Title: Shame and Disclosure: Strategies for addressing the negative impact shame has on public health and diagnosis and treatment in the context of STIs and HIV

Author: Phil Hutchinson (Ph.D.)

Affiliation: Manchester Metropolitan University, Department of Interdisciplinary Studies (Applied Philosophy) & Institute of Humanities and Social Science Research.

Abstract

There are four ways in which shame negatively impacts on attempts to combat and treat HIV, which emerge from the stigma HIV carries and STI-stigma in general.
1. Shame can prevent individuals presenting at clinics for STI and HIV testing.
2. Shame can prevent an individual from disclosing all the relevant facts about their sexual history to the physician.
3. Shame can prevent an individual from disclosing their HIV (or STI) status to new sexual partners.
4. Shame can serve to psychologically imprison people, it makes the task of living with HIV a much worse experience than it should or needs to be.

Drawing on my own work on shame and the philosophy and psychology of emotion (Hutchinson on 2008, 2009 & 2011) I (a.) propose a way of understanding how shame operates upon those who experience the emotion, and (b.) propose a strategy for combatting the negative role shame plays in the fight against STI’s and HIV.

Introduction

In this paper I propose four ways in which shame plays a negative practical role in the areas of public health and diagnosis and treatment, with specific focus on STIs/HIV. I progress to suggest that a better understanding of shame, and a development of strategies which will enable people to overcome shame, will contribute significantly to enhancing diagnosis, militating against new infections and improve early diagnosis rates.

There are four ways in which shame negatively impacts on attempts to combat and treat HIV, which emerge from the stigma HIV carries and STI-stigma in general.

   a. Shame can prevent individuals presenting at clinics for STI testing.
   b. Shame can prevent an individual from disclosing all the relevant facts about their sexual history to the physician.
   c. Shame can prevent an individual from disclosing their HIV (or STI) status to new sexual partners.
   d. Shame can serve to psychologically imprison people, it makes the task of living with HIV a much worse experience than it should or needs to be.

Shame, therefore, has consequences, both in the clinical setting and for public health. I shall here discuss the first three in the list. The paper will then progress to provide a framework for understanding the way shame operates and propose strategies for helping people overcome their shame.
1. Understanding Shame

When shame is discussed in the philosophical and psychological literature it is usually depicted as a (higher) cognitive or complex emotion of self-assessment. While there are some problems inherent to this depiction, it will do as starting point. When one unpacks this categorisation, it means simply that the experience of shame is characteristically constituted and type-individuated by evaluative beliefs about the self. Where guilt is primarily associated with a belief that one has acted in a transgressive manner, violating a law or social norm, shame, it is proposed, operates on one’s being: it is less about what one does and more about who one is, and how this might stand in relation to a person’s awareness of how others perceive them. In addition, shame often leads to a desire to hide from the lifeworld.

While this will do as a preliminary depiction, it is important not to be misled. I have proposed (2008) that the evaluation which gives rise to shame operates not at the level of propositionally-structured evaluative beliefs or judgements, but rather at the level of cognitive or conceptual frames.

1.2 Autonomy and Heteronomy

To feel shame is to take oneself to be worthy of shame, and this shame-worthiness can have a number of sources. It can be heteronomous, such that shame is an acknowledgement, a taking-on-board, of the judgements (or moral perceptions) of others about one’s self, and in so doing considering oneself, one’s being, to be in someway evaluatively diminished. Shame can also be autonomous, such that shame serves as testament to a mismatch between the sense of self one assumes and seeks to project to others and the self that one considers oneself to be on reflection. Autonomous shame, therefore, might emerge from a mismatch prompted by acknowledging all one’s actions and all one’s beliefs rather than focusing only on some convenient or self-serving selection of these. For example, consider the ‘liberal’ who must ‘face-up’ to their sexism or racism, when they have reflected on their subtle-but-there-all-the-same propensity to racial or gender stereotype. In this case, shame might emerge as our ‘liberal’ comes to acknowledge the tension between this aspect of their character—their propensity to subtle gender- or racial stereotyping—and the liberal character they had assumed and projected as theirs. Shame, the emotion, can testify to this (if they are merely embarrassed they really haven’t acknowledged the true significance of the tension). This provides us with an example of autonomous shame.

However, as remarked, it is a characteristic of the emotion that one can experience shame owing to tensions which testify to mismatches between social norms or mores on the one hand and aspects of one’s character on the other. Here the self-evaluation that one falls short of some standard relates to a standard which transcends the character of the specific individual. This is the kind of shame which testifies to perverse social norms and mores, the sort of shame in evidence when one considers the shame that some rape victims experience. Here the tension has its source in the way in which social norms intersect with one’s sense of self and how this, despite one’s beliefs about oneself, seems to impose upon one a sense of shame. This type of shame can often be accompanied by a desire to flee or hide from others, from the society (the audience, the honour group) that has conferred upon one this shame. This provides us with an example of heteronomous shame.
While there has been much discussion of whether shame is a characteristically heteronomous or autonomous emotion, I have argued (Hutchinson 2008) that it can operate, at turns, both autonomously and heteronomously. Indeed, my argument was that the distinction is somewhat misleading in that it commits one to a particular problematic view of meaning, but we do not need to explore this further here. This is an important point to be clear on, because if one holds that shame is always autonomous, then that will lead one to focus any attempt to alleviate shame solely on the individuals who bear shame. One will see it as a purely psychological problem for individuals. Conversely, if one were to assume that shame is always heteronomous, that shame is instantiated in individuals by their acceptance of the judgement of others, others who form their honour group, then that will lead one to identify that which is in need of change as being the social norms of which the honour group (the shame-instantiating audience) are an embodiment or the attachment the individual experiencing shame has to those social norms. In this latter, heteronomous sense, therefore, addressing shame might be a political and social task in addition to being a psychological task.

To provide an example, the rape victim who feels shame for the tainting of the family name that has resulted from their rape might well benefit from psychological treatment which serves to enable them to detach from the social norms that stigmatise rape victims and their families. But it would be crass to believe that this is all that needs addressing in response to the shame experienced here. The social norms, and the honour groups that embody them, need subjecting to criticism and transformation.

### 1.3 Shame: causal stimuli and response, belief and expectation or meaning relations?

Shame does not operate in a manner that can be captured through causal explanation of how a person relates to their world, such as in terms of stimulus and response mechanisms. Neither is it apt for understanding in terms of a person’s beliefs or judgements about their world and others occupying that world. Shame can simply descend on one, one can be struck by shame. Shame operates at the level of meaning relations, where a person takes in their meaningful—their conceptually-saturated—world. The lifeworld. Understanding shame, therefore, requires a way of re-presenting these meaning relations in all their richness, and not succumbing to temptation to reduce it to cognitivist (propositional beliefs and Judgements) or Jamesian (causal) accounts. I have proposed a framework for making sense of shame expressions, where they might pose difficulty (Hutchinson 2008 and 2011). I called this framework “world-taking cognitivism”. Though the label is ultimately unimportant, unpacking it will serve to bring out my reasons for proposing the framework. The “world-taking” part is there to emphasise that what we need concern ourselves with when we seek to make sense of a particular emotional expression is the way the person expressing the emotion has taken-in the lifeworld: how they have read the world, or the situation. The “cognitivism” part is employed in the way that term is used in analytic meta-ethics (not in cognitive psychology or cognitive science) as a commitment to the idea that thoughts track the world, or are answerable to the way the world is. So, “world-taking cognitivism” understands emotions as based in a person’s takings (perceptions) of loci of significance in a meaningful world (lifeworld), to which those emotions are answerable. Understanding an emotional expression will therefore be arrived at through reconstructing the (internal) relationship that holds between a person’s conceptualisation of a situation (including their conceptualisation of self) and the concept of the emotion. Put simply,
shame stems from a person’s perception that a situation involving them is characteristically shameful, and their being is tainted by this perception.

Shame emerges from meanings encoded in our language at a more fundamental level than is captured by a focus on propositionally-structured beliefs. What this means is that shame can often remain untouched by demonstrating to a person feeling shame that their shame does not find support in rationally-defensible beliefs about the lifeworld and that person’s role in that lifeworld. Shame often rests on framing concepts, that is to say those concepts which frame one’s world-view. Treating shame (often) requires reframing.

2. Shame and STIs

I remarked at the opening of this paper that shame impacts on diagnosis and treatment and on public health with regards STIs and HIV. I’ll here say a little more about these.

2.1 Shame’s Impact on Diagnosis and Treatment

Let us make what might seem a rather obvious point: better diagnosis and treatment is founded in better epistemic conditions. Put another way, a significant hindrance to any attempt at diagnosis and therefore treatment can be located in a patient’s willingness and ability to fully and honestly disclose relevant details in response to the questions of health practitioners. Knowledge is central to diagnosis, and something acting as an impediment to that knowledge in turn acts as an impediment to accurate diagnosis and to treatment. Of course, the relevance and significance of the role of patient disclosure can vary across health contexts. My suggestion is that in the area of STI diagnosis and treatment, particularly with regards to Hepatitis and HIV, the significance is high. It is important, maybe even crucial, for the health practitioner to have available to them all the relevant facts, without that availability being diminished by the patient withholding relevant details. Unfortunately, STI treatment is also the context in which shame is often operative as prominent source of a patient’s resistance and failure to disclose. This is because of the stigma-effect. Illness and infections which carry social stigma give rise to shame and that shame can serve as a hindrance to full disclosure of the relevant facts.

2.2 Shame and Public Health

Combatting STIs does not begin and end with diagnosis and treatment, it also has a large public health component, which is not reducible to vaccination (they don’t exist for many STIs) and prophylaxis (expensive, complex regimes, and small time-windows between exposure and effective administration). This public health component of the battle with STIs has, in turn, two components: a. disclosure to new sexual partners; and b. Presentation for testing.

2.2.1 Shame and Disclosure to New Sexual Partners

The stigma of STI’s and HIV give rise to a sense of shame, and one of the ways in which individuals might manage this is to withhold their STI or HIV status. For when others are unaware of one’s status then their gaze cannot be shaming. While from this perspective this can seem like a rational
response to the fear of shame, it can have rather catastrophic consequences from the perspective of public health. For not only is it likely to contribute to increased infections (there is even anecdotal evidence that those who have difficulty communicating their status might also be wary of suggesting condom use, on the grounds that that suggestion might serve to hint at a known requirement for protection) but it is also likely to contribute to the problem of late diagnosis, because a person who has no reason to believe that they have been exposed to an infection is a person who also finds that they have little reason to the believe they should be tested for infection. In the case of infections with prolonged incubation periods such as HIV (up to 3 months), this is particularly relevant.

2.2.2 Shame and Testing

The act of going for a test is shaming in itself, in that the person perceives that attending a clinic for testing serves as a confirmation or admittance to oneself that one warrants the suspicion that one might be infected. In this sense the act of attending a clinic for testing serves to reinforce an already-existing framing of STIs and HIV as shameful. The act of attending clinic and presenting oneself for testing serves to validate or confirm the underlying framing-concepts.

3. Addressing Shame in the context of STIs and HIV

Shame and stigma operate on individuals at a deep psychological level, which can make them difficult to overcome. Put another way, shame can often be experienced by an individual who concurrently believes that they have nothing about which to feel ashamed while experiencing shame. (Indeed, this is often depicted as one of the defining characteristics of shame). So, pointing out to someone that there is no reason to feel ashamed of one’s HIV status, or of one’s sexual behaviour when responding the confidential questions posed by a physician at a STI clinic, will often leave untouched the shame which that individual feels. This is because our emotional reactions are based on the meaning the social world (lifeworld) has for us and the way that is mediated through our language. Invariably, the ways such meaning is mediated does not operate at the level of beliefs one has about the world, but rather stems from the way certain meanings are metaphorically encoded in our language, and therefore structure or frame our beliefs.

It is a characteristic of much shame experience that it is a feeling of guilt, which occurs accompanied by a clear sense that one is not guilty of anything. Providing someone who has been raped with a set of reasons for why they are guilty of nothing will often leave their shame untouched because the shame functions at a more fundamental level than does guilt. Shame is rarely constituted by a set of evaluative beliefs but is rather based in the way our language at a pre-propositional level frames our reading of the lifeworld. This understanding shows us that relieving shame is not about refuting false beliefs, but of facilitating the decoding of the meanings which are conferred, often by stealth, by the linguistic frames.

One illustration of this point is to look at the ways people sometimes communicate about aspects of sexual health, such as a negative test result being communicated as "I'm clean", thereby implying that infections are dirty. While a person might well believe there is nothing “dirty” about having contracted an infection, the fact that such metaphors are operative, are encoded in the way we talk about STIs, means that at a deep psychological level, irrespective of what one might believe, sexually-transmitted infections are framed in terms of cleanliness and dirtiness. Here the framing metaphor of cleanliness/dirtiness, and the moral connotations these concepts carry with them, lead
to a kind of moral framing of an otherwise amoral, or morally inert, test result. So, at the level of propositionally-structured belief, the recipient of a positive HIV test rightly takes the test result in a completely morally neutral way, at a deeper level, at the level of framing metaphors, the result is morally-cast. It is like the metaphor of cleanliness/dirtiness serves to colour the meaningful content of the test result in a way which diminishes the very being of the person who has had a positive result. The person feels themselves to be viceful, while concurrently being clear that they have committed no immoral act. Their being is diminished.

Because shame operates at this level, nullifying it or combating it requires appropriate methods. One cannot seek to combat shame by simply presenting to those afflicted by shame an argument such that they have transgressed no rules according to which it might be suggested they warrant a feeling of guilt. To re-employ the "cleanliness" example, the task is to first bring the person who is ashamed to the realisation that this metaphor of cleanliness-dirtiness is operative in their subconscious and the moral framing that it brings in being so operative. The method for combating or nullifying shame is one of identifying the source of the shame, how it is encoded in one's way of framing the world. Bringing to consciousness this encoding will in itself do much to break the grip of shame.