CHRISTIAN JOURNAL for GLOBAL HEALTH

Shame as a determinant of health: a Christian public health perspective

Rebecca Bates[a]

[a] MSW, Professor, School of Health Human and Justice Studies, Loyalist College, Ontario, Canada

Abstract

Shame is a pervasive yet underexamined determinant of health that shapes psychological, social, and spiritual well-being. While guilt concerns personal wrongdoing ("I did something bad"), shame involves the self in relation to others ("I am bad" or "I am unworthy"). In many parts of the world, shame plays a key role in sustaining social cohesion, shaping moral expectations, and reinforcing communal identity. Although chronic or internalized shame contributes to depression, anxiety, trauma-related disorders, and physiological stress, certain forms of socially mediated shame can function adaptively by promoting responsible behavior and affirming shared values. At the same time, shame can be wrongly assigned—publicly or privately—as seen in the unjust dishonor experienced by Jesus. This commentary draws on interdisciplinary research in psychology, sociology, theology, and public health to explore the complex and culturally situated nature of shame across the lifespan. It highlights how shame interacts with early attachment experiences, trauma, stigma, and social exclusion and how these dynamics influence health inequities globally. From a Christian perspective, shame affects the imago Dei and disrupts relationships with God and community, yet Scripture also emphasizes God's power to remove misplaced shame and restore dignity. Recognizing both the destructive and potentially constructive dimensions of shame, this commentary argues for shame-informed, culturally sensitive approaches within global health and faith-based settings that promote compassion, belonging, and restoration while challenging harmful or oppressive uses of shame.

Keywords: Shame, determinants of health, health equity, stigma, faith-based health, public health

According to Brené Brown,[1] "shame is the fear of not being worthy of connection." Shame involves more than a transient feeling; it can become a deeply rooted belief about the self that shapes thoughts, behaviors, and relationships. When internalized, shame often fuels an inner critic and contributes to patterns such as isolation, depression, anxiety, addiction, eating disturbances, or aggression. Shame may emerge from cultural expectations, family dynamics, social oppression, attachment disruptions, mental health challenges, childhood trauma, or intergenerational experiences.[2] Scripture likewise portrays shame as a barrier to relationship with God and others,[3] describes misplaced shame even after forgiveness,[4] and affirms God's commitment to removing shame from His people.[5]

Although often misunderstood, shame is universal and expressed differently across cultures. These varied expressions can obscure its influence, allowing it to operate silently within

individuals and communities. Evidence demonstrates that shame significantly shapes physical, mental, emotional, and relational health, yet its role as a social determinant of health remains undervalued. Shame intersects with psychological well-being, cultural experiences, and identity formation, and in some contexts, certain forms of socially mediated shame may even function adaptively by reinforcing social cohesion or moral norms. Recognizing these complexities allows for the development of shame-informed approaches that support healing and health equity. This article argues that shame should be understood as a determinant of health and that Christian public health practitioners and policymakers have a unique role in addressing shame through both evidence-based and faith-informed practices.

Conceptualizing shame

Shame can be understood in multiple ways, encompassing psychological, social, developmental, and cultural dimensions. Adverse childhood experiences (ACEs)—such as witnessing domestic violence, neglect, bullying, or growing up in poverty—can foster internalized feelings of worthlessness and self-blame.[6] Similarly, early attachment disruptions may heighten vulnerability to shame; when caregivers fail to respond to an infant's emotional cues, neurodevelopmental processes related to emotional regulation are affected, forming a foundation for shame-based self-perceptions later in life.[7,6]

Shame is not an innate emotion but a learned response, often emerging from perceived moral transgressions, violations of social norms, or experiences of failure.[8,9] Whereas guilt focuses on a specific behavior ("I did something wrong"), shame implicates the entire self ("I am wrong"). Shame may be internal (self-directed) or external (linked to fears of judgment),[10] and empirical research demonstrates that shame also functions as a communal emotion shaped by group expectations, social norms, and relational obligations.[11,12] Studies across non-Western societies, including Burkina Faso, Indonesia, and Jordan, show that shame regulates social behavior and maintains group cohesion at the community level.

Shame can serve both adaptive and maladaptive functions. Adaptive shame may prompt accountability and prosocial behavior by signaling threats to valued relationships or community cohesion.[13,14] However, when shame becomes internalized and global, focused on being inherently defective rather than having made a mistake, it can become pathological, associated with avoidance, self-condemnation, depression, anxiety, and impaired relational functioning.[15] Physiologically, chronic shame activates stress-related pathways that may contribute to long-term health risks.[16]

These psychological and social dynamics parallel Christian theological understandings of shame. Within Christian anthropology, shame conflicts with the belief that humans are created in God's image—worthy, loved, and designed for relationship.[17] Internalized shame, particularly when reinforced by religious or community contexts, can distort this inherent dignity, fostering isolation, fear, and self-rejection.[18,19] Yet Christian theology emphasizes healing and restoration through Christ, renewing emotional and relational wholeness. Empirical studies support this theological vision: seeking divine forgiveness and relating to God personally are associated with improved well-being and restored self-concept.[20]

Shame as a determinant of health

Shame has profound impacts on mental, emotional, and physical health. Although not classified as a clinical disorder, it contributes to depression, anxiety, post-traumatic stress, isolation, aggression, and difficulties in relationships[21,22] and is also associated with addictive behaviors and eating disorders.[23,24,25] Shame is linked to impaired emotion regulation, lower self-esteem, aggression, and reduced well-being, highlighting its role as a significant determinant of psychological and relational health.

Shame often involves feeling "othered" or "less than," decreasing willingness to seek support and reinforcing avoidance behaviors.[26,16] Beyond these immediate effects, shame can

operate in chronic, health-relevant ways. Persistent shame undermines health through long-term behaviors such as substance use, avoidance and self-numbing, social stigma and status threat, and biological stress mechanisms.[16] Neurophysiologically, shame engages the brain's limbic system, where cognitive schemas amplify responses to triggers, activating the stress response and increasing cortisol levels.[27,28] Chronic stress can alter brain plasticity, produce hypervigilance and heightened fear responses,[29] and even affect gene expression via neuroendocrine pathways with potential epigenetic effects across generations.[30] Physical manifestations of shame can include sweating, muscle tension, gut discomfort, and elevated body temperature, and prolonged shame exposure increases risk for cardiovascular and immune system compromise.[31,16]

From a Christian perspective, shame conflicts with the inherent dignity and relational flourishing intended by God. Humans are created for connection and holistic well-being, yet shame can distort self-worth, foster fear and anxiety, and undermine relational and spiritual flourishing.[18,19,17] Internalized shame, particularly when reinforced by religious or communal expectations, distorts one's sense of belonging and divine design. However, through Christ's work and God's grace, these wounds can be healed and reintegrated, restoring mental, emotional, physical, and spiritual well-being. Engaging relationally with God and seeking divine forgiveness supports emotional restoration and aligns with the theological promise of reconciliation and renewal.[20]

Critical review of evidence

As noted, shame consistently correlates with negative mental, emotional, and physical health outcomes.[24,15,25,16] However, the quality of evidence varies. Many studies rely on Westernized self-report measures, which may limit cross-cultural generalizability and obscure how shame manifests in diverse social, cultural, and spiritual contexts.[11,32] Recognizing these limitations emphasizes the need for culturally informed research and careful interpretation of findings when applying shame-informed approaches in both public health and faith-based practice.

Childhood development, trauma, and shame

Early life experiences significantly shape how shame develops and persists. Adverse childhood experiences (ACEs)—such as witnessing domestic violence, neglect, or bullying—can overwhelm a child's developing brain, fostering survival strategies that protect against emotional harm.[6] In Internal Family Systems therapy, these strategies are referred to as "parts,"[33] which may include vulnerable emotions, memories, or learned behaviors aimed at avoiding or distracting from painful experiences. Over time, these internalized messages can manifest as persistent self-criticism, negative self-talk, or barriers to forming healthy boundaries and relationships.[34]

Building on the conceptualization of shame, childhood trauma can intensify internalized and relational shame, reinforcing feelings of unworthiness, isolation, and fear of judgment.[10,11] From a Christian perspective, such internalized shame distorts the divine image in which humans are created,[35] undermining inherent worth, relational connection, and spiritual flourishing.[18,17,19] Yet God's grace through Christ provides a path for healing and integration: the "parts" carrying fear, guilt, or shame can be restored, allowing individuals to reclaim dignity and develop healthy relationships with themselves, others, and God.[20,36]

Shame as disease-related stigma

Shame is closely linked to stigma, and cultural beliefs strongly shape how it is perceived and managed. In some contexts, shame is viewed as a weakness, prompting individuals to hide struggles or isolate themselves, limiting access to support and resources.[37] It is also connected to self-stigma, the internalization of negative beliefs or stereotypes. For instance, individuals may feel ashamed of chronic conditions or obesity, blaming themselves for circumstances influenced by broader social, economic, or systemic factors. Internalized shame can

obscure authentic identity, hinder care-seeking, and reinforce health disparities.

Brené Brown describes shame as "the fear of not being worthy of connection."[1] Releasing shame requires vulnerability—sharing thoughts and feelings, accepting compassion, and resisting internalized negative narratives. From a Christian perspective, shame-based exclusion undermines mental, emotional, and spiritual well-being by disrupting relational and communal flourishing intended by God.[18,17] Promoting connection, compassion, inclusion, and practices such as seeking divine forgiveness supports psychological restoration, spiritual wholeness, and health equity.[20]

Shame is embedded in social structures and cultural norms. Socioeconomic disadvantage strongly predicts shame: people living in poverty frequently report self-loathing, depression, suicidal thoughts, and social "othering."[38,39] Anti-poverty policies that fail to address systemic inequities can unintentionally intensify shame.[39] Shame also manifests in embodied ways, altering how individuals perceive themselves, their abilities, and their relational presence in the world.[40]

Cross-cultural research highlights the relational and moral functions of shame. In East Asian cultures, concerns about "loss of face" tied to family and community reputation influence mental health stigma and help-seeking avoidance.[41,42] In India, youth report that shame and social misunderstanding contribute to reluctance to access mental health services.[43] African honor–shame frameworks similarly emphasize communal expectations and social standing, regulating behavior and moral accountability.[44] Group-based shame is common in collectivist societies, often supporting social cohesion and reparative action.[11,41,45] Theoretical perspectives underscore shame's relational and moral dimensions across cultures.[46,47] Interventions in low- and middle-income countries demonstrate that culturally informed, shame-sensitive approaches can reduce stigma.[48]

Shame's consequences extend beyond psychological distress to physical, relational, and spiritual domains. It undermines participation in community and society, while faith-based, global health approaches emphasize inclusion, compassion, advocacy, and relational and spiritual restoration.[49] Addressing shame requires attention to structural inequities, cultural norms, and embodied experiences and practices promoting divine forgiveness, compassionate community, and spiritually grounded support systems.[20,49]

Considerations

Shame-informed care begins by recognizing its pervasive impact on mental, physical, and social health. Because shame is universal, addressing it requires more than behavior modification. It must be integrated with trauma-informed care, as shame both results from and intensifies traumatic experiences.[50] Key practices include cultivating self-compassion, autonomy, and collaboration; building shame resilience; and fostering awareness of power, privilege, and cultural shaming practices. Providers can offer gentle curiosity, empathetic listening, and support for authentic connection by creating environments of dignity, trust, and vulnerability. Educating communities about shame triggers—such as language, policies, and actions—further promotes healing. Ultimately, shame-informed care is critical for fostering resilience and "post-shame growth."[50]

Although shame contributes to health disparities,[24] Christian theology distinguishes destructive shame from healthy conviction. Paul writes: "Godly sorrow brings repentance that leads to salvation and leaves no regret, but worldly sorrow brings death."[51] Conviction framed in grace fosters accountability and transformation, whereas destructive shame—characterized by unworthiness, humiliation, and social isolation—undermines spiritual and physical health.[52] Christian public health practice should cultivate shame-informed care that differentiates helpful conviction from harmful shame, creating safe, supportive spaces for individuals to work through moral and emotional struggles without stigma. While this article emphasizes the harms of shame, some scholars note that it can also serve developmental and societal purposes.

Conclusion

A deeper understanding of shame and trauma is critical for both public health and faith-based practice.[18] Shame is a collective responsibility, shaped by cultural norms that must be challenged to foster inclusion, belonging, and dignity. Future research should examine connections between shame, adverse childhood experiences, and resulting mental, physical, and global health outcomes. Evidence shows that addressing and reducing shame supports healing from depression, anxiety, and post-traumatic stress disorder (PTSD).[24,10,53]

Faith communities can promote shame resilience and post-shame growth by creating environments grounded in grace, forgiveness, and acceptance, transforming experiences of unworthiness into opportunities for self-compassion, accountability, and relational restoration.[20] Cross-cultural research can further guide interventions that honor both spiritual and psychosocial well-being.

Treating shame as a determinant of health underscores the importance of education, inclusive policies, and public awareness campaigns that foster acceptance, belonging, and holistic flourishing. By integrating shame-informed approaches into healthcare and faith-based practice, organizations can reduce stigma, support healing, and cultivate communities that nurture resilience and post-shame growth.[20,49] Without such attention, shame remains a hidden barrier to health equity, spiritual flourishing, and human dignity.[18,17]

Recognizing shame as a social, cultural, and spiritual determinant of health calls for collective action: through evidence-informed interventions, culturally sensitive practices, and faith-rooted care, society can transform shame from a source of isolation into a catalyst for healing, connection, and human flourishing.[24,18]

References

1. Brown B. Daring greatly: how the courage to be vulnerable transforms the way we live, love, parent, and lead. New York: Avery: 2012.
2. Santoro G, Sideli L, Musetti A, Schimmenti A. The relationship between childhood trauma and shame: the mediating role of dissociation. Eur J Investig Health Psychol Educ. 2025;15(8):151. https://doi.org/10.3390/ejihpe15080151
3. BibleGateway.com. *Genesis 3:6–10, New International Version* [Internet]. Grand Rapids (MI): Bible Gateway; c1995–2025 [cited 2025 Nov 22]. Available from: https://www.biblegateway.com/passage/?search=Genesis%203%3A6-10&version=NIV
4. BibleGateway.com. *Romans 8:1, New International Version* [Internet]. Grand Rapids (MI): Bible Gateway; c1995–2025 [cited 2025 Nov 22]. Available from: https://www.biblegateway.com/passage/?search=Romans%208%3A1&version=NIV
5. BibleGateway.com. *Isaiah 54:4, New International Version* [Internet]. Grand Rapids (MI): Bible Gateway; c1995–2025 [cited 2025 Nov 21]. Available from: https://www.biblegateway.com/passage/?search=Isaiah+54%3A4&version=NIV
6. Wojcik KD, Cox DW, Kealy D. Adverse childhood experiences and shame- and guilt-proneness: examining the mediating roles of interpersonal problems in a community sample. Child Abuse Negl. 2019;98:104233. https://doi.org/10.1016/j.chiabu.2019.104233
7. Gee DG, Cohodes EM. Influences of caregiving on development: a sensitive period for biological embedding of predictability and safety cues. Curr Dir Psychol Sci. 2021;30(5):376-83. https://doi.org/10.1177/09637214211015673
8. Buchanan LP. There is no place for shame. From change your story – change your life [Internet]. 2019 May 13 [cited 2025 Jul 13]. Available from: https://www.lindapaulkbuchanan.com/post/there-is-no-place-for-shame
9. Terrizzi JA Jr, Shook NJ. On the origin of shame: does shame emerge from an evolved disease-avoidance architecture? Front Behav Neurosci. 2020;14:19. https://doi.org/10.3389/fnbeh.2020.00019

10. Cândea D-M, Szentágotai Tătar A. Shame and psychopathology: from research to clinical practice. J Cogn Behav Psychother. 2013;13(1):101-13. Available from: https://www.researchgate.net/publication/274071849_Shame_and_psychopathology_From_research_to_clinical_practice
11. de Groot M, Schaafsma J, Castelain T, Malinowska K, Mann L, Ohtsubo Y, et al. Group-based shame, guilt, and regret across cultures. Eur J Soc Psychol. 2021;51(7):1198-212. https://doi.org/10.1002/ejsp.2808
12. Sznycer D, Xygalatas D, Agey E, Alami S, An X-F, Ananyeva KI, et al. Cross-cultural invariances in the architecture of shame. Proc Natl Acad Sci U S A. 2018;115(39):9702-7. https://doi.org/10.1073/pnas.1805016115
13. Tangney JP, Dearing RL. Shame and guilt. New York: Guilford Press; 2002. https://doi.org/10.4135/9781412950664.n388
14. Luyten P, Fontaine JRJ, Corveleyn J. Does the Test of Self-Conscious Affect (TOSCA) measure maladaptive aspects of guilt and adaptive aspects of shame? An empirical investigation. Pers Individ Dif. 2002;33(8):1373-87. https://doi.org/10.1016/S0191-8869(02)00197-6
15. Cândea D-M, Szentágotai Tătar A. Shame proneness, guilt proneness and anxiety symptoms: a meta-analysis. J Anxiety Disord. 2018;58:78-106. https://doi.org/10.1016/j.janxdis.2018.07.005
16. Dolezal L, Lyons B. Health-related shame: an affective determinant of health? Med Humanit. 2017;43(4):257-64. https://doi.org/10.1136/medhum-2017-011186
17. Ha SN. Because of who we are: a fresh perspective on Calvin's doctrine of the image of God and human dignity. Religions. 2024;15(10):1162. https://doi.org/10.3390/rel15101162
18. Downie A. Christian shame and religious trauma. Religions. 2022;13(10):925. https://doi.org/10.3390/rel13100925
19. Zimmerman K-S, Kao GY, Dávila MT. Christian family ethics and shame: three perspectives [Internet]. J Moral Theol. 2024;13(2). https://doaj.org/article/66571393023b4fbd980ffdee3e4217bb
20. Maranges HM, Fincham FD. Psychological perspectives on divine forgiveness: trait self-control is associated with well-being through seeking divine forgiveness. Front Psychol. 2024;15:1292537. https://doi.org/10.3389/fpsyg.2024.1292537
21. Schuster P, Beutel ME, Hoyer J, Leibing E, Nolting B, Salzer S, et al. The role of shame and guilt in social anxiety disorder. J Affect Disord Rep. 2021;6:100208. https://doi.org/10.1016/j.jadr.2021.100208
22. Saraiya T, Lopez-Castro T. Ashamed and afraid: a scoping review of the role of shame in post-traumatic stress disorder (PTSD). J Clin Med. 2016;5(11):94. https://doi.org/10.3390/jcm5110094
23. Swan S, Andrews B. The relationship between shame, eating disorders and disclosure in treatment. Br J Clin Psychol. 2003;42(4):367-78. https://doi.org/10.1348/014466503322528919
24. Bilevicius E, Single A, Bristow LA, Foot M, Ellery M, Keough MT, et al. Shame mediates the relationship between depression and addictive behaviours. Addict Behav. 2018;82:94-100. https://doi.org/10.1016/j.addbeh.2018.02.023
25. Velotti P, Garofalo C, Bottazzi F, Caretti V. Faces of shame: implications for self-esteem, emotion regulation, aggression, and well-being. J Psychol. 2017;151(2):171-84. https://doi.org/10.1080/00223980.2016.1248809
26. Shaughnessy MJ. Integrative literature review on shame. J Holist Nurs. 2018;36(1):24-34. https://doi.org/10.1177/0894318417741120
27. Michl P, Meindl T, Meister F, Born C, Engel RR, Reiser M, et al. Neurobiological underpinnings of shame and guilt: a pilot fMRI study. Soc Cogn Affect Neurosci. 2014;9(2):150-7. https://doi.org/10.1093/scan/nss114
28. Lupis SB, Sabik NJ, Wolf JM. Role of shame and body esteem in cortisol stress responses. J Behav Med. 2016;39(2):262-75. https://doi.org/10.1007/s10865-015-9695-5
29. Sapolsky RM. Stress and plasticity in the limbic system. Neurochem Res. 2003;28(11):1735-42. https://doi.org/10.1023/A:1026021307833
30. Franco F. Intergenerational transmission of trauma. J Health Serv Psychol. 2023;49(3):185-90. https://doi.org/10.1007/s42843-023-00096-7

31. Kozlowska K, Walker P, McLean L, Carrive P. Fear and the defense cascade: clinical implications and management. Harv Rev Psychiatry. 2015;23(4):263-87. https://doi.org/10.1097/HRP.0000000000000065
32. Uskul AK, Cross SE, Günsoy C. The role of honour in interpersonal, intrapersonal and intergroup processes. Soc Personal Psychol Compass. 2022;17(1):e12719. https://doi.org/10.1111/spc3.12719
33. Sweezy M. The teenager's confession: regulating shame in Internal Family Systems therapy. Am J Psychother. 2011;65(2):179-91. https://doi.org/10.1176/appi.psychotherapy.2011.65.2.179
34. Sedighimornani N, Rimes K, Verplanken B. Factors contributing to the experience of shame and shame management: adverse childhood experiences, peer acceptance, and attachment styles. J Soc Psychol. 2020;160(2):129-45. https://doi.org/10.1080/00224545.2020.1778616
35. BibleGateway.com. *Genesis 1:27, New International Version* [Internet]. Grand Rapids (MI): Bible Gateway; c1995–2025 [cited 2025 Nov 22]. Available from: https://www.biblegateway.com/passage/?search=Genesis%201%3A27&version=NIV
36. BibleGateway.com. *2 Corinthians 5:17, New International Version* [Internet]. Grand Rapids (MI): Bible Gateway; c1995–2025 [cited 2025 Nov 22]. Available from: https://www.biblegateway.com/passage/?search=2%20Corinthians%205%3A17&version=NIV
37. Mayer CH, Vanderheiden E. Transforming shame in the pandemic: an international study. Front Psychol. 2021;12:641076. https://doi.org/10.3389/fpsyg.2021.641076
38. Walker R. The shame of poverty. Oxford: Oxford University Press; 2014.
39. Chase E, Walker R. Shame as a co-constructed emotion: people's accounts of their lives. Sociol. 2013;47(4):739-54. https://doi.org/10.1177/0038038512453796
40. Merleau-Ponty M. Phenomenology of perception [Landes DA, translator]. London: Routledge; 2012.
41. Ran MS, Hall BJ, Su TT, Prawira B, Breth-Petersen M, Li XH, et al. Stigma of mental illness and cultural factors in Pacific Rim region: a systematic review. BMC Psychiatry. 2021;21:8. https://doi.org/10.1186/s12888-020-02991-5
42. Samari E, Teh WL, Roystonn K, Devi F, Cetty L, Shahwan S, et al. Perceived mental illness stigma among family and friends of young people with depression and its role in help-seeking: a qualitative inquiry. BMC Psychiatry. 2022;22:107. https://doi.org/10.1186/s12888-022-03754-0
43. Gaiha SM, Salisbury TT, Koschorke M, Raman U, Petticrew M. Stigma associated with mental health problems among young people in India: a systematic review. BMC Psychiatry. 2020;20:252. https://doi.org/10.1186/s12888-020-02937-x
44. Freeman SE, Calenberg RD. Understanding honor shame dynamics for ministry in Sub Saharan Africa [Internet]. Bibliotheca Sacra. 2018;175(700):425-38. Available from: https://www.galaxie.com/article/bsac175-700-04
45. Bierle I, Becker JC, Nakao G, Heine SJ. Shame and anger differentially predict disidentification between collectivistic and individualistic societies. PLoS One. 2023;18(9):e0289918. https://doi.org/10.1371/journal.pone.0289918
46. Shield M. Is shame a global emotion? Hum Stud. 2024;47(3):793-809. https://doi.org/10.1007/s10746-024-09731-8
47. Hu JI. Shame, vulnerability, and change. J Am Philos Assoc. 2022;8(2):373-90. https://doi.org/10.1017/apa.2021.21
48. Heim E, Henderson C, Kohrt BA, Koschorke M, Milenova M, Thornicroft G. Reducing mental health-related stigma among medical and nursing students in low- and middle-income countries: a systematic review. Epidemiol Psychiatr Sci. 2019;29:e28. https://doi.org/10.1017/S2045796019000167
49. Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the spiritual dimension of whole person care: reaching national and international consensus. J Palliat Med. 2014;17(6):642-56. https://doi.org/10.1089/jpm.2014.9427

50. Dolezal L, Gibson M. Beyond a trauma-informed approach and towards shame-sensitive practice. Humanit Soc Sci Commun. 2022;9:214. https://doi.org/10.1057/s41599-022-01227-z

51. BibleGateway.com. *2 Corinthians 7:10, New International Version* [Internet]. Grand Rapids (MI): Bible Gateway; c1995–2025 [cited 2025 Nov 22]. Available from: https://www.biblegateway.com/passage/?search=2%20Corinthians%207%3A10&version=NIV

52. Exline JJ, Rose E. Religious and spiritual struggles. In: Pargament KI, editor. APA handbook of psychology, religion, and spirituality. Vol. 1. Washington (DC): American Psychological Association; 2013. p. 459-75. https://doi.org/10.1037/a0036465

53. López-Castro T, Saraiya T, Zumberg-Smith K, Dambreville N. Association between shame and posttraumatic stress disorder: a meta-analysis. J Trauma Stress. 2019;32(4):484-95. https://doi.org/10.1002/jts.22411

Submitted 23 Sep 2025, Accepted 20 Dec 2026, Published Apr 2026

Acknowledgement: The author received no additional support for this review.

Funding: The author received no specific funding for this work.

Conflicts of Interest: The author declares no potential conflicts of interest.

Cite this article as: Bates R. Shame as a determinant of health: a Christian public health perspective. Christ J Glob Health. 2026 Apr; 13(1). https://doi.org/10.15566/cjgh.v13i1.619