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Ways of seeing

Joe Bouch

FROM THE
EDITOR

Writing in the aftermath of the hurricane Katrina disaster in New Orleans, the anthropologist Virginia Dominguez was struck by people's surprise at the level of social deprivation that was so clearly on show. Criticising commentators who likened the scenes to the 'Third World', she suggested that this exposed a shared, hidden and false assumption that social inequalities are of little import in the USA; that fundamentally the USA is a wealthy and powerful country in which problems can easily be sorted. She warned of complicity in rendering the problems of social disadvantage invisible unless such 'habits of thought' are broken: 'Seeing doesn't just happen. We learn to see things in certain ways. We teach others to do the same. And once we're accustomed to it we just do it, largely without noticing. To see ourselves seeing others in particular ways – to allow ourselves to learn from an experience such as the Katrina disaster – we have to work hard to catch ourselves doing it' (Dominguez 2006).

Exposing our own familiar but outworn ways of seeing is a challenge for psychiatrists. There are some areas in which we too need to break habits of thought to see differently. Domestic abuse is one such area. It has the highest rate of repeated victimisation of any violent crime. It is common, both caused by and a cause of psychiatric disorders, yet domestic abuse is 'underdetected in [mental health] services internationally, with only 10–30% of recent violence asked about and disclosed in clinical practice' (Howard, pp. 129–136). Engagement in a supportive and trusting therapeutic relationship with a confident and competent clinician facilitates disclosure. Shame acts as a barrier (Rose 2011).

Guilt and shame

Shame is a basic emotion present even in infants (Raju, pp. 82–93). Although it teaches us how to live together, intense or chronic levels cause great distress. Shame occurs in many psychiatric disorders. How it manifests and how to work with shame in clinical practice is a focus of the article that is my Editor's pick (Clark, pp. 137–143). As Clark explains, 'shame tends to hide itself', resulting in problems for patients, carers and clinicians: 'the body is a key mediator of shame' and shame is strongly associated with disease, disability and abuse. In emotional dysregulation it occurs as the body switches from a hyperaroused state mediated by the sympathetic nervous system to a parasympathetically mediated hypoaroused state, at the point that fight or flight turns to numbness and despair (Raju, pp. 82–93). Attempts to soothe distress by using substances may lead to addiction, 'a further source of shame leading to a vicious cycle' (Clark, pp. 137–143). In therapy, acceptance, forgiveness and compassion are important themes and perhaps underpinning these is 'a humble awareness of [the clinician's] own humanity'.

Dominguez VR (2006) Seeing and not seeing: complicity in surprise. Social Science Research Council (<http://understandingkatrina.ssrc.org/Dominguez/>).

Rose D, Trevillion K, Woodall A, et al (2011) Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *British Journal of Psychiatry* 198: 189–194.