REVISTA CARIBEÑA DE PSICOLOGÍA

Fundación para el Desarrollo de la Psicología en el Caribe

Original Article

The Relationship of Shame, Emotional Well-being, Self-efficacy, and Substance Use Disorder Severity: An Exploratory Study among Latinos in Correctional Settings

La Relación entre la Vergüenza, el Bienestar Emocional, la Autoeficacia y la Gravedad de los Trastornos por Consumo de Sustancias: Un Estudio Exploratorio entre Latinos en Centros Penitenciarios

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Received: February 15, 2024 | **Accepted**: April 13, 2024 | **Published**: March 8, 2025

WWW.REVISTACARIBENADEPSICOLOGIA.COM

Cite as:

Planas-García, B. Y., Rodríguez-Gómez, J., & Pérez-Pedrogo, C. (2025). The relationship of shame, emotional well-being, self-efficacy, and substance use disorder severity: An exploratory study among Latinos in correctional settings. *Revista Caribeña de Psicología, 9*(1), e9057. https://doi.org/10.37226/rcp.v9i1.9057

ABSTRACT

Shame has been associated with a range of psychopathology, including substance use disorders (SUD). However, little is known about how shame could be related to emotional well-being, self-efficacy, and substance use severity. This study examines the possible relationship between internalized shame and emotional well-being, self-efficacy, and substance use severity among people living in prison. Three hundred-eleven participants (*n=311)* who were under criminal justice supervision at the time of the study were considered for this study. Internalized shame was significantly negatively associated with emotional well-being *(r=.642, p<.001)* and self-efficacy *(r=.370, p<.001)*. Participants who reported higher levels of internalized shame also reported significantly more substance use disorder (SUD) symptoms (*r=.329, p<.001)* and met criteria for more SUD diagnoses *(r=.226, p<.001)*. Results suggest internalized shame is related to poorer functioning and severity of SUDs. Shame has received meager attention in the SUD context, especially in vulnerable populations. Further research is required to elucidate the behavioral manifestations of shame in the well-being of people with SUDs.

Keywords: shame, substance use disorders, self-efficacy, people living in prison

RESUMEN

La vergüenza está relacionada con una variedad de psicopatologías, incluyendo los trastornos por uso de sustancias (TUS). Sin embargo, es escaza la literatura que explora cómo la vergüenza podría estar relacionada con el bienestar

emocional, la autoeficacia y la severidad de los trastornos por uso de sustancias. Este estudio examina la posible relación entre la vergüenza internalizada, el bienestar emocional, la autoeficacia y la severidad de los TUS entre las personas que viven en prisión. Para este estudio se tuvo en cuenta a 311 participantes (n = 311) que en el momento del estudio estaban bajo la supervisión del sistema correccional. La vergüenza internalizada se asoció significativamente de forma negativa con el bienestar emocional (r = .642, p < .001) y la autoeficacia (r = .370, p <.001). Los participantes que reportaron niveles más altos de vergüenza internalizada también reportaron significativamente más síntomas del TUS (r = .329, p <.001) y cumplieron más criterios diagnósticos de TUS (r = .226, p < .001). Los resultados sugieren que la vergüenza internalizada está relacionada con menor funcionamiento y mayor severidad de los TUS. La vergüenza ha recibido escasa atención en el contexto del TUS, especialmente en las poblaciones vulnerables. Se requieren más investigaciones para dilucidar las manifestaciones conductuales de la vergüenza en el bienestar de las personas con TUS.

Palabras Claves: vergüenza, trastornos por uso de sustancias, autoeficacia, personas viviendo en prisión

INTRODUCTION

Shame is defined as a complex, universally experienced emotion associated with experiences of rejection or abuse from family, as well as addictive behaviors (Cook, 1988). It has been conceptualized as a self-conscious emotion that focuses on the self, exhibited through feelings of diminishment and worthlessness (Tangney et al., 2014). Shame involves a negative evaluation of oneself and is considered a maladaptive emotion that rarely has adaptive functions (Luoma et al., 2019). In a sample of people living in prison, shame was correlated with higher levels of recidivism (Hosser et al., 2008). Often, people with mental disorders are overrepresented in the criminal justice system (citation) and mental disorders such as Borderline Personality Disorder (BPD), Social Anxiety Disorder (SAD), and Major Depressive Disorder (MDD) have all been associated with intense feelings of shame (Scheel et al., 2014; Gilbert, 2000; Kim & Thibodeau, 2011).

Substance Use Disorders are similarly overrepresented in correctional facilities, with about half of the individuals living in prison meeting the criteria for an SUD (Mumola & Karberg, 2004) compared to 8.4% of the total population of adults (Lipari & Van Horn, 2017). In Puerto Rico, a study with 500 males living in prison found over 75% of the sample met the criteria for lifetime SUD. The investigators also reported SUD comorbidity with disorders such as Attention Hyperactivity Disorder (ADHD), MDD, Generalized Anxiety Disorder (GAD), BPD, and Antisocial Personality Disorder (Vélez-Pastrana et al., 2020). Another study with 1,179 men and women from 26 penal institutions in Puerto Rico found men with PTSD also screened positive for co-occurring conditions such as childhood ADHD, SUD, and Major Depression symptomatology (Pérez-Pedrogo et al., 2018). These findings are consistent with existing literature stating SUDs are often comorbid with other psychopathologies among people living in prison (McNiel et al.,2005; Abram et al., 2003; Abram &Teplin, 1991). Therefore, people living in prison and mental health providers within criminal justice settings face a complex panorama regarding treatment.

Shame has also been of interest in the context of substance use disorders (SUDs) (Tangney et al., 2011). Nevertheless, an agreement on the nature of the relationship between shame and SUDs has not been reached. Some studies have found a significant positive relationship between shame and substance use, with shame predicting drinking at an earlier age, using a greater variety of substances, and other risky behaviors (Stuewig et al., 2014). On the other hand, a recent systematic review and meta-analysis by Luoma and colleagues (2019) found that subjects with higher levels of shame did not use substances at a higher frequency. However, of the 16 studies they analyzed, 11 only assessed alcohol use, making this statement more representative of alcohol and no other substances. Nonetheless, individuals in treatment for SUDs reported higher levels of experienced shame when compared to non-SUD samples (Luoma et al., 2019). This finding suggests shame could be essential in developing appropriate interventions for individuals with SUDs. Although shame has been correlated with multiple mental disorders and overall maladaptive behaviors, it has received scant attention as a

potential transdiagnostic factor. This study seeks to understand better the association of shame with other substances besides alcohol in correctional settings.

Treatment protocols (e.g., Cognitive-behavioral programs) offered to people living in prison generally include sessions focusing on cognitive, emotional, and behavioral skills, assumed to be lacking in this population (Brazão et al., 2018). Self-efficacy, an individual's cognitions regarding their capabilities in dealing with everyday situations (Bandura, 1986), has been diminished in people living in prison (Cásares-López et al., 2011; Jiang & Winfree, 2006). Perceived self-efficacy addresses self-coping capabilities and recognizes how these perceptions impact behavior, thought patterns, and emotional reactions (Bandura, 1986). Moreover, self-efficacy has been significantly and positively related to self-rated health among males aged 50 to 74 living in prison (Loeb et al., 2011). Since shame involves a negative evaluation of oneself (Luoma et al., 2019) and feelings of diminishment (Tangney et al., 2014), this complex emotion could hinder an individual's self-efficacy, affecting the development of coping skills and behavioral change. Loeb and Steffensmeier (2006) explored the relationship between health status, self-efficacy beliefs, and behaviors. They found that individuals living in prison with greater self-efficacy rated their health better and engaged in more adaptive health-promoting behaviors. Other studies have also suggested self-efficacy could predict physical and emotional well-being (Hochhausen et al., 2007).

Emotional well-being refers to difficulties confronted in day-to-day situations resulting from any emotional problem (Agrawal & D'Silva, 2017). A lack of emotional well-being could likely impact a person's quality of life, resulting in lower self-confidence and a sense of belonging (Agrawal & D'Silva, 2017). Evidence suggests that substance use severity decreases as self-efficacy increases, portraying an inverse relationship (Herrera, 2015). Literature reviews have suggested self-efficacy is a predictor and mediator of treatment outcomes (Kadden & Litt, 2011). Individuals living in prison with low perceived self-efficacy levels had heavier drug use, welfare deficiencies, and mental health problems (Friestad & Hansen, 2005). Conversely, people living in prison who reported more outstanding emotional support had a lower likelihood of poor health self-efficacy (Noujaim et al., 2017). These findings suggest self-efficacy and emotional well-being are important factors for general health, particularly for SUDs, which represent one of the most prevalent conditions in the United States, affecting more than 20.2 million Americans, with 8.5 million Americans having both a SUD and a mental illness (SAMHSA, 2018; Merikangas, 2010). While these numbers increase significantly, little is known about how internalized shame could be related to SUD severity, self-efficacy, and emotional well-being among disadvantaged and marginalized groups.

The purpose of this study is to address this knowledge gap by examining the relationship between internalized shame, SUD severity, self-efficacy, and emotional well-being among people living in correctional facilities. Based on current literature, we hypothesized that internalized shame would positively correlate to SUD severity and negatively to self-efficacy and emotional well-being. Investigating these relationships will help elucidate if specific populations are more susceptible to experiencing more significant levels of shame and how shame could affect their overall health. Since shame has been claimed as "insidious, pervasive and pernicious, and so critical to the clinical and political discourse around health…" (Dolezal & Lyons, 2017, p.257), examining these potential associations is also relevant to develop prevention campaigns, adequate and effective treatment interventions, and promote sensitive public policies.

METHOD

Research Design

We used secondary data from *A Self-Stigma Scale for Latinos with SUD/HIV under the Criminal Justice Supervision* study. The principal investigators of this study granted authorization to use the dataset. The sample consisted of de-identified information of 311 men and women serving a sentence under the Department of Correction and Rehabilitation of Puerto Rico at the time of the original study. A causal relationship cannot be established within variables; therefore, this study will be correlational. The correlational analysis will help describe the relationship, if any, among internalized shame, emotional well-being, self-efficacy, and severity of substance use disorders. Additionally, internal consistency analyses will

be performed to assess the reliability of the measures in the current study.

Participants and Procedures

The sample was drawn from the NIDA-funded study entitled: A Self-Stigma Scale for Latinos with SUD/HIV under Criminal Justice Supervision. The participants of this study were men, 21 or older, who were currently serving a sentence in the Department of Corrections and Rehabilitation of Puerto Rico. A total of 311 men and women living in prisons around Puerto Rico participated in the study. The sample was by availability, and the participation was voluntary.

Entirely eligible participants were subjects with SUD and SUD/HIV. However, the whole prison community was invited to participate, and 77 participants categorized as placebo were also part of the study to avoid direct disclosure. A screener questionnaire was administered to assess physical and emotional conditions to determine which group the subject was ascribed to.

Recruiters/interviewers completed a three-week intensive training program covering aspects of human subjects' protection, the vulnerability of persons who live in prisons, informed consent protocols, interviewing protocols, computerized interviews technical training, data safety, work ethics, and self-care. Interviews were prearranged inside the correctional facility, which facilitated computer arrangements and safeguarded confidentiality. To avoid indirect disclosure, all people who were living in prison at the time of the study were invited to participate. A flyer was utilized as an initial invitation, including details of the date, time, and place where the orientation took place. The general aims of the study were discussed, emphasizing that everyone was invited to participate regardless of their health conditions. An individual orientation was given to those who expressed interest in participating in the study, covering the discussion of informed consent, and obtaining written authorization. Finally, the primary inclusion criteria were examined: 21 years old or older, currently serving a sentence, and accepting voluntarily to complete a computerized questionnaire.

The computerized questionnaires were administered in a private room to protect subjects from indirect disclosure. Depending on their screener questionnaire answers (including the history of drug abuse, HIV self-report, and other emotional and health conditions), they were then ascribed to a group to answer pertinent questionnaires regarding their health conditions. Those who did not report a history of drug problems completed a placebo questionnaire. On the other hand, only subjects who reported an HIV-positive status-completed HIV-related questions. A written authorization was obtained from participants who self-reported HIV-positive status to validate their diagnosis. In this study, we will not be focusing on the between-group differences of SUD only and SUD/HIV subjects.

As part of the efforts to ensure human subjects' protection and rights, the original study was approved by the Institutional Revision Board (IRB) of an institution affiliated with the lead investigator of the original study. Since the study gathered information about people living in prison, it was made a priority to comply with special regulations from the Office for Human Research Protection (OHRP) regarding people living in prison as human subjects in research. Additionally, a confidential certificate was obtained from the National Institute of Health (NIH) of the United States of America as part of the commitment to maintaining the highest standards for sensitive and confidential information. For this study, IRB approval was obtained for a secondary analysis and only the subjects who completed the Internalized Shame Scale (ISS), RAND 36-item Health Survey (version 1.0), The Composite for International Diagnostic Interview Screener (CIDI), and the General Self-Efficacy Scale (GSES) were considered.

Measures

Computerized interviews. The anonymous questionnaires were assessed using the Questionnaire Development System (QDS) software, version 3.0, a widely used system for developing and administering data applications or modules. Two programs were used: the Audio Computer Administered Self Interview (ACASI; Estes et al., 2010) and Computer Assisted Personal Interview (CAPI; Lavrakas, 2008). The ACASI application allows the computer to do the interview process while the interviewer mainly supervises and supports the data collection process. With ACASI, respondents hear and read the question displayed by the computer and answer the premises

using the keyboard or mouse. The option of "refuse to answer" was programmed. In CAPI, a face-to-face interview was conducted by an experienced interviewer with assistance from a computer, reducing the likelihood of interview and data error.

Internalized Shame Scale. The Internalized Shame Scale (Chang, 1988; Blavier, 1994) consists of 24 negatively worded items and self-reports using a 5-point Likert scale (never to almost always) to measure the frequency of intense affect and self-cognitions involving internalized shame. Higher scores reflect the subject experiences internalized shame more frequently. Previous research has shown construct validity and high internal consistency with alpha coefficients from α=.88-.96 (Rosario & White, 2006). A modified version consisting of 18 out of the 24 items of the ISS in the Puerto Rican population portrayed excellent internal consistency with Cronbach's α=.90 (Blasini-Méndez, 2020). Our study portrayed excellent psychometric properties (α=.952).

Emotional Wellbeing. The original study assessed emotional well-being using the RAND 36-item Health Survey v1.0 (Hays et al., 1993). Specifically, all items from the emotional well-being subscale were administered for a sum of 5 items. The RAND 36-item Health Survey v1.0 is a self-administered questionnaire that asks participants questions regarding their health using the Likert scale (Always to Never) and yes/no answers and includes the same items as the Medical Outcomes Study (MOS) SF-36 (Ware & Sherbourne, 1992). Higher scores are indicative of better emotional well-being. SF-36 has shown good internal consistency with Cronbach's α=.80 in a prison population sample (Jenkinson et al., 1994). Our findings are consistent with the latter showing good psychometric properties in our sample (α=.819).

Self-efficacy. The General Self-Efficacy Scale (GSE) (Schwarzer & Jerusalem, 1995) is a self-report measure of self-efficacy consisting of 10 items using a 4-point Likert scale (Not at all true to Exactly true) with higher scores indicating more self-efficacy. The GSE assesses perceived self-efficacy regarding one's ability to perform tasks and cope with adversity. It has been tested and used worldwide for more than two decades portraying adequate consistency and reliability with an average Cronbach's α=.86 across different populations (Scholz et al., 2012). A Puerto Rican sample showed good internal consistency with Cronbach's α=.81 (Serra-Taylor & Irizarry-Robles, 2015). Our sample also portrayed adequate psychometric properties (α=.834).

Substance Use Disorder. Substance Use Disorders (SUD) was assessed with an adapted version of The Composite for International Diagnostic Interview Screener (CIDI) to agree with Diagnostic and Statistical Manual V (DSM-5) criteria (American Psychiatric Association, 2013), which included three (3) modules representing three (3) time frames: lifetime user, year before prison and current use. Only current use was considered for this study. Substances assessed by CIDI are cigarettes, alcohol, cannabis, cocaine, heroin, opioids, amphetamines, hallucinogens, sedatives, and inhalants. Symptoms for each drug are accounted for independently; the severity of the disorder increases as more symptoms are reported. Two indicators for severity were used: the number of symptoms and the number of SUD diagnoses met (polysubstance).

RESULTS

Descriptive statistics

The sample consisted of 311 participants (282 males, 27 females, and 1 transgender person). Only one person refused to answer. Participants ranged from 21 to 63 years, with a mean of 35 years. Other sociodemographic variables are shown in Table 1.

Correlations

Pearson correlational analyses are shown in Table 2. Internalized shame portrayed a positive significant inverse association with self-efficacy (r=-.370, p<.001) and emotional well-being (r=-.642, p<.001). Thus, higher levels of internalized shame were associated with lower levels of self-efficacy and emotional well-being. Internalized shame also exhibited a significant positive relationship with SUD symptom severity (r=.329, p<.001) and number of SUD diagnoses met (r=.412, p<.001). Therefore, participants who reported higher levels of internalized shame had a more significant number of SUD symptoms and met the criteria for multiple SUD diagnoses. Consequently, internalized shame was associated with SUD severity.

Table 1

Demographic variable	N=311
Age (mean and SD)	35.3 (9.9)
	%
Gender	
Female	8.7
Male	91.0
Transgender	0.3
Marital status	
Single	25.7
Single, but going out with someone	13.5
Married	45.3
Living with someone as married	6.8
Divorced	1.0
Widowed	7.4
Separated	0.3
Education	
Did not graduate from high school	38.9
Graduated high school	35.7
Higher education, but did not complete degree	11.9
University degree	2.2
Other	9.6
Refuse to answer	1.6

Table 2

Summary statistics and zero order correlations

	Mean (S.D.)	Internalized Shame
1. Internalized shame	25.19 (16.87)	-
2. Emotional wellbeing	16.00 (5.71)	*-.642***
3. Self-efficacy	21.91 (4.65)	*-.370***
4. SUD symptoms	22.41 (15.91)	*.329***
5. SUD diagnoses	2.83 (1.57)	*.412***

*** Correlation is significant at the 0.01 level (2-tailed)*

DISCUSSION

This study primarily aimed to examine the relationship between internalized shame, emotional well-being, self-efficacy, and substance use disorder severity among people living in prison. We also wanted to examine the psychometric properties of the measures within the Puerto Rican population in correctional settings. All measures had good internal consistency, suggesting they are appropriate measures to use with the Puerto Rican population and people living in prison. As the investigators expected, internalized shame was negatively associated with emotional well-being and self-efficacy. Hence, people with higher levels of internalized shame have poorer emotional functioning and coping skills, both factors important for day-to-day life stressors (Loeb et al., 2011; MacDonald et al., 1998) and potentially crucial elements to consider in SUD treatment. Our results also indicate that internalized shame is related to SUD severity and polysubstance use, consistent with existing literature (Stuewig et al., 2014). Participants with higher levels of internalized shame reported a higher number of SUD symptoms and clinically met more SUD diagnoses. Therefore, our results suggest higher levels of internalized shame were associated with more severe SUD and substance use. Although causality and directionality cannot be established with

our research design, findings suggest internalized shame is an essential factor to consider when developing treatment and public policy for SUDs, particularly for populations in disadvantaged settings.

Although Luoma and colleagues (2019) found no association between shame and using substances at a higher frequency, our study provides insight into the relationship between shame and substance use severity as well as polysubstance use. This implies clinical relevance since SUD severity is related to cognitive, behavioral, and physiological symptoms that lead to social impairment (American Psychiatric Association, 2013). Individuals with higher levels of internalized shame had significantly lower levels of self-efficacy. Since shame-prone individuals are more likely to have negative views of themselves and lower self-esteem (Snoek et al., 2021), addressing internalized shame during SUD treatment could be a key factor given that self-efficacy is also related to SUD severity (Herrera, 2015; Friestad & Hansen, 2005). There is also a growing amount of research suggesting shame-prone individuals experience higher levels of functioning impairment, with a higher risk of developing psychopathology and earlier drug use onset (Rahim & Patton, 2015). Tailoring existing evidence-based treatments to recognize shame as an essential element and include techniques and strategies aimed at reducing the inconspicuous yet potentially pervasive consequences of shame could be especially beneficial for disadvantaged populations.

Furthermore, our study also indicates subjects with higher levels of internalized shame reported significantly lower levels of emotional well-being. Given that emotional well-being plays a role in a person's day-to-day coping skills (Agrawal & D'Silva, 2017), experimenting with internalized shame may result in higher vulnerabilities to deal with daily life stressors, including perceived stigma due to the chronic condition. While shame has had limited attention in substance use disorders and other psychosocial variables, it has been proposed as an affective determinant of health with: "…insidious, pervasive and pernicious…" characteristics (Dolezal & Lyons, 2017, p.257). Overall, existing literature and our study suggest shame is an essential and complex variable within SUD and other mental health disorders, potentially being a transdiagnostic target treatment. This is especially relevant for mental health providers in criminal justice settings where time and resources are limited. Integrating internalized shame measures as part of screening and treatment outcome protocols could be beneficial for people with SUDs in their path to social reintegration where coping skills and emotional health are of the essence.

Limitations of this study include findings more representative of the male experience since most of the sample is composed of males. However, literature has recognized men are more likely to have access to substances when compared with women, which appears to account for the gender difference in the prevalence of SUD (McHugh et al., 2018). Given that feelings of shame could arise as a consequence of substance use (Cook, 1987, Corrigan et al., 2006; Luoma et al., 2007) and substance use itself can be a coping mechanism to deal with shame (Quiles et al., 2002), this study emphasizes the importance of negative affect such as shame should be given when tailoring SUD treatment. Future research should examine the underlying mechanisms and potential gender differences in these relationships, particularly how they could lead to effective treatment development and implementation.

Financing: This study was funded by the National Institute on Drug Abuse (NIDA), [grant number 5R24DA024868-02, 2016] under the Diversity Promoting Institutions Drug Abuse Research Program (DIDARP) at the Graduate School of Public Health, University of Puerto Rico Medical Sciences Campus, and the supplement grant number 3UG1DA050072-02S1 from the NIDA. The study sponsor did not have a role in the analysis and interpretation of data, in the writing of the manuscript, or in the decision to submit the paper for publication.

Conflict of Interest: The authors declare that there is no conflict of interest.

Review Process: This study has been reviewed by external peers in double-blind mode.

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