being perceived as a burden to health systems; around pandemic citizenship and non-compliance with public health regulations or subjective valuations of 'common sense'; around national performance and slights to exceptionalism; and around the uptake or refusal of masks, vaccines, and testing.

Language and symbolism have been of vital significance in creating, deflecting, and attaching shame, and can be subjected to rigorous philosophical and linguistic analysis; this work can help show the mechanisms by which shame travels, demonstrate the power relations which condition where and how it lands, and suggest ways to minimise or prevent shame rather than letting it flourish.

Further information

Scenes of Shame and Stigma in Covid-19: https://shameandmedicine.org/covid-19/

Wellcome Centre for Cultures and Environments of Health: https://wcceh.org/

COVID-19, Online Shaming, and Health-care Professionals: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01706-2/fulltext

Shame-sensitive Practice and COVID-19: https://www.exeter.ac.uk/media/universityofexeter/research/policy/briefs/Shame-Sensitive_Practice_and_Covid-19.pdf

'Saving Face' and Public Health Policy during Covid-19: https://blogs.bmj.com/medical-humanities/2020/05/26/saving-face-and-public-health-policy-during-covid-19/

Stigma and the Logics of Wartime: https://culanth.org/fieldsights/stigma-and-the-logics-of-wartime

'Fat Shaming' under Neoliberalism and COVID-19: Examining the UK's 'Tackling Obesity' Campaign: https://osf.io/2ymun

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