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Hopelessness and shame in relation to suicide attempts by Cuban adolescents

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Abstract

Youth suicide rates in Cuba are very high compared with most other countries, despite considerable improvement in recent years. The purpose of our study was to determine whether hopelessness and shame distinguish adolescent suicide attempters from non-attempters, over and above the effects of depression and suicidal ideation. Participants were 844 Cuban adolescents from the province of Holguin in Eastern Cuba. The attempter groups included 38 participants being treated for suicide attempts in a day hospital and 82 participants in the community who self-reported a previous suicide attempt. The other participants were non-attempter controls. All participants were asked to complete measures of depression, hopelessness, shame and suicidal ideation. As expected, attempters scored higher than non-attempters on the control variables of depression and suicidal ideation. In addition, attempters self-reported greater shame, especially behavioral and characterological shame, than non-attempters. Contrary to our hypothesis, there was no significant difference in hopelessness between attempters and non-attempters. The results are inconsistent with the considerable narrative lore about hopelessness as a reason for suicide in Cuba and other socialist countries. However, some collective socialization practices may lead to shame.

Keywords

adolescence, cultural differences, shame, suicide

Suicide is the second leading cause of death among young people worldwide. Within the global population of 10 to 24-year-olds, it is only surpassed by road accidents for most deaths caused annually. Adolescent suicide is a particular problem. In 2003, Cuba had the highest rate of youth suicide of any Latin American country, at 9.2 per 100,000, compared to 8.0 for the US and a world average of 7.4. (Wasserman, Cheng, & Jiang, 2005). Importantly, the rate of suicide mortality among Cuban adolescents 15 to 19 years old, although very high in 2003 at 9.0 per 100,000, was lower than the rate of 12.9 per 100,000 in 1995. Although the precise reasons for the improvement cannot be demonstrated empirically, it may be attributable to the efforts of the Ministry of Health and health professionals across Cuba (Quinlan-Davidson, Sanhueza, Espinosa, Escamilla-Cejudo & Maddaleno, 2012). In this study, we explore the possible contributions of shame and hopelessness to suicide attempts by Cuban adolescents.

Shame in collectivistic cultures

The powerful emotion of shame pertains to the total dislike of oneself, which may be related to personal characteristics or past actions, as opposed to the emotion of guilt, which refers to regret about a specific behavior but not one's entire self. Shame may lead to devastating consequences when the individual believes that he or she will never be able to regain the positive regard of one's peers (Coster & Lester, 2013) Theories

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linking shame with suicidality negate the presumption that suicide is essentially predicated on psychopathology within the individual (Mokros, 1995). They emphasize the threat to close social bonds as the reason for a link between shame and suicide. Scheff's (2003) social/emotional theory of 'mental illness' (original quotation marks) maintains that shame is "the primary social emotion" (p. 239) and that shame arises "because the self is social" (p. 242). Shame may be one of the factors "that cast vulnerable individuals adrift, disconnecting them from a sense of social place" (Mokros, 1995, p. 1092).

In certain cultures, considered *cultures of shame* (as opposed to *cultures of guilt*; Morris & Benedict, 1947), individuals are known to suffer heightened shame because their peers disapprove of them. When shame reaches the level at which it may provoke depression and suicide, the person who feels shame feels that his or her entire self is placed into question and that no easy means of self-improvement will restore his or her reputation (Tangney, Youman, & Stuewig, 2009). In cultures of shame, shame is thought to be an important precipitator of suicide (Lester, 1997), which often occurs in East Asia and especially in Japan (Doi & Schwaber, 2016).

Unlike the East Asian cultures traditionally considered cultures of shame, shame in Cuban culture does not emanate primarily from underlying religious and philosophical roots. Considerable shame, however, may be evoked inadvertently by Cuban socialization practices. Following the Cuban Revolution, the government introduced compulsory youth activities designed to promote respect for physical labor, concern for the community, collective discipline and help for individuals in need. One such activity is the *escuela del campo* (field school), where pupils help with harvesting and other agricultural activities for two weeks each year, complementing the academic learning that takes place in the *escuela de la ciudad* (city school). Throughout the school year, community service is emphasized in the compulsory Young Pioneers movement, which resembles the Scout movement in other countries in some respects. The Pioneers are encouraged to share whatever they have. During the regular outbreaks of dengue fever, a mosquito-borne illness, many Pioneers are sent around their neighborhoods to look for places where mosquitoes might breed, such as tires or receptacles used to store rainwater.

The children's behavior, personalities, and attitudes are evaluated regularly and publicly in terms of congruence with the goals of the Pioneer movement, in which all Cuban children and youth participate (Bunck, 1994). The evocation of shame as part of the collective socialization process is arguably compounded by the close family ties and close *barrio* (neighborhood) relationships that are traditional in Latin American culture (Greenfield & Quiroz, 2013). Class sizes are small in Cuba and teachers coordinate with parents, often on a daily basis, advising parents about how to facilitate their children's schooling; they also coordinate with the leaders of the Pioneers groups. This means that an event that evokes shame in school may also evoke shame within and upon the extended family, with repercussions throughout the neighborhood, leading to the feeling that there is no way of escaping one's tarnished reputation.

In order to clearly understand and address the force of cultural influences, different types of shame must be distinguished. According to Velotti, Garofalo, Bottazzi, and Caretti (2002), characterological shame is shame related to personal habits, manner with others, the kind of person one is, and personal skills, while behavioral shame is shame related to doing something wrong or inappropriate and failing in competitive contexts. Bodily shame refers to being ashamed of one's physical appearance. Different types of shame may be related to suicidality for different reasons. Collective socialization in Cuba seems more likely to be related to behavioral and characterological shame than to other forms such as bodily shame.

Suicide evoked by cyclical hope and disappointment

Early Cuban history, from the enslavement of the Taino tribe by the Spaniards in the 16th century onward, is characterized by a succession of undelivered promises (Perez, 2007). Similarly, Cuban history from Cuban independence to the establishment of the current communist government in 1959 was punctuated by successive leaders who promised prosperity but ultimately failed to deliver it, disappointing their earnest supporters. Louis A. Perez, a Cuban-American historian who conducts extensive documental research in Cuba, argues that the struggles that Cubans have historically faced have directly contributed to Cuban citizens not only seeing suicide as a viable option to escape from hardship, but seeing it as a noble and patriotic option: "The narrative of sacrifice emerged as the dominant discursive mode by which the duty of death insinuated itself into the conventions of Cuban" (Perez, 2007, p. 84). Perez describes historical events that are quite heterogeneous, ranging from enslavement to poverty (e.g., stemming from declines in the price of sugar on the world market) to the end of the capitalist system. In some cases, Perez depicts suicide as an honorable or patriotic event; in others it is the result of desperation and hopelessness. Some of these events can be seen as causing defeat, particularly among Cubans who lost property and status during the Cuban Revolution. Almost all of these events can be

seen as causing feelings of entrapment, that is, a desire to flee that has been blocked. Defeat and entrapment are the core features of the social rank theory of psychopathology (Gilbert & Allen, 1998). In that theory, depression is seen as a way of reacting to the loss of status and the loss of hope that status will ever be regained. In that theory, the depressive response is not seen as necessarily maladaptive.

Hopelessness is known to be a major correlate of both depression and suicide. In most of the mental-health literature, hopelessness is discussed as an individual rather than a collective variable. In the *hopelessness theory of depression* formulated by Abramson and colleagues, hopelessness is seen as the cause of subsequent depressive symptoms in many cases. Central to their theory is, first of all, the expectation that a highly desired outcome will not occur. Furthermore, the hopeless individual feels that there is nothing he or she can do that will affect the outcome (Abramson, Metalky & Alloy, 1989). Hopelessness based on perceptions of negative outcomes in life has been associated with suicide among at-risk adolescents (Horwitz, Berona, Czyz, Yeguez, & King, 2017).

Culture may exacerbate the link between hopelessness and suicide. In collectivistic cultures, where individuals are highly embedded in family and community social networks, hopelessness may interact with social isolation to generate distress. The inability to alleviate social isolation may also be the substance of the hopelessness. Page et al. (2006) found that adolescent suicide attempters in three collectivistic Asian countries – Thailand, the Philippines and Taiwan – were characterized by high levels of hopelessness as well as loneliness. In the most important Cuban research on predictors of suicide attempts, a thesis by Martínez-Brito (2007), hopelessness did indeed differentiate a group of adult patients admitted to a psychiatric hospital because of suicide attempts or suicidal thinking from a control group of adults in the community. Although attempters reported slightly lower frequencies of social support and less satisfaction with social support, the differences did not achieve statistical significance.

Hopelessness may be compounded by a lack of incentive and agency in a society. Cuba shares the communist economic and social system that was dominant in Eastern Europe throughout the middle of the 20th century. Mokhovikov (1998), writing after the collapse of the Soviet Union maintains that *constriction* is a core element in suicide. Constriction includes the discouragement of alternative solutions to collective social problems and the inability to express one's feelings. He maintains that, because of this societal constriction, feelings of helplessness and hopelessness were prevalent under the Soviet system and that individuals felt powerless. Stewart et al. (2005), researchers who compared suicidality in the US and Hong Kong proposed that hopelessness is the most powerful cognitive process linked with suicidality and that the central role of hopelessness transcends differences among cultures.

The current desperate economic situation in Cuba may provoke feelings of both helplessness and hopelessness in both current and future adults, whether or not it provokes feelings of personal defeat. The high levels of education in the country and the extensive current contact with foreign visitors may make young Cubans well aware that no matter how hard they try, they are not likely to achieve the economic and reputational advantages that educated professionals enjoy in other countries. Poverty by itself is linked with suicide in some countries, such as India (Parkar, Dawani & Weiss, 2008). The economic problems of Cuba affect almost all Cubans, who therefore do not face the same comparisons with members of other social classes as in India. However, educated Cubans and Cubans with high educational and vocational aspirations may be prone to perceive a discrepancy between the life outcomes they desire and those they are likely to achieve.

It should be noted that hopelessness by itself does not always correlate with adolescent suicidality once the attempters' level of depression is controlled for, as in a study conducted in the US by Cole (1989). In a more recent study, however, Horwitz et al. (2017) found that positive-expectation hopelessness was indeed correlated with suicidal behavior after controlling for depression.

Objectives and hypotheses

The limited literature on suicide in Cuba pertains to adults rather than young people. The major purpose of our study was to determine whether shame and hopelessness, together with depressive symptomatology, distinguish Cuban adolescents who had attempted suicide from their non-suicidal peers. We expected the differences in shame to be most pronounced in the area of characterological and behavioral shame, given the emphasis on character education in Cuba, the evaluation of individual behavior within the collective socialization process and the very interconnected nature of Cuban society. Furthermore, we expected these differences in shame and hopelessness to discriminate attempters from non-attempters even after controlling for the effects of depression.

Methods

Participants

Participants in the study were 844 Cuban adolescents (543 females). The adolescents' ages ranged from 13 to

18 years with a median age of 16. Participants were recruited from four different Cuban high schools and a psychiatric day hospital. Of the community-based participants, 82 self-reported at least one suicide attempt. The day hospital group consisted of 47 adolescents being treated after suicidal attempts or severe depression with suspected risk of suicide. Of these 47, 38 confirmed by self-report that they had attempted suicide at least once. The remaining community participants served as a control group. In order to maximize the conceptual clarity of our analytic strategy and to avoid drastically unequal cell sizes, we conducted the final analysis with three groups: 1) a *hospital attempters* group ($n = 38$); 2) a *community attempters* group ($n = 82$); and 3) a *community non-attempters group* consisting of 82 randomly selected members of the remaining community sample. We did this to avoid the problems inherent in conducting analysis of variance with groups of very unequal size (Keppel, 1993).

This study was approved by the Departments of Education and Health of Holguin. Ethics clearance was obtained from the Ethics Committee of the Universidade Federal do Rio Grande do Sul, Brazil, which provided final support and training to author Yuri Sanz Martinez. Neither participant nor parental consent was legally required because Cuban schools act *in locus parentis*. However, we did inform the parents of the study and offered them the chance to withdraw their children; none did. We also obtained child assent.

Measures

Instruments for which there was no established Spanish-language version were translated into Spanish by a native speaker (the first author) and then back-translated into English by a native speaker (the second author) to ensure the accuracy of the translation. Given the time restrictions imposed by the schools, we had to use short forms of the instruments. We used published short forms where available. For other scales, we based our choice of items on our own judgment of their applicability to daily life in Cuba and the findings of the limited Cuban literature on suicide, especially the thesis by Martínez-Brito (2007).

Beck's Suicide Intent Scale (SIS). The Suicide Intent Scale was originally a 15-item scale developed by Aaron Beck in 1974. It was designed to measure a patient's will to die and the severity of past suicide attempts (Stefansson, Nordstrom & Jokinen, 2012). The scale has strong psychometric properties including construct validity, internal consistency, and criterion validity. In order to limit the number of negatively worded items presented to the participants, we selected six items from the original Suicide Intent Scale relating to isolation, precautions against discovery/intervention, alleged purpose of attempt, degree of premeditation, final acts in anticipation of death and timing of attempt. In our study, the Cronbach's alpha for the short scale is .81, compared with .89 for the original American version with the original American sample (Beck, Kovacs & Weissman, 1979).

Positive and Negative Suicide Ideation Inventory (PANSI). The PANSI is a 14-item scale designed to measure risk and protective factors of suicidal thinking (Osman, Gutierrez, Kopper, Barrios, & Chiros, 1998). The scale measures respondents' suicidal ideation during the past two weeks using a 5-point Likert scale. There are two separate scales, representing negative ideation and positive alternatives that are considered protective. For adolescent psychiatric inpatients in the U.S., the PANSI-Negative has a Cronbach's alpha of .96 while the PANSI-Positive has an alpha of .89 (Osman et al., 1998). In our Cuban sample, the Cronbach's alpha for the positive scale is .87; the alpha for the negative scale is .98.

Hopelessness. We used a six-item short form of the *Beck Hopelessness Scale* (Beck, Weissman, Lester & Trexler, 1974) to measure the participants' feelings about the future. The original scale has been validated extensively, with adolescent clinical and non-clinical populations including adolescents hospitalized after suicide attempts (Swedo et al., 1991). It has been widely reported that short forms ranging from one to four items are sufficient to measure the construct of hopelessness while correlating highly with the full scale and displaying similar internal consistency (Aish, Wasserman & Renberg, 2001; Bouvard, Charles, Guerin & Amard, 1992; Perczel Forintos, Rozsa, Pilling & Kopp, 2013; Tanaka, Sakamoto, Ono, Fujihara & Kitamura, 1998; Yip & Cheung, 2006). The internal consistency for our 6-item version, inspired by the previous short versions, was .74.

Experiential Shame Scale (ESS). The Experiential Shame Scale measures current bodily, emotional, and social markers of shame experiences. It has high construct and discriminant validity. The Cronbach's alpha for the original scale is .92; the value from our data set is also .92. The ESS contains three subscales referring to the three previously mentioned markers of shame: bodily ("Have you felt ashamed of any part of your body?"), characterological ("Have you felt ashamed of the person you are?) and behavioral ("Have you felt ashamed of what other people think of you when you do things wrong?"). The ten items in each subscale are answered via self-report.

Children's Depression Inventory (CDI). The Children's Depression Inventory is a self-rated assessment of depressive symptoms in children 7 to 17 years old (Finch, Saylor, Edwards & McIntosh, 1987). It has five dimensions to measure negative mood, interpersonal problems, ineffectiveness, anhedonia, and negative self-esteem (Finch et al., 1987). It has high internal consistency, reliability, construct validity, and predictive validity (Finch et al., 1987). The Cronbach's alpha for the scale is .77, averaged by 22 studies using CDI, showing high reliability (Ahlen & Ghaderi, 2016); the alpha in our Cuban sample was .79.

Analytic strategy

Although there were significant gender differences in some of the criterion variables, these gender differences are not germane to the hypotheses. As there were no significant interactive effects between gender and the predictor variables (depression, hopelessness and the three categories of shame) in the prediction of any of the dependent variables, we conducted the remaining analyses without considering gender so that the analyses could be performed with maximum statistical power.

We began with logistic regression analysis using a theoretically driven, forced entry method, starting with Depression and Negative Suicidal Ideations in the first block, followed by the shame variables and hopelessness. For this analysis, we combined the two groups of attempters (i.e., community attempters and day hospital attempters) into a single attempter group. We supplemented this main analysis with MANOVA in order to provide additional detail on any differences between attempters in treatment at the day hospital and community attempters. Finally, we performed another ANOVA using only the data from the two attempter groups (i.e., those in the community and those in treatment at the day hospital) to determine whether previous suicide attempts differentiate these two groups.

Results

Logistic regression results: Attempters vs. non-attempters

As expected, a significant model emerged when Depression and Suicidal Ideation were entered in Step 1: $\chi^2(2) = 170.07$; $p < .001$. Both Depression (Wald $= 67.7$; $p < .001$) and Negative Suicidal Ideation (Wald $= 35.8$, $p < .001$) emerged as significant, with 86.3% of cases correctly classified. When Hopelessness and the three categories of shame were entered in Step 2, there was no significant improvement of the model, as three of the four variables entered were not significant. However, Behavioral Shame remained a significant predictor of membership in the attempters group (Wald $= 4.3$; $p < .05$).

Three-group MANOVA results

Initial tests indicated no significant main or interactive effects for gender. Therefore, we performed the remaining analyses without considering gender in order to conduct the analyses with maximum statistical power. The multivariate F statistic was $F14{,}358 = 10.66$; $p = .0008$. This means that there was a general difference among the groups when all of the variables were considered together. We conducted follow-up univariate ANOVAs to determine exactly which groups differed significantly according to which variables (Bray & Maxwell, 1985).

The results of follow-up ANOVAs are displayed in Table 1, together with the results of the ANOVA comparing the two attempter groups in terms of previous suicide attempts. The effect sizes appear in the right-hand column. As shown, there were significant group differences for all variables except hopelessness. The community non-attempters group scored significantly lower than both attempter groups in depression. As well, the hospital attempters group scored higher in depression than both community attempters and community non-attempters. The non-attempters displayed less suicidal ideation and more positive ideation than the community attempters. However, there were no significant differences in ideation between attempters in the day hospital and in the community.

As also detailed in Table 1, there were significant differences between attempters and non-attempters in all three categories of shame. Hospital attempters scored higher than non-attempters in both Character Shame and Behavioral Shame but there were no significant differences between community and hospital attempters. Community attempters scored significantly higher on bodily shame than both community non-attempters and hospital attempters. The difference in bodily shame between hospital attempters and community non-attempters did not reach conventional levels of statistical significance.

Discussion and conclusion

We expected to find pronounced differences in shame, particularly characterological and behavioral shame, between suicide attempter and non-attempter groups. Our results support this hypothesis, with behavioral shame remaining a significant differentiator even after statistical control for depression. We also expected to find statistically significant differences in scores on hopelessness between attempter and non-attempter

Table 1. Summary of follow-up ANOVA results.

Variable		Community attempter (n = 82)	Community Non-attempter (n = 82)	Hospital attempter (n = 38)	F (df)	η^2
Depression	M	5.66_a	2.81_b	7.18_c	25.67***	.207
	(SD)	(3.26)	(2.51)	(4.94)	(2, 198)	
Hopelessness	M	0.94	0.69	0.97	0.79	.008
	(SD)	(1.45)	(1.45)	(1.24)	(2, 198)	
Character shame	M	23.59_a	18.49_b	23.86_a	12.44***	.113
	(SD)	(8.02)	(5.52)	(8.41)	(2, 196)	
Behavioral shame	M	23.72_a	19.53_b	24.53_a	8.62***	.081
	(SD)	(6.99)	(8.08)	(7.23)	(2, 196)	
Bodily shame	M	7.15_a	5.02_b	5.92_b	12.54***	.112
	(SD)	(3.02)	(2.32)	(2.87)	(2, 196)	
Negative suicidal ideation	M	51.51_a	5.69_b	53.87_a	87.99***	.476
	(SD)	(31.09)	(10.46)	(30.88)	(2, 198)	
Positive ideation	M	15.33_a	21.57_b	13.37_a	27.32***	.218
	(SD)	(6.37)	(6.95)	(6.06)	(2, 198)	
# of attempts	M	1.83_a	n/a	2.21_b	7.52**	.018
	(SD)	(1.18)		(1.54)	(1, 118)	

Note: Different subscripts denote significant differences ($p < .05$).
**$p < .01$, ***$p < .001$.

groups but our data do not support this hypothesis, as there were no significant differences in hopelessness between attempters and non-attempters.

We emphasized earlier the role of the regular evaluation of pupils' behavior and character in Cuban schools and youth groups as a salient cultural feature that may provoke shame. Several other factors that were not considered in our study may complete the picture. For example, it is possible that shame is linked to suicide attempts particularly in individuals who are already prone to shame for other reasons. Hence, it may be important to include in future studies a wide range of potential risk and protective factors both within and around the individual. Risk and protective factors within the family may be of particular importance. Cuban society is not only very collectivistic but, as are most Latin American countries, very oriented to extended family. Although loss of face and dishonoring one's family are often associated with shame in East Asia (Lewin, 1986), it is possible that compromising a family's reputation, perceived or real, may be linked with shame in Cuba and other Latin American countries to some extent. It is not clear whether the traditional Latino style of parenting, which involves close, affectionate love in combination with firm demands for obedience (Calzada, Fernandez & Cortes, 2010), socializes children towards guilt or shame.

The fact that our clearest findings regarding shame pertained to characterological and behavioral shame strengthens our conjecture about the strength of the evaluation of those individual features in school and youth-group life in Cuba. There were also some significant findings regarding bodily shame that are difficult to explain but, in any case, not germane to our hypotheses. For example, community attempters had higher levels of bodily shame than either hospital attempters or non-attempters. Our findings do not suggest that hopelessness is a particular motivator of suicide, contrary to Perez's (2007) articulate account of collective hopelessness as a factor in suicide throughout Cuban history. It is also contrary to the results of the study conducted with adults in Havana by Martínez-Brito (2007), in which hopelessness emerged as a discriminator of suicide attempts among depressed adult in-patients, as mentioned earlier.

There are several possible explanations for the difference between our findings and many other studies linking hopelessness to suicide in various parts of the world. Age effects are one possibility, providing the most probable explanation. Adolescents may hope, for example, that the economy they will enter as adults may change before or during their adult years. There could also be era effects that can be characterized as socio-historical and/or generational. The participants in our study have probably not known any economic decline during their lifetimes because they were born during the very difficult "special period" following the collapse of the Soviet Union when there were severe shortages of basic goods, more so than in Cuba today. Although conditions have improved markedly since then, the economic situation of the

country remains desperate. It is also possible that adolescents experience the stress of economic deprivation less directly than adults do.

There are different methodological advantages and disadvantages to defining the suicide-prone population by hospital records and by self-report. The suicidal gestures and thinking of the hospital attempters is confirmed by the information provided by the hospital clinicians and is not entirely based on self-report, a method known for evoking self-presentation biases of several kinds. However, those in the hospital may experience increased shame and depression to some extent because of their hospitalization, making shame a consequence rather than a predecessor of their suicide attempts, unlike the community attempters group. It is important to bear in mind that the community attempters were identified with a questionnaire that referred to lifetime attempts whereas day hospitalization occurred after fairly recent attempts. Thus, the attempt rates of the two groups are not entirely compatible. Our measures, unfortunately, do not include information about the possible role of Cuban families in invoking shame. In view of the central importance of the extended family in Latin cultures including Cuban culture, this would be an important issue for future researchers to consider. Future researchers should also consider adding open-ended questions about the reasons for suicidal thinking so that they might uncover reasons not measured in standardized measures used in other countries.

Future research is also needed that explores the role of shame in adolescent suicide attempts in Cuba. The internet is arriving slowly in Cuba and is still not as accessible as it is to adolescents in most other countries. With the advent of public wi-fi parks across the country, however, electronic communication is becoming a feature of life in Cuba. It has been observed that the internet may be creating a new culture of shame in which individuals face possible scorn by their peers online (Brooks, 2016).

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