Original Article

The Emotion of Shame: Theoretical Approaches in Relation to the Experience of Mental Illness and Social Stigma

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Abstract
Shame constitutes a pivotal emotional mechanism through which social stigma exerts its influence on individuals experiencing mental illness. Despite its conceptual prominence, empirical research directly addressing the subjective and affective dimensions of shame in the context of mental health-related stigma remains limited. This paper synthesizes sociological, psychoanalytic, feminist, and cognitive-affective theoretical frameworks to elucidate the complex interrelations between shame and mental illness. While adopting a broad theoretical perspective, the paper places particular emphasis on psychotic and mood disorders, examining how shame operates within these diagnostic contexts and shapes subjective experience, symptom expression, and social functioning. Within clinical contexts, shame emerges as a salient psychological dimension in psychosis and mood disorders, exerting measurable influence on symptom severity, functional outcomes, and adherence to treatment.
Scheff's sociological theory conceptualizes shame as a regulator of social bonds, activated through perceived rejection. Psychoanalytic perspectives frame shame as an internalized response to unmet personal and societal standards. Gilligan's relational lens highlights the significance of care and social connection in the emergence of shame. Cognitive-affective models further demonstrate how internalized stigma fosters self-devaluation, anger, and social withdrawal. The paper differentiates shame from guilt, emphasizing shame's distinctive association with self-condemnation and social isolation. Understanding shame within this context holds significant implications for psychotherapy, social policy, and the promotion of self-acceptance, underscoring the necessity of supportive environments that mitigate stigma and strengthen emotional resilience.

Keywords: shame, mental illness, stigma, internalized stigma, psychosis, mood disorders, social psychology, psychotherapy, self-acceptance

Introduction

The experience of mental illness encompasses not only symptoms and functional impairments but also the social responses and evaluative judgments elicited by such conditions. Social stigma operates as a mechanism of exclusion through which individuals are labeled, marginalized, and devalued due to their mental state. Shame frequently serves as the mediating emotional link between mental illness and the

stigmatizing reactions of the social world. While stigma is rooted in collective representations, shame emerges as a subjective affective response shaped by external evaluation (Parker and Aggleton 2003; Nyblade 2006). Shame manifests both as public shame provoked by stigmatizing reactions, exposure, and the gaze of others and as internal shame, stemming from internalized standards and self-critical processes. Among individuals with mental illness, these two forms often converge, as social devaluation becomes internalized and transformed into a persistent sense of personal inadequacy (Drapalski et al., 2013).

While shame constitutes a transdiagnostic emotional process, the present paper focuses specifically on its role in severe mental disorders, particularly psychotic and mood disorders. These diagnostic contexts are examined in greater depth due to their strong association with social stigma, identity disruption, and vulnerability to both external and internalized shame.

Purpose

The purpose of this study is to explore, through a comprehensive theoretical lens, the central role of shame in shaping the relationship between mental illness and social stigma. By integrating insights from psychoanalytic, sociological, feminist, and cognitive-affective perspectives, the study seeks to clarify how shame functions as a mediating emotional process that transforms external stigmatizing messages into internalized self-devaluation. It aims to distinguish shame from related constructs such as guilt, to illuminate its unique association with self-condemnation, social withdrawal, and symptom intensification, and to highlight the ways in which shame influences therapeutic engagement and overall mental health outcomes. Ultimately, the study aspires to deepen understanding of shame not only as an intrapersonal emotional experience but also as a socially embedded phenomenon, underscoring its significance for clinical practice, anti-stigma interventions, and the promotion of self-acceptance.

Research Questions

1. In what ways does social stigma contribute to the emergence of shame among individuals with severe mental disorders, particularly psychotic and mood disorders?

2. How does shame influence the clinical trajectory, functional outcomes, and therapeutic engagement of individuals with severe mental disorders, with a focus on psychotic and mood disorders?

Methodology

This study adopts a theoretical and conceptual methodology based on a narrative review of the literature. It draws on key psychoanalytic, sociological, feminist, and cognitive-affective frameworks to examine how shame operates in the context of mental illness and social stigma. Through a systematic examination of these theoretical perspectives, the study analyzes and synthesizes central concepts that explain the mechanisms linking shame with internalized stigma, self-evaluation processes, and the progression of mental disorders. Existing research findings are used to contextualize the role of shame across different psychiatric conditions and to illuminate its impact on help-seeking, social withdrawal, and therapeutic engagement. Rather than presenting empirical data, the methodology relies exclusively on the integration and interpretation of theoretical and bibliographic sources, aiming to generate a comprehensive, conceptually grounded understanding of shame and its significance for clinical practice, anti-stigma efforts, and interventions that promote self-acceptance.

A systematic literature search was conducted from February to October 2025 across the PubMed, Scopus, and Google Scholar databases to identify relevant theoretical and empirical contributions. Search terms were used individually or in combination and included: ***shame, mental illness, stigma, internalized stigma, self-stigma, psychosis, mood disorders, social psychology, mental health, help seeking, Corrigan internalized stigma theory, social identity theory, psychotherapy, self-acceptance, and mental illness stigma.***

To refine the selection, studies were included if they were published in English, involved adult individuals with mental illness living in the community, and addressed experiences of shame, internalized stigma, mental illness stigma, and help-seeking behavior in relation to mental health professionals. No time restriction was applied to the theoretical literature concerning theories of shame and psychoanalytic perspectives, while a 15-year limit was imposed for the remaining sections of the review.

The search yielded a substantial number of studies examining various aspects of shame. To refine the selection, studies were excluded if they: (a) conceptualized shame solely as an emotion without reference to the population of interest; (b) addressed shame primarily in relation to guilt and/or self-compassion; (c) focused exclusively on resilience and its association with shame; or (d) involved hospitalized individuals with mental illness, thus maintaining the review's focus on adults living in the community, where experiences of shame and internalized stigma are shaped by everyday social contexts. Following the evaluation of the retrieved studies and based on these inclusion and exclusion criteria, 13 articles were ultimately included, as they were directly relevant to the focus of the present review (Table 1).

Tablet 1. Key review references

	Authors	Type/ Population	Contributions
1	Kim et al., 2011	Meta-analysis-shame, guilt and depression	Shame more linked to depression than guilt
2	Stuewig et al., 2011	Comparative study-Bipolar disorder patients	Bipolar patients show high trait shame, low guilt; pervasive negative self-image
3	Thompson et al., 2011	Systematic review-psychosis risk factors	Shame mediates trauma and negative self-concept in psychosis
4	Boyd et al., 2014	Systematic review-shame and psychosis	Internalized stigma reduces self-esteem, hinders recovery, and promotes avoidance
5	Gumley & MacBeth, 2014	Theoretical model-Shame and psychosis	Theoretical model: Shame and dissociation amplify hallucinations
6	Michail & Birchwood, 2014	Cross-sectional study-Individuals with psychosis	Social anxiety in psychosis strongly linked to shame
7	Pulcu et al., 2014	fMRI study-Individuals with a history of depression	fMRI: Shame activates amygdala in depression history
8	Clement et al., 2015	Systematic review-Psychosis	Shame and stigma are major barriers to help-seeking
9	Kimhy et al., 2021	Observational study – Ultra-High-Risk (UHR) youth	UHR youth show high shame-proneness; early vulnerability factor
10	López Pérez & García Fernández, 2021	Qualitative study-individuals with psychosis	Shame discourages help-seeking and disclosure in psychosis
11	Rathbone et al., 2021	Meta-synthesis of qualitative studies in mental illness	Shame and stigma reduce trust in therapists and engagement
12	Baker et al., 2024	Meta-analysis -Shame and psychosis	Shame correlates with psychotic symptoms, especially paranoia and intrusive thoughts

13	Corcoran & Tully, 2024	Empirical study-Individuals with Psychosis	Trauma-related shame mediates psychotic experiences via identity disruption

Theoretical Approaches to Shame

A wide range of theoretical traditions has sought to explain the structure, function, and psychological consequences of shame, particularly in the context of mental illness.

Psychoanalytic accounts, such as those formulated by Harold Lansky (1992, 2005), understand shame as arising from the discrepancy between the Ego and the Ego Ideal. Shame is triggered when individuals perceive themselves as failing to embody internalized ideals or expectations, leading to heightened vulnerability to judgment and rejection. Within mental illness, this dynamic may intensify tendencies toward withdrawal, secrecy, and disruptions in the therapeutic relationship.

From a sociological perspective, Thomas Scheff (1998, 1990), conceptualizes shame as a fundamental social emotion that regulates the integrity of social bonds. Shame emerges when interpersonal or communal connections appear threatened or ruptured. Although often regarded as a negative effect, shame can motivate individuals to maintain or restore social relationships; however, unacknowledged shame may generate defensive responses such as aggression, isolation, or psychopathology.

Carol Gilligan's (1982), relational and feminist approach positions shame within the ethics of care. According to her, shame arises when care, relational responsibility, or interpersonal connection is jeopardized. Women, in particular, may experience shame more intensely, given gendered expectations concerning relational maintenance and caregiving. In this framework, shame signals relational disconnection and jeopardized belonging.

Jack Elison's (2005), contributions emphasize the linkage between shame and aggression. He conceptualizes the Compass of Shame, delineating four principal defensive reactions: withdrawal, self-attack, avoidance, and other-attack. These patterns elucidate the behavioral expressions commonly associated with unregulated or unacknowledged shame in individuals with mental illness.

June Tangney and Ronda Dearing (2002), advance a cognitive-affective distinction between shame and guilt. Guilt pertains to specific actions ("I did something bad"), whereas shame pertains to the global self ("I am bad"). Shame is thus more closely associated with self-condemnation, withdrawal, and depressive symptoms, whereas guilt may encourage reparative behavior.

Donald Nathanson (1992) similarly identifies shame as a primary affect emerging when positive interpersonal connection is disrupted. His Compass of Shame parallels Elison's model and underscores the defensive strategies that individuals may employ, often unconsciously to mitigate or avoid the experience of shame.

Shame and Mental Illness According to Theoretical Perspectives

The literature consistently identifies shame as a central mechanism underlying internalized stigma. Individuals who adopt stigmatizing societal stereotypes regarding mental illness tend to experience heightened shame, diminished self-worth, and decreased self-efficacy. These processes are strongly associated with reduced treatment adherence, social withdrawal, and exacerbation of psychiatric symptoms (Corrigan & Watson 2002).

Within a psychoanalytic framework, shame is understood as emerging from a disjunction between the self and the idealized self. Individuals with mental illness may thus internalize critical, devaluing self-appraisals, leading to pervasive feelings of inadequacy. In depressive disorders, shame frequently constitutes a core element of the individual's negative internal dialogue. In psychotic disorders, shame may manifest indirectly,

such as through persecutory delusions or hallucinatory experiences involving themes of scrutiny or humiliation (Tanghey & Dearing 2002).

Sociological interpretations highlight the role of shame as a regulator of social bonds. When mental illness becomes stigmatized, the individual may experience rejection and alienation, leading to intensified social shame and consequent self-stigmatization (Weiss et al., 2006).

Gilligan's relational perspective conceptualizes shame as a response to disrupted care. Women, in particular, may experience shame when they perceive themselves as failing to meet relational expectations. Therapeutically, recognizing shame as a signal for reconnection, rather than moral inadequacy, is essential (Scheff 1990).

Cognitive-affective theories emphasize excessive self-focus and self-critical evaluation as mechanisms through which shame becomes pathological. Shame appears prominently in depressive and anxiety disorders, as well as in personality disorders characterized by fluctuations between shame and grandiosity. Elison's model explains how unacknowledged shame may convert into anger, aggression, or self-harm (Michail & Birchwood 2013).

Shame and the Social Stigma of Mental Illness

Although the relationship between stigma and shame is widely accepted, the direct examination of shame within stigma research remains relatively scarce. Shame is often mentioned tangentially within discussions of internalized stigma, yet a clear conceptualization of how shame and stigma interact is frequently absent (Weiss et al., 2006; Boyd et al., 2014).

Scheff's sociological theory posits that stigma triggers the perception of social rejection, thereby activating shame. Individuals may respond to this shame through concealment or withdrawal, which paradoxically reinforces stigma. Psychodynamic accounts contend that internalized stigma becomes internalized shame, leading to persistent experiences of personal deficiency or defectiveness. Gilligan's relational ethics suggest that when society withdraws care and acceptance, individuals experience shame as a form of relational abandonment (Bennett et al., 2016).

Cognitive-affective approaches emphasize how negative public discourse becomes internalized and integrated into the individual's self-concept. Shame may thereby give rise to defensive reactions- including withdrawal, avoidance, aggression, and self-attack- that perpetuate social disconnection and psychological distress (Clement et al., 2015).

Therapeutic and Social Implications

Understanding shame as a central affective response to stigma carries substantial clinical and societal implications. In psychotherapy, the recognition and safe exploration of shame are essential for fostering therapeutic alliance, emotional authenticity, and self-acceptance (Scheff 1991). On a societal level, stigma reduction requires educational initiatives, open dialogue, and the cultivation of empathy within communities and institutions (Rathbone at al., 2021). On an intrapersonal level, acknowledging and understanding shame is fundamental to nurturing self-compassion, dignity, and agency.

Shame in Psychosis and Mood Disorders

Shame plays a central role in the experience, development, and course of both psychotic and mood disorders. Research in recent years has increasingly highlighted that shame is not a secondary or superficial emotion but one of the core psychological processes influencing symptoms, functioning, and help-seeking. In schizophrenia and schizoaffective disorder, shame is consistently found to be elevated and to correlate with the severity of psychotic symptoms (Yalom 1980; Kim et al., 2011). External shame, meaning the perception that others see one as inadequate, inferior, or damaged, is particularly associated with paranoid ideation and with the sense that others are threatening or judgmental. Shame can intensify the distress linked to hallucinations or intrusive experiences, partly because it reinforces avoidance strategies such as emotional withdrawal, dissociation, concealment of symptoms, or the avoidance of social contexts (Corrigan 2006). These avoidance strategies, while intended to reduce

exposure to perceived judgment, can inadvertently worsen psychotic experiences, increase social isolation, and create a cycle in which symptoms increase shame and shame increases symptoms (Davies et al., 2024).

Shame in psychosis is also closely linked to trauma. Individuals with a history of childhood abuse or interpersonal trauma frequently internalize shame, and this shame appears to mediate the relationship between traumatic experiences and later psychotic symptoms (Corcoran & Tully 2024). Psychosis itself can activate old shame but also generate new shame: shame about being different, about needing help, about experiencing loss of function, about stigma, or about being labeled as mentally ill (Thomson 2011). Many service users describe feeling fundamentally devalued after receiving a diagnosis, often expressing that they «do not belong» socially anymore. This experience is especially strong among those with comorbid social anxiety, who often report a loss of social status after diagnosis and intense self-consciousness in social interactions (Baker et al., 2024). For young people at clinical high risk for psychosis, studies show heightened shame-proneness even before the onset of full psychosis, indicating that shame may be a psychological vulnerability factor that shapes early social functioning, identity, and emotional reactivity (Lopez-Perez 2021).

Shame also contributes significantly to depression within psychotic disorders. Individuals with schizophrenia who report higher external shame often experience more severe depressive symptoms, suggesting that how one imagines being seen by others has a deep impact on mood. Shame is a major component of self-stigma, the internalization of negative societal stereotypes about mental illness. Self-stigma is known to reduce self-esteem and self-efficacy and is associated with poorer recovery, reduced social functioning, and less engagement with mental health services. The relational nature of shame makes psychosis particularly sensitive to the social environment: stigma, rejection, and discriminatory attitudes strongly feed the experience of shame and, consequently, the severity of symptoms (Elison 2005).

In mood disorders, shame plays an equally important role. In major depressive disorder, shame tends to have a stronger association with depressive symptoms than guilt. Shame involves global negative evaluations of the self ("I am bad") rather than specific evaluations of actions ("I did something bad"), and this globality makes it particularly corrosive for mood (Clement et al., 2015). Neurobiological studies show that the amygdala reacts more intensely to shame than to guilt in individuals with a history of depression, which supports the idea that shame sensitivity may be a trait vulnerability, not only a symptom. High shame-proneness is linked to recurrent depressive episodes, suicidal ideation, social withdrawal, and persistent feelings of defectiveness or inferiority (Gilbert & Miles 2002).

In bipolar disorder, research shows that individuals tend to exhibit higher trait shame compared to those with unipolar depression or healthy controls. At the same time, they often show lower trait guilt, suggesting that they engage less in reflective or reparative evaluation of their actions and more in global self-attacks (Barney 2006). Shame in bipolar disorder may arise from identity disruption, from difficulties reconciling different mood states, or from post-episode reflections on behaviors during mania or hypomania. These shame experiences can contribute to depressive episodes, avoidance of treatment, and fears of facing others after mood instability. This can be especially pronounced in bipolar II or schizoaffective bipolar presentations, where mood swings and psychotic features combine to create complex layers of vulnerability to shame (Stuewing 2011).

Across psychotic and mood disorders, shame influences the course of illness in several ways. High shame is associated with worse symptoms, increased relapse risk, poorer functional outcomes, lower adherence to medication or therapy, and greater social withdrawal. Shame often becomes a barrier to seeking help, as many individuals fear judgment, diagnosis, or exposure. Anticipated stigma plays a major role here: people often avoid mental health services because they worry about being labeled, misunderstood, or seen as weak or defective. This avoidance can

delay diagnosis, increase symptom severity, and undermine long-term recovery. In therapy, shame can manifest as reluctance to disclose symptoms, difficulty forming therapeutic relationships, or silence around the most distressing experiences (Birchwood 2007).

Given these dynamics, clinical interventions benefit from being shame-sensitive. Approaches such as Compassion-Focused Therapy explicitly address shame, self-criticism, and threat sensitivity and have shown promise in both psychosis and mood disorders. Reducing external shame through psychoeducation, family involvement, and anti-stigma interventions is crucial, as shame is not only internal but also socially constructed and socially maintained. Supporting individuals in reconstructing a positive and stable identity, particularly after episodes of psychosis or mood destabilization, helps counteract the global negative self-evaluations characteristic of shame. Addressing trauma, when relevant, is also important, as trauma-related shame often underlies both psychotic and depressive experiences and can be a hidden driver of symptoms (Bennett 2016).

Overall, shame is a powerful and often underestimated factor shaping symptoms, functioning, social relations, treatment engagement, and recovery in both schizophrenia-spectrum and mood disorders. Understanding and addressing shame can substantially improve clinical outcomes and support individuals in rebuilding a coherent sense of self and connection to others (Cumley & Macbeth 2014).

Limitations: This review has several limitations. It relies exclusively on a narrative and theoretical approach, without the collection of primary data, which limits the ability to draw empirically grounded or causal conclusions. The integration of diverse theoretical frameworks, psychoanalytic, sociological, feminist, and cognitive, affective, may pose challenges for providing a unified interpretation of shame and its effects. The selection of sources may be subject to bias, and the generalizability of findings across different cultural or social contexts remains limited. Finally, the review does not systematically assess the quality of included studies and links shame to symptoms and functioning theoretically, without evidence of causal relationships, which should be considered when interpreting the results.

Conclusions: The reviewed literature highlights shame as a central emotional mechanism in mental illness, particularly in relation to internalized and social stigma (Sartorius, 2007). Across psychoanalytic, sociological, feminist, and cognitive-affective frameworks, shame consistently functions as a mediator linking stigmatizing experiences to adverse psychological outcomes. Elevated internalized stigma is associated with intensified shame, leading to self-rejection, reduced self-efficacy, and withdrawal from treatment and social relationships, thereby exacerbating symptom severity and reinforcing maladaptive internal narratives (Kimhy et al., 2021).

In psychotic disorders, shame contributes to threatening self-appraisals, social withdrawal, and avoidance of help-seeking, maintaining psychotic distress (Birchwood et al., 2007). In mood disorders, particularly depression, shame is closely linked to negative self-concept, self-criticism, and rumination, processes that intensify affective symptoms and impede recovery (Kim et al., 2011).

Distinguishing shame from guilt clarifies its unique role in undermining self-worth and sustaining avoidance-based coping strategies. Therapeutically, the careful recognition and exploration of shame are essential for fostering self-compassion, strengthening interpersonal connection, and supporting recovery. At a societal level, reducing public stigma through education and inclusive policies remains crucial for mitigating the harmful effects of shame (Michail & Birchwood, 2014).

An integrative understanding of shame as both an internal emotional experience and a socially constructed phenomenon is therefore necessary for developing effective interventions that promote mental health, resilience, and social inclusion (Pulcu et al., 2014).

References

Baker, K., Lappin, J. M., Gott, C., & Steel, Z. (2025). Experiencing psychosis and shame: A systematic review and meta-analysis of the strength and patterns of association. *Schizophrenia Bulletin, 51*(5), 1296-1311.

Barney, L. J., Griffiths, K. M., & Jorm, A. F. (2006). Stigma and help-seeking for mental health problems: A review. *Australian Psychologist, 41*(1), 36-45.

Bennett, D. S., Traub, K., Mace, L., Juarascio, A., & O'Hayer, C. V. (2016). Shame among people living with HIV: A literature review. *AIDS Care, 28*(1), 87-91.

Birchwood, M., Trower, P., Brunet, K., Gilbert, P., Iqbal, Z., & Jackson, C. (2007). Social anxiety and the shame of psychosis: A study in first-episode psychosis. *Behaviour Research and Therapy, 45*, 1025-1103.

Boyd, J. E., Otilingam, P. G., & Deforge, B. R. (2014). Brief version of the Internalized Stigma of Mental Illness (ISMI) scale: Psychometric properties and relationship to depression, self-esteem, recovery orientation, empowerment, and perceived devaluation and discrimination. *Psychiatric Rehabilitation Journal, 37*(1), 17-23.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*(1), 11-27.

Corcoran, M., & Tully, S. (2024). Trauma-related shame in psychosis: A narrative identity perspective. *Frontiers in Psychiatry, 15*, 1421032.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice, 9*(1), 35-53.

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology, 25*(9), 875-884.

Davies, K., Lappin, J. M., Gott, C., & Steel, Z. (2024). Experiencing psychosis and shame: A systematic review and meta-analysis of the strength and patterns of association. *Schizophrenia Bulletin, 51*(5), 1296-1311.

Drapalski, A. L., Lucksted, A., Perrin, P. B., Aakre, J. M., Brown, C. H., DeForge, B. R., & Boyd, J. E. (2013). A model of internalized stigma and its effects on people with mental illness. *Psychiatric Services, 64*(3), 264-269.

Elison, J. (2005). Shame and aggression: The Elison model of shame-related behavior. In J. P. Tangney & R. L. Dearing (Eds.), *Shame and guilt* (pp. 111-134). New York: Guilford Press.

Gilbert, P., & Miles, J. N. (2000). Sensitivity to social put-down: Its relationship to perceptions of social rank, shame, social anxiety, depression, anger and self-other blame. *Personality and Individual Differences, 29*(4), 757-774.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Gumley, A., & MacBeth, A. (2014). A trauma-based model of psychosis: Conceptualising hallucinations as a response to shame and dissociation. *Psychology and Psychotherapy: Theory, Research and Practice, 87*(3), 334-345.

Kim, J. H., Lee, S.-R., Li, L.-H., Park, H.-J., Park, J.-H., Lee, K. Y., Kim, M.-K., Shin, B. A., & Choi, S. Y. (2011). High cleavage efficiency of a 2A peptide derived from porcine teschovirus-1 in human cell lines, zebrafish and mice. *PLoS ONE, 6*(4), e18556.

Kim, S., Thibodeau, R., & Jorgensen, R. S. (2011). *Shame, guilt, and depressive symptoms: A meta-analytic review.* Psychological Bulletin, 137(1), 68-96.

Kimhy, D., Damme, K. S. F., Sloan, R. P., Bartels, M. N., Ozsan, A., Ospina, L. H., & Mittal, V. A. (2021). Psychosis risk individuals show poor fitness and discrepancies with objective and subjective measures. *Scientific Reports, 11*, 9851.

Lansky, M. R. (1992). The uses of psychoanalytic knowledge to study the social construction of emotion: The case of shame. *Psychoanalytic Quarterly, 61*, 22-45.

Lansky, M. R. (2005). Hidden shame. *Journal of the American Psychoanalytic Association, 53*(4), 1193-1215.

López Pérez, B., & García Fernández, L. (2021). Shame and help-seeking in psychosis: A qualitative study. *Qualitative Health Research, 31*(6), 1112-1126.

Michail, M., & Birchwood, M. (2013). Social anxiety disorder and shame cognitions in psychosis. *Psychological Medicine, 43*(1), 133-142.

Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the self*. New York: W. W. Norton.

Nyblade, L. C. (2006). Measuring HIV stigma: Current knowledge and gaps. *Psychology, Health & Medicine, 11*(3), 335-345.

Parker, R., & Aggleton, P. (2003). Stigma and discrimination related to HIV and AIDS: A

conceptual framework and implications for action. *Social Science & Medicine, 57*, 13-24.

Pulcu, E., Zahn, R., & Elliott, R. (2014). The neural correlates of shame: A functional MRI study. *Social Cognitive and Affective Neuroscience, 9*(10), 1506-1514.

Rathbone, J. A., Jetten, J., & Cruwys, T. (2021). Non-stigmatising alternatives to anti-obesity public health messages: Consequences for health behaviour and well-being. *Journal of Health Psychology, 27*(7).

Sartorius, N. (2007). Stigma and mental health. *The Lancet, 370*(9590), 810-811.

Scheff, T. J. (1988). Shame and conformity: The deference-emotion system. *American Sociological Review, 53*(3), 395-406.

Scheff, T. J. (1990). *Microsociology: Discourse, emotion, and social structure*. Chicago: University of Chicago Press.

Scheff, T. J., & Retzinger, S. (1991). *Emotions and violence: Shame and rage in destructive conflicts*. Lexington, MA: Lexington Books.

Stuewig, J., Tangney, J. P., Kendall, S., & Meyer, C. (2011). Shame and guilt in bipolar disorder: Trait differences and clinical implications. *Journal of Affective Disorders, 135*(1-3), 388-394.

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. New York: Guilford Press.

Thompson, A., Nelson, B., & Yung, A. (2011). Predictive validity of personal vulnerability factors for psychosis: A systematic review. *Schizophrenia Research, 125*(1), 1-8.

Weiss, M. G., Ramakrishna, J., & Somma, D. (2006). Health-related stigma: A review of concepts and interventions. *Psychology, Health & Medicine, 11*(3), 277-287.

Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.