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Self-Conscious Emotions and Mental Health: Associations of Shame and Guilt with Depressive and Anxiety Symptoms among Albanian University Students

Angela Sula*

Faculty of Social Sciences, University of Tirana, Tirana, Albania

Abstract

Background: Shame and guilt are self-conscious emotions that differ in their focus and potential psychological consequences. Shame involves a global negative evaluation of the self, whereas guilt is more closely related to specific behaviors. Both emotions have been associated with psychological difficulties, although shame has generally shown stronger associations with internalizing symptoms.

Aims: The present study aimed to examine the statistical associations of shame and guilt with depressive and anxiety symptoms among Albanian university students and to determine the unique statistical contribution of each emotion to these psychological outcomes.

Study Design: A quantitative, cross-sectional study.

Methods: A quantitative, cross-sectional correlational study was conducted with 459 university students aged 18–24 years from four public universities in Albania. Shame and guilt were assessed using the Test of Self-Conscious Affect–3 (TOSCA-3), while anxiety and depressive symptoms were assessed using the Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM). Descriptive statistics, Pearson correlation analyses, and two multiple linear regression analyses were conducted. Pearson correlation analyses were used to examine bivariate associations among shame, guilt, anxiety symptoms, and depressive symptoms, while separate multiple linear regression analyses examined the statistical

Address for correspondence: Angela Sula*, Faculty of Social Sciences, University of Tirana, Tirana, Albania. E-mail: angela.sula@ymail.com

contribution of shame and guilt to depressive and anxiety symptoms.

Results: Pearson correlation analyses showed that shame was positively associated with both depressive and anxiety symptoms. Guilt was also positively associated with both outcomes, although these associations were weaker than those observed for shame. Subsequent multiple linear regression analyses showed that shame and guilt together accounted for 15.3% of the variance in depressive symptoms and 14.7% of the variance in anxiety symptoms. In the depressive symptoms model, shame made a significant positive unique statistical contribution after accounting for the shared variance between shame and guilt, whereas guilt did not. In the anxiety symptoms model, shame made the stronger unique statistical contribution, while guilt made a small and marginally significant positive unique statistical contribution. Given the cross-sectional design, these associations should not be interpreted as evidence of causal or temporal relationships.

Conclusion: The findings indicate that shame showed a stronger and more consistent statistical association and unique contribution to depressive and anxiety symptoms than guilt among Albanian university students. The findings highlight the relevance of shame and negative self-evaluation when considering psychological symptoms in university populations. However, given the cross-sectional design, the observed associations and statistical contributions cannot be interpreted as evidence of causal or temporal relationships.

Keywords: mental health, shame; guilt; depressive symptoms; anxiety symptoms; university students; Albania.

INTRODUCTION

Shame and guilt are self-conscious emotions that play a significant role in psychological health. Although both involve self-evaluation, they differ in their focus. Shame reflects a global negative evaluation of the self ("I am bad"), whereas guilt is directed toward a specific behavior ("I did something bad") (1). These differences have important implications for mental health, as shame is generally associated with avoidance, withdrawal, and self-criticism, whereas guilt is more likely to motivate reparative behavior (2).

Shame involves not only harsh self-criticism but also heightened sensitivity to others' evaluations. Individuals prone to shame frequently perceive themselves as inadequate, defective, and unworthy, often projecting their own negative self-evaluations onto others and believing they are being judged or rejected (3). Because shame centers on the whole self rather than a specific action, it is closely associated with low self-esteem, emotional distress, and impaired interpersonal functioning (4).

Gilbert (2002) conceptualized shame as a multidimensional experience consisting of social, cognitive, emotional, behavioral, and physiological components (5). Shame typically occurs in interpersonal contexts and involves beliefs that others perceive the individual as inferior or unworthy (6). These beliefs are accompanied by negative self-evaluations, emotions such as anxiety and self-disgust, behavioral responses including avoidance and withdrawal, and physiological stress reactions (7). Unlike basic emotions, shame requires self-awareness, internalization of social standards, and the capacity for self-evaluation, distinguishing it as a self-conscious emotion (8).

Cognitive-attributional theories further explain the development of shame by emphasizing how individuals interpret negative events. Shame arises when failures are attributed to stable, internal, and uncontrollable characteristics of the self rather than to specific behaviors. Similarly, Weiner's (1985) attribution theory proposes that emotions following negative outcomes are shaped by three key causal dimensions: locus, stability, and controllability (9). Building on this framework, research has demonstrated that internal, stable, and uncontrollable attributions for failure are associated with greater experiences of shame, whereas internal, unstable, and controllable attributions are more strongly linked to guilt. Thus, when individuals interpret negative outcomes as reflecting enduring and uncontrollable aspects of the self, they may be more likely to experience shame, whereas attributing failure to specific and changeable behaviors may elicit guilt and encourage corrective action.

These maladaptive attributional styles may contribute to the development and maintenance of persistent negative self-beliefs, thereby being associated with greater psychological difficulties. In particular, shame-related attributions may reinforce global self-criticism and feelings of inadequacy, which are central features associated with internalizing psychopathology. A

substantial body of research demonstrates that shame is consistently associated with internalizing psychopathology, particularly anxiety and depression. Higher levels of shame have been linked to increased depressive symptoms across adolescence and young adulthood, as well as elevated anxiety symptoms (10). Furthermore, shame has been shown to mediate the relationship between broader psychopathology and suicidality, highlighting its clinical importance among adolescents and young adults (11).

Evidence also suggests that shame remains significantly associated with both depression and anxiety when the overlap with the other symptom domain is statistically accounted for. Shame remains significantly associated with depressive symptoms even after controlling for anxiety, and similarly predicts anxiety symptoms after accounting for depression (12). These associations are thought to arise because shame promotes pervasive negative self-attributions, feelings of helplessness, hopelessness, inferiority, and fear of negative evaluation, all of which are central features of depression and anxiety (13). Shame also contributes to maladaptive social information processing, including interpreting ambiguous social situations negatively and attributing adverse events to personal deficiencies, thereby increasing vulnerability to internalizing disorders (14).

In contrast, guilt is generally considered a more adaptive self-conscious emotion because it focuses on specific behaviors and encourages reparative actions rather than global self-condemnation (15). However, maladaptive guilt may also contribute to anxiety and depression when it becomes excessive or transforms into generalized negative self-evaluation resembling shame (16).

Emerging adulthood, spanning approximately 18 to 29 years, is a developmental period characterized by identity exploration, increasing autonomy, educational and occupational transitions, and the formation of intimate relationships (17).

These developmental challenges may make young adults particularly vulnerable to self-conscious emotions and internalizing psychological symptoms. Although research on psychological health among Albanian university students has examined symptoms of depression, anxiety, and stress (18), research specifically examining the relationships between shame, guilt, anxiety, and depression among Albanian young adults remains relatively limited. Recent research has begun to address the role of self-conscious emotions in this population, including evidence on the associations between shame, guilt, and depressive symptoms among Albanian university students (19). Nevertheless, the literature examining these emotions in relation to broader indicators of psychological health remains limited.

Considering the relevance of family-oriented social norms, honor, reputation, and collective shame within Albanian social and cultural

contexts (20, 21), investigating the role of shame and guilt in psychological health within this cultural context may contribute to addressing an important gap in the literature.

MATERIALS AND METHODS

The present study aimed to examine the statistical associations between shame, guilt, anxiety, and depressive symptoms among Albanian university students during emerging adulthood. Given that self-conscious emotions such as shame and guilt play an important role in self-evaluation, emotional regulation, and interpersonal functioning, this study explored their statistical relationships with psychological health indicators in a university student population.

Research Design

A quantitative, cross-sectional correlational research design was employed to examine the relationships between shame, guilt, depressive symptoms, and anxiety symptoms among Albanian university students. Multiple linear regression analyses were used to examine whether shame and guilt made a significant unique statistical contribution to variance in depressive and anxiety symptoms and to determine the unique statistical contribution of each self-conscious emotion to the respective outcome.

The cross-sectional correlational design was selected because the study examined naturally occurring psychological characteristics without manipulating the study variables. A key strength of this design is that it allows the examination of associations among multiple psychological variables within a naturalistic setting and provides an efficient approach for identifying patterns of relationships that may warrant further investigation. However, an important limitation is that all variables were assessed at a single point in time, which prevents the determination of temporal precedence and causal direction. Thus, the observed associations cannot establish whether shame or guilt precedes depressive or anxiety symptoms, whether psychological symptoms are associated with subsequent experiences of shame or guilt, or whether the relationships may be reciprocal or influenced by other variables. The analyses therefore focused on statistical associations and unique statistical contributions rather than causal or temporal effects.

Pearson correlation analyses were first conducted to examine bivariate associations among the variables, followed by two separate multiple linear regression models to examine the unique statistical contribution of shame and guilt to variance in depressive and anxiety symptoms. Accordingly, the regression analyses were interpreted as estimates of the extent to which shame and guilt were uniquely associated with the respective psychological outcomes after accounting for the other self-conscious emotion, rather than as evidence that these emotions cause, precede, or predict the development of depressive or anxiety symptoms.

Research procedures were conducted in accordance with ethical principles for

psychological research. Participation was voluntary, informed consent was obtained before data collection, and participants were assured that their responses would remain anonymous and confidential.

Participants

A total of 494 questionnaires were distributed among university students from the University of Tirana, University "Luigj Gurakuqi" in Shkodër, University "Aleksandër Xhuvani" in Elbasan, and University "Aleksandër Moisiu" in Durrës. Of these, 459 completed questionnaires were returned and included in the final analysis, resulting in a response rate of approximately 93%. The study included 459 university students aged between 18 and 24 years, recruited from public universities in Albania. The sample consisted of 65% female and 35% male participants.

Measures

TOSCA-3

Shame and guilt were assessed using the Test of Self-Conscious Affect–3 (TOSCA-3) (22, 23). The TOSCA-3 is a scenario-based self-report measure consisting of 16 everyday situations, followed by possible emotional and behavioral responses. Participants rate how likely they would be to respond in each way using a 5-point Likert scale ranging from 1 (not likely) to 5 (very likely). The instrument evaluates several self-conscious emotions, including shame, guilt, externalization, detachment, alpha pride, and beta pride. The Albanian version of the TOSCA-3 has demonstrated good psychometric properties.

In the present study, the shame and guilt subscales were used as the primary measures of self-conscious emotions. The scale demonstrated high overall internal consistency (Cronbach's α = .89), with subscale reliabilities ranging from α = .72 for detachment, α = .76 for externalization, α = .78 for alpha pride, α = .75 for beta pride, α = .81 for guilt to α = .83 for shame.

CORE-OM

Anxiety and depressive symptoms were assessed using the Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM) (24). The CORE-OM is a 34-item self-report questionnaire designed to assess a broad range of mental health difficulties in both clinical and non-clinical populations. Items are rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (most or all of the time), with higher scores indicating greater psychological distress. The instrument assesses four primary domains of psychological functioning: subjective well-being, psychological problems/symptoms, life functioning, and risk to self and others. In addition, the CORE-OM includes subscales assessing specific symptom domains, including anxiety, depression, physical symptoms, trauma, as well as general, social, and close relationship functioning. The Albanian version of the CORE-OM has been validated and standardized for use in the Albanian population (25). In the original Albanian validation study, the instrument demonstrated excellent overall internal consistency (Cronbach's α = .94).

Similarly, in the present study the internal consistency coefficients for the major domains

were acceptable to excellent, ranging from α = .53 for subjective well-being to α = .93 for psychological symptoms, with values of α = .83 for life functioning and α = .84 for risk to self and others. For the present analyses, anxiety and depressive symptom scores were examined as separate dependent variables in the respective regression models.

Procedure

Participants were recruited through convenience sampling from common university areas, including libraries and other shared spaces. Students were approached voluntarily and informed about the purpose of the study, confidentiality procedures, and their right to withdraw at any time. After providing informed consent, participants completed the questionnaires anonymously, and the collected data were used exclusively for research purposes.

Hypotheses

H1: Shame and guilt will be positively associated with depressive symptoms among Albanian university students and will make a significant statistical contribution to depressive symptoms.

H2: Shame and guilt will be positively associated with anxiety symptoms among Albanian university students and will make a significant statistical contribution to anxiety symptoms.

Pearson correlation analyses were used to examine the bivariate associations specified in the hypotheses, while multiple linear regression analyses were used to examine the statistical contribution of shame and guilt to the respective psychological outcomes.

RESULTS

Data were analysed using IBM SPSS Statistics 25. Descriptive statistics were calculated to summarize the study variables, followed by Pearson correlation analyses to examine bivariate associations among shame, guilt, depressive symptoms, and anxiety symptoms. Finally, two multiple linear regression analyses were conducted to examine the statistical contribution of shame and guilt to depressive symptoms (H1) and anxiety symptoms (H2), respectively.

Descriptive statistics for the study variables are presented in Table 1. The analyses included 459 participants. As shown in Table 1, participants reported mean levels of shame (M = 2.49, SD = 0.64) and guilt (M = 3.58, SD = 0.71). The mean scores for anxiety and depressive symptoms were 1.64 (SD = 1.02) and 1.43 (SD = 0.95), respectively. Skewness values ranged from −0.68 to 0.49, indicating no substantial deviations from normality.

Pearson correlation analyses were conducted to examine the relationships among shame, guilt, anxiety symptoms, and depressive symptoms. As presented in Table 2, shame was positively and significantly correlated with anxiety symptoms, $r(457) = .373$, $p < .001$, and depressive symptoms, $r(457) = .390$, $p < .001$. Guilt was also positively correlated with anxiety symptoms, $r(457) = .240$, $p < .001$, and depressive symptoms, $r(457) = .143$, $p = .002$, although these associations were weaker than those observed for shame. Shame and guilt were moderately positively correlated, $r(457) = .439$, $p < .001$,

indicating that the two self-conscious emotions were related but distinct constructs. Anxiety and depressive symptoms were strongly positively correlated, $r(457) = .723$, $p < .001$.

Overall, the correlation analyses demonstrated statistically significant positive associations between shame and both psychological outcomes, as well as between guilt and both outcomes. These findings supported the association component of H1 and H2 and provided a basis for examining the statistical contribution of shame and guilt through the subsequent multiple linear regression analyses.

To test H1, a multiple linear regression analysis was conducted to examine whether shame and guilt made a significant statistical contribution to depressive symptoms among Albanian university students.

The regression model was statistically significant, $F(2, 456) = 41.21$, $p < .001$, indicating that shame and guilt together accounted for a significant proportion of variance in depressive symptoms. The model explained 15.3% of the variance in depressive symptoms ($R^2 = .153$, Adjusted $R^2 = .149$).

As shown in Table 3, shame made a significant positive unique statistical contribution to depressive symptoms ($B = 0.600$, $SE = 0.071$, $\beta = .405$, $t = 8.45$, $p < .001$), indicating that higher levels of shame were associated with higher levels of depressive symptoms. In contrast, guilt did not make a statistically significant unique contribution to depressive symptoms ($B = -0.047$, $SE = 0.064$, $\beta = -.035$, $t = -0.74$, $p = .462$).

Table 1. Descriptive statistics for the study variables

Variable	Min.	Max.	M	SD	Skew.
Shame	1.00	4.50	2.4895	.64099	.441
Guilt	1.00	4.94	3.5812	.70595	-.681
Anxiety	.00	4.00	1.6356	1.01530	.322
Depression	.00	4.00	1.4314	.94841	.486

Table 2. Pearson correlations among shame, guilt, anxiety symptoms, and depressive symptoms

Variable	1	2	3	4
1. Shame	1	.439**	.373**	.390**
2. Guilt		1	.240**	.143**
3. Anxiety	.373**	.240**	1	.723**
4. Depression	.390**	.143**	.723**	1

Table 3. Multiple linear regression model for depressive symptoms

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
Constant	.108	.224		.481	.631
Shame	.600	.071	.405	8.453	.000
Guilt	-.047	.064	-.035	-.737	.462
a. Dependent Variable: DEPRESSION					

Table 4. Multiple linear regression model for anxiety symptoms

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
Constant	-.160	.241		-.665	.506
Shame	.526	.076	.332	6.892	.000
Guilt	.136	.069	.095	1.965	.050
a. Dependent Variable: ANXIETY					

Therefore, H1 was partially supported. Both shame and guilt were positively associated with depressive symptoms in the correlation analysis, and the overall regression model was statistically significant. However, only shame made a significant unique statistical contribution to depressive symptoms, whereas guilt did not make a significant unique contribution after accounting for the shared variance between shame and guilt.

To test H2, a multiple linear regression analysis was conducted to examine whether shame and guilt made a significant statistical contribution to anxiety symptoms among Albanian university students.

The regression model was statistically significant, $F(2, 456) = 39.19$, $p < .001$, indicating that the model significantly accounted for variance in anxiety symptoms. The model explained 14.7% of the variance in anxiety symptoms ($R^2 = .147$, Adjusted $R^2 = .143$).

As shown in Table 4, examination of the individual predictors showed that shame made a significant positive unique statistical contribution to anxiety symptoms ($B = 0.526$, $SE = 0.076$, $\beta = .332$, $t = 6.89$, $p < .001$). This indicates that higher levels of shame were associated with higher levels of anxiety symptoms. Guilt also showed a positive unique statistical association with anxiety symptoms, although the magnitude of

this association was small (B = 0.136, SE = 0.069, β = .095, t = 1.97, p = .050). Thus, while guilt reached the conventional threshold for statistical significance, its standardized coefficient was substantially smaller than that of shame and should therefore be interpreted cautiously.

Therefore, H2 was supported at the level of the overall regression model. Both shame and guilt were positively associated with anxiety symptoms, and the regression model was statistically significant. At the level of the individual predictors, shame demonstrated the stronger unique statistical association, whereas guilt showed a small unique association that reached the conventional threshold for statistical significance.

DISCUSSION

The present study examined whether shame and guilt were associated with and showed significant unique statistical associations with depressive and anxiety symptoms among Albanian university students. The findings showed that both self-conscious emotions were associated with psychological distress, however, shame emerged as the strongest most consistent statistical association with both depressive and anxiety symptoms. These findings support previous research suggesting that shame, due to its focus on negative evaluations of the self, represents a stronger correlate of internalizing difficulties than guilt (26).

The first hypothesis was partially supported. Although the overall regression model significantly accounted for variance in depressive symptoms and explained 15.3% of the variance, only shame showed a significant unique statistical association with depressive symptoms, whereas guilt did not show a significant unique statistical association with depressive symptoms after accounting statistically for shame. At the bivariate level, however, both shame and guilt were positively associated with depressive symptoms. Although the model was statistically significant, the proportion of explained variance was modest, suggesting that additional psychological, interpersonal, and environmental factors are likely to be associated with depressive symptoms.

This finding is consistent with previous literature indicating that shame is strongly related to depression through processes such as self-criticism, feelings of worthlessness, and negative self-evaluation (27). The present findings may be understood in light of the fundamental distinction between shame and guilt. Unlike guilt, which is directed toward a specific behavior and may facilitate reparative actions, shame involves a global negative evaluation of the self, leading individuals to perceive themselves as defective, inadequate, or unworthy (28). This pervasive self-devaluation may help explain the stronger statistical association between shame and depressive symptoms, as it is consistent with stable and uncontrollable negative beliefs about the self. In contrast, guilt localizes blame to specific, changeable behaviors and is more likely to elicit adaptive responses, such as apology,

reparation, and corrective action, rather than persistent self-condemnation (29). This distinction may explain why guilt did not show a unique statistical association with depressive symptoms once the shared variance with shame was taken into account. The non-significant unique association of guilt suggests that its relationship with depression may overlap substantially with the variance shared with shame in the present sample.

The distinction between shame and guilt related experiences may also provide a useful conceptual framework for understanding depressive symptoms among Albanian students. Shame based depressive experiences are characterized by a global negative evaluation of the self, in which distress is associated with beliefs such as being defective, inadequate, or fundamentally unworthy. Such self-focused evaluations may be closely aligned with self-criticism, worthlessness, and persistent negative self-beliefs, which are commonly observed in depressive symptomatology. In contrast, guilt based depressive experiences may be more closely related to negative evaluations of specific actions or perceived failures, accompanied by self-blame and a sense of having caused harm or violated personal standards. Whereas guilt can sometimes be associated with reparative motivation, excessive or persistent guilt may nevertheless become maladaptive when it involves disproportionate self-blame or repeated preoccupation with perceived wrongdoing. Thus, the present finding that shame showed a significant unique statistical association with depressive symptoms, whereas guilt did not, is consistent with the possibility that global self-devaluation represented by shame was more closely associated with depressive symptomatology than behavior focused negative evaluations represented by guilt in this sample. However, because the present study did not directly assess “shame based” or “guilt based” forms of depression, these interpretations should be regarded as conceptual rather than as evidence of distinct depressive subtypes.

The second hypothesis was supported at the level of the overall regression model. The regression model significantly accounted for variance in anxiety symptoms and explained 14.7% of the variance. At the bivariate level, both shame and guilt were positively associated with anxiety symptoms. Shame was the strongest statistical correlate, whereas guilt showed a small positive unique statistical association that reached the conventional threshold for statistical significance. Because the p= .050 for guilt, this association should be interpreted cautiously and should not be considered comparable to the association observed for shame. As with depressive symptoms, the proportion of explained variance was modest, indicating that factors beyond shame and guilt are also likely to be associated with anxiety symptoms among university students.

The relationship between shame and anxiety may be explained by shame-related concerns about social evaluation, rejection, and perceived

inadequacy. Individuals with higher shame tendencies may be more likely to fear negative judgment and experience heightened self-consciousness, which are important features of anxiety symptoms (30). Although guilt showed a weaker association, excessive guilt may still be associated with anxiety through increased self-blame and worry.

An additional finding was the strong positive correlation between anxiety and depressive symptoms ($r = .723$, $p < .001$). This substantial bivariate association indicates considerable overlap between the two symptom domains in the present sample. However, because anxiety and depressive symptoms were examined as separate dependent variables in separate regression models, the present analyses do not determine the extent to which one symptom domain uniquely explains the other.

Importantly, the cross-sectional nature of the present study limits causal interpretation. Although shame demonstrated significant statistical associations and unique statistical associations in both regression models, these findings do not establish that shame causes depressive or anxiety symptoms. The direction of these associations cannot be determined from the present data; for example, depressive or anxiety symptoms may also be associated with subsequent or concurrent experiences of shame and guilt. Reciprocal relationships or the influence of unmeasured third variables also cannot be excluded. Similarly, the absence of a significant unique statistical association of guilt with depressive symptoms should not be interpreted as evidence that guilt has no relationship with depression; rather, guilt did not explain additional unique variance beyond shame in the present regression model.

A further consideration is that the regression models explained a modest proportion of the variance in depressive and anxiety symptoms (15.3% and 14.7%, respectively). Accordingly, the findings should be understood as identifying statistically significant relationships within the variables examined rather than as providing a comprehensive explanation of psychological symptoms among university students. Future longitudinal and prospective research could help clarify the temporal ordering of shame, guilt, anxiety, and depressive symptoms and could determine whether these relationships are reciprocal or influenced by additional psychological, interpersonal, and cultural factors.

CONCLUSION

Overall, the findings indicate that shame was more strongly and consistently associated with depressive and anxiety symptoms among Albanian university students, and showed stronger unique statistical associations with these outcomes, whereas guilt demonstrated weaker and less consistent unique statistical associations. These results highlight the importance of considering self-conscious emotions when understanding psychological symptoms among university students and suggest that shame and negative self-evaluation represent relevant areas

for further investigation in research on student mental health.

Given the cross-sectional correlational design, the findings should not be interpreted as demonstrating causal relationships. Future research using longitudinal or experimental designs may help clarify the temporal and causal relationships between shame, guilt, depressive symptoms, and anxiety symptoms.

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