

Original research

The Role of *Communitas* in the Prevention of Suicide in Italy A Comparison with the United States

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Abstract: There is a marked difference between the suicide rates and trends in the U.S. versus Italy, with Italy having lower rates and a downward trend. It is hypothesized this suicide decrease may be explained in terms of an anthropological-based theory that a period of liminality and resulting *communitas* occurred. During research conducted in Italy, I interviewed four mental health practitioners, toured medical facilities, attended educational lectures and took various history related tours. I have chosen to undertake a qualitative approach with literature searches on suicide and related phenomena in both the U.S. and Italy. Combined with semi-structured interviews and first-hand observations, information on the “why” reveals disparity between the two countries. More structured studies of this nature must occur to address the epidemic of suicide in the U.S. and to validate the success of practices outside the United States.

Keywords: *suicide, communitas, liminality, Italy, United States*

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Why is there such a large disparity in suicide rates between Italy and the U.S.? According to the World Health Organization [WHO] (2014), Italy’s suicide rates have decreased 22.4% for females, 7.4% for males, and 7.4% overall in the period between 2000 and 2012 (p. 83). These percentages equate to an overall rate of 4.7 suicides per 100,000 Italians (p. 83). During the same period, the U.S. experienced an increase in suicides of 36.6% for females, 19.9% for males, and 24.2% overall (p. 87). These increases account for a rate of 12.1 per 100,000, over 2.5 times Italy’s rate. Italy’s overall suicide rates have been on average in decline since the 1980s (Guaiana, D’Avanzo, & Barbui, 2002; Levi et al., 2002).

According to the WHO (2014), among the 172 member nations with a population of 300,000 or more, 128 countries (73.8%) had a suicide rate lower than the U.S. with one country -Uruguay-

at the same rate. Further, WHO (2014) data reveals 123 countries (71.5%) experienced a decrease in suicide rates during the 2000-2012 period with one remaining unchanged. During this same period, the U.S. was among 48 countries (27.9%) experiencing an increase in suicides, with only nine countries having higher increases (pp. 80-87). It is imperative -a matter of life and death- that we make comparisons between countries with increasing and high rates of suicide to those with decreasing and/or low rates of suicide.

I hypothesize, that when compared to the U.S., the lower and decreasing rates of suicide in Italy are due to a period of liminality, which gave rise to a more pronounced sense of *communitas*. Liminality, originally postulated by van Gennep (1960 /1909), holds that when a societal issue or state of crisis exists, the crisis precipitates conflict and action, a ritual may be enacted to resolve the issue, and reintegration of the society occurs. Turner (as cited in Thomassen, 2009, p. 17), later held out that a ritual could also be a political or societal change. In 1969, Turner asserted that reintegration may result in

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communitas - a state of collective being with societal goals (as cited in Thomassen, 2009). This is different from community, often thought of as a physical place or description of a group of people. Italy went through a period of liminality during the 1960s and 1970s. During these two decades, a crisis of how to care for people with mental illnesses occurred and resulted in major mental health system reform; it was during this time that asylums closed and a philosophical change happened, including that those with psychiatric illness have a right to the community (Davidson, Mezzina, Rowe, & Thompson, 2010, p. 436). A notable exception was the leaving of six forensic mental hospitals, for treatment of dangerous criminal offenders with mental illness, intact (Burti, 2016, p. 13). On March 31, 2015, community-based security facilities replaced the forensic hospitals (Carabellese & Felthouse, 2016; Cassacchia et al., 2015). Tararelli et al. (2011) observed, "Institutionalism objectified and alienated patients" and "largely resulted in stigma for mental illness" in Italy (p. 9). Over time, communitas developed around the idea that people with psychiatric disabilities should be a part of the community as much as possible. The concept of rehabilitation evolved to include the regaining of rights (Burti, 2016, p. 12). Suicide rates in Italy began to decline notably in 1980 (Vichi et al., 2010) and it has been speculated this is because of the change in the Italian healthcare system that this rate decrease began and continued (Pompili, 2010). This brings me to my secondary hypothesis, that communitas in Italy is a major factor in lower and decreasing rates of suicide in comparison to the U.S. because it disrupts at least one of the three criteria, identified by Joiner (2005), that interact to cause an individual to kill oneself. These criteria are a thwarted sense of belonging, a perceived sense of burdensomeness, and the acquired ability to enact lethal self-harm (p. 228). Reason's (2000) Swiss Cheese Model holds that undesirable outcomes, like suicide, are the result of a series of disastrous events and factors that accumulate and chainreact until the tipping point. Removal of a factor or prevention of an event will stop the negative outcome from happening (Peltomaa, 2012). Communitas removes one or more of these criteria for disaster and reduces what is referred to as a psychache -an unbearable psychological pain caused by loneliness, angst, fear, or any number of other internal factors (Shneidman, 1993, p. 51).

Method

Review of the WHO (2014) rates and trends between the U.S. and Italy allows us to see there is a notable difference in suicide deaths between the two countries. This quantitative data does not allow

us to understand why that difference exists. To answer "why" there is a disparity requires a qualitative approach. Suicide is phenomenological, having different meanings and causes -real or perceived- from culture to culture (La Fontaine, 2012). As such, I make my observations from a phenomenological perspective, recognizing the view that mental illness readily explains the phenomenon that often over-shadows consideration of socio-cultural factors as contributing to suicide (Feldmann, 2014; Pompili, 2010). This perspective considers suicide not only a biological or psychological vantage, but also from a socio-cultural view requiring an ethnographic approach (Staples & Widger, 2012).

During a two-week period in May of 2016, I traveled to Italy with eight peers, as part of a study abroad program tied to a course in a U.S. doctoral program. The main objective was to learn about critical issues in the context of Italian higher education and, in the process, learn about Italian culture more broadly. This experience included 20 hours of internship in an area of personal interest. Having studied mental illness and suicide extensively, I chose experiences that would expose me to the nature of suicide and related phenomena from an Italian perspective. My original intent was not to conduct research or write a paper of comparison between the U.S. and Italy on the issue of suicide. It was after returning to the U.S., and reflecting on my experience, that it became clear documenting my findings might yield valuable information.

The study abroad course was based out of Macerata, Italy and academic contacts at the University of Macerata (UNIMC) assisted me in selecting and arranging to meet with appropriate and reliable contacts who met my criteria -native Italians with academic, occupational, and experiential credentials in the Italian mental health system. My four primary contacts included the head nurse of a psychiatric clinic (Umberto), a practicing clinical psychologist (Marco), a doctor and medical director working as a general practitioner at an outpatient clinic and hospital (Roberto) -who had also worked as a psychologist/psychoanalyst, and a psychiatrist/suicidologist at a hospital (Paolo) - who is also a university professor. I withhold names, physical locations, and affiliations to preserve anonymity. For ease of writing, I have used pseudonyms in place of actual names. While Marco and Paolo spoke fluent English, I interviewed Umberto and Roberto with the aid of an interpreter, who has an undergraduate degree in translation and interpretation and is currently pursuing a graduate degree in translation/interpretation.

I conducted semi-structured interviews of informants (see Appendix) and toured several

medical facilities. My travel took me to Ancona, Camarino, Florence, Rome, and Senigallia, Italy, where I encountered multiple other healthcare practitioners, members of the public, and university faculty and students. I engaged in informal conversation and participant observation, keeping detailed hand-written field notes. As part of my academic experience, I attended a series of lectures from university professors on Italian culture, history, and language. In a lecture on Italian culture and demographics, a professor of social psychology -Mario- provided applicable information towards my research. I later scanned and uploaded all notes (field, interview, etc.) to the Atlas.ti qualitative analysis software program for coding and theme recognition.

I validated respondent information by allowing the four primary contacts the opportunity to review my interpretations of their responses. I pursued further validity by using triangulation -observations, literature search, and other informants - to corroborate information provided. I obtained institutional review board (IRB) approval prior to writing this paper.

Results and Discussion

The interviews and observations revealed four main themes that relate to *communitas* and the overall discourse found among the communities I visited the healthcare system, politics, religion, and family/community. Another theme that possibly interfered with the optimal benefits of *communitas* and came to light -an economic downturn causing high unemployment rates.

Healthcare System

Researchers attribute mental illnesses to 90% of all suicide deaths with the remainder lacking a known diagnosis (Goldsmith, Pellmar, Kleinmann, & Bunney, 2002, p. 70). In Italy, researchers attribute a decline in suicide attempts resulting in death to improved mental health care and increased help-seeking behaviors (Preti, 2012). For this reason, healthcare systems, including physical facilities, have a critical bearing on suicide and life-threatening behavior within a country. In contrast, among 191 WHO countries, the U.S. healthcare system is ranked 37th in overall efficiency while Italy is ranked second (WHO, 2000, p. 153-155). The U.S. spends 16.4% of its gross domestic product (GDP) on healthcare compared to Italy's 8.8% (Organisation for Economic Co-operation and Development [OECD], 2015a, p. 3), yet the average life expectancy in the U.S. is notably less than Italy across all age and sex metrics (OECD, 2015b, p. 23). Measured per 100,000, the U.S. has a rate of 7.79 psychiatrists, 29.03 psychologists, and 17.93 social

workers (WHO, 2011b, p. 3) in contrast to Italy's 7.81 psychiatrists, 2.58 psychologists, and 1.93 social workers (WHO, 2011b, p. 2). It appears Italy is doing more with less.

According to Umberto, the mental health system is different from region to region, although central laws regarding healthcare are all the same. Umberto further advises that each province within his region have their own mental health organization, including a community mental health center. An article by Lora (2009) supports Umberto's assertions. Umberto further noted each center has nurses, social workers, psychologists, psychiatrists, and educators at their disposal. Paolo informed me there are "five or six" suicide prevention call lines throughout Italy, but only one -that happens to serve the most people- is funded by a hospital. In the U.S., a national suicide prevention call line routes callers to a call center in one of dozens of call centers close to their geographic location. This routing enables the caller to receive support from crisis team and mental health professionals in their area.

Roberto relayed that his facility does not treat many people with mental illness, "but they really aren't looking for them either," meaning that his clinic does not actively seek mental health referrals or communicate with the public about such services. As a result, Roberto's hospital and clinic do not provide treatments, such as electroconvulsive therapy (ECT). While on tour of Paolo's hospital, I spoke to the head psychiatric nurse, who said they primarily treat people with severe psychosis who have schizophrenia or borderline personality disorder. Unlike Roberto's health center, Paolo's hospital does provide ECT in cases of severe depression resistant to other treatment methods. In the U.S., ECT treatment has been steadily decreasing for decades (Case et al., 2013; Weiner & Prudic, 2013). In Italy, the use of ECT is controversial, with more ethical than scientific reasons for non-use (Buccelli et al., 2016). Umberto mentioned his patient types are those with bipolar disorder (most common), depression, schizophrenia, anxiety, and those who have suicidal ideation or attempts.

Umberto stated assignment of a doctor to a family - and often a family nurse- to provide general healthcare. In the U.S., physician home medical visits are virtually unheard of. When it comes to mental illness, Umberto noted that, "every effort is made to treat people in their homes." Most Italians needing mental health care access the system through general practitioners and hospital physicians while approximately 33% access the system directly (Volpe et al., 2014, p. 511). All the people interviewed affirmed that the focus of

mental health treatment is care in the home and limiting of hospitalization only to those who are a danger to themselves or others, have no family to care for them, and/or are unable to care for themselves. In other words, unlike in the U.S. where hospitalization is common-place and care in the home is less common, in Italy hospitalization is a last resort in extreme circumstances. Like other countries, it appears that Italians generally seek mental health services for depression, anxiety, and eating disorders. Unlike comparison countries (Japan, Croatia, Spain, United Kingdom), Italians are less likely to seek treatment for insomnia, interpersonal issues, and undefined “disturbed behaviors” (p. 512).

According to a national survey of Italians by Munizza et al. (2013), 98% of respondents were aware of depression with 77% believing it is common, 58% believing it is a mental illness, and 55% believing it is a “personal weakness” (p. 3). Regarding stigma, 75% agreed Italians hide their mental health issues, 31% thought one can overcome a mental health problem by themselves, 30% said employers should not hire those with mental health problems, 27% thought people with mental illnesses are dangerous, and 16% thought mental illness was contagious (p. 4). Interestingly, there appears to be significant concern that antidepressants are dangerous and addictive (p. 7). Evidence suggests that addiction to antidepressants is exceedingly rare (Dean, 2002; Heddad, 1999). Regarding danger, as with any other medication, there are potential metabolic, liver, and heart complications (Kubiszyn & Mire, 2014), which is why people should work closely with their healthcare providers. While there have been concerns about the risk of increased suicidal ideation in children taking antidepressants, there is minimal concern of this complication in adults (Pompili, Girardi, Lester, & Tartarelli, 2011). Italy has a relatively non-diverse population, with most people having native Italian ethnicity with comparatively small groups of French, German Albanian, Greek, and Slovene people (CIA, n.d.a.). In comparison, over one-third of U.S. citizens report their race or ethnicity as other than non-Hispanic Caucasian (U.S. Census Bureau, 2011). This unequal ethnic composition assesses the U.S. population’s beliefs on mental health problematic because a literature search on U.S. public opinion produces multiple results based on differences in religion, ethnicity/race, and occupation with a lack of data on the majority population.

Political Environment

According to the university lecturer, Mario, and several guides, nearly every city has a central tower

that is the center of political or religious power – a symbol of the power wielded by State and Church alike. This was evident as we traveled the countryside going from town to town. It was observed by Marco that politicians are motivated to support and provide programs to help people with mental illnesses, but this is often out of “fear they will be blamed or associated” with someone who hurts themselves or others.

Umberto confirmed the outlawing and closure of asylums for those with psychiatric disorders in the interest of improving the mental health of the general population. This deinstitutionalization occurred in 1978 and, as of 2010; Italy was the only country in the world to outlaw asylums completely with the philosophy that social inclusion, self-determination, and citizenship during treatment are rights to be protected (Davidson, Mezzina, Rowe, & Thompson, 2010, p. 442). Lora (2009) characterized the reform of the Italian mental health system as “radical.” As such, 1978 was when the “ritual” or political action component of Italy’s liminality occurred. In contrast, the U.S. has deinstitutionalized asylums, yet jails and homeless shelters serve the purpose of the asylum (Osborn, 2009, p. 239). Given the “checkered past” of the classification of psychiatric disorders, those in the U.S. tend to generally see imprisonment and homelessness as causal to mental illness and often have difficulty in distinguishing “mental disorder from natural distress” (Horowitz & Grob, 2011, p. 652).

Roberto stated that the approval of the mayor and a judge are the last two steps in the process needed to commit a person to an inpatient mental health facility. In the U.S., the involuntary transport of a person for mental health reasons typically requires no more than a form, documenting a perceived threat to the person or others, by law enforcement or a health officer. This form enables transport against the patient’s will where they may receive a further 72-hour hold at the facility. In the U.S., civil commitment generally only requires the testimony of a single psychiatrist before a judge (Gordon, 2016). Observers note the psychiatrist appears to wield a lot of power in the commitment proceeding with the judge simply taking the word of the psychiatrist at face value (p. 677). Unfortunately, civil commitment in the U.S. is often a mechanism treat people with a mental health problem who “dangerous” to the neglect of others who are ill but will not receive treatment (p. 700). Once perceived or real dangerousness is reduced, the person civilly committed often stops receiving treatment, which means they will often relapse and enter the system again later (Manahan, 2004).

Firearm is the number one method of suicide among Americans, with gun ownership positively associated with suicide (Miller, Warren, Hemenway, & Azrael, 2015; Siegel & Rothman, 2016). In Italy, where guns are much more restricted, it is a distant second highest method -hanging being the most frequent method (Vichi et al., 2010). It is worth mentioning that researchers have proven time-after-time that restricting means to suicide does not statistically result in people choosing another method or going elsewhere to kill themselves (Joiner, 2010).

Religion

I learned from Mario that of Italy's population, the majority -he estimated 85%- are Catholic. Other estimates put the Catholic population anywhere from just below 80% (Central Intelligence Agency [CIA], n.d.a) to 83% (Pew Research Center [PRC], 2011, p. 23). Government officials and researchers estimate the U.S. has a Catholic population of approximately 24% (CIA, n.d.b, PRC, 2011). The university lecturer, Mario, advised that despite the Catholic Church's heavy influence over Italy, the government and the Vatican have long been at odds. There has been much turmoil when it comes to politics and the role of Church versus State (Giorgi, 2013). Having said this, while conflict often arises and the religious and political camps may differ, culture in Italy has been heavily influenced by "diffused religion" (Cipriani, 1983), and is still the case at present (Ferrara, 2009). The concept of diffused religion is consistent with the identification of cultural axes by Inglehart and Baker (2000) that divides the world into cultural zones of similarity and maintains the persistence of traditional values despite modernization. Italy falls into the Catholic Europe Zone whereas the U.S. is in a zone identified as English Speaking (p. 29).

When asked what bearing the Catholic belief system might have on suicide and suicidal behavior, Marco advised the Pope does not divulge his thoughts on suicide. Roberto indicated there was not much of a market for grief counseling, psychological services, or physical pain treatment because a strong Catholic belief is that "pain and suffering is a means to gain entrance to heaven," and that "Catholicism is preventative to suicide." Paolo advised that the Catholic Church has changed its historical view on suicide within the past few years and that a recent pope said, "Only God can judge the people [who suicide]," although doctrines of previous popes are in the collective memory. Paolo cautioned that suicide rates among Catholics might be underreported. I looked for literature on deaths classified as undetermined or accidental as they may indicate whether this caution is valid. Italy

and the U.S. have the same ratios of underdetermined manners of death (7.1:1), but Italy has a lower accident to sui-cide ratio (0.8:1) than the (1.1:1) ratio of the U.S. (Pritchard & Hansen, 2015, p. 370). Given the higher population percentage of people who are Catholic in Italy, Paolo's caution warrants serious consideration.

As I discovered during ethnographic research in the U.S., in Wyoming, I strongly suspect a phenomenon, which I call *Theological Doctrine Distortion* (TDD), is in operation. Namely, "the amount of stigma attached to mental illness and suicide appeared to correlate generally with one's position within the church hierarchy, with leaders being the least stigmatizing, and the church members being among the most stigmatizing" (Caulkins, 2014, p. 49). This stigma and distorted understanding of doctrine in TDD appears to be on a spectrum that increases in intensity as one goes down the hierarchical chain. The official stance of the Catholic Church, as written in the Catechism is, "grave psychological disturbances, anguish, or grave fear of hardship, suffering, or torture can diminish the responsibility of the one committing suicide" (Catholic Church, n.d., para. 6). Catholic people have a lower rate of suicide than those who are Protestant, which is likely related to higher church attendance resulting in greater social connection (Torgler & Schaltegger, 2014). Additionally, divorce -a suicide risk factor in the U.S. (Denney, Rogers, Krueger, & Wadsworth, 2009)- is discouraged by the Catholic Church as well as Italian culture and is not common (Masocco et al., 2008). A meta-analysis conducted by Wu, Wang, & Jia (2015) cautions that the protective factor of religion varies depending on the religion and cultural context in which it is situated.

Alighieri's writing, *The Divine Comedy* (1320/2004) was mentioned by three informants as a major influence on the perception of suicide within the Catholic community. Indeed, as recently as 2011, the Church held out *The Divine Comedy* as, "...lessons that illuminate the Catholic moral vision..." (Topping, 2011, p. 43). Pope Benedict XV declared Dante Alighieri a genius for which Catholicism can be proud (Benoît, 2006). While traveling, I encountered many statues and paintings of Alighieri. This was especially true in Florence, which was Dante's birthplace. Our guide in Florence emphasized the importance of Dante to the community and Dante's contributions to literature and politics. Alighieri (1320/2004) wrote a fictional visit to hell depicting those who die by suicide imprisoned in oak trees for monstrous birds to feed on for all eternity. Stack (2018) found those who believe in killing themselves results in going to hell in the afterlife have significantly lower suicide rates.

Family and Community

Umberto stated, "Community, family, and health services are central, and may very well be part of the reason suicides are less prevalent than in the United States." Blangiardo and Rimoldi (2014) found that while Italian families are modernizing, there are still strong family connections because of holding to traditional ideals of remaining with one's family of origin and the influence of the family on the behavior of the individual (p. 217). According to Umberto, "in smaller towns people know there are problems and they get help." Marco points out the negative aspects of small town living when he relayed that because, "everyone knows" what is going on with everyone else, it can result in stigma and a reaction from the person being stigmatized. For example, Marco told the story of a 19-year-old friend who hanged himself in the forest near his small town. Because of the stigma, the friend's mother, even 23 years later, does not leave the house much and no longer associates with her son's old friends. Roberto maintains that the "public sees suicide as a failure [emphasis added] to live." Regarding quality of life (QOL), young Italian males tend to fare better in urban areas, whereas elderly men experience higher QOL in rural settings. Italian women are less sensitive to changes in QOL regarding where they live (Carta et al., 2012). While no comparable U.S. QOL research was discovered, one study notes more rural areas near large urban centers are prized as providing a better QOL among the "creative class" of Americans -like those in art and design, education, and engineering (McGranahan & Wojan, 2017). Another study found that QOL was higher in urban areas for U.S. veterans, likely because of improved access to healthcare (Wallace et al., 2010).

Regarding grief, Roberto stated he can refer people for grief support if needed, but no one has ever requested such a referral from him -probably because, "Grieving is seen as a thing to be dealt within the family." Roberto further notes that grief support is not a component of hospice care. There may be sex-related differences involving grief and the community when a person's spouse dies. Roberto claims widowers get much more support even though women are expected to fare worse. The men are encouraged to enter a relationship again, whereas women who do so are considered sexually promiscuous. Italian widowers, those never married, and divorced or separated males, are more likely to suicide compared to their married counterparts (Masocco et al., 2008; Masocco et al., 2010). An analysis of Italian females reveals, in descending order, that the marital status of those dying by suicide are those never married, divorced or separated, widowed, and married (Masocco et

al., 2010). In contrast, U.S. suicide rates for males, in descending order, are highest among those widowed, divorced or separated, and never married as opposed to females that, in descending order, are divorced or separated, never married, and widowed (Denney et al., 2009).

Umberto maintains that children live with their parents longer and are close with their families as a result. Roberto also mentioned it is common that children live with parents longer and said staying in the family home up to the age of 25 to 30 was not uncommon -his own 30-year-old son still lives with him and his wife. Manacorda and Morretti (2006) state that 80% of 18 to 30-year-old Italian males - many more than their U.S. and Northern European peers- live with their parents and refer to the phenomenon as a "normal good" (p. 825). Roberto speculates there are fewer youth suicides because of these family connections despite many youths being chronically unemployed. Having said all of this, in 2014, the U.S. experienced a slight rise in the number of 18 to 34-year-old adult children living with their parents for the first time in 130 years (Fry & Pew Research Center, 2016).

Economy

During his lecture at the university, Mario spoke about high unemployment rates. For the general population, the rates of unemployment were 8.9%, 12%, and 11.3% in 2013, 2014, and 2015 respectively. Among youth, unemployment was over 43% in 2015 and is down to 39.3% in mid-2016. The CIA (n.d.a) estimated the Italian unemployment rate at 12.7% for 2014 and 12.2% for 2015. Roberto mentioned the economic crisis and that it precipitated a rash of suicides among small business owners. Paolo was more specific in his description of the "rash" of suicides and referred to it as the "2012 epidemic of suicide among small business entrepreneurs in North Italy." On further investigation, suicides during times of high unemployment has been consistent in Italy (Ceccherini-Nelli & Priebe, 2011; Pompili et al., 2014) and the U.S. (Ceccherini-Nelli & Priebe, 2011). These findings lead one to wonder whether the Italian suicide rate decrease would have been even more profound had it not been for the recession in the late 2000s.

Limitations of the Study

These observations were conducted over a two-week period and involved only four primary, albeit impressively credentialed, people involved in mental healthcare. All four were males ranging from 30 to 60-years-old and did not include observations of females or those outside this age range. This report is the result of relatively unplanned study of

suicide and related phenomenon in Italy. As such, was no formal research protocol and findings are retrospective. Additionally, I visited only five cities in Italy.

Recommendations for Further Research

There is a need for more planned and systematic research comparing countries with steadily decreasing suicide rates to the U.S. rates. This research needs to build on quantitative data to answer the “why” questions. Insight by incorporation of ethnographic methods supplemented with psychological autopsy investigations (PAIs) is desirable. The PAI is a technique that gathers and analyzes all pertinent information related to specific individual deaths due to suicide (Knoll, 2008).

Conclusion

The suicide rates in Italy are, and have been, lower in percentage than the U.S., and are decreasing overall (WHO, 2014, p. 83). The U.S. rates continue to increase in a steady manner (p. 87). Compared to most the world, the U.S. has an epidemic of suicide on its hands. During my education in Italy, which included an internship in various medical facilities, it occurred to me there were identifiable socio-cultural factors that may explain the marked difference in suicide deaths. Although I did not set out to study suicide in Italy formally, my observations may serve as a catalyst for future planned research.

Because of a mental health care crisis, Italy went through a liminal period that culminated in 1978 with political action that drastically changed the mental health system (Davidson, Mezzina, Rowe, & Thompson, 2010). The new system embraced a philosophy of “the right to the community” and became more community-centered with asylums being abolished, people being reintegrated into their communities, and treatment provided at the patient’s home -except in extreme cases (p. 442). Over time, this reintegration fostered a deeper sense of community, *communitas*- a state of collective being with the goal of making people well and helping them become a part of the society. The seeds of *communitas* planted by political change, aided by already strict firearm laws, was fostered by an already existing rich culture. This culture includes the importance of family and a sense of community and is supported by a religious framework that is effective, not so much because of the religiosity per se, but because of the connection and integration it affords. These seeds yielded an improved mental healthcare system and futures for people who may otherwise have died tragically. *Communitas* prevents people from feeling burdensome, allows

them to belong, and mitigates from developing or intensifying the ability to enact self-harm.

Of course, Italy’s mental health care system is a work in progress and still has work to do on reducing stigma and putting plans in place to mitigate the psychiatric fallout of economic downturns. In retrospect, looking at the two different nations, it is of little surprise that the suicide rates of the U.S. are higher and increasing. To reduce suicide worldwide, future research must systematically examine what countries with low and decreasing suicide rates are doing to prevent suicide and how their respective cultures influence these results.

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References

- Alighieri, D. (1320/2004). *The divine comedy*. Retrieved from <http://www.gutenberg.org/files/8789/8789-h/8789-h.htm#link13>
- Benoît, S. (2006). Encyclical letter on the In Praeclara Summorum: From S.S. Benedict the 15th to the sixth centenary occasion of the death of Dante Alighieri. *Infini*, (94),
- Blangiardo, G. C. & Rimoldi, S. (2014). Portraits of the Italian family: Past, present and future. *Journal of Comparative Family Studies*, 45(2), 201-219.
- Buccelli, C., Di Lorenzo, P., Paternoster, M., D’Urso, G., Graziano, V., & Niola, M. (2016). Electroconvulsive therapy in Italy: Will public controversies ever stop? *Journal of Electroconvulsive Therapy*, 32(3), 207-211.
- Burti, L. (2016). Thirty-five years of psychosocial rehabilitation in Italy. *International Journal of Men-tal Health*, 45, 7-14. doi:10.1080/00207411.2015.1119374
- Carabellese, F., & Felthous, A. R. (2016). Closing Italian forensic psychiatry hospitals in favor of treating insanity acquittees in the community. *Behavioral Sciences & The Law*, 34(2-3), 444-459. doi:10.1002/bsl.2234

- Carta, M. G., Aguglia, E., Caraci, F., Dell'Osso, L., Di Sciascio, G., Drago, F., & ... Balestrieri, M. (2013). 'Quality of life and urban/rural living: Preliminary results of a community survey in Italy': Erratum. *Clinical Practice and Epidemiology In Mental Health*, 9.
- Case, B. G., Bortollo, D. N., Laska, E. M., Price, L. H., Siegel, C. E., Olfson, M., & Marcus, F. C. (2013). Declining use of electroconvulsive therapy in United States general hospitals. *Biological Psychiatry*, 73(2), 119-126.
- Cassachia, M., Malatova, M., Bianchini, V., Giusti, L., Di Michele, V., Giosuè, P., . . . Roncone, R. (2015). Closing forensic hospitals in Italy: a new deal for mental health care? *Rivista Di Psichiatria*, 50(5), 199-209. doi:10.1708/2040.22158
- Catholic Church. (n.d.). Catechism of the Catholic Church: Respect for human life. Retrieved from http://www.vatican.va/archive/ENG0015/_P7Z.HTM#110
- Caulkins, C. G. (2014). *Suicide in the Intermountain West: A Syndemic in Park County Wyoming? (Master's thesis)*. Retrieved from ProQuest Dissertations and Thesis Database Open. (UMI No. 1528221)
- Ceccherini-Nelli, A., & Priebe, S. (2011). Economic factors and suicide rates: associations over time in four countries. *Social Psychiatry & Psychiatric Epidemiology*, 46(10), 975-982. doi:10.1007/s00127-010-0275-2
- Central Intelligence Agency. (n.d.a.) The world factbook: Italy. Retrieved from <https://www.cia.gov/library/publications/resources/the-world-factbook/geos/it.html>
- Central Intelligence Agency. (n.d.b.) The world factbook: United States. Retrieved from <https://www.cia.gov/library/publications/resources/the-world-factbook/geos/us.html>
- Cipriani, R. (1983). Religion and politics. The Italian case: diffused religion. *Studi Di Sociologia*, 21(3), 245.
- Davidson, L., Mezzina, R., Rowe, M., & Thompson, K. (2010). "A life in the community": Italian mental health reform and recovery. *Journal Of Mental Health*, 19(5), 436-443. doi:10.3109/09638231003728158
- Dean, A. J. (2002). Are antidepressants addictive? *Drug and Alcohol Review*, 21(4), 317-319.
- Denney, J. T., Rogers, R. G., Krueger, P. M., & Wadsworth, T. (2009). Adult suicide mortality in the United States: Marital status, family size, socioeconomic status, and differences by sex. *Social Science Quarterly*, 90(5), 1167-1185.
- Feldmann, K. (2014). *Suicidology prevents the cultivation of suicide*. Retrieved from <http://www.ssoar.info/ssoar/handle/document/38900>
- Ferrara, A. (2009). The separation of religion and politics in a post-secular society. *Philosophy & Social Criticism*, 35(1/2), 77-91. doi:10.1177/0191453708098755
- Fry, R., & Pew Research Center. (2016). For First Time in modern era, living with parents edges out other living arrangements for 18 to 34-year-olds: Share living with spouse or partner continues to fall. Retrieved from http://assets.pewresearch.org/wp-content/uploads/sites/3/2016/05/2016-05-24_living-arrangemnet-final.pdf
- Giorgi, A. (2013). Ahab and the white whale: the contemporary debate around the forms of Catholic political commitment in Italy. *Democratization*, 20(5), 895-916. doi:10.1080/13510347.2013.801257
- Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (eds.). (2002). *Reducing suicide: A national imperative*. Washington, D. C.: The National Academies Press.
- Gordon, S. (2016). The danger zone: How the dangerousness standard in civil commitment proceedings harms people with mental illness. *Case Western Law Review*, 66(3), 657-700.
- Guaiana, G., D'Avanzo, B., & Barbui, C. (2002). Update of suicide trends in Italy from 1986 to 1996. *Social Psychiatry & Psychiatric Epidemiology*, 37(6), 267.
- Heddad, P. (1999). Do antidepressants have any potential to cause addiction? *Journal of Psychopharmacology*, 13(3), 300-307.
- Horowitz, A. V. & Grob, G. N. (2011). The checkered history of American psychiatric epidemiology. *The Milbank Quarterly*, 89(4), 628-657.
- Joiner, T. E. (2010). *Myths about suicide*. Cambridge, MA: Harvard University Press.
- Joiner, T. E. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.
- Inglehart, R. & Baker, W. E. (2000). Modernization, culture change, and the persistence of traditional values. *American Sociological Review*, 65(1), 19-51.

- Knoll, J. L. (2008). The psychological autopsy, part I: Applications and methods. *Journal of Psychiatric Practice*, 14(6), 393-397.
- Kubiszyn, T. & Mire, S. S. (2014). A review of recent FDA drug safety communications for pediatric psychotropics. *Journal of Child and Family Studies*, 23(4), 716-727. Doi:10.1007/s10826-12-9706-x
- La Fontaine, J. (2012). Explaining suicide: An afterword. *Cultural, Medicine, & Psychiatry*, 36(2), 409-418. doi:10.1007/s11013-012-9256-0
- Levi, F., La Vecchia, C., Lucchini, F., Negri, E., Saxena, S., Maulik, P.K., & Saraceno, B. (2003). Trends in mortality from suicide, 1965–99. *Acta Psychiatrica Scandinavica*, 108(5), 341–349.
- Lora, A. (2009). An overview of the mental health system in Italy. *Annali Dell Istituto Superiore di Sa-nità*, 45(1), 5-16.
- Manacorda, M., & Moretti, E. (2006). Why do Most Italian Youths Live with Their Parents? Intergenerational Transfers and Household Structure. *Journal of The European Economic Association*, (4), 800-829.
- Manahan, V. J. (2004). When our system of involuntary commitment fails individuals with mental ill-ness. Russell Weston and the case for effective monitoring and medication delivery mecha-nisms. *Law and Psychology Review*, 28(1), 1-36.
- Masocco, M., Pompili, M., Vanacore, N., Innamorati, M., Lester, D., Girardi, P., Tatarelli, R., & Vichi, M. (2010). Completed suicide and marital status according to the Italian region of origin. *Psy-chiatric Quarterly*, 81(2), 57-71. doi:10.1007/s11126-009-9118-2
- Masocco, M., Pompili, M., Vichi, M., Vanacore, N., Lester, D., & Tatarelli, R. (2008). Suicide and Marital Status in Italy. *Psychiatric Quarterly*, 79(4), 275-285. doi:10.1007/s11126-008-9072-4
- McGranahan, D. & Wojan, T. (2017). Recasting the creative class to examine growth in rural and urban counties. *Regional Studies*, 41(2), 197-216.
- Miller, M., Warren, M., Hemenway, D., & Azrael, D. (2015). Firearms and suicide in US cities. *Injury Prevention (1353-8047)*, 21(2), e116-e119. doi:10.1136/injuryprev-2013-040969
- Munizza, C., Argentero, P., Coppo, A., Tibaldi, G., Di Giannantonio, M., Picci, R. L., & Rucci, P. (2013). Public beliefs and attitudes towards depression in Italy: A national survey. *Plos ONE*, 8(5), 1-8. doi:10.1371/journal.pone.0063806
- Organisation for Economic Co-operation and Development. (2015a). Health at a glance: How does the United States compare? Retrieved from <https://www.oecd.org/unitedstates/Health-at-a-Glance-2015-Key-Findings-UNITED-STATES.pdf>
- Organisation for Economic Co-operation and Development. (2015b). Health at a glance 2015: OECD indicators. Retrieved from <http://www.oecd-ilibrary.org/docserver/download/8115071e.pdf?expires=1487484038&id=id&accname=guest&checksum=2F4B8E886402C6F414322E34F49FBE5F>
- Osborn, L. A. (2009). From Beauty to Despair: The rise and fall of the American state mental hospital. *Psychiatric Quarterly*, 80, 219-231. doi:10.1007/s11126-009-9109-3
- Peltomaa, K. (2012). James Reason: Patient safety, human error, and Swiss cheese. *Quality Management in Health Care*, 21(1), 59-63. doi:10.1097/QMH.0b013e3182418294
- The Pew Research Center. (2011). Global Christianity: A report on the size and distribution of the world's Christian population. Retrieved from <http://www.pewforum.org/files/2011/12/Christianity-fullreport-web.pdf>
- Pompili, M. (2010). Suicide on my mind. A look back and ahead at suicide prevention in Italy. *Minerva Medica*, 101(5), 353-361.
- Pompili, M., Girardi, P., Lester, D., & Tartarelli, R. (2011). Antidepressants therapy and risk of suicide among patients with major depressive disorders. New York, NY: Nova Science Publishers, Inc.
- Pompili, M. (2010). Exploring the phenomenology of suicide. *Suicide and Life-Threatening Behavior*, 40(3), 234-244.
- Pompili, M. (2014). Suicide in Italy during a time of economic recession: Some recent data related to age and gender based on a nationwide register study. *Health and Social Care in the Community*, 22(4), 361-367. doi:10.1111/hsc.12086
- Preti, A. (2012). Trends in suicide case fatality in Italy, 1983-2007. *Psychiatry Research*, 196(2/3), 255-260. Doi:10.1016/j.psychres.2011.08.020

- Pritchard, C. & Hansen, L. (2015). Examining undetermined and accidental deaths as source of 'under-reported-suicide' by age and sex in twenty western countries. *Community Mental Health Journal*, 51(3), 365-376. doi:10.1007/s10597-014-9810-z
- Reason, J. (2000). Human error: Models and management. *British Medical Journal*, 320(7237), 768-770.
- Siegel, M., & Rothman, E. F. (2016). Firearm ownership and suicide rates among US men and women, 1981-2013. *American Journal of Public Health*, 106(7), 1316-1322. doi:10.2105/AJPH.2016.303182
- Shneidman, E. S. (1993). *Suicide as psychache: A clinical approach to self-destructive behavior*. Northvale, NJ: Jason Aronson Inc.
- Stack, S. (2018, May). Does religiousness prevent suicide? An analysis of youth and young adults in 24 Asian/Pacific nations. In S. Collings & J. Pirkis (Co-Chairs). *International Association for Suicide Prevention 2018 Asia Pacific Regional Conference*. Symposium conducted at the meeting of the IASP, Bay of Islands, New Zealand.
- Staples, J. & Widger, T. (2012). Situating suicide as an anthropological problem: Ethnographic approaches to understanding self-harm and self-inflicted death. *Culture, Medicine, and Psychiatry*, 36(1), 183-203. doi:10.1007/s11013-012-9255-1
- Tatarelli, R., Serafini, G., Innamorati, M., Lester, D., Girardi, P., & Pompili, M. (2011). Psychiatric diagnoses during institutionalization: an investigation of 1334 psychiatric patients hospitalized in an Italian asylum during the 20th Century. *Wiener Klinische Wochenschrift*, (5-6), 135.
- Thomasson, B. (2009). The uses and meanings of liminality. *International Political Anthropology*, 2(1), 5-27.
- Topping, R. N. S. (2011). The Divine Comedy and four lessons in the Catholic moral vision. *Logos*, 14(4), 39-54.
- Torrgler, B. & Schaltegger, C. (2014). Suicide and religion: New evidence on the differences between Protestantism and Catholicism. *Journal for the Scientific Study of Religion*, 53(2), 316-340.
- Turner, V. W. (1969). Liminality and communitas. In V. Turner, *The ritual process: Structure and anti-structure* (pp. 359-374). Chicago, IL: Aldine Publishing.
- United States Census Bureau. (2011). 2010 census shows America's diversity. Retrieved from http://www.census.gov/newsroom/releases/archives/2010_census/cb11-cn125.html
- van Genneep, A. (1960/1909). *The rights of passage*. London, UK: Routledge & Kegan Paul.
- Vichi, M., Masocco, M., Pompili, M., Lester, D., Tatarelli, R., & Vanacore, N. (2010). Suicide mortality in Italy from 1980 to 2002. *Psychiatry Research*, 17589-97. doi:10.1016/j.psychres.2008.12.008
- Volpe, U., Fiorillo, A., Luciano, M., Del Vecchio, V., Palumbo, C., Calò, S., & ... Sartorius, N. (2014). Pathways to mental health care in Italy: Results from a multicenter study. *International Journal of Social Psychiatry*, 60(5), 508-513. doi:10.1177/0020764013501648
- Wallace, A. E., Lee, R., MacKenzie, T. A., West, A. N., Wright, S., Booth, B. M., & ... Weeks, W. B. (2010). A longitudinal analysis of rural and urban veterans' health-related quality of life. *The Journal of Rural Health*, 26(2), 156-163. doi:10.1111/j.1748-0361.2010.00277.x
- Weiner, R. D. & Prudic, J. (2013). Electroconvulsive therapy in the United States. How often is it used? *Biological Psychiatry*, 73(2), 105-106.
- World Health Organization. (2011a). *Mental health atlas 2011: Italy*. Retrieved from http://www.who.int/mental_health/evidence/atlas/profiles/ita_mh_profile.pdf?ua=1
- World Health Organization. (2011b). *Mental health atlas 2011: United States of America*. Retrieved from http://www.who.int/mental_health/evidence/atlas/profiles/usa_mh_profile.pdf?ua=1
- World Health Organization. (2014). *Preventing suicide: A global imperative*. Retrieved from http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/
- World Health Organization. (2000). *The world health report 2000*. Retrieved from http://www.who.int/whr/2000/en/whr00_en.pdf?ua=1
- Wu, A., Wang, J., & Jia, C. (2015). Religion and completed suicide: A meta-analysis. *Plos ONE*, 10(6), doi:10.1371/journal.pone.0131715

Appendix

Semi-Structured Interview Questions

1. Can you give me a brief overview of the services you provide?
2. What are the most prevalent mental health issues among the population you serve?
3. What community services are available to those struggling with mental illness?
4. How does the public perceive mental health and illness?
5. Do you have a suicide prevention program in place? If so, what does it consist of?
6. Why do you believe that Italy's Suicide rates are lower than the U.S. and showing a decline?
7. What is it that is effective in reducing Italian suicides?
8. Is there anything I have not asked that I should know?