Shame, Sexual Health, and Psychological Flexibility

Supporting patients — and ourselves — in difficult sexual-health conversations

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“The DMV Experience”



certified birth certificate + Social Security card + current school photo ID + official transcript/school record + parent/guardian/address documentation

- Frozen and stuck.
- Felt physically in the body.
- A strong urge to disappear.
- Supported by family.

Reflecting on Shame

Recall a moment you experienced shame

Body

Physical Sensations

Notice where shame lived physically in your body.

Action Impulse:

- Hide or Withdraw?

Mind

Cognitive Reaction

Notice where shame lived in your thoughts and narrative.

Action Impulse:

- Explain or Fight?

Relationship

Interpersonal Dynamic

Notice where shame lived in your connection with others.

Action Impulse:

- Escape?

Impact on Sexual Health

Clinical Observations & Behavior Patterns

Adherence

- Missed doses
- Concealed medication (PrEP, ART)

Engagement

- Delayed testing
- Poor follow-up
- Lack of disclosure

Decision Making

- Risky behaviors
- Avoiding condoms or STI testing

Key Clinical Takeaway

Stigma directly reduces healthcare access and utilization.

Reframing Patient Behavior

"Is it 'noncompliance' or is it shame in motion?"

Observed Behaviors

- Resistance
- Defensiveness
- Avoidance
- Poor follow-through

Provider Reflection

Ask yourself:

What might this behavior be protecting?

UNDERSTANDING SHAME

Today's Goals

01
Recognize shame.

02
Understand how it shapes behavior.

03
Respond without escalating it.

04
Notice what shame, frustration, and resentment evoke in us.

The Context of Sexual Shame



Shame begins long before the exam room.

- Sexual violence culture
- Virgin/whore narratives
- HIV/AIDS stigma
- Queer criminalization

Patients carry deep narratives about bodies, morality, and identity into care.

Recognizing Learned Shame

CLINICAL OBSERVATION & INTERNAL DYNAMICS

THE INTERNAL SHIFT (PROCESS FLOW)

EVENT
"Something happened"

→

BEHAVIOR
"I did something bad"

→

INTERNALIZED SELF-STIGMA
"Something is wrong with me."

PHYSICAL SIGNS

- Looking down
- Silence
- Nervous laughter
- Tension
- Overexplaining

EXPRESSIONS

“I’m disgusting.”

“They’ll judge me.”

Nathanson’s Compass of Shame

CLINICAL FRAMEWORK

Withdrawal

Go quiet, disappear.

Avoidance

Minimize, joke, change the subject.

Attack Self

"I'm disgusting."

Attack Other

"Why are you asking me that?"

Note: *These are responses to shame, not fixed personality types.*

Clinical Presentations of Shame

PASSIVE VS. ACTIVE DEFENSE MOVES

PASSIVE DEFENSE MOVES

- **Withdrawal:** Missed appointments, delayed STI testing.
- **Avoidance:** Minimizing risk ("It's no big deal").

ACTIVE DEFENSE MOVES

- **Attack Self:** Extreme guilt, difficulty with pleasure.
- **Attack Other:** Defensiveness, rejecting medical recommendations.

Takeaway: Behavior gives us information.

FROM SHAME TO FLEXIBILITY

Provider Check-In

Have you heard:

"I don't want to talk about it."

"It's not a big deal."

"I'm disgusting."

"Why are you asking me that?"

REFLECT

Which phrase activates your urge to fix, confront, or withdraw?

SECTION 02 • PSYCHOLOGICAL FLEXIBILITY

Breaking the Cycle of Silence

Shame grows in Silence • Secrecy • Isolation.

Our Goal is NOT to:

- Erase shame
- Debate it
- Force disclosure

Our True Goal

Help the patient stay present long enough to have a choice.

Fostering Psychological Flexibility

Openness

Can we make room for what is here?

Awareness

Can we notice what is happening?

Engagement

What matters and what is the next workable step?

PRACTICAL PROVIDER RESPONSE SCRIPTS

Handling Withdrawal & Avoidance

Withdrawal

Open

“We can go at your pace.”

Notice

“What are you noticing right now?”

Move

“What is one doable step today?”

Avoidance

Open

“Part of you may want to move away.”

Notice

“What do you notice yourself wanting to do?”

Move

“What would taking care of yourself look like here?”

Handling Attack Responses

Provider Response Scripts & De-escalation Strategies

Attack Self

Open

"That sounds painful to be carrying."

Notice

"The thought went to 'something is wrong with me.'"

Move

"What does the part of you that wants care want to do next?"

Attack Other

Open

"That’s a fair question."

Notice

"It sounds important you know why I’m asking."

Move

"What feels most important to focus on today?"

SHAME IN THE PROVIDER: Redefining Success

CLINICAL PRACTICE & REFRAMING METRICS

Success may simply be:

- Staying in the conversation.
- Asking a question.
- Naming a fear.
- Scheduling a follow-up.
- Knowing they can come back.

Sometimes flexibility begins with staying in the room.

Provider Reactions and Stress

Provider Check-in & Reflection

Providers experience reactions too:

- Frustration & Resentment
- Helplessness & Fear
- Exhaustion & Self-doubt
- Shame over past interactions

Key Takeaway

Provider stress shapes communication just as much as patient shame.

Quick Activity: Authentic Relating

SPECTRUM EXERCISE & EMBODIED REFLECTION

Position yourself along the spectrum based on your response:

Notice what feelings, bodily sensations, or thoughts arise as you take your stance.

Totally Agree

"This statement strongly resonates with my personal or clinical experience."

Totally Disagree

"This statement does not align with my perspective or lived experience."

Key Reflection: What do you observe about where the group lands, and how does connection form across different points on the spectrum?

Shame Reduction Happens in Connection

Shame grows in isolation. A key part of reducing shame is finding community, affinity, and spaces where we do not have to explain every part of ourselves.

As you move through this conference, I invite you to find some identity restoration:

- Find your people.
- Tell the truth about the work.
- Let yourself be known beyond your role.
- Remember who you are outside of what you provide for others.

Key Takeaway

Connection does not remove the difficulty of this work.

It reminds us that we do not have to carry it alone.