Dissertation

"The relationship between Suicidality and Religious/Spiritual Dimensions: A Multicenter study of Austrian and Italian psychiatric patients"

Submitted by

Mag.rer.nat. Stefan Stefa

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Department of Psychiatry LKH

Under the supervision of

Priv.-Doz. DDr. Human-Friedrich Unterrainer

Univ.-Prof. DDr.Hans-Peter Kapfhammer

Assoz. Prof.in Dr.in Sandra Johanna Wallner-Liebmann

Dr. Giancarlo Giupponi

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“Declaration

I hereby declare that this thesis is my own original work and that I have fully acknowledged by name all of those individuals and organisations that have contributed to the research for this thesis. Due acknowledgement has been made in the text to all other material used.

Throughout this thesis and in all related publications I followed the “Standards of Good Scientific Practice and Ombuds Committee at the Medical University of Graz“.

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Keywords: Depression; Multic center study, Suicidal Ideations; Suicidal behavior; Personality factors; Psychological Well-Being; Spirituality.

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Zusammenfassung

Einleitung

Der Klassifikation des Eurobarometer 2010 folgend, zeigen die Länder des mediterranen Raums die niedrigste Suizidrate, während die Länder Zentral- und Nordeuropas die höchste Suizidrate aufweisen. In der Vergangenheit wurden zahlreiche Faktoren untersucht, um einen Teil dieser europäischen Realität zu erklären, allerdings waren Spiritualität und Religiosität niemals Teil dieser Betrachtungen.

Das Ziel unserer Studie war, die interkulturellen sowie intra-kulturellen Unterschiede in religiöser/spiritueller Befindlichkeit und deren Auswirkung auf Suizid und psychische Krankheiten in drei klinischen Stichproben und in drei Studenten-Stichproben zu untersuchen. Weiteres Ziel war, die unterschiedlichen Zusammenhänge zwischen den Dimensionen von Suizid, von Spiritualität und den „Big Five“ Persönlichkeitsfaktoren zu zeigen.

Methode

Insgesamt wurden 1043 Personen in drei unterschiedlichen europäischen Regionen getestet: in Lazio (Zentral-Italien), Südtirol und Veneto (Norditalien) sowie in der Steiermark (Mittel-Ost-Österreich). Die Fragebögen wurden von 410 psychiatrischen Patienten (175 Männer, 235 Frauen) aus drei Psychiatriezentren und 633 Studenten (134 Männer, 499 Frauen) von drei Universitäten ausgefüllt. Folgende Testverfahren wurden angewandt:

- Soziodemografischer Fragebogen (mit 2 zusätzlichen visuellen Analogskalen für Spiritualität und Religiosität)
- C-SSRS, Baseline (Columbia- Beurteilungsskala zur Suizidalität, Basisversion)
- MI-RSB (Multidimensionales Inventar zum religiös-spirituellen Befinden)
- BFI (Big Five Inventory)
- SCL-90-S (Symptom-Checklist)

Ergebnisse

Die steirischen Patienten, welche sich selbst als „Gläubige” definierten, zeigten die höchsten Werte in „Suizid Gedanken“ und „Suizidales Verhalten“, allerdings nicht bei „Tatsächlicher Suizidversuch“. Ähnliche Ergebnisse ergaben sich für Südtirol/Veneto, aber nicht für Lazio. Die MI-RSB Dimensionen „Hoffnung immanent“, „Hoffnung transzendent“ und „Erfahrung von Bedeutung und Sinn“ korrelierten in fast allen Stichproben negativ mit den Suizid-Dimensionen und „Psychische Beeinträchtigung“. Im Gegensatz dazu korrelierten „Spiritualität” und die Dimensionen des MI-RSB „Allgemeine Religiosität”, „Allverbundenheit”

positiv mit Suizid und „Psychische Beeinträchtigung“.

Die lineare Regressionsanalyse ergab für die Studentenstichprobe, dass zwischen „Allverbundenheit“, „Spiritualität“ und „Suizid“ ein positiver Zusammenhang besteht. Die anderen Dimensionen zeigten sich eher als Schutzfaktoren gegen „Suizid”. Für die klinische Stichprobe zeigte „Existentielles Wohlbefinden“ einen negativen Zusammenhang mit „Suizid“, „Allgemeine Religiosität“ hingegen einen positiven Zusammenhang mit „Suizid“.

Des Weiteren korrelierte „Neurotizismus“ signifikant mit „Depression“ und allen anderen Dimensionen psychiatrischer Symptome. Im Zuge der gründlichen Untersuchung der Beziehung zwischen „Neurotizismus“, „Depression“ und Suizid in unseren Post-Tests, fanden wir heraus, dass „Neurotizismus“ in der Kombination mit „Depression“ einen signifikanten Risikofaktor für Suizid darstellt. Ohne die Beteiligung von „Depression“ hingegen, zeigte sich, dass „Neurotizismus“ ein Schutzfaktor gegen Suizid ist.

Diskussion

Bisher zeigte die Mehrheit der vorangegangenen Studien eine Tendenz in Richtung negativer Korrelationen zwischen spirituell/religiösen Dimensionen und Suizid. Unsere Studie hingegen zeigte eher gegensätzliche Ergebnisse und eröffnet interessante Optionen für weiterführende Forschungen.

Schlagwörter: Depression; Multicenter Studie; Suizidale Gedanken; Suizidales Verhalten; Persönlichkeitseigenschaften; Psychische Beeinträchtigung; Psychologisches Wohlbefinden; Spiritualität.

Abstract

Introduction

According to the European classification of mortality rate by suicide, the countries of the Mediterranean area show the lowest mortality rate by suicide, while the countries of the Central and Northeast European area show the highest death rate by suicide. Many factors have been investigated in an attempt to explain a fragment of this European reality, but aspects such as spirituality or religiosity have not been included.

The aim of this multicenter study was to investigate the intercultural and intra-cultural differences in spiritual/religious condition and their impacts on suicide and psychiatric diseases in three clinical samples and three student samples. In addition, this study identifies correlations between dimensions of suicide, spirituality and the “Big Five personality traits”.

Methods

In total, 1043 people were tested in three different regions of Europe: Lazio (central Italy), South Tyrol/Veneto (north Italy) and Styria (middle-eastern Austria). The questionnaires were filled in by 410 psychiatric inpatients (175 Males, 235 Females) from three departments of psychiatry and 633 students (134 Males, 499 Females) from three different universities. In this clinical study the following test procedures were applied:

- **Sociodemographic questionnaire** (with two additional visual analogue scales for spirituality and religiousness)
- **C-SSRS,** Baseline *(Columbia Suicide Severity Rating Scale, basic version)*
- **MI-RSWB 48** *(Multidimensional Inventory for Religious/Spiritual Well-Being)*
- **BFI** *(Big Five Inventory Questionnaire)*
- **SCL-90-S** *(Symptom-Checklist)*

Findings

The Styrian patients who defined themselves as “Believers” presented the highest values in “Suicidal ideation” and “Suicidal behavior” but not in “Actual suicide attempts”. Similar results were found in the South Tyrolean/ Venetian clinical sample. The “Nonbeliever” patients from central Italy revealed the highest values in “Actual suicide attempts”. The MI-RSB dimensions “Hope Immanent”, “Hope transcendent” and “Experience of sense and meaning” were found to be negatively related to the suicide dimensions and to the “Global mental impairment” in almost all samples. Conversely the MI-RSB dimensions of “General religiousness”, “Connectedness” and also “Spirituality” were positively related to suicide and to “Global mental impairment”. Surprisingly, in central Italy the student sample presented higher values than the clinical sample in religiosity and spirituality.

The linear regression analysis revealed that in the student sample “Connectedness” anf “Spirituality” were the only predictors to have a positive relationship to “Suicide”. In our clinical sample the graded predictors were: “Existential Well-being” with a negative relationship to “Suicide”, and “General Religiousness” with a positive relationship to “Suicide”.

We also noted that “Neuroticism” correlated significantly with “Depression”. As we thoroughly investigated the relationship between neuroticism, depression and suicide in our post tests we discovered that “Neuroticism” in combination with “Depression” represents a significant risk factor for suicide but without the involvement of “Depression”, “Neuroticism” turned out to be a protective factor against suicide.

Conclusions

There are many contradictory findings in this field. Most research has illustrated a tendency toward negative correlations between spiritual/religious dimensions and suicide. Our study rather found the opposite to be true and offers interesting options for further cross-cultural research.

Keywords: Depression; Multicenter study, Suicidal Ideations; Suicidal behavior; Personality factors; Psychological Well-Being; Spirituality.

1. Introduction

Since the beginning of history religion, medicine and healthcare have been interwoven in all sections of the population. In modern and postmodern times these systems of healing have been separated, especially in the highly developed countries of the West. This separation can hardly be observed in less developed countries. Religious organizations were the first to build hospitals in the West for the care of the sick in the general population. From the Middle Ages up to the French Revolution, many physicians were clergymen and religious institutions were even responsible for authorizing physicians to practise medicine (Koenig, McCullough & Larson, 2001).

Almost the same anthropological evolution took place at different times in other continents. Suicide, as one of the most important indicators of mental health was only part of these historical changes during époques and among religions. Western civilization, developed by Greco-Roman and Judeo-Christian values, has always nourished an ambivalent attitude toward suicidal behaviour. Up to nine references to suicide can be found in the Old Testament and at least one in the New Testament. In Islam there also exists a very condemnatory attitude towards killing oneself but not towards self-martyrdom. Suicide is in many Islamic countries, as a result of the Islamic law, a crime, and suicide attempts may lead to prosecution. The severity of the sin is so strong that people are not allowed to offer a funeral prayer to a suicide even if Muslims may be more willing to accord funeral rites to suicides (Colucci & Martin, 2008). According to the World Health Organisation (2006) because of the social stigma in Islamic countries, we have inconsistent findings in the field of suicide due to the underreporting of suicide rates.

This hostile attitude towards suicide in the Christian world began in the 4fourth century with St. Augustine´s “City of God” –whose ideas were further reinforced by Thomas Aquinas. Before this time, among the early Christians, martyrdom was a means to prove one´s love and fidelity to God. Of course this attitude existed and remains so in many spiritual/religious communities. As noted by Abdel-Khalek et al., (Abdel-Khalek et al., 2003, as cited in Colucci & Martin, 2008) for many authors martyrdom implies one's death in defence of one's homeland or culture by inflicting losses on an enemy. Nevertheless, an intense spiritual aspect of love and fidelity to God as well as the conviction that life doesn't end at death, remains a part of suicidal motivation. The major religions officially describe suicide as a sin. In fact, as history teaches us, there are many interpretations, free inquiries and fewer shared beliefs and practices within these religions. In contrast, in Asia, Hinduism, Brahmanism, Buddhism, and Shinto-the state religion of Japan, not only sanctioned but institutionalized suicide. Furthermore, both Hinduism and Buddhism taught the

transmigration of souls. Hindu philosophies of karma and reincarnation mean that life does not end with death but that death leads to rebirth. This view has led to a more tolerant attitude towards suicide, although Hindu scriptures appear relatively ambivalent towards suicide. Suicide is still a punishable legal offence in India (Colucci & Martin, 2008).

In Europe, Emile Durkheim in 1897 was the first scientist who worked systematically on the epidemiological aspect of suicide. He suggested that spiritual components should be included when considering the mental condition of suicidal patients for a better understanding of their inner, emotional processes. Over a hundred years after Durkheim, one might ask what has become of taking spiritual issues into account when assessing people at risk of suicide. As noted by Grom (2007), after a period of stagnation, researches involving spirituality and its implications on suicide or more generally on mental health experienced a remarkable revival around the end of the 1990s. Acoording to Ambrosio (Ambrosio, 2002, as cited in Stefa-Missagli et al. 2014) this trend of scientific interest in the different dimensions of religiousness/spirituality and its impact on suicide grew even more after the events of September 11th , 2001. The subsequent terror attacks in Paris 2015 emphasized this trend. Accordingly, myriads of psychological approaches have been developed to investigate religiousness and spirituality as being potentially linked with various psychological parameters, these, involved nearly all kinds of mental disorders as well as health behaviour, longevity, coping with serious terminal illness, personality, subjective well-being, work and study performance, therapeutic counseling outcomes and many others (Pargament, 1997; Emmons, 1999; Moreira-Almeida, Neto & Koenig, 2006; Ostermann & Büssing, 2007; Saroglou & Cohen, 2011; Unterrainer, Lewis & Fink, 2012). The basis of the interdisciplinary discourse is always the bio-psycho-social model in which, for every disease not only the biological but also the psychosocial und sociological aspects are taken into account (Stefa-Missagli et al., 2014).

1.1 Suicide in the World

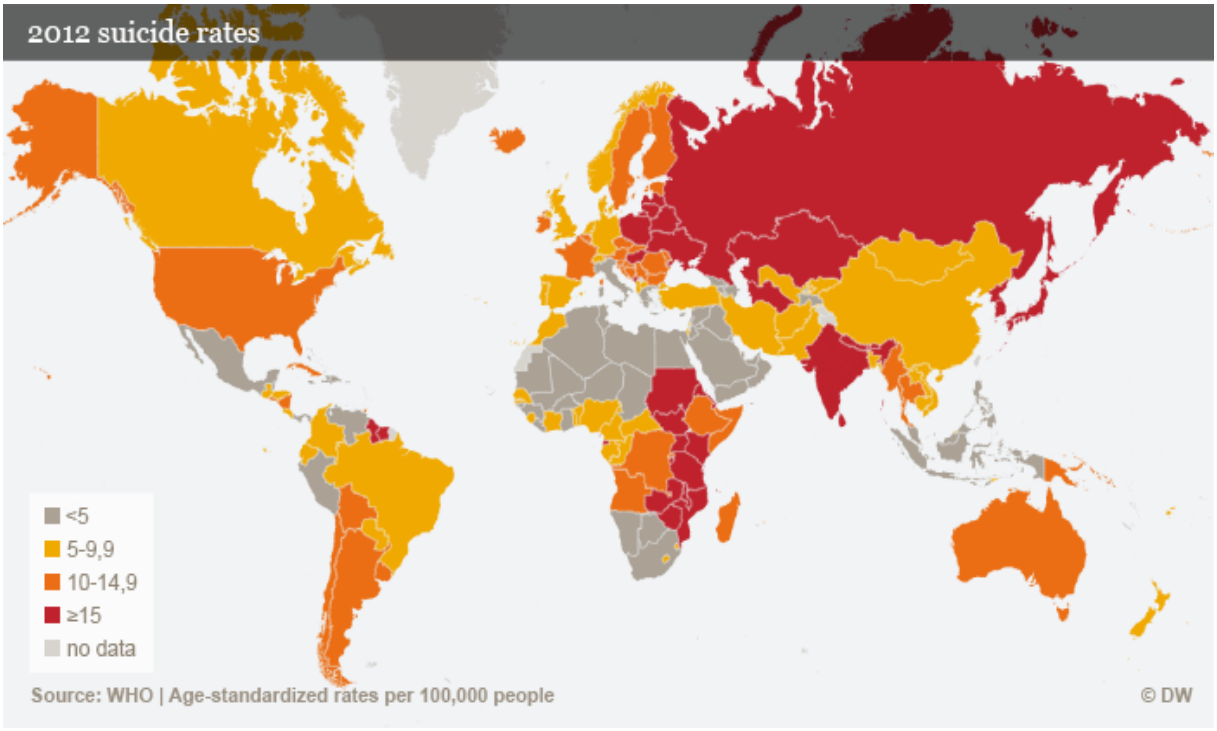
The World Health Organization (WHO) defines "suicide" *"…as an act deliberately initiated and performed by a person in the full knowledge or expectation of its "fatal" outcome*" (The world health report, 2001, p. 9). Suicide is often considered a proxy indicator of the mental health status of a nation´s population, due to its association with problems in personal relationships, alcohol, unemployment, depression and drug abuse during crisis periods. Preparations related to suicidal ideation or an attempt to commit suicide are signs of a massive psychological strain. In such a situation, help needs to be provided by therapeutic

consultation or even medical treatment. Experience does show that suicidal crises abate, when the concerned person receives assistance. As people with suicidal intentions are not usually able to seek help because of their psychological strain, it is necessary actively to pay attention to suicidal indications or announcements, to take them seriously and to provide help to reduce the risk of suicide (Sonneck, Hirnsperger & Mundschütz, 2012).

After analysing ten years of research from around the world, the World Health Organization (WHO) published its first detailed report on suicide in 2012. According to this report, every 40 seconds one person in the world commits suicide. An interesting result revealed by the report, was that three quarters of the estimated 800,000 suicides per year occurred in countries with low or middle income. The report showed that in wealthier countries, male suicide rates were three times higher than female rates. According to the report, suicide is the second leading cause of death in people between the ages of 15 and 29. Also, people over 70 are most likely to commit suicide. Other factors influencing suicide rates worldwide are varying cultural, religious, economic and social environments. While the suicide rate in North Korea lies at 39.5 suicides per 100,000 population, suicide rates in nations whose religions oppose suicide, e.g. countries with large Catholic or Muslim populations, show a tendency towards lower rates. The member states of the WHO have committed themselves to the reduction of worldwide rates of suicide by ten percent by the year 2020. Limited access to firearms, toxic chemicals and dangerous psychotropic drugs has already shown some success in reducing suicide rates. A few countries have introduced a national strategy for the reduction of suicide rates, but in many countries suicide remains a taboo topic and is subject to stigmatization. In India for example, an attempt to commit suicide is still illegal. Despite the possibility of punishment by imprisonment, India has one of the world's highest suicide rates with almost 21 deaths per 100,000 population, which corresponds to ten more deaths per 100,000 than the world average. Beyond that, the WHO report states that there is one suicide for every estimated 20 or more suicide attempts (DV. Made for Minds. (2014).

Dr. Margaret Chan, who serves as the Director-General of the WHO, declared that suicide is prioritized as a major public health problem. At the present time, national suicide prevention strategies exist only in 28 countries. According to reports, public education is an important element through which awareness should be raised in order to prevent suicide. Identifying vulnerable groups, improving societal attitudes towards people with mental illness or suicidal behaviour and reducing stigma are other key strategies in preventing suicide. "No matter where a country currently stands in suicide prevention, effective measures can be taken, even just starting at local level and on a small scale," said Alexandra Fleischmann (as cited in DV made for Minds, 2014), a scientist at WHO's department of mental health and substance abuse. In view of the tragic death of the well-known actor and comedian Robin

Williams, the WHO once more emphasized the importance of responsible reporting of suicide in the media “to avoid sensationalizing tragic deaths” (DV. Made for Minds. 2014).



In the “top ten” countries with the highest suicide rates in the world we have: Kazakhstan in Central Asia in tenth place. In Kazakhstan, suicide has long been a social issue and a rather common cause of death, especially among young people and students. According to the WHO report of 2011, 3.23 percent of worldwide deaths by suicide belong to Kazakhstan and it is this country that has the highest number of suicides among girls between the ages of 15 and 19 worldwide.

- In ninth place is Nepal, a small country in South Asia, which has regularly featured in the “top ten”-list of countries with the highest suicide rate. In recent times there has been a regrettable trend in the suicidal behaviour in the country that mainly concerns Nepalese women; the number of suicide attempts among women in Nepal has increased dramatically, with 20 women out of 100,000 taking their lives.

- In eighth place is Tanzania, a country in East Africa. A big part of Tanzania’s population suffers from various problems such as hunger, poverty, violence, lack of health care facilities, HIV etc., which constitute the main factors for the high suicide rate in the country. Sadly, even children and students frequently show suicidal behaviour and try to commit suicide due to problems within the family, general stress, school failures or other reasons.

- Seventh place goes to Mozambique. Southeast African country, occupying over

800,000 square kilometers. More than 27 out of 100,000 Mozambicans decide to commit suicide. Due to insufficient medical care, the people of this country have the shortest life expectancy in the world. Diseases like HIV contribute to the extremely high suicide rate in Mozambique with over 3,000 people taking their lives every year.

- Sixth is Suriname. With a population of only 570,000 people, it is the smallest country on the South American continent and one of only two South American countries that are ranked in this list. The population of Suriname suffers from various economic and social problems such as poverty, violence, alcohol abuse and high unemployment rates. Every year 44 men and almost 12 women out of 100,000 inhabitants kill themselves.

- Fifth is Lithuania, which has an annual suicide rate of 28.2 out of 100,000 Lithuanians. This high number of suicides committed every year reached its peak in the late 1990s and has been an important social national issue in Lithuania for decades. Though the suicide rates have been decreasing since then, Lithuania is still the country with the highest suicide rate in Europe and the fifth most suicidal country worldwide. The main factors behind this high suicide rate are social and financial problems.

- In fourth place is Sri Lanka, a little country in South Asia with over 20 million inhabitants, which has one of the highest suicide rates despite, being among the most developed countries on this list. Since the independence of the country in 1948, the number of people committing suicide has been consistently increasing for no obvious reason. Among the most frequent suicide methods in Sri Lanka are hanging and poisoning.

- In third place is South Korea. Though South Korea is known to have the fastest internet connection, modern technologies and one of the best educational and health care systems in the world, this country still has an extremely high suicide rate. The main causes of this elevated suicide rate are social pressure and family relationship problems. Since access to firearms is restricted, the most common method to end one's life is poisoning.

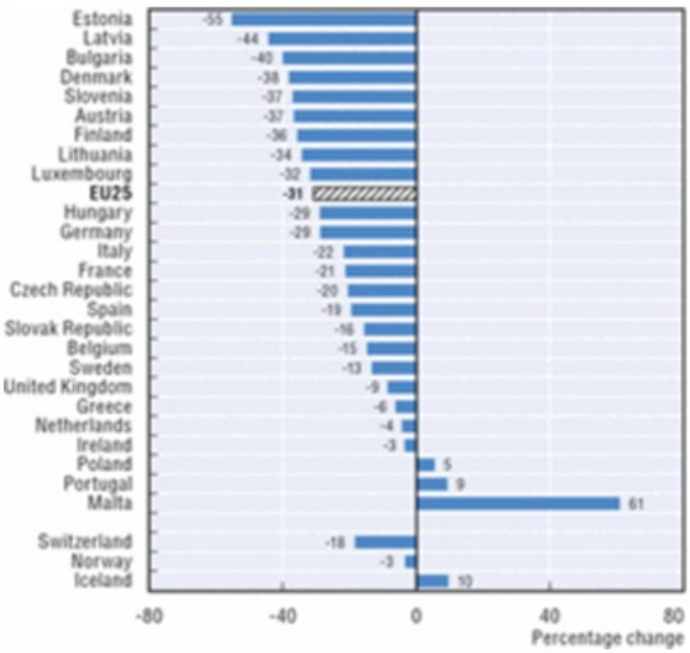
- In second place is North Korea, which is known for its restrictive environment, human rights violations, authoritarian regime and economic misery. Stress and the aforementioned living conditions are the main reasons for more than 10,000 North Korean people to commit suicide every year. There have been reports of whole families ending their lives to evade punishment by the totalitarian regime

- In first place is Guyana. With a population of 740,000, Guyana is the second South American country ranked in this list. The suicide rate of this rather rural country is the highest worldwide and even four times higher than the global average. Deep rural poverty, alcohol abuse and easy access to deadly pesticides constitute the main reasons for more than 44 out of 100,000 inhabitants ending their lives every year. Though over 900 people died in a mass murder-suicide in 1978, mass cults have no bearing on today's suicide rate (Habarta, 2015).

1.2 Suicide in Europe

With approximately 60,000 cases of death in 2010, suicide is an important cause of death in many of the 28 EU member states. Suicide rates are rather low in the countries of Southern Europe (Cyprus, Greece, Italy, Malta, Portugal and Spain) as well as in the United Kingdom, where the suicide rates lie at eight deaths or fewer per 100,000 inhabitants. The Baltic states of Estonia, Latvia, Lithuania and Central Europe (Hungary, Slovenia and Austria) showed the highest suicide rates with more than 17 deaths per 100,000 inhabitants.

In Lithuania, the country with the highest death rate by suicide, ten times as many people take their lives as in Greece, which is the European country with the lowest suicide rate. Since 1995, the number of suicides committed every year has been decreasing in many of the EU member countries, with an outstanding decline of 40 percent and more in Bulgaria, Estonia and Latvia (see Figure 1.7.2). Despite this positive development, Estonia and Latvia still have among the highest suicide rates in Europe. In contrast, the suicide rates in Malta, Portugal, and Poland as well as in Iceland, Italy and Greece have been increasing since 1995. Despite the described increase in death rates from suicide, Malta, Greece, Iceland, Portugal and Italy, which has not known such a negative development in suicide rates since the 1990s, remain below the EU average. In the last 30 years, the highest percentage of suicide in Greece occurred in 2012 (Branas & Wiebe, 2015).



1.7.2 Change in suicide rates, 1995-2010

As noted in a study by Chishti, Stone, Corcoran, Williamson & Petridou (2003), differences in suicide rates in European countries can be attributed to many different factors. Besides the personal and social factors, which have most often been investigated, the external environment may also have an impact on suicide rates. Recently, 20 OECD (Organisation for Economic Co-operation and Development) countries published a report aiming to investigate the hypothesis that the exposure to sunshine may provoke suicidal behaviour. The authors observes that this report “suggested that suicide followed a seasonal pattern with a dominant peak during the month of maximum daylight” (Chishti,

Stone, Corcoran, Williamson & Petridou, 2003, p.112). Seasonal trends influencing suicide rates are only one of the time patterns that have under observation in the past. The time around major holidays is another critical period that seems to have an impact on the increase in suicide attempts. The authors also mentioned a longitudinal study between 1989 and 1996 in Europe, which reported fewer suicide attempts before Christmas and 40 percent more attempts after Christmas than expected. An investigation into the causes of international variation in suicide rates is also made difficult by differing classification, coding and recording systems. A part of the variation in suicide rates in Europe may be explicable by national differences in the procedures for recording a death. Many studies have considered the comparability of cause of death statistics in European countries to be an issue of special significance. Suicide registration systems in the EU are not organised uniformly. "Some countries (e.g. Luxembourg) require a suicide note in order to register a death as suicide while others (e.g. UK) require an assessment of intent to be made by a coroner " (Chishti, Stone, Corcoran, Williamson & Petridou, 2003, p. 112). Other factors playing a role in the registration of a death as suicide are cultural as well as social norms. In countries where committing suicide is looked at as socially or culturally unacceptable, a suicide is likely to be classified as "undetermined cause of death", which leads to falsified data. A further factor leading to differences in suicide rates is mental illness: in the case of a mentally ill person committing suicide, the pre-existing mental illness is more likely to be recorded as the cause of death than suicide. In cases of child fatality, the recording system may confront a certain reluctance to employ the term "suicide" (Chishti, Stone, Corcoran, Williamson & Petridou, 2003).

Besides the insufficiencies in the usual recording of suicide, there are other failings concerning suicide mortality data. Though most of the EU countries register variables such as age, sex, method of suicide and region, other important factors reinforcing suicide and suicidal behaviour such as occupation, social class or marital status are not recorded. Although certain countries record detailed information concerning suicide, essential factors such as the exposure to risk can sometimes not be obtained because of the confidentiality of personal data which disallows public access to such sensitive information. Of course, suicide is a delicate issue requiring confidentiality clauses. At the same time, it is of the utmost importance for health care professionals and epidemiologists to have access to detailed information to be able to develop effective prevention strategies. In order to avoid misclassifications, many analyses of suicide trends tend to define "undetermined deaths" in their suicide statistics. Suicides and "undetermined deaths" were also subject to separate analyses to find out whether misclassification could explain at least some of the geographical and temporal differences in suicide rates. In this regard the analyses reveal great variations, though misclassification of deaths could not explain the changing suicide rates for most of

the EU members. Five member states showed declining suicide rates, while the rates of "undetermined deaths" did not change over time. Greece was the European country having consistently both the lowest suicide rates and the lowest rates of death by undetermined cause. In Germany, Belgium, Ireland and Spain the interaction of suicide rates and undetermined death rates indicates that in these four countries, misclassification may be responsible for at least some of the variation in suicide rates. Though the combined rates were higher than the suicide rates alone, the combination of the data of deaths by suicide and undetermined causes of death basically resulted in no bigger variation in the significance or pattern of the development over time. The only exception to this trend was Spain (Chishti, Stone, Corcoran, Williamson & Petridou, 2003). .

In Ireland, for instance, several attempts have been made to explain the rise in suicide rates in the recent past. One reason might be the underreporting and the subsequent misclassification of suicides as undetermined deaths. This hypothesis is based on the assumption that there has been a sort of development within Irish society making the recording of suicide as a cause of death increasingly acceptable. Although the rates of undetermined cause of death in Ireland decreased by 34 percent during the study period, this drop still seems small compared to the enormous change in Irish suicide rates, which increased by 89 percent during the same period. In 1989, which was chosen as the base year, the suicide rates in Ireland rose by 65 percent. The same year the rates for undetermined causes of death decreased by 50 percent, which led to the assumption that misclassification might at least partially explain temporal variations in Irish suicide rates. Using 1984 as the base year, the results from a linear regression analysis demonstrated that undetermined death rates explained statistically 46 percent of the variation with a strong interdependence of -0.71. As the misclassification of deaths cannot entirely explain the rise in Irish suicide rates, other factors have to be taken into account. Implicated factors may be important changes in Irish society in the recent past, such as changes in social structure, the improvement of the wealth of the country and changes in religious attitudes. Whatever the precise reasons for the rise in suicide rates may be, the issue of misclassification remains a complex problem. "These findings suggest that in the EU countries there is no consistent geographical or temporal inverse relationship between death rates from suicide and from undetermined causes" (Chishti, Stone, Corcoran, Williamson & Petridou, 2003, p. 114).

Misclassification only contributes to a minor extent to the variation in suicide rates in European countries and doesn't seem to be able to explain them. Future research should try to promote a standardized approach by exploring alternative hypotheses as well as documenting varying suicide recording, reporting and classification across the EU member states. Without a European-wide code of practice in the form of a standardized and adequate EU-wide collection, recording and reporting of data on suicide epidemiology, an effective

strategy for suicide prevention is likely to remain undefined (Chishti, Stone, Corcoran, Williamson & Petridou, 2003).

In a very interesting research report from Värnik et al. (2008) about suicide methods in Europe, based on 160,460 suicide cases in 16 European countries, 119,122 (74 %) males and 41 338 (26 %) females, who committed suicide during the years 2000–4/5, the following results emerged. In all 16 European from European Alliance Against Depression (EAAD) countries studied, hanging was the most common suicide method among both genders (54.3% of male and 35.6% of female suicides). For male "suicidents", the next most frequent methods of committing suicide were by firearms (9.7%) and poisoning by drugs (8.6%). For females, hanging was followed by poisoning oneself by taking drugs (24.7%) and jumping from a high place (14.5%). Hanging was the most frequent way to commit suicide among males in all countries but Switzerland. In Switzerland the most common suicide method for males was the use of firearms. In Belgium, Estonia, Finland, Germany and Slovenia, suicide by the use of firearms was ranked second among males. In Scotland, firearms were ranked lowest. For female "suicidents", hanging was ranked first in Belgium, Hungary, Estonia, Germany, Netherlands, Ireland, Slovenia and Portugal (Värnik et al., 2008).

Poisoning by taking drugs was the most common method among females in England, Finland, Iceland, Scotland and Switzerland. The most frequent way to end ones life for females in Italy (South Tyrol), Spain and Luxembourg was jumping from a high place. Males, in contrast to females, showed a statistically lower risk of poisoning by drugs, drowning and jumping from a high place and a significantly higher risk of using firearms, hanging and poisoning by other means. Without exception, males had a higher risk of hanging than females in all of the EAAD countries. The situation is similar for the use of firearms with reservations concerning Italy, where the male-female difference was not statistically significant. In all of the EAAD countries, females used poisoning by drugs more often than male "suicidents". It is again Italy where the male-female difference in poisoning by drugs didn't reach statistical significance. In all countries except for Luxembourg, females were at higher risk of committing suicide by drowning than males. The risk of jumping was also higher for females than males, with the exception of Iceland. Other methods to end one's life showed varied results from country to country (Värnik et al., 2008).

1.3 Suicide in Italy

The recent Report on Global Rights 2013 analysed suicide rates from the years 2012 and 2013 and found that financially related suicides in Italy had increased by 40 per cent in the first three months of 2013, compared with the same period in 2012. The major reasons

for those suicides was the poor financial and economic situation in Italy as well as the high unemployment rate, which "explains" 28 per cent of the committed suicides. According to the Italian National Institute for Statistics (ISTAT, 2012) the number of Italians living at risk of poverty rose from 16 per cent in 2010 to 25 per cent in 2012. In May 2012 the unemployment rate in Italy reached a record high of 13.2 per cent. Moreover an Italian study conducted by Di Vittorio (2013), revealed further interesting facts on recent suicide trends in Italy. From 2007 to 2012 the real GDP in Italy shrank by -8.5 per cent, at the same time the unemployment rate increased from 6.1 per cent to 10.7 per cent. The economic crisis in Italy remained severe, which led to a diminishment of the living standard for the average Italian. Di Vittorio used data provided by the Italian National Institute of Statistics to display suicide trends. That data encompassed information on suicide motivations, including economic reasons. The total suicide rate decreased between 2003 and 2008. Financially related suicides though increased after 2007. De Vogli, Marmoth and Stuckler (De Vogli, Marmoth & Stuckler, 2012, as cited in Di Vittorio, 2013) assumed an extra 290 suicides and suicide attempts for economic reasons were ascribable to the economic recession in Italy. Although the unemployment rates in Italy increased drastically after 2007, unemployment and suicide based on the poor financial situation do not seem to be correlated (Ceccherini-Nellie, & Priebe, 2011).

> "Italy compared with other countries, has an intermediate suicide rate characterized by major geographic variability. The Italian north-east and north-west regions but also the rural areas presented the highest suicide rates. Suicide-related mortality rates showed also important gender differences among adults and adolescents" (Pompili et al., 2010, p.3).

The fact of being married generally seemed to exert a protective effect against suicide, while the risk of suicide resulting from unmarried status (never-married, divorced/separated, or widowed) appeared to vary with age and gender. A comparison of suicide risks and risks for death by natural causes, resulted in relatively higher risks for suicide among divorced/separated women, divorced/separated men under the age of 64, and widowers. Factors such as separation, divorce and the death of a spouse were associated with higher suicide risks among both men and women. Suicide rates also revealed important geographical differences. The highest male suicide rate in Italy was found in Sardinia, while the highest number of married and unmarried individuals committing suicide was recorded in the northern regions of the country (Pompili et al., 2010).

1.4 Suicide in South Tyrol

South Tyrol an Italian province which borders on Austria, is one of the regions with the highest suicide risks in Italy. A study conducted between 1980 and 1992 by Deisenhammer, Haring, Kemmler, Pycha & Hinterhuber (1996*)* about the influence of affiliation to different language groups in South Tyrol examined ethnic influence on suicide rates in South Tyrol. "The region has historically been under the cultural influence of both countries, with its population composed of three ethnic groups: the German-, Italian- and Ladinian language groups" (Deisenhammer, Haring, Kemmler, Pycha & Hinterhuber 1996, p. 273). The authors noted that the percentage of the German-speaking people and the male suicide rate correlated significantly. The suicide rates of the Italian- and German-language groups showed an approximation compared to the national rates of Italy and Austria, which could be interpreted as a consequence of cultural interaction.

Another very interesting south Tyrolean study from Pycha et al. (2008) researched suicide in South Tyrol by trying to reconstruct what a person thought, felt, and did before committing suicide, also called psychological autopsy, to evaluate both ethnic and sex differences. Previous studies have suggested that sex and ethnicity could influence the characteristics and methods of suicidal behaviour. Studies combining suicidal risk and ethnicity are rather rare, though several minority groups live in Italy, particularly in South Tyrol. As mentioned above, Deisenhammer found higher rates of suicide in Ladins or Germans than in the Italian-speaking ethnic group. Following these results, Germans have a 1.4 times higher suicide risk than Italians. Although the rate of suicide risk for Ladins was found to be the highest, the difference in the suicide rates and suicide risk for Ladins, Germans and Italians was not significant due to the small number of Ladins committing suicide. Nevertheless, ethnicity and sex showed a link to different risk factors. Another important characteristic of suicide in South Tyrol might be the low education level of suicide victims, who mostly attended school for eight years or even fewer. However, the feature applies to almost 76% of the South Tyrolean adult population aged 20, who went to school for eight years or fewer, which shows the characteristic of low education is not "reserved" for suicide victims. "The overlying finding fits with the social stress process, which postulates that disadvantages based on education, income and lack of social resources may result in poor mental health outcomes" (Pycha et al. 2008, p. 8). In addition Clarke et al. (2008) reported

> "…ethnic differences in the pathways to suicidality among Canadian ethnic groups. Francophone whites and Aboriginals shared some common pathways to high risk of suicidality when compared to Anglophone whites,

including the pathways through education, income, depression, alcohol dependence/ abuse" (Clarke et al., 2008, as cited in Pycha et al. 2008, p. 8).

Following these findings, low education may also have had great influence on the suicidal behaviour of South Tyrolean suicide victims. Among adolescent people, the risk of committing suicide increases after a period of absence from school or school dropout. Thus it appears that the school attendance of adolescents and suicidal behaviour are linked in a particularly strong way. In contrast, school attendance and academic achievement appear to be protective factors against suicide and suicidal behaviour.

Furthermore, a low educational level and alcohol or drug abuse may interact. Almost 50% of the Ladinian suicide victims suffered from alcoholism, which corresponds to the findings of Kolves et al. (Kolves et al., 2006, cited in Pycha et al. 2008), who studied 427 deaths by suicide. In the abovementioned study, alcohol abuse proved a reliable predictor of successful suicides. Another difference within the three ethnic groups concerned the rate of psychotic disorders and schizophrenia. In total, more than 12% of the Ladinian suicide victims suffered from psychotic disorders as opposed to only 2.8% of the Italian group. Genetic variability may be another factor reinforcing the differences between ethnic groups. "Ladins, the ethnic group with the higher suicide rates, are also characterized by higher rates of alcohol abuse, psychotic disorders, and genetic differentiation with their geographical neighbours" (Pycha et al. 2008, p. 8). Marusic and Farmer (Marusic and Farmer, 2001, as cited in Pycha et al. 2008) found that genetic differences in population groups may at least partly explain the differing suicide rates in European countries. "Nations with higher suicide rates form a so-called J-curve, which starts in Finland and extends down to Slovenia, an area characterized by inherited factors for suicidal susceptibility" (Pycha et al. 2008, p. 8).

Although genes may imply a hereditary predisposition for suicide, the influence of alcohol consumption and abuse always has to be taken into account. Therefore, suicidal behaviour may be regarded as the interaction of several factors such as diathesis, socioeconomic status, and alcohol abuse. Furthermore, these results confirm reported differences between men and women. South Tyrolean men, compared to female victims, showed higher suicide rates and higher lethality attempts. "Male victims, when compared to women, have lower rates of suicide attempts, more frequently choose a rural area in which to commit suicide, and less frequently sought mental health treatment or communicated their suicide intent" (Pycha et al. 2008, p. 8). However, it has to be taken into account that some of these differences were weak and thus not significant. The suicide sample of South Tyrol revealed the loss of connection with their close social network to be a more prevalent factor in female suicides. In addition, women seem to be more sensitive to factors such as older age, loss of partners and living alone, in a hospital or community residential home. Though

the findings of this study are based on almost 75% of suicides which occurred in South Tyrol in the period interval under observation. The authors described certain limitations to the generalizability of the study due to the "source of information" being the psychological autopsy, the analyses being characterized by low numbers of individuals in some subgroups and the study not including controls (Pycha et al. 2008).

1.5 Suicide in Austria

In Austria in 2013 there were 1300 cases of death through suicide (Statistik Austria, 2014). With a suicide rate of 12.8 per 100.000 inhabitants (mean values from 2007 to 2011), Austria was within the European average. Reasons for the decline in suicide rates since the 1980s are inter alia the development of psycho-social healthcare in Austria, new antidepressants and increasing utilization of health care services. This also indicates a growing acceptance of mental disease. According to an Austrian study conducted by Kapusta et al. (2011), a total of 2,139 people committed suicide in Austria in 1985 vs. 1,261 people in 2010. Though prevention work certainly contributed to the reduction of deaths by suicide, these numbers suggest an increase in the underreporting of suicide cases. Another factor influencing the reporting of suicides are autopsy rates. Countries with high autopsy rates, such an Estonia, Latvia, Lithuania or Hungary, in comparison to countries with lower autopsy rates, also show higher suicide rates. Moreover, falling autopsy rates result in fewer deaths by suicides being recorded. The increasing average over the last ten years shows the highest suicide rates in the Austrian regions of Styria, Carinthia and Salzburg. In contrast, Vienna and the Burgenland have the lowest suicide rates. Since the middle of the 1980s the suicide rate in the Austrian provinces has decreased, though the decline of the suicide rate was more pronounced in urban than in rural areas (Kapusta et al., 2011).

In this regard an interesting study by Watzka, (2012) reported recent research findings concentrating on specific characteristics of Austrian society which revealed the relevance of social factors in fatal suicide attempts. Regarding the sociodemographic variables of gender, age, parenthood, partnership and marital status, older men were shown to be at high risk of committing suicide. In contrast, married persons showed the lowest relative suicide risk. A study for the region of Styria examining the relevance of social status, revealed the highest suicide rates at the lower end of the occupational prestige scale, composed of factory workers, unskilled workers and farmers. A particularity of the category of farmers is the heterogeneity regarding their members' economic status. Another factor

influencing suicide rates is occupation. Economically active people as compared to people without occupation, had a more than five times lower risk of ending their lives in the years 2000 to 2004 (Watzka, 2012).

1.6 Terminology

Before we introduce the main theories which speak for either a protective factor or for a risk factor of spirituality on suicide, it is necessary to give some clarification of terms. Suicidal ideation represents the suicidal thoughts and the intensity of such ideation is understood as the frequency of the suicidal thoughts every day, per week or per month. Suicidal behaviour is the most researched suicide dimension due to its accessibility on the mortality databases. Suicidal behaviour can in some questionnaires include the interrupted suicide attempt, the aborted suicide attempt and the preparatory suicide behaviour. There are also the actual suicide attempts which include the lethality of the suicidal behaviour and the potential lethality in other words, how big the risk is that an individual could die.

Moreover, intrinsic religiosity is understood as the living of a religion out of inner conviction and of one's own accord, whilst extrinsic religiosity stands for using religion as a means of recognition and of increasing social contacts. Furthermore there is a distinction between positive and negative religiosity. The belief in a benevolent God, who gives solace and provides support, is called positive religiosity. If a God, who's seen as a ruler, or sovereign, punishing and reprimanding, we speak of negative religiosity (Unterrainer, H.F., Lewis, A., Collicutt , J. & Andreas Fink (2013). Pollner (1989), pointed out, that a negative image of God correlates negatively with a general feeling of happiness, while this is the opposite case with positive religiosity. Religious affiliation is another term which can be misunderstood. Within Europe looking at countries such as Austria, persons can have an affiliation to the Roman Catholic Church but yet at the same time define themselves as atheists. Thus religious affiliation doesn't necessarily indicate a belief in God.

Furthermore spirituality and religiousness are widely accepted to overlap with each other but they are not the same think. As noted by Galanter M. (2010) in the modern time spirituality has become to be an expression of personal meaning and transcendent commitment for many people, more so than religiosity per se. Spirituality on one hand might be described as a feeling of connectedness to nature, humanity, and the transcendent. Not

necessarily but usually, spirituality is connected to a religious tradition, i.e., a specific system of belief, worship, and conduct (as cited in Koenig, McCullough & Larson, 2001).

1.7 The Main Theories of Spirituality/Religiosity as a Protective Factor for Suicide

The Integration Theory (1897/1997): In Durkheim´s theorization (as cited in Colucci & Martin, 2008) Catholicism and Judaism had a protective effect against suicide thanks to their capacity to integrate individuals by means of communal ties and strong prohibition against the act of suicide. Durkheim's first work on suicide and religious integration was based on Morselli's observation that members of the Catholic Church had a traditional structure combined with strong sanctions against suicide. According to Durkheim, Catholicism and Protestantism prohibit suicide; Roman Catholicism was characterized by lower suicide rates for its higher level of integration. Protestantism, conversely, permits free inquiry and has fewer shared beliefs and practice.

Moreover Durkheim suggested that suicide rates are generally higher among men than women, higher for single persons than married persons, higher for childless people than people who have children and of course higher in soldiers than civilians. However, compared to men, married women who remained childless, showed a higher suicide rate. An interesting assertion is that suicide rates are lower in times of war than in times of peace. Durkheim inferred this conclusion from the facts that suicide rates in Austria and Italy fell by 14% after war broke out in 1866 and there was a decline of suicides in France after the *coup d'état* of Louis-Napoleon Bonaparte in 1851. Other interesting statements according to Durkheim´s theory are the elevated number of suicides in Scandinavian countries as well as the positive correlation between a higher education level and suicide. To put it differently, the higher the education level was, the more likely it was for an individual to commit suicide. However, the interdependency between an individual's religion and suicide was stronger than the correlation between suicide and the level of education. Many Jewish people for instance had a high education level but low suicide rates (Colucci & Martin, 2008).

The Religious Commitment Theory, Stack (1983): This theory was developed in response to a "need" for a new theory on the effect of religion on suicide based on alternative religious concepts, such as religious commitment, aware that new measures of religiosity perhaps needed to be developed and tested. Secondly, most of the work since Durkheim

had focused on only a few nations. Comparative analysis was needed to examine the suicide/religion relationship in a variety of nations with different institutional and cultural settings. Thirdly, most of the previous relationship was marked by simple methodologies that attended mainly to the bivariate relationship. Moreover by developing a theory about the effect of religion on suicide based on the concept of religiosity rather than on religious integration and by testing the theory using multivariate analysis of rates in many nations with varied institutional contexts, some of the problems of previous research could be resolved (Stack 1983, cited in Colucci & Martin, 2008). According to this theory, a devotion to spiritual or religious beliefs may be all that is needed for a religious shield against suicide, such as a belief in the afterlife or in a responsive God or that suffering has a purpose.

The Network Theory, Pescosolido and Georgianna (1989): Basically, the authors concentrated their work on central theoretical questions to find out how and why religion protects its members from harming oneself. In order to investigate these questions and explain the complexity of religion's influence on suicide, Pescosolido and Georgianna particularly used, analyses of cultures and cultural changes from the sociology of religion and united these ideas with a concise perspective (Pescosolido and Georgianna 1989, cited in Colucci & Martin, 2008). Their approach did not refute Durkheim's theory, but they modified it, recast it and postulated the importance of the spiritual/religious community: that is, the degree to which religions vary in terms of adherents´ participation and network contacts. The authors contended that the influence of religion on suicide may be modelled within certain social and geographical contexts (Colucci & Martin, 2008).

Furthermore, in clinical as well as in health related research, religiosity and spirituality have been investigated in the context of various indicators of mental health and subjective well-being. An appropriate example of this might be the concept of Spiritual Well-Being (SWB), which was developed by Ellison and Paloutzian (Ellison & Paloutzian, 1983, as cited in Stefa-Missagli et al. 2014) and further developed by Unterrainer, Huber, Ladenhauf, Wallner-Liebmann, & Fink (2010). The original SWB scale comprises two subscales: "Religious Well-Being" (RWB) subscale and the "Existential Well-being" (EWB) subscale. The RWB sub-scale addresses the transcendent realm of well-being, whereas EWB measures the amount of well-being for the immanent area of perception. Relying on this concept, an interdisciplinary research group located at the Medical University of Graz, Austria, developed the Multidimensional Inventory for Religious/Spiritual Well-Being (MI-RSB) as an attempt to expand the bio-psycho-social model with a religious/spiritual component (Stefa-Missagli et al., 2014).

The majority of previous research supports a tendency towards negative correlations between the spiritual/religious dimensions and suicide or more generally mental health (Gearing and Lizardi 2009; Dervic et al 2004; Ineichen et al 1998; Stack 1983, Pargament, 1997; Emmons, 1999; Moreira-Almeida, Neto & Koenig, 2006; Ostermann & Büssing, 2007; Saroglou & Cohen, 2011; Unterrainer, Lewis & Fink, 2012 etc.).

As reported by Koenig (2012), the relationships between religiosity/spirituality, suicide attempts, completed suicide, and attitudes towards suicide are in agreement with the correlations found for depression, self-esteem, and hope. However, depressed people with low self-esteem and without hope, showed a greater risk of ending their lives. To this day, a total of 141 studies have tried to investigate the correlations between religiosity/spirituality and the above mentioned suicide variables. Of those studies 106, found inverse relationships and four, reported a positive correlation. Out of the 49 studies showing the highest methodological validity, 39, being 80%, found lower suicide rates, fewer attempts to commit suicide and higher negative attitudes towards suicidal behavior among high spiritual people. However, two studies out of 49, being 4%, reported a positive correlation.

But the question arises: are all these previous surveys scientifically significant and persuasive concerning such negative correlations?

1.8 Spirituality/Religiosity as a Risk Factor for Suicide

With his writings, Sigmund Freud, greatly influenced the relationship in the study of human sciences between mental Health and spirituality by leading a separation of these two aspects of reality. In the mid-1880s Sigmund Freud was introduced by the well-known French psychiatrist Jean Charcot to the neurotic and hysterical aspects of religion. As a result, Sigmund Freud highlighted this approach in a series of written works from_1907 to 1939. "*Religious Acts and Obsessive Practices", "Psychoanalysis and Religion",* "*Future of an Illusion" and "Moses and Monotheism"*. Freud famously defined religion as "a collective compulsion neurosis". Religion confers the regressive desire for protection from one´s over-powerful father, impedes autonomous thinking, restricts the freedom of decision and thereby generates neurosis (Freud, 1927, as cited in Koenig, 2012). A study conducted by Maltby (Maltby, 1999, as cited in Agorastos, Demiralay & Huber 2014), revealed a significant positive correlation between "frequent churchgoers" and compulsive-obsessive disorder compared to "infrequent churchgoers". Similar findings emerge from Steketee, Quay and White (1991) as well as from Grennberg and Witztum (1994) using Christian subjects but

also from an Israelite Jewish sample in a study by Abrahamovitz et al. (2002) and from an Arabic Muslim sample Mahgoub & Abdel-Hafeiz (1991) (Agorastos, Demiralay & Huber 2014).

Recently published findings reported that 5 and 25 per cent of people suffering from a compulsive-obsessive disorder (OCD) have attempted to commit suicide at least once in their lives. Suicidal ideation, also called suicidal thoughts, was found to be rather frequent among people with compulsive-obsessive disorder (OCD and Suicide, 2015).

A small number of studies suggest that religious beliefs may expose individuals or groups of believers to a greater risk of suicidal ideation or behaviour. According to Rickgarn (1990) the individual´s loss of faith or the perceived need to live up to the standard of the faith are among those situations that may facilitate suicide. Zhang and Jin (1996) showed that the more religious Chinese students were, the more they thought about killing themselves and held pro-suicidal attitudes. The authors explained this pattern by noting that since Marxism and Communism had been rejected by young people, there had been nothing to replace these ethic ideals (Colucci & Martin 2008).

Spirituality can also put individuals at major risk of suicide if devotion to a religious community is bonded to a rejection from the same community or a rejection from others who hold different beliefs. This hypothesis can be seen as the reverse interpretation of the network theory from Pescosolido and Georgianna but this requires further research.

Furthermore, episodes of mass suicide in the past are mostly related to a search for spirituality, for God, for a meaning of life or for rebirth. Some of those who killed themselves had strong beliefs in the afterlife and their deaths were self-inflicted in order to hasten arrival in the afterlife. For example, in 1978, 912 people from the “People´s Temple” killed themselves in Guyana and more recently 600 members of the sect “The Ten Commandments of God” died by self-immolation in Uganda (Colucci & Martin 2008).

1.9 Main Issues with Previous Surveys

To better understand the complexity of the relationship between suicide and spirituality we have to contextualize the research findings to the culture and societal organization of the group under examination. These groups can be very different within religions or cultures as well as between them. These kinds of intracultural and intercultural studies are unfortunately very rare (Colucci & Martin 2008).

A further problem is that the majority of the studies in this field are based on suicide mortality statistics. As the most common measure of religiosity they researched religious affiliation; they did not address non-religious forms of spirituality or the different dimensions of religiosity. Spirituality and religiousness are widely accepted to overlap at least partially and are most prominently defined as feelings, thoughts, experiences and behaviours that arise from the search for the sacred (Pargament, 1999). However, it is even more important to conceive and to interpret spirituality and religiousness as independent constructs. Spirituality on one hand might be described as a feeling of connectedness to nature, humanity, and the transcendent. However usually but not necessarily, spirituality is connected to a religious tradition, i.e., a specific system of belief, worship, and conduct (Koenig, McCullough & Larson, 2001). Either way, modern spirituality must be seen as a multidimensional construct. It inherently includes experiences referred to as spiritual, transcendent or even mystical.

As briefly mentioned above, the World Health Organization defined "suicide" as “An act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome” (The world health report, 2001, p. 9). But do spiritual/religious people with a strong belief in an afterlife consider death as a “fatal” outcome”? Studies which consider more thoroughly the wide range of cultural “tolerated” or “non-tolerated” suicide motivations are rather rare. For a better understanding of this distinction we must recognize the integral role that Religion has played for centuries worldwide. By excluding the culturally dark sides of the relationship suicide- spirituality such as martyrdom, revenge, the strong beliefs in the afterlife etc. which are regarded as “tolerated” suicide motivations in many religious communities, we risk a scientific bias. To our knowledge, all previous quantitative suicide studies focused only on non-tolerated suicide motivations e.g. the intent to end or stop the pain. These motivational categories are present in many mental diseases such as strong depression, personality disorders, etc., but not in healthy persons.

As noted by Watzka (2012) only 13 per cent of the persons who died by suicide in Austria from 2002 to 2004 were inpatients in a psychiatric hospital. According to the Austrian authorities and based on retrospective analysis, only fifty percent of the suicide victims were known or suspected to have had psychological problems. This indicates a substantial presence of suicide in “healthy” subjects but also in undiagnosed individuals.

Suicide was also researched in many studies as a one-dimensional indicator (e.g. suicidal behavior). The suicidal ideation as well as the intensity of ideation or the potential lethality in the suicidal behaviour was usually not elevated. The fact that the indicators used to study the impact of religion on the suicidal behavior were one-dimensional (only one variable such as religion affiliation was used) instead of multidimensional argues for inconsistent findings in the majority of the previous literature.

Another reason for inconsistent findings could be due to the underreporting of suicide rates due to social stigma, according to the World Health Organisation. In particular countries with religious sanctions (India, Indonesia, Taiwan, Mexico and in the Islamic countries) were overall less likely to reveal suicide rates to the WHO (Sorri, Henriksson, Lonnqvist, 1996).

1.10 Suicide and Psychiatric Symptoms

It is noteworthy that suicide itself is not considered as a mental illness, but as a possible consequence of a variety of mental disorders such as bipolar disorder, borderline personality disorder, post-traumatic stress disorder, obsessive compulsive disorder, substance use disorders, anxiety disorders as well as schizophrenia and major depression. To date, depression is the most frequently examined mental disorder. Following the estimation by the WHO (World Health Organization), around 121 million people worldwide were suffering from depression, with 5.8% of men and 9.5% of women going through depressive episodes every year (World Health Organization 2001). However, it is important to be aware of the wide range of forms and experiences depression comprises. The illness forms of depression, range from mild to severe and from momentary to permanent. Furthermore the suicide risk differs considerably with the depression type.

Among people diagnosed with depression, a Finnish study (Petteri Sokero et al., 2005, as cited in the Canadian mental health association 2006) reported previous self-harm, severity of the illness, alcohol abuse, drug abuse, serious physical illnesses, chronic physical illnesses, anxiety and personality disorders as well as the lack of a partner to be very important indicators for suicidal behaviour. A person suffering from major depressive disorder experiences a kind of sadness that differs in degree and modality from the sadness a person might feel during hard times. In general, the effects marking major depression are more prevalent and last longer than those suggesting normal states of grief or sadness. Moreover, several of the symptoms experienced by people diagnosed with severe depression, seldom appear in those experiencing a kind of normal sadness that strikes anyone at times. These symptoms comprise hopelessness, loss of the ability to experience pleasure, as well as the inability to feel a mood uplift after experiencing something positive. The combination of suicidal thoughts, psychotic symptoms and depressive symptoms usually allows the conclusion that the concerned person suffers from a serious depressive disorder (Canadian mental health association Toronto, 2006).

About five people on 1,000 suffer from bipolar depression, men and women are affected in equal measure (Sane, 2000). Individuals with bipolar depression have a 15 times higher risk of committing suicide than the general population. Factors such as family and emotional pressures, work and study, with a certain intensity may lead to suicide. The suicidal risks in women rise during menopause or after giving birth. Optimal treatment of persons with bipolar disorder may enable a normal functioning in most cases. However, trivial treatments or dangerous drugs will lead, in the long term, to increased suicide. Unfortunately, evidence indicates a generally trivial treatment. Long-term observational studies found that the extremely high lifetime suicide prevalence of 50% in people suffering from bipolar affective disorder may decrease by maintaining the right drug treatment combined with the right treatment of comorbit drug abuse, depression and comorbid alcohol.

According to the Canadian mental health association of Toronto (2006), “Adequate treatment goes beyond the simple supplying of treatment regimes, and it is at these times that suicide risk is particularly high” (p. 2). People suffering from bipolar disorder require intense assistance in beginning a treatment and staying in therapy. Despite its side effects, lithium has long been the most widely used drug for the treatment of bipolar affective disorder. The suicidal protection effectiveness of several other types of medications over the past 10 years has not been demostrated their effectiveness (Canadian mental health association Toronto 2006).

Another interesting study from the World Health Organization found the most common cause of death in those suffering from schizophrenia was suicide. Risk factors for suicide amongst people with schizophrenia are: co-morbidity with depression and inadequate treatment. Furthermore, the probability of committing suicide is higher early in the course of the disease. Globally seen, alcohol is the most widely abused substance, though the degree of drinking varies to a large extent. Worldwide about 1.7% suffer from alcoholism, while the estimations reach 5% in parts of North America and Eastern Europe. Illegal drug abuse and drug addiction concerns between 0.4% and 4% of the world’s population. According to an estimate by the World Health Organisation, around five million people worldwide injected illegal drugs in 2003. Studies concerned with the examination of risk factors, reported that drug abuse and alcohol abuse are more likely to occur among adolescents and young adults than in older people. In addition, men, as compared to women, show a higher risk factor for substance abuse and suicide. For minority groups with a different culture such as indigenous peoples, depression and alcohol abuse seem to be co-existing risk factors for suicide. Substance and alcohol abuse, which influence suicidal behaviour in multiple ways, are usually accompanied by several other risk factors for suicide. The problems of persons abusing substances and alcohol seem to multiply; in addition to suffering from depression, those individuals are also likely to have economic as well as social

problems. Alcohol and drug abuse seem to occur often among people with an impulsive personality or a preference for high-risk behaviors that can cause them harm. However, intoxication may lead to an impulsive and aggressive suicide attempt that the person would not have performed if not intoxicated. (Canadian mental health association Toronto 2006).

A study conducted by Kaplan (2013) revealed that anxiety psychiatric symptoms can also induce in suicide. Yaseen et al. (Yaseen et al. 2011, as cited in Kaplan, 2013) demonstrated similar results. In their study they include 2679 community-dwelling people who suffered from major depressive episodes and who participated in the NESARC, the National Epidemiologic Survey on Alcohol and Related Conditions. An important result of their study was the significant correlation between the past-year´s history of panic attacks and suicide attempts, the lifetime history of suicidal ideation and being among ideators. Another finding of this study was that the relationship between suicide attempts and adverse cognitions of panic such as fear of dying, losing control or going insane was more significant than the correlation between suicide attempts and dissociation, sensations of choking or chest pain. The authors of the study assumed, those adverse cognitions may lead to suicide attempts by triggering suicidal thoughts and interacting with limbic activations (Kaplan, 2013).

Another study conducted by Diaconu & Turecki (2009), revealed that irrespectively of the risk associated with depressive disorders, obsessive-compulsive personality disorder is another factor contributing to the increase of the risk of suicidal behavior. Those individuals with comorbid obsessive-compulsive personality disorder and depression, in comparison to those individuals with depression alone, no depression or personality disorders, showed elevated current and lifetime suicidal thoughts. The subjects in the comorbid obsessive-compulsive personality disorder OCPD-depression group also had a raised history of suicide attempts and frequently committed multiple attempts. In addition, they ranked lower on the Death Anxiety Questionnaire as well as on the Reasons for Living Inventory. It is interesting to note that in the moral objections items of the RFL questionnaire, those subjects with comorbid OCPD-depression were different from and scored lower than the patients who suffered from depression alone (Diaconu & Turecki, 2009).

An interesting Italian meta-analysis conducted by Pompili et al. (2005) about suicide in individuals suffering from borderline personality disorder found suicide to be the major cause of death among borderline patients. However, the literature on fatal suicide attempts in borderline personality disorder remains inconclusive due to the high variation in suicide rates among patient cohorts. In order to find papers concerned with suicide in borderline personality disorder, Pompili et al. collected various publications (from MedLine, Excerpta Medica and PsycLit) from 1980 to 2005 to investigate the suicide rate for specific years and country in the age groups. The authors conducted a meta-analysis of eight studies encompassing a total of 1179 patients with diagnosed borderline personality disorder. Out of

these patients, 94 ended their lives by committing suicide. The results of each study were calculated together in order to obtain the means for each year of suicides per 100,000 subjects with borderline personality disorder. Following this meta-analysis, all of the study analyses showed that patients suffering from a borderline personality disorder, compared to their correspondents in the general population, showed a higher tendency towards suicide. Moreover, suicidality was found more worrying in the first stages of follow-up than during the chronic states of disease (Pompili et al. 2005).

1.11 Religious -Spiritual Wellbeing and Mental Health

In clinical as well as in health-related research, religiosity and spirituality have been investigated in the context of various indicators of mental health and subjective well-being (Johnstone et al., 2012; Womble, Labbé, & Cochran, 2013). A good example of this might be the concept of Spiritual WellBeing (SWB), which was developed by Ellison and Paloutzian. This original SWB scale is comprised of two subscales: the “Religious Well-Being” (RWB) subscale and the “Existential Well-being” (EWB) subscale. The RWB subscale addresses the transcendent realm of well-being, whereas EWB measures the amount of well-being for the immanent area of perception. Relying on this concept, an interdisciplinary research group located at the Medical University of Graz, Austria, developed the Multidimensional Inventory for Religious/ Spiritual Well-Being (MI-RSB) as an attempt to expand the bio-psycho-social model by means of a religious/spiritual component, (Unterrainer, Ladenhauf, Moazedi, Wallner-Liebmann, & Fink, 2010). This effort culminated in an instrument, comprised of six different dimensions of religious/spiritual well-being (RSWB): “Hope Immanent,” “Forgiveness,” “Experiences of Sense and Meaning” for the measurement of the Immanent well-being area (or existential), and “Hope Transcendent,” “General Religiousness,” and “Connectedness” for the Transcendent (or religious/spiritual) area of RSWB. A universal definition for RSWB is provided as follows: “the ability to experience and integrate meaning and purpose in existence through connectedness with self, others or a power greater than oneself” (Unterrainer, Ladenhauf, Wallner-Liebmann, & Fink, 2011).

Moreover, a significant interconnection of the RSWB with personality factors, as well as with varying indicators of psychological wellbeing, could be confirmed in several studies. Most recently, the highly convincing psychometric properties of the MI-RSB have been replicated by adapting the scale to English, Bosnian, and Mexican-Spanish language (Unterrainer, Lewis, & Fink, 2012). However, it should be noted that the research on the

relationship between spiritual well-being and mental health issues has been heavily criticized by authors such as, for example, Koenig (2008), who argued that these results, where spirituality, measured by indicators of good mental health, is found to be correlated with good mental health, are meaningless and tautological. More in general the endeavour to link the spiritual dimension with the bio- psycho-social model of mental health and illness has been scrutinized by Sloan, Bagiella, and Powell (1999) who highlighted the conceptual flaws of studies reporting substantial health benefits associated with a higher amount of religious/spiritual well-being. Furthermore it should be noted that there is still solely a small amount of studies focusing on the possible pathological aspects of religiosity and spirituality. As suggested by Bennett, Shepherd, and Janca (2013), some aspects of religiosity and spirituality might be positively linked with specific facets of a disordered personality structure. This assumption gets confirmed by own research, where RSWB-dimensions such as "Hope" or "Connectedness" were found to be substantially increased in persons exhibiting a higher amount of "Narcissism" (Kämmerle, M. Unterrainer, H.-F., Dahmen-Wassenberg P., Fink A., Kapfhammer H.-P. 2014). In previous research this very "Connectedness" dimensions also showed to be heightened in substance disordered patients as being generally positively associated with the "openness" personality factor which in turn might be taken as a predisposition for "sensation seeking," Traditionally "sensation seeking" was found to be high in substance dependent patients (Lackner, Unterrainer, & Neubauer, 2013; Unterrainer, Lewis, Collicutt, & Fink, 2013).

1.12 Suicide, Mental Health and Personality Dimensions

Other factors that may play an important role and which we must consider simultaneously for a multidimensional understanding of the relationship between suicide and spirituality are the personality characteristics. Many studies have shown that the association between religion and suicide is mediated or influenced by other variables such as social demographic variables and in particular personality variables, leading to an overall weak association. For this reason the suicidal behavior can be regarded as the consequence of the co-occurrence of a personality characteristic and psychiatric problems. To date, the relationship between the "big five" personality characteristics (agreeableness, openness, neuroticism, conscientiousness and extraversion) and almost every psychological condition has been investigated in detail. However, the connections between several factors of the "big five" personality factors and suicide have only been researched accompanied by other

comorbid variables.

In order to obtain a more comprehensive picture of the effects which personality traits may have on the risk of committing suicide in the general population, Blüml et al. (2013) conducted a study analyzing community participants. 2,555 adults were evaluated for past suicidality, present and potential suicidal behavioutor as well as for the “big five” personality traits. In addition other risk variables such as depression, anxiety, post traumatic stress disorder and socioeconomic status were controlled. The obtained results showed that specific big five traits had a different impact on the risk for male suicide than female suicide. Blüml discovered an elevated suicide risk for women with high levels of openness and neuroticism. For men, the risk for suicide was increased by low levels of conscientiousness and extraversion. Moreover, women were found to be more likely to commit nonfatal or failed suicide attempts than men. “Blüml believes that neuroticism, which is a risk factor for depression, could increase depressive symptoms in women, making them more vulnerable to maladaptive coping and impulsivity” (Blüml et al., 2013, doi: 10.1371/journal.pone.0076646). This assumption represents a possible explanation for the correlation between neuroticism and female suicides. Looking at the “big five” scores for men, Blüml was unable to find a direct connection between openness or neuroticism and suicidality. However, when scores were low, extraversion, being associated with positive affect, was found to be predictive of suicide for males. Comparably, low values for conscientiousness, which directly influences hopefulness, were also shown to be linked to suicide risk in men. “Blüml also found that these trends persisted even when other factors such as anxiety, unemployment and stress were considered” (Blüml et al., 2013, doi: 10.1371/journal.pone.0076646). These findings clearly demonstrate the gender differences in the influence of a specific personality factor on suicide.

Voracek (2009), in his multicentre studies within the United States, found significant negative associations between Neuroticism and suicide rates. The correlations were significant for both historical and the contemporary suicide rates of the total or the older part of the sample. The “big five” traits of agreeableness and extraversion were found to be negatively, although not reliably, correlated with suicide rates, which corresponded with former cross-national findings (Voracek, 2009). Another interesting study conducted by McCann (2010) revealed that lower neuroticism and lower agreeableness corresponded to higher suicide rates. In this study, multiple regression analysis was used to examine the relationship between state suicide rates and personality states with reference to depression rates, socioeconomic status, urban population percentage and white population percentage. When sociodemographic variables and depression were controlled, the multiple regression analysis revealed that neuroticism explained 32.0% of the total suicide rate variance and agreeableness another 16.3%. Conclusively, this study demonstrated that lower neuroticism

and lower agreeableness values correlate negatively with suicidal ideation and suicide attempts and positively with completed suicide (McCann, 2010).

As reported in a study from Koenig (2012) the correlations between religiosity/spirituality and neuroticism were searched in more than 54 quantitative studies. 24% of them described an negative relation, while 9% found a positive correlation. The biggest part of the other studies, reported no association at all. Of the 50 studies investigated with regard to extraversion, 38 % reported a positive correlation with religiosity/spirituality and 6% showed negative interrelations. Concerning “Conscientiousness”, only 3% found significant inverse relationships and the greater part (63%) of the examined 30 studies, found significant positive correlations with religiosity/spirituality. Regarding “Agreeableness”, there have been 30 researches investigating the relation with religiosity/spirituality, out of which 87% found positive interrelation, while none of these studies found inverse relationships. “Openness” has been investigated in 26 different studies, resulting in 42% having positive relation with religiosity/spirituality and 12% having negative interelation. To conflate, religious/spiritual individuals usually have higher scores in the personality traits of conscientiousness, extraversion, agreeableness and openness to experience, and lower scores in psychoticism and neuroticism. The religious/spiritual persons have especially low values on psychoticism and high values on conscientiousness and agreeableness.

Based on the assumption that the relationship between personality and religiosity/spirituality is fundamental, Piedmont proposed an extension of the five factor model of personality traits by proposing a sixth factor, the so-called “spiritual transcendence” (Unterrainer et al., 2011). Furthermore, on the basis of a meta-analytical review, Saroglou (2002) reported the “openness” personality factor as a psychological factor correlated with a more open kind of religiousness/spirituality; in addition to this, the “openness” personality factor turned out to be negatively related with religious fundamentalism. Another example might be the highly substantial negative correlation of a sense of meaning and purpose for existence with “neuroticism” (MacDonald, 2000). As mentioned before Stefa-Missagli et al. (2014) demonstrated also that the religious/spiritual well-being total score, and the subscales correlate positively with at least one of the Big Five personality characteristics, neuroticism, which conversely, turned out to be the only personality characteristic, negatively correlated with forgiveness, hope immanent and hope transcendent.

1.13 The development of our project

By following in the footsteps of many illustrious authors (e.g. William James, Emile Durkheim, Sigmund Freud, Erwin Ringel) who researched the epidemiological psycho-social aspects of suicide and of the relationship between spirituality and mental health, we decided in the previous multicenter study of Stefa-Missagli et al. (2014) to gain initial results for the adaptation of the Multidimensional Inventory of Religious/Spiritual Well-Being (MI-RSB) in the Italian language. Additionally, we intended to further investigate the relationship between Religious/Spiritual Well-Being and the "Big Five" dimensions of personality, as well as their relationship to a global severity measure of mental illness (GSI). We used a sample of Italian college students from Padua/Veneto (noth Italy), from Rom/Lazio (central Italy). In total, 416 (104 males [24.1%] and 306 [75.9%] females) Italian undergraduate students were tested. This sample was not restricted by any specified inclusion or exclusion criteria. The mean age of the sample was M = 21.6 years (SD = 2.8), ranging from 18 to 43. Students from four universities of three different cities and regions of Italy filled in the questionnaires. The participating universities were the "University of Padova" (northern Italy) with 320 students, the "University of Urbaniana" and the "University of LUMSA" with 91 students, both located in Rome (central Italy). Moreover, socio-demographic data revealed that 7.6% were married, 3.5% were in a relationship, and 88.6% were single. 97% of the participants were of Italian nationality. The participants were tested in different sized groups, ranging from 6 to 130 students, within a 4-month period. The testing sessions lasted approximately between 25-40 minutes. Ethical approval was granted by the Ethics Committee of the University of Graz.

As hypothesized, the Italian version of the MI-RSB questionnaire has proven its efficacy in measuring religious/spiritual well-being in a manner similar to the original Austrian-German version. All MI-RSB-I sub-dimensions, as well as the whole scale, demonstrated a convincing amount of internal consistency and the proposed six-factor structure was also found to be robust (Unterrainer et al., 2013; Unterrainer, Lewis, & Fink, 2012). Moreover there were found substantial relations between MI-RSB-I dimensions and personality factors. Corresponding with Saroglou (2002), three of the "Big Five" personality dimensions, namely "Agreeableness," "Conscientiousness," and "Extraversion," turned out to be significantly associated with the "RSWB" total score. Furthermore, a negative association could be demonstrated with "Neuroticism," which mirrors the results of the Austrian-German MI-RSB version. In addition to this, the MI-RSB-I sub-dimensions "General Religiousness," "Forgiveness," "Connectedness." and the total score RSWB, turned out to be strongly correlated with the "Centrality" scale.

This finding also replicates the results of former research, where we found these three dimensions as highly correlated with the amount of religious well-being (Unterrainer et

al., 2012). In addition, several dimensions of MI-RSB-I were found to be negatively related with psychiatric symptoms, whereby “Hope” and “Forgiveness” were confirmed to be the strongest negative correlates of mental illness, which mirrors the results of previous research (Unterrainer et al., 2010). In contrast to our main theoretical assumptions “Connectedness” was found to be positively correlated with mental illness as measured by the “Global Severity Index” (GSI). More generally we found weak support for the assumed positive relationship between religion and health, since it was observed that General Religiosity was unrelated with parameters of mental health such as “Neuroticism” or the GSI of psychiatric symptoms (GSI). Moreover, the Christian-Catholic group (as the group of religiously affiliated people) did not exhibit any health benefits in comparison with the non-religious group. In line with the literature (Saraglou, 2002) they showed, in fact, a higher amount of “Agreeableness” and “Conscientiousness” as well as a higher amount of “Forgiveness” (as prominently discussed in the literature as a strong predictor of mental health; McCullough, Pargament, & Thoresen, 2001), however, we did not observe either a lower amount of “Neuroticism” nor diminished psychiatric symptoms.

Furthermore, we did not observe a higher amount of religiosity among Italian students in comparison to the Austrian norm population. However, at this point it has to be restrictively noted, that in previous research we also found the amount of religiosity as decreased in Austrian college students (Unterrainer et al., 2013). Like Austrian students, their Italian colleagues also exhibited an excessively low amount of hope (for a better future). Accordingly, this result might mirror the insecure life situation of students more in general. Furthermore we learn from this data, that there might prevail an increased amount of religiosity in the central and southern parts of Italy. In conclusion, these initial findings suggest the Italian version of the MI-RSB (MI-RSB-I) as virtually identical to the original Austrian-German scale. Therefore it might be considered as a reliable and valid instrument for the assessment of the different facets of religiosity and spirituality in the context of personality and health-oriented research in Italy. However this finding also needs to be clarified, as we did not control for the origin of the respondents (e.g., someone who was born in Palermo might have decided to study in Rome, etc.). The MI-RSB was used for the first time in different regions of the same country. The data collection took place in different parts of Italy, and thus we might assume substantial differences in dimensions such as religiosity or spirituality based on different cultural backgrounds (Stefa-Missagli et al., 2014).

In the above mentioned multicenter study there were also same limitations. Our results certainly might have been influenced by the fact that females were overrepresented in our study, accounting for 75% of the respondents. This might be further explored in an in-dept data evaluation, as previous research found RSB dimensions to be increased in females as well as, generally, in older people. In the present study our sample was too

homogenous to reveal any effects that “age” might have on spirituality and religiosity. However, regardless of these strong limitations, our results still offered us some attractive options for further research (Stefa-Missagli et al., 2014).

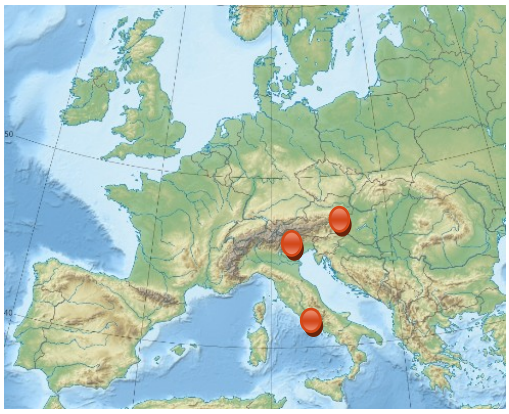
The regional differences in the European classification of mortality rate by suicide and its remarkable results provided a reason to pursue our study, focusing this time on the aspects of suicide as one of the most important indicators of health care. According to this classification, the countries of the Mediterranean area show the lowest mortality rate by suicide, while the countries of the Central and Northeast European area show the highest death rate by suicide (Eurobarometer 2010). Many factors have been investigated, attempting to explain a fragment of this European reality, but cultural dimensions such as spirituality or religiosity were never included. Our Study aimed to fill this vacuum based on a cross-cultural scientific survey in the field of suicide, spirituality and personality.

2. Aims of the Study

The aim of the study was to investigate multi-dimensionally the intercultural (central Italy vs. north Italy vs. middle-eastern Austria) and intra-cultural (believers vs. nonbelievers and clinical samples vs. student samples etc.) differences in spiritual/religious condition and their impacts on suicide and psychiatric diseases in three clinical samples compared to three student samples. In addition, this study surveys different correlations between suicidal ideation, spirituality and the “Big Five personality characteristics”. In this regard we were particularly interested to discover the role that “Neuroticism” simultaneously plays in the triangle of suicide-spirituality-personality. Our hypothesis consisted of confirming the important role of “Neuroticism” in the abovementioned relationship. We were also interested to know how strongly the differences in levels of spiritual/religious beliefs between countries contribute to the geographical variation in suicide rates. We hypothesized that the differences in several dimensions of spirituality/religiosity influence these geographical variation in suicide. We also presume that the impact on suicide of the single spiritual/religious dimensions is not equally significant. Furthermore we hypothesized that the student samples and the clinical sample in all analyzed regions would demonstrate different levels of suicide, spirituality and personality characteristics. Moreover we presumed that several psychiatric symptoms would influence the geographical variation in suicide between all samples.

3. Methods and measures

3.1. Participants and Procedure



In total, 1042 people were tested in three different regions of Europe; Lazio (central Italy), South Tyrol &Veneto (north Italy) and Styria (middle-eastern Austria). In Lazio we included 125 inpatients, 40.8% were males and 59.2% were females, the mean age of the sample was *M*= 40.5*, SD*= 14.5 and 94 undergraduate Students, 20.7% were males and 79.3% were females. The mean age of the sample was *M*=23.6*, SD*= 3.5. In South Tyrol &Veneto were included 146 inpatients, 45.9% were males and 54.1% were females, the mean age of the sample was *M*=40.2*, SD*=13.3 and 320 undergraduate students, 20.9% were males and 79.1% were females. The mean age of the sample was *M*=21.1*, SD*= 2.3. In Styria were tested 139 inpatients, 40.6% were males and 59.4% were females, the mean age of the sample was *M*= 40.6*, SD*= 13.9 and 221 undergraduate students, 21.7% were males and 78.3% females. The mean age of the sample was *M*=24.5*, SD*= 5.8. Moreover socio-demographic data revealed that 27.5% of the inpatients in Styria (Austria) were married, 21% were in a long-term-relationship, 33.3% were single and 18.1% were divorced. Of the Styrian student sample 4.1% were married, 43.9% were in a long-term-relationship, 51, 1% were single and 0.9 were divorced. In South Tyrol &Veneto (north Italy) 27.4% of the inpatients sample were married, 18.8% were in a long-term-relationship, 33.6% were single and 10.3% were divorced. Of the north Italian student sample 1.9% were in a long-term-relationship and 98.1% were single. In Lazio (central Italy) 24.8% of the inpatients sample were married, 4% were in a long-term-relationship, 59.2% were single and 12% were divorced. Of the student sample from middle Italy 6.5% were married, 3.3% were in a long-term-relationship and 90.2% were single.

The occupation distribution of the different samples is shown in **Table 1.**

Table 1. Occupation distributions in %

		Employed	Unemployed	In Education
Styria	Patients	46,4	24,6	29
	Students	21,3	1,8	76,9
South Tyrol/Veneto	Patients	52,7	15,8	31,5
	Students	-	-	100
Lazio	Patients	36	47,2	16,8
	Students	-	-	100

The student samples were restricted by inclusion criteria (no participation for students who were not born and raised in Austria or Italy) and exclusion criteria (for students over 35 years old). The inpatients samples were also restricted by inclusion criteria (no participation for people less than 18 Years old) and exclusion criteria (acute psychosis, uncontrollable emotional triggers and extreme levels of mania). Psychiatric inpatients from three departments of psychiatry and students from universities of three different cities and regions of Europe filled in the questionnaires. The participating universities were; the *"Department of Psychology, University of LUMSA"*, and the "*Institute of Philosophy, University of Urbaniana"* both located in Rome (central Italy), the *"Institute of Psychology, University of Padova"* (north Italy) and the *"Institute of Psychology, Karl-Franzens-University"* in Graz (middle-eastern Austria). The participating psychiatric departments were "*Department of Psychiatry, Sant'Andrea Hospital, University of Rome La Sapienza,"* in Rome, "*Department of Psychiatry of the South-Tyrol Health Service,* Bozen, and "*Department of Psychiatry, LKH Medical University of Graz*".

The participants were tested either one by one (in case of the clinical samples) or in different sized groups (by student samples), varying in size from 1 to 100, within an 18 month period. The testing sessions lasted approximately 35-50 minutes. Moreover the collection of the socio-demographic and suicide data on clinical samples was conducted from doctors of medicine or psychologist who received training in the administration of our questionnaires and were prepared to answer the questions which patients may ask (e.g. "What is a Pantheist?"). In Austria, the ethical approval concerns the clinical sample was granted by the *Ethics Committee of the Medical University LKH Graz* and for the student sample by the *Ethics Committee of Karl Franzens University Graz.* In Italy, the ethical approval for the clinical sample was granted by the *Ethics Committee of the South-Tyrolian Health Service, Bolzano* and for the student sample by the *Ethics Committee of University of Padova.* All subjects gave written informed consent to participate in our study as required by the ethics committees (see Appendix).

3.2. Socio-Demographic Data

A data sheet (self-provided) was used in order to assess socio-demographic characteristics such as age, gender, level of education, nationality, occupation and family status. Concerning the clinical sample, it was relevant to elevate the psychiatric diagnosis for each inpatient, obtained from the archived clinical files. Where several diagnoses were given we decided to use only the principal diagnosis (Table 2.).

In addition a dichotomous, one-item control variable for the divine dimension was utilized by asking a general single question: "*Do you believe in a divine dimension*?" this question could be answered either with "yes= Believers" or "no= Non-Believers"; we also asked the confession of faith (*"Roman Catholic", "Continental reformed church",* "*Non-denominational" etc*.). The intensity of the participant's belief and how they would define themselves was also questioned; this question could be answered with *"Atheist"* (who don´t believe that any deities or divine dimensions exists), "*Agnostic"* (who maintain that the existence of the ultimate cause, as God, and the essential nature of things are unknown and unknowable), *"Deist"* (who do not believe in God´s superintendence and government, revelation and the religious authority as a source of religious knowledge with the conclusion that reason and observation of the natural world are sufficient to determine the existence of a single creator), "*Pantheist"* (who believe that the universe or nature as the totality of everything, is identical to divinity) and "*Theist"* (or "frequent churchgoers": who believe that there is a God or gods who made and governs over the universe, without rejection of revelation all creation,). Moreover, the amount of the participants' spiritual belief and religious belief was assessed by means of a 2 visual; 6-level analogue scales (see Appendix).

3.3 Suicide Rating Scales

-The Columbia-Suicide Severity Rating Scale, Baseline version (C-SSRS) from Posner et al. (2009) was used firstly as a suicide questionnaire on the clinical samples. The test affords the compilation of suicidal ideation and suicidal behavior. It is used extensively across primary care, clinical practice, surveillance, research, and institutional settings. It is available in over 100 country-specific languages**,** and is part of a national and international

public health initiative in USA. The C-SSRS has been administered several times and has exhibited excellent feasibility (Mary et al., 2013). The suicidal dimensions based on Item-Categories were; 1) *Suicidal ideation* (5 items), 2) *Intensity of Ideation* (5 items), *Suicidal Behavior* (5 items), *Actual Suicide Attempts* (2 items). The dimension-items from Suicide Ideation and Suicide Behavior had binary responses (yes/no). The dimension-items from Intensity of Ideation and Actual Suicide Attempts had a six point Likert scale (ranging from 0 to 5) and a three point Likert scale (ranging from 0 to 2). Concerning the quality of the data, in our clinical sample, all the suicidal dimensions were found to be not normally distributed as tested with One-Sample-Kolmogorov-Smirnov tests for their goodness of fit. However we found the distribution of the items to be fit for further analysis in respect of their skewness and kurtosis values. The scores showed small, mainly positive, deviations from normality as revealed by their Skewness *z*-values and kurtosis, indicating that most of the participants tended to answer negatively to the items. The Kurtosis indices were within an acceptable range in the clinical sample, although they tended to a more leptokurtic distribution. The distribution flatness resulted from the higher concentration of the data around its mean, accounting for the larger level of variance within the samples.

-The dimension Suicide taken from the Symptom Checklist -90 -Standard (Suicide SCL-90) was the second survey instrument used to collect the suicide ideation and the intensity of suicidal ideation throughout the entire sample. The Symptom Checklist 90 (SCL-90***)*** is a highly established self-report scale designed to investigate a broad range of psychological problems. The ability of the symptom-check-list (SCL-90-R) to identify and define acute suicidal tendencies has been demonstrated in many studies (Mangholz & Manfred 2006; Tinakon & Nahathai 2013; Recklitis 2015). The suicidal dimension (Suicide SCL-90) included two sub-dimensions (based on two items): “Suicidal Ideation”, and “Intensity of Suicidal Ideation”. Both items are assessed by a six point Likert scale ranging from 0 [“not at all”] to 5 [“extremely”] (Appendix SCL-90). The Cronbach *α* for the scale was 0.82

3.4 Dimensions of Religious/Spiritual Well-Being

Beyond the five items in the socio-demographic data which measured different definitions, intensities or categorizations of spirituality, we decided to elevate the content of the different dimensions of spirituality by using the Multidimensional Inventory for Religious/Spiritual Well-Being (MIRSWB). This questionnaire comprises six distinct dimensions, each with eight items for every dimension, for a total of 48 items. In total there

are six different dimensions of RSWB to be measured by the instrument: “Hope Immanent” (HI) - “I view the future with optimism”; “I think my life is moving in the right direction”, “Forgiveness” (FO) - “There are things which I cannot forgive*[1]”; “I have forgiven those who have hurt me”, “Experience of Sense and Meaning” (SM) - “I have experienced deep affection”; “I have experienced true friendship”, “Hope Transcendent” (HT) - “All hope ends with death*”; “I would do anything to prolong the lives of those I love*”, “General Religiousness” (GR) - “My faith gives me a feeling of security”; “ I know that God is merciful” and “Connectedness” (CO) —“I believe that I will be reborn after death”; “There are people with whom I feel a supernatural connection” (Unterrainer, Nelson, Collicutt, & Fink, 2012). It was also possible to identify two large overdimensions groups. The first three dimensions “Hope immanent”, “Forgiveness” and “Experience of sense and Meaning” represented the values of experiential spirituality. Together they comprised “Existential Well-being” (EWB). The other three dimensions “General religiousness”, “Hope transcendent” and “Connectedness” comprised “Religious Well-Being” (RWB) which represented transcendent, ideological spirituality. Concerning the scale-quality, all of the MI-RSB-I sub-dimensions as well as the total score (RSB), except for “General Religiousness”, were found to be normally distributed as tested with One-Sample-Kolmogorov-Smirnov test for their goodness of fit. The scores showed small, mainly negative, deviations from normality as revealed by their *Skewness z-values* and *Kurtosis*, indicating that most of the participants tended to answer positively to the items. The Kurtosis indices were within the acceptable range in this sample, although they tended to a more mesokurtic distribution. The distribution flatness resulted from the lesser concentration of the data around its mean, accounting for the larger level of variance within the sample. In this study we found Cronbach *α* for the scales as ranging from .70 to .94.

3.5 Personality Characteristics

The ***Big Five Inventory Test*** (***BFI 44)*** is a self-report inventory, developed to measure the Big Five dimensions of personality (Traits); “Neuroticism” (N), “Extraversion” (E), “Agreeableness” (A), “Conscientiousness” (C) and “Openness” (O), by means of items per each dimension (in total 44 items). Each of the factors is further divided into personality facets. “Neuroticism” in: Anxiety (tense), Angry hostility (irritable), Depression (not contented), Self-consciousness (shy), Impulsiveness (moody), Vulnerability (not self-

[1]Items marked with an asterisk [*] are inversely coded. Please contact the corresponding author for details about the list of items (including a short manual in Italian language).

confident). “Extraversion” in: Gregariousness (sociable), Assertiveness (forceful), Activity (energetic), Excitement-seeking (adventurous), Positive emotions (enthusiastic), Warmth (outgoing). “Agreeableness” in: Trust (forgiving), Straightforwardness (not demanding), Altruism (warm), Compliance (not stubborn), Modesty (not show-off), Tender-mindedness (sympathetic). “Conscientiousness” in: Competence (efficient), Order (organized), Dutifulness (not careless), Achievement striving (thorough), Self-discipline (not lazy), Deliberation (not impulsive). “Openness” in: Ideas (curious), Fantasy (imaginative), Aesthetics (artistic), Actions (wide interests), Feelings (excitable), Values (unconventional). A five point Likert scale, ranging from 0 (“not like me at all”) to 4 (“absolutely like me”) has been applied to all mentioned scales. The 44 items are short phrases with relatively accessible vocabulary. As demonstrated by many authors (Bouchard & McGue 2003; Tkach & Lyubomirsky 2006; Shiota Keltner & John 2006) the BFI has convincing psychometric properties. Furthermore in our study, all of the BFI -44 dimensions, were found to be normally distributed as tested with One-Sample-Kolmogorov-Smirnov test for their goodness of fit. Also in this case the scores showed small, mainly negative, deviations from normality as revealed by their Skewness *z*-values and kurtosis, indicating that most of the participants tended to answer positively to the items. The Kurtosis indices were within the acceptable range in the clinical and student sample, although they tended to a more mesokurtic distribution. In this study we found Cronbach *α* for the scales as ranging from *.69* to *.83*

3.6 Psychiatric Symptoms

As mentioned previously the *Symptom Checklist -90 –Standard (SCL-90-S)* was used to investigate the dimension “*suicide”* on the entire sample. The SCL-90-S as a highly established self-report questionnaire was used to investigate a broad range of psychological problems and symptoms of psychopathology (Derogatis & Savitz, 1999). There are nine dimensions of psychiatric symptoms, namely “Psychoticism”, “Interpersonal Sensitivity”, “Hostility/Aggressivity”, “Anxiety”, “Somatisation”, “Phobic anxiety”, “Paranoid Ideation”, “Depression”, “Obsessive-Compulsion” and additional questions. The symptom severity for the past 7 days was rated on a 5-point likert scale ranging from 0 (“not at all”) to 5 (“extremely”). Due to the inclusion of both clinical and student samples we decided to expand the asked period of time from *the past 7 days* to the *prior month*. It was also possible to calculate a global mental impairment through the Global-Severity-Index (GSI) by summing up all the sub-scales. In our inpatients samples, all the SCL-90 dimensions, except for “Aggressivity” and “Phobic anxiety” were found to be normally distributed as tested with One-

Sample-Kolmogorov-Smirnov test for their goodness of fit. On the other hand, in our student samples all of the SCL-90 dimensions were found to be not normally distributed, except for "Depression". However we found that the distribution of the items was fit for further analysis in respect of their skewness and kurtosis values. The scores showed small and positive deviations from normality as revealed by their skewness *z*-values and kurtosis, indicating that most of the participants tended to answer negatively to the items. The Kurtosis indices were within the acceptable range in the clinical and student sample, although they tended to a more leptokurtic distribution. In this study we observed a Cronbach *α* for the scales as ranging from *.77* to *.90*

4 Results

4.1 Socio-Demographic Data

Evaluation of the socio-demographic data revealed that in Styria (middle-eastern Austria) the level of education (based on the highest graduation) on the inpatients sample was as follows: 68.1% with compulsory education, 20.3% with higher school education, 2.9% with bachelor´s degree, 7.2% with master´s degree and 1.4% with a doctorate (PhD). For the middle-eastern Austrian student sample the level of education was: 66.1% higher school education, 20.8% bachelors' degree, 13.1% master's degree. In South Tyrol &Veneto (north Italy) on the inpatients sample the distribution was as follows: 44.6% compulsory education, 39% higher school education, 11.6% bachelor's degree and 2.7% masters' degree. In the north Italian student sample the level of education was: 99.4% higher school education and 0.6% with a master's degree. In Lazio (central Italy) within the inpatients sample we found: 29.6% compulsory education, 38.4% higher school education, 6.45% bachelor´s degree, and 24% master´s degree. In the middle Italian student sample the level of education was: 93.5% higher school education and 6.5% with a master's degree.

Moreover 84.8% of the tested inpatients in Styria believed in a divine dimension (Believers) and 15.2% did not believe (Nonbelievers). The main religion was "Roman Catholic" 76.1%, followed by "Non-Denominational" 19.6% and "Others" 4.3% (Buddhism, Continental reformed Church, Islam etc.). Of the Styrian student sample 50.2% were Believers and 49.8% Nonbelievers. The main religion was "Roman Catholic" *67%,* "Non-Denominational" 30.3% and "Others" 2.7%. In South Tyrol &Veneto (north Italy) in the inpatients sample we had: 69.2% "Believers" and 30.8% "Nonbelievers". The main Religion was "Roman Catholic" with *67.1%* followed by "Non-Denominational" 31.5% and "Others" 1.4%. Of the north Italian student sample *52.2%* were "Believers" and 47.8% "Nonbelievers". The main religion was "Roman Catholic" 53.1% followed by "Non-Denominational" 40.3% and "Others" 6.6%. In Lazio (central Italy) 76% of the inpatients sample were "Believers" and 24% "Nonbelievers". The main religion was "Roman Catholic" 63.2% followed by "Non-Denominational" 30.4% and "Others" 6.4%. Of the middle Italian student sample 71.7% were "Believers" and 28.3% "Nonbelievers". The main religion was also "Roman Catholic" 73.9%, "Non-Denominational" 25% and "Others" 1.1% (see Table 1.1).

Within the "Believers" group in both Styrian samples the majority defined themselves as "Theists" or as "Pantheist". In South Tyrol/Veneto and in Lazio the majority of "Believers" defined themselves as "Theist" or as "Deist". Regarding the group of "Nonbelievers" in the Styrian clinical sample, the majority defined themselves as Agnostic. In the Styrian student

sample there were no differences and in Italy in all subsamples the majority of the "Nonbelievers" group was Atheist. The distribution of the intensity of the participant´s belief and how they define themselves is revealed on Table 2.

Table 1.1- Subsample distribution from believers, nonbelievers and confession of faith

		Believers	Nonbelievers	Roman Catholic	Non-denomi.	Others
Styria	Patients	84,8	15,2	76,1	19,6	4,3
	Students	50,2	49,8	67	30,3	2,7
South Tyrol/Veneto	Patients	69,2	30,8	67,1	31,5	1,4
	Students	52,2	47,8	53,1	40,3	6,6
Lazio	Patients	76	24	63,2	30,4	6,4
	Students	71,7	28,3	73,9	25	1,1

Subsample distribution in %

Table 2- Intensity of the participant's belief & how they define themselves in the different subsamples

		Atheist	Agnostic	Deist	Pantheist	Theist
Styria	Patients	4,3	21	5,8	16,7	52,2
	Students	25,8	25,8	4,1	22,6	21,7
South Tyrol/Veneto	Patients	14,4	12,3	15,1	5,5	52,7
	Students	22,2	16,9	5,3	6,3	49,4
Lazio	Patients	9,6	6,4	22,4	7,2	54,4
	Students	10,9	9,8	6,5	3,3	69,6

Subsample distribution in %

4.1.1 Diagnostic geographical differences

In the clinical samples it was very important to identify the psychiatric ICD-10 diagnoses and to establish whether there were regional differences in mental disorders. For this purpose we examined the clinical diagnosis from the clinical files obtained from the archives of each hospital. It was interesting to note that in Lazio (central Italy) the most common diagnosed mental disorders were: *F1.x -Mental and behavioral disorders due to psychoactive substance* use and *F31.x -Bipolar disorders*. In South Tyrol & Veneto (north Italy) the most common diagnosed mental disorders were: *F33.x -Major recurrent depressive disorders* and *F60.x -Specific personality Disorders* and in Styria (middle eastern Austria) the

most common diagnosed mental disorders were: *F33.x -Major recurrent depressive disorders* and *F32.x -Depressive disorders*. From these data we noted an increasing tendency on *Depression* diagnoses the further north the inpatients lived. The diagnosis distributions in the three different regions are shown in Table 3.

We correlated the distribution values of "Suicidal ideation", "Suicidal behavior", "Religiosity" and "Spirituality" to the different diagnosis we didn't note any significant pattern between the single diagnoses and "Suicide ideation", "Suicide behavior", "Spirituality" and "Religiosity". Nonetheless, it was possible to observe that the diagnosed patients with "Anxiety disorder" (F 40.x, F 41.x) revealed without a significant difference, the lowest values in "Suicide ideation" (*M*=1.13, *SD*=1.45), in Suicide behavior (*M*=0.13, *SD*=.50) but also in "Spirituality" (*M*=3.19, *SD*=1.27) and in "Religiosity" (*M*=2.49, *SD*=1.09). The highest values in "Suicidal ideation" (*M*=4.25, *SD*=0.9) and in "Religiosity" (*M*=4.25, *SD*=0.5) and "Spirituality" (*M*=4.25, *SD*=0.5), were manifested by the patients with the diagnosis of "*Compulsive-obsessive disorder*" (F 42.x). Furthermore the highest values in "Suicide behavior" (*M*=1.33, *SD*=1.15) were seen in patients diagnosed with "Dissociative and conversion disorder" (F 44.x) (see Figure 4).

Figure 4

ICD-10 Diagnosis & Suicidal Ideation, Suicidal Behavior, Religiosity and Spirituality

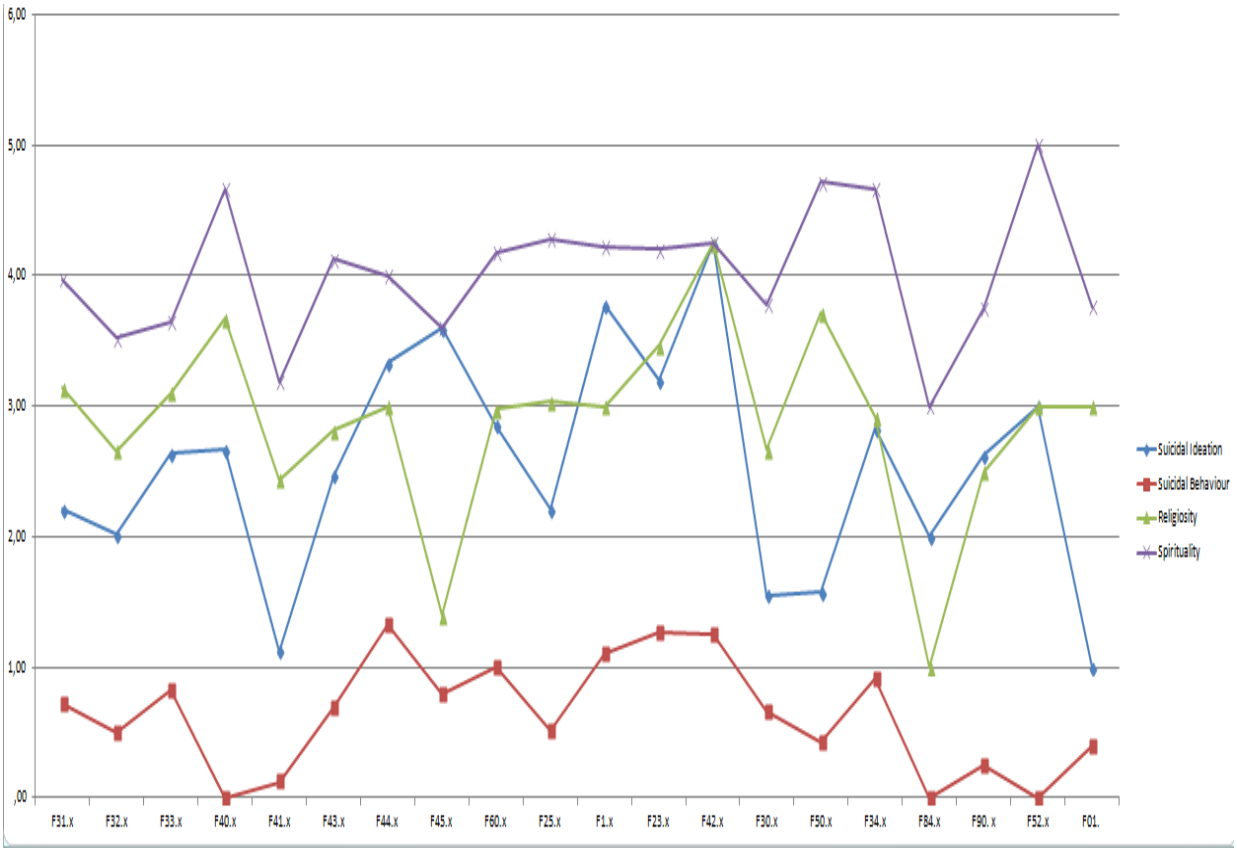


Table 3 - Inpatients' Diagnosis ICD-10

.

		Lazio	South Tyrol/Veneto	Styria
Bipolar D.	1- F 31.x	17,6	13,0	12,3
Depres. D.	2- F 32.x	12,8	6,2	18,1
Maj-recurr. Depre D.	3 -F 33.x	-	19,2	35,5
Phob.anxiety D.	4 -F 40.x	-	1,4	,7
Other anxiety D.	5 –F 41.x	-	8,2	2,9
Adjustment D.	6 -F 43.x	,8	8,2	13,8
Dissocia. & conver. D.	7 -F 44.x	-	,7	1,4
Somatof.D.	8 -F 45.x	-	-	3,6
S.Personal.D.	9 -F 60.x	11,2	13,7	4,3
Schizoaffective. D.	10- F 25.x	16,8	3,4	2,2
Sedative, hypnotic, or anxiolytic related D.	11- F 13.x	,8	3,4	2,2
Brief psychotic D.	12- F 23.x	6,4	3,4	1,4
Obsessive-compulsive D.	13 -F 42.x	-	1,4	1,4
Manic episode	14- F 30.x	-	6,2	-
Eating D.	15 -F 50.x	3,2	2,1	-
Persistent affective D.	16 -F 34.x	6,4	2,7	-
Pervasive developmental D.	17- F 84.x	-	,7	-
Attention-deficit hyperac. D.	18 -F 90.x	-	5,5	-
Sexual dysfunction	19- F 52	-	,7	-
Mental &behave. D. due to use of psychoactive subst.	20- F 1 x	24,0	-	-

Subsample distribution in %

4.2 Gender Differences

Because of the large sample we tested and to our complex design, it was crucial to establish whether gender differences would play an important role on suicide dimensions; it was therefore necessary to further subdivide all subsamples accordingly. As seen in Table 4.1 there were no gender differences in any suicide dimensions in both total samples. For this reason we didn't include "Gender" as a factor in all our further analyses. However we found gender differences in both samples in the *Big Five* personality characteristics regarding "Agreeableness", "Conscientiousness" and "Neuroticism" and in the dimensions of religious/spiritual wellbeing (MI-RSB) as "Forgiveness", "Hope Transcendent", "Experiences of Sense and Meaning" and in "Spirituality". The final two dimensions presented differences only in the student sample. The female sample showed higher values in all variables mentioned above, except for "Hope Transcendent". The male subsample revealed in "Hope Transcendent" the highest values (M=32.57 SD=7.74). The female subsample on the total student sample presented higher values than the females of the total clinical sample in "Forgiveness" (M=34.55 SD=7.79), "Experiences of Sense and Meaning" (M=37.33 SD=5.62) and in "Religious/Spiritual Wellbeing" (M=183.91 SD=27.88). Contrariwise in the *Big Five* personality characteristic of "Agreeableness" (M=33.79 SD=5.34), "Conscientiousness" (M=32.88 SD=6.66) and also in "Spirituality" (M=4.04 SD=1.54), the females of the total clinical sample revealed higher values than the females of the total student sample.

Table 4.1- Differences between Males and Females

		Total Clinical Sample						Total Student Sample					
				M		F				M		F	
	α	T	p	Mean	SD	Mean	SD	T	p	Mean	SD	Mean	SD
SCL-90_ Global Mental Impairm.	.97	.90	.368	1.07	.66	1.01	.69	-.51	.611	.65	.42	.68	.48
SCL-90_Suicide	.82	1.00	.314	2.16	2.48	1.91	2.37	1.47	.142	.81	1.35	.61	1.34
Extraversion	.83	-.59	.550	24.69	5.69	25.08	6.97	-1.74	.081	25.29	5.80	26.33	6.19
Agreeableness	.69	-2.79	.003	32.26**	5.60	33.79**	5.34	-4.72	.000	30.65**	5.21	33.01**	5.10
Conscientiousness	.80	-2.88	.004	30.98**	6.46	32.88**	6.66	-3.83	.000	30.19**	6.48	32.46**	5.95
Neuroticism	.80	-.94	.340	27.22	5.63	27.80	6.51	-3.81	.000	23.87**	6.60	26.16**	6.00
Openness	.81	.53	.071	36.33	7.27	35.91	8.21	1.80	.071	38.70	6.05	37.59	6.36
MIRSB_GR	.94	.31	.750	26.56	12.16	26.18	12.55	-1.62	.105	20.00	11.91	21.86	11.72
MIRSB_FO	.83	-3.13	.001	31.50**	9.72	34.42**	9.00	-3.32	.001	31.99**	8.36	34.55**	7.79
MIRSB_HI	.87	-.16	.870	30.29	9.24	30.46	10.33	-1.45	.147	32.48	7.17	33.45	6.80
MIRSB_CO	.78	-.37	.707	26.77	8.84	27.13	10.02	-2.13	.033	24.27	7.92	25.91	7.90
MIRSB_HT	.70	-.36	.714	29.89	7.50	30.16	7.55	2.40	.006	32.57**	7.74	30.81**	7.49
MIRSB_SM	.72	-.10	.916	35.23	6.86	35.31	8.11	-2.07	.039	36.19*	5.84	37.33*	5.62
MIRSB_RSWB	.87	-1.07	.282	180.2	28.54	183.6	33.80	-2.33	.020	177.5*	29.37	183.9*	27.88
Religiosity	-	-1.00	.920	2.95	1.61	2.97	1.60	-2.14	.032	2.28*	1.53	2.59*	1,49
Spirituality	-	-1.97	.005	3.72**	1.64	4.04**	1.54	-2.11	.000	3.24**	1.68	3.79**	1.49
Suicidal Ideation	-	.24	.808	2.37	2.00	2.32	2.00						
Intensity of Ideation	-	-.21	.830	8.45	7.28	8.61	7.12						
Suicidal Behavior	-	.67	.500	.74	.93	.67	.93						
Actual Suicide Attepts	-	.97	.330	.51	.94	.61	1.11						

***= Significant differences between Males and Females* at the *p< .01 level (2-tailed). *= Significant differences between Males and Females* at the *p< .05 level (2-tailed). GR = "General Religiousness"; FO = "Forgiveness"; HI = "Hope Immanent"; HT = "Hope Transcendent"; CO = "Connectedness"; SM = "Experiences of Sense and Meaning"; RSWB = Religious /Spiritual Well-Being;*

4.3 Significant Correlations

The next step consisted in conducting a *Pearson product-moment correlation coefficient (r)* and *t tests.* These measures were used to understand further about the degree of the main linear dependence between two *interval-scale variables*. We calculated separately the correlations between all the interval-scale variables for the inpatient sample

and the student sample. As a second step we calculated the correlations for both samples together, between "Suicide (SCL-90)", "Global Mental Impairment (GSI-SCL-90)", the Big Five factors of personality model (BFI), "Religiosity", "Spirituality", the six dimensions of religious/spiritual wellbeing (MI-RSB), and the nine dimensions of psychiatric symptoms (SCL-90) (see Table 5). All the reported correlation coefficients were tested by *0.01* significant levels *(2-tailed)*.

4.3.1 Main correlations with Age

In our total clinical sample we found "*Age"* being positively associated with *"Religiosity"* (r =.29, p<.01), "*Spirituality"* (r =.22, p<.01), "*General Religiousness"* (r =.32, p<.01), "*Forgiveness"* (r =.22, p<.01), "Existential Well-being" (r =.11, p<.01), "Religious Well-Being" (r =.22, p<.01), and the *Big Five* personality trait, "*Agreeableness"* (r =.22, p<.01), "Conscientiousness" (r =.14, p<.01). Age also turned out to be negatively related to the psychiatric symptoms of "Interpersonal sensitivity" (r =-.14, p<.01) and "Hostility/Aggressivity" (r =-.16, p<.01). The total student sample was too young (Mean age M=22.1) and too homogenous to reveal any effects that "Age" might have had on the correlations.

4.3.2 Main correlations with the Big Five personality Traits

The suicide dimensions of *C-SSRS* as well as the suicide dimension or the *"*Global Mental Impairment" of *SCL-90-S* were found to correlate significantly with at least one of the Big Five personality traits in both samples. "Extraversion" was found to be negatively related with "Global Mental Impairment" as well as with "Suicidal Ideation" (r =-.11, p<.01), "Intensity of Ideation" (r =-.13, p<.01), "Suicide SCL-90" (r =-.14, p<.01; r =-.12, p<.01) and with "Global Mental Impairment (GSI)" (r = -.26, p<.01) in both samples (see: Table 5). "Neuroticism" conversely, turned out to be substantially positive correlated to "Global Mental Impairment" (r =.54 p<.01) and to all suicide dimensions as "Suicidal Ideation" r =.14, "Intensity of Ideation" r =.24, "Suicidal Behavior" r =.10, "Suicide SCL-90" r =.22 (Clinical S), "Suicide SCL-90" r =.23 (Student S.) except for "Actual Suicide Attempts". Furthermore in the total student sample we found negative correlations between Conscientiousness and Suicide

SCL-90 (r =-.14, p<.01) and between Agreeableness and Suicide SCL-90 (r =-.12, p<.01) (see Table 5).

4.3.3 Main correlations with the religious/spiritual dimensions

Moreover in our total clinical sample, “Spirituality” tended to be positively related to “Suicidal Ideation” (r =.11 p<.01), “Intensity of Ideation” (r =.11 p<.01), and to “Suicidal Behavior” (r =.10 p<.01). In our total sample “Spirituality” also shows a positive relation to “Global Mental Impairment” (r =.11 p<.08). “Religiosity” tended to be positively related to “Actual Suicide Attempts” (r =.10 p<.01) in our total clinical sample and to “Suicide SCL-90” (r =.08 p<.01) in our total sample (see Table 5).

The dimensions of “Religious/Spiritual Well-Being” (MI-RSB) were found to correlate negatively with at least one of the suicide dimension, except for “General Religiousness” which tended to a positive relation with “Suicide SCL-90” (r =.07 p<.01) (see Table 5) but also with the psychiatric symptoms of “Psychotizismus” (r =.08 p<.01) in our total sample. “Hope Immanent” presented in both samples the strongest negative relation to all suicide dimensions and to the “Global Mental Impairment” (see Table 5). Also a tendency of negative correlations was found for the dimension “Forgiveness” to “Intensity of Ideation” (r =-.11 p<.01), to “Suicide SCL-90” (r =-.16 p<.01), and to “Global Mental Impairment” (r =-.28 p<.01) (see Appendix, Correlation Table 1, 2, 3). And finally “Connectedness” was the second dimension which tended to a positive relation with “Global Mental Impairment” (r =.10, p<.01) and almost with all the other psychiatric symptoms in our total student sample and with “Paranoid Ideation” (r =.12, p<.01) in our total clinical sample (see Appendix, Correlation Table 1).

4.3.4 Main correlations with psychiatric symptoms

In addition, in both samples the “Depression” symptoms, “Anxiety” symptoms, “Phobic anxiety” symptoms and “Obsessive-Compulsion” symptoms turned out to have the highest significant relations to all suicide dimensions and to the “Global Mental Impairment” (see Table 5). “Psychoticism” turned out to be positively related for the most with “Suicide SCL-90” in all three total samples.

Table 5 – Correlations between the four dimensions of suicide (*C-SSRS)* + suicide (SCL-90), the five factors of personality model (BFI), religiosity, spirituality, the six dimensions of religious/spiritual wellbeing (MI-RSB), and the nine dimensions of psychiatric symptoms (SCL-90)

		Total Clinical Sample					Total Student Sample	Total Sample	
	α	Suicidal Ideation	Intensity of Ideation	Suicidal Behavior	Actual Suicide Attempts	Suicide SCL-90-S	Suicide SCL-90-S	Suicide SCL-90-S	Global Mental Impairment (GSI)
Age	-			.12*			-.08*	.25**	.15**
Personality Factors:									
Extraversion	.83	-.11*	-.13**	-.03	.00	-.14**	-.12**	-.15**	-.26**
Neuroticism	.80	.14**	.24**	.10*	.08	.22**	.23**	.25**	.54**
Openness	.81	.01	.01	.02	.07	-.12*	.08*	-.07*	-.15**
Conscientiousness	.80	.02	.01	.05	.03	-.01	-.14**	-.05	-.20**
Agreeableness	.69	.03	.00	.11*	.12*	.00	-.12**	-.04**	-.17**
Spirituality	-	.11*	.11*	.10*	.08	.08	,05	.04	.08**
Religiosity	-	.03	.01	.09	.10*	.09	-.03	.08**	.07*
Dimensions of Religious/Spiritual Well-Being (MIRSWB)									
Hope Immanent	.87	-.18**	-.27**	-.12**	-.19*	-.26**	-.23**	-.28**	-.38**
Forgiveness	.83	-.10*	-.11*	-.07	-.03	-.16**	-.15**	-.16**	-.28**
Experience of Sense and Meaning	.72	.01	-.00	.00	-.02	-.13**	-.05	-.14**	-.09**
Hope Transcendent	.70	.05	.05	.02	.05	-.07	-.28**	-.12**	-.30**
General Religiousness	.94	.03	-.01	.05	.01	.03	.05	.07**	.05
Connectedness	.78	.03	.01	.09	.05	.01	.05	.05	.10**
Mental Health (SCL90)									
Somatisation	.86	.19**	.25**	.18**	.10*	.38**	.30**	.40**	.80**
Obsessive-Compulsion	.87	.25**	.29**	.21**	.11*	.46**	.42**	.49**	.87**
Interpersonal Sensitivity	.86	.25**	.26**	.11**	.12**	.46**	.36**	.41**	.85**
Depression	.90	.36**	.40**	.32**	.21**	.63**	.52**	.63**	.91**
Anxiety	.88	.25**	.30**	.25**	.15**	.50**	.44**	.53**	.91**
Hostility/Aggressivity	.77	.22**	.23**	.20**	.13**	.35**	.39**	.37**	.71**
Phobic anxiety	.85	.22**	.26**	.24**	.13**	.42**	.43**	.49**	.77**
Paranoid Ideation	.78	.19**	.23**	.17**	.13**	.39**	.37**	.39**	.77**
Psychoticism	81	.22**	.26**	.27**	.13**	.48**	.47**	.52**	.84**

** Significant correlations at the *p< .01 level (2-tailed)*. * Significant correlations at the *p< .05 level (2-tailed)*.

4.4 Differences among groups

The next step consisted in conducting a one-way multivariate analysis of variance (MANOVA) for comparing multivariate sample means. This multivariate procedure was applied for testing the impact of more nominal scaled variables on an interval scaled variable. This procedure was followed by significance tests with "Bonferroni correction", involving individual dependent variables. This procedure helped us to answer the question of whether changes in the independent variables (e.g. "Regional differences", "Believe in a divine dimension", "Spirituality", "Personality dimension" etc.) had significant effects on the suicide dimensions and mental health?

We began with a review of the MANOVA requirements such as the variance homogeneity with *Levene Test* and multivariate normal distribution with *Kolmogorov-Smirnov test*. For most of the following results it was very unrealistic to fulfil all MANOVA requirements due to the strict criteria we dispose. For this reason we undertook further inspections of skewness and kurtosis for only the relevant variables subjecting them to further tests only if they met the criteria.

We proceeded by analyzing the significant effects of the co-variables "Age", "Region", "Spirituality" and "Religiosity" on the suicide dimensions in our clinical sample. We observed that "Age" had a significant effect on "Suicide behavior" (F=4.39, p<.03) in all clinical samples and "Region" had a significant effect on "Suicide ideation" (F=5.06, p<.007), on "Intensity of ideation" (F=3.51, p<.007), and on "Suicidal behavior" (F= 4.07, p<.009). "Spirituality" tended also to a significant effect on the "Intensity of suicidal thoughts" (F=3.41 p<.06) and on "Suicidal behavior" (F=4.67, p<.03).

4.4.1 Intercultural and Intra-cultural differences

The next step was to further research the co-interaction of "Region" x "Believers" and "Nonbelievers" on suicide dimensions. In this regard we found significant differences between the analyzed regions on "Suicidal Ideation" of "Believers" (M=2.97 SD=1.88) and "Nonbelievers" (M=2.62 SD=1.85). The Styrian "Believers" presented the highest values in "Suicidal Ideation" and "Suicidal behaviour" (M=.99 SD=1.11) but not in "Actual suicide Attempts". Here, the "Believers" of the north-Italian sample (M=.71 SD=.93) and the

“Nonbelievers” of central-Italian sample (M=.90 SD=.99) presented higher values as the Austrian sample (see Table 6).

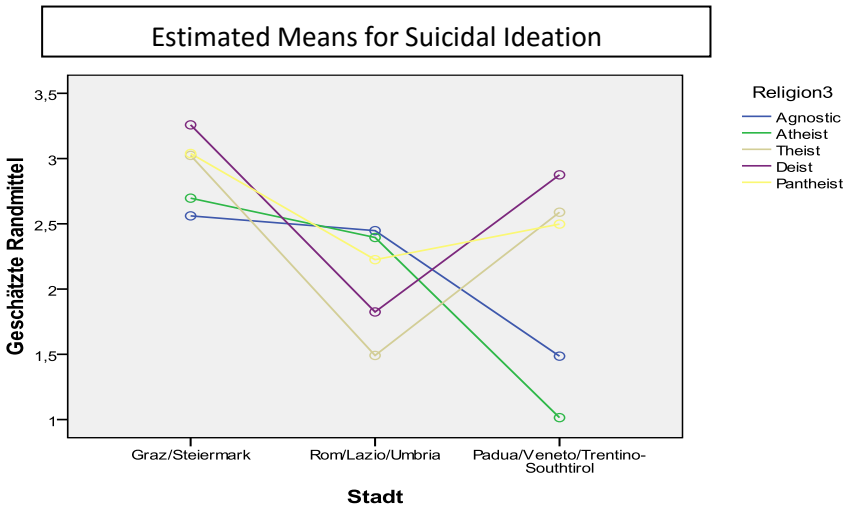
The first two self definition categories “Atheist” and “Agnostic” composed the group of “Nonbelievers”. The other three self definition categories “Deist”, “Pantheist” and “Theist” composed the group of “Believers”. As shown in **Figure 1**, we found that the Styrian (middle-east Austrian) psychiatric inpatients who define themselves as “Deist” (*M*=3.38 *SD*=1.68) or as “Pantheist” (*M*=3.13 *SD*=1.74) revealed the highest values in “Suicidal Ideation”. Between South Tyrol/Veneto (north Italy) and Lazio (central Italy) there were no significant regional differences. With the Styrian psychiatric patients was noted almost the same pattern for “Suicidal Behaviour” and “Deists” (*M*=1.50 *SD*=1.30) and also for “Suicidal Behaviour” and “Theists” (*M*=1.01 *SD*=1.20). In northern Italy, the highest values in “Suicidal Behavior” were found by “Pantheists” (*M*=.75 *SD*=1.03) and “Theists” (*M*=.75 *SD*=0.94) whereas in middle Italy the highest values in “Suicidal Behavior” were found by “Pantheists” (*M*=.78 *SD*=1.09) and “Agnostics” (*M*=.63 *SD*=.74) (see Table 6, see Figure 1, 2, 3).

Table 6- Regional differences in suicide-dimensions among clinical subsamples, believers / nonbelievers and self definition/intensity of believe**.**

		Region x Believers / Nonbelie. or Self definition		Suicidal Ideation		Region x Believers / Nonbelie. or Self definition		Suicidal Behaviour		Region x Believers / Nonbelie. or Self definition		Actual Suicide Attempts	
		F	p	Mean	SD	F	p	Mean	SD	F	p	Mean	SD
	Believers	13.6	,008	2.97**	1.88	3.10	.046	.96*	1.11	7.1	.001	.23	.60
	Nonbelievers			2.62**	1.85			.76*	.94			.05	.21
Styria (Austria)	1 Agnostic	1.87	,053	2.48	1.84	.913	.505	.69	.89	2.51	,011	.07	.37
	2 Atheist			2.50	2.07			.67	1.03			.00	.00
	3 Theist			3.00	1.94			1.01	1.20			.26	.65
	4 Deist			3.38**	1.68			1.50	1.30			1.00	.92
	5 Pantheist			3.13*	1.74			1.00	.85			.04	.20
	Believers	13.6	,008	2.78	2.00	3.10	.046	.75	.94	7.1	.001	.71**	.93
	Nonbelievers			1.18	1.49			.31	.59			.33**	.67
South Tyrol/Veneto (N. Italy)	1 Agnostic	1.87	.053	1.43	1.66	.913	.505	.43	.67	2.51	.011	.48	.75
	2 Atheist			.83	1.26			.22	.54			.28	.66
	3 Theist			2.61	2.10			.75	.94			.70	.93
	4 Deist			2.91	1.60			.55	.85			.50	.85
	5 Pantheist			2.63	2.38			.75	1.03			.75	1.0
	Believers	13.6	,008	1.52	1.86	3.10	,046	.47	.74	7.1	.001	.47**	.82
	Nonbelievers			2.67	2.09			.67	.75			.90**	.99
Lazio (Central Italy)	1 Agnostic	1.87	.053	2.38	2.06	.913	.505	.63	.74	2.51	.011	.75	1.03
	2 Atheist			2.25	2.09			.50	.52			.83	1.03
	3 Theist			1.53	1.92			.46	.72			.43	.77
	4 Deist			1.86	1.90			.57	.79			.71	.97
	5 Pantheist			2.44	2.45			.78	1.09			.78	.97

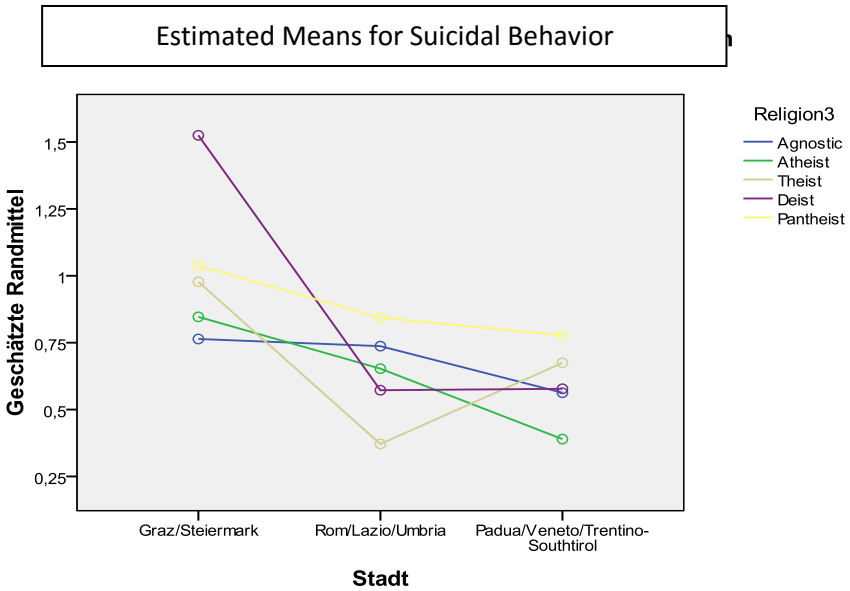
**= *Significant Differences* between Regions at the *p< .01 level (2-tailed) ; *= *Significant Differences between Regions* at the *p< .05 level (2-tailed);*

Figure 1. Suicidal Ideation



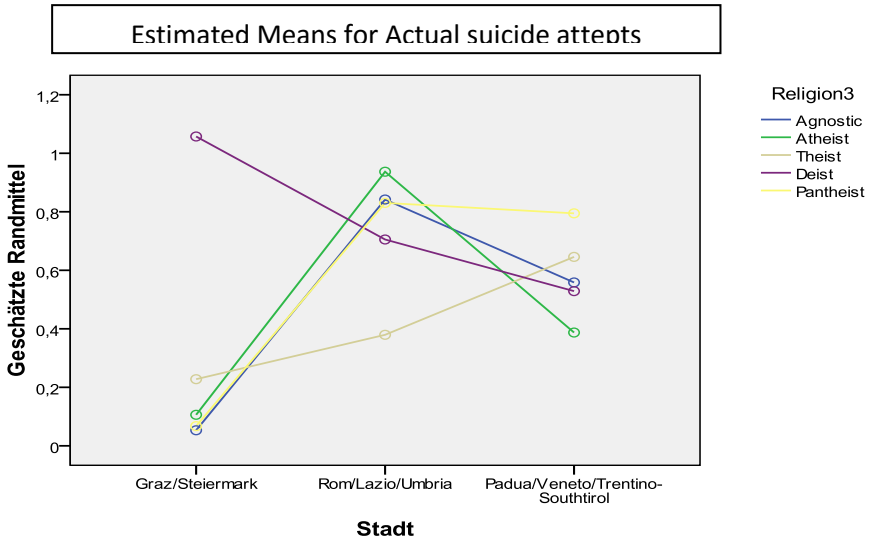
Die Kovariaten im Modell werden anhand der folgenden Werte berechnet: Alter = 40,46, Religiosität = 2,96, Spiritualität = 3,90

Figure 2. Suicidal Behaviour



Die Kovariaten im Modell werden anhand der folgenden Werte berechnet: Alter = 40,46, Religiosität = 2,96, Spiritualität = 3,90

Figure 3. Actual suicide attempts



Die Kovariaten im Modell werden anhand der folgenden Werte berechnet: Alter = 40,46, Religiosität = 2,96, Spiritualität = 3,90

4.4.2 Differences in Psychiatric Symptoms

We also observed that “Region” and “Clinical State” (patients vs. students) had the highest significant impact on all dimensions of psychiatric symptoms including “Suicide SCL-90” (F=14.50, p<.000) and “Global Mental Impairment GSI” (F=26.14, p<.000). Spirituality revealed also a significant effect on “Somatisation” (F=6.25, p<.013), “Paranoid Ideation” (F=5.08, p<.024) and on “Global Mental Impairment (GSI)” (F=4.19, p<.041). The clinical sample in Lazio (central Italy) compared to the other clinical samples, revealed the lowest values in “Depression” (M=10.96 SD= 9.21), and “Global Mental Impairment” (M=.55 SD=.47). Styria (middle-east Austria) presented in the same variables the highest one. Whereas in Lazio the clinical sample and the student sample appeared to have almost the same “Global mental impairment” levels (see Table 7). The clinical sample in South Tyrol/Veneto presented the lowest values in “Anxiety” (M=6.74 SD=6.27) and in “Suicide SCL-90” (M=1.02 SD= 1.71).

4.4.3 Differences in the Big Five Personality Traits

Regarding the Big Five personality traits we noted that “Region”, “Clinical state”, “Age” and “Spirituality”, still represented the highest impact in almost all personality characteristics. In “Extraversion” “Region” had an impact of F=3.75, p<.023, the “Clinical State” an impact of F=9.25, p<.002 and “Spirituality” of F=17.40, p<.000. In “Neuroticism” the impact was even more significant: Region had an impact of F=5.25, p<.005; Clinical state of F=32.00, p<.000, and “Gender” an impact of F=12.57 p<.000. Over all three regions, in the clinical samples as well as in the student samples, females revealed higher levels of neuroticisms than male subjects.

“Agreeableness” was the third variable which fulfilled almost all *MANOVA* requirements. “Gender” (F=19.60, p<.000) “Spirituality” (F=4.91, p<.027), “Religiosity” (F=10.46, p<.001) and “Age” (F=18.90, p<.000) presented a significant effect in “Agreeableness”. Females revealed higher levels in “Agreeableness” in all three regions both in the clinical samples as well as in the student samples.

Both samples in Styria revealed higher values in “Extraversion” and “Neuroticism” compared to Lazio or South Tyrol/Veneto. Lazio presented the highest values in “Agreeableness“. The student sample in all regions presented significantly higher values in “Extraversion” and lower values in “Neuroticism” and “Agreeableness” than the psychiatric patients (see Table 7).

4.4.4 Differences in the Religious/Spiritual dimensions

The Religious/Spiritual dimensions of MI-RSB as well as “Religiosity” or “Spirituality” were also significantly influenced from “Region”, “Age” and “Clinical state”. Between the Religious/Spiritual dimensions of MI-RSB, “Experience of sense and Meaning” was one which was most influenced from “Region” differences (F=17.50, p<.000) and “General Religiosity” turned out to be least influenced (F=5.22, p<.006). Region influenced significantly also the separately elevated “Religiosity” (F=11.35, p<.000) and “Spirituality” (F=14.70, p<.000). “Age” had the most effect on “Forgiveness” (F=26.00, p<.000) and the least effect on “Experience of sense and meaning” (F=4.70, p<.029).

Moreover the student sample in Styria and in South Tyrol/Veneto had significantly higher values in “Hope Immanent” (Styria M=36.05 SD=7.33; South Tyrol/Veneto M=31.72 SD=6.25) and in “Experience of Sense and Meaning” (Styria M=38.48 SD=6.01; South Tyrol/Veneto M=36.54 SD=5.25) than the clinical sample. The student sample in Lazio

presented higher values in “Religiosity” (*M*=3.23 *SD*=1.59) and “Spirituality” (*M*=4.14 *SD*=1.45) than the clinical one. The clinical samples revealed in Styria and in South Tyrol/Veneto higher values in “Connectedness” (Styria *M*=27.45 *SD*=9.23; South Tyrol/Veneto *M*=25.67 *SD*=9.48), “Hope Transcendent” (Styria *M*=30.0 *SD*=7.54; South Tyrol/Veneto *M*=30.75 *SD*=7.04), “Religiosity” (Styria *M*=2.83 *SD*=1.42), and “Spirituality” (Styria *M*=3.76 *SD*=1.54) whereby the significant differences in “Religiosity” and “Spirituality” between clinical sample and student sample were found only in Styria (see Table 7).

Table 7- Differences among patients and students

			Styria				South Tyrol/Veneto				Lazio			
			Patient		Student		Patient		Student		Patient		Student	
	F	p	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
SCL-90 Depression	7.1	.000	24,1**	12,1	9,8**	8,6	21,6**	11,3	13,1**	8,74	10,9**	9,2	12,0**	8,0
SCL-90 Anxiety	11.1	.000	16,2**	9,7	5,0**	5,2	6,7**	6,2	8,1**	6,00	14,1**	7,7	8,5**	6,5
SCL-90 Suicide	21.8	.000	2,6**	2,6	0,7**	1,2	1,0**	1,7	0,5**	1,27	2,2**	2,4	0,6**	1,4
SCL-90 GSI	9.1	.000	1,3**	0,7	0,5**	0,4	1,1**	0,5	0,7**	0,49	0,5**	0,4	0,7**	0,4
BFI Extraversion	9.2	.001	25,2**	6,6	27,1**	6,4	24,3**	6,1	25,4**	5,89	25,2**	6,5	26,1**	5,8
BFI Neuroticism	32.2	.000	27,9**	6,1	23,7**	6,0	27,7**	5,5	26,2**	5,94	26,9**	6,7	26,1**	6,4
BFI Agreeablenes	1.7	.003	33,3*	5,2	32,9*	5,1	32,4*	5,9	32,0*	5,18	33,6*	5,2	33,3*	5,2
BFI Conscientous.	6.0	.014	33,3	5,7	32,3	5,9	31,4	7,0	31,3	6,33	31,4	7,0	33,4	5,7
BFI Opennes	7.0	.008	34,1	7,4	37,9	6,5	35,8	7,4	37,8	5,99	38,4	8,1	37,0	6,9
MIRSB-GR	.08	.77	25,5	12,2	21,4	12,5	25,7	11,5	19,8	10,75	27,9	13,3	27,2	12,1
MIRSB-FO	17.0	1.00	32,5	9,8	35,0	8,3	33,8	9,3	33,0	7,70	33,1	9,1	34,8	7,7
MIRSB-HI	13.1	.001	31,7**	10,2	36,0**	7,3	29,5**	8,7	31,7**	6,26	29,9	10,6	31,7	5,7
MIRSB-CO	4.2	.001	27,4**	9,2	25,6**	9,4	25,1**	9,2	25,0**	6,85	28,5	9,8	27,1	7,1
MIRSB-HT	5.4	.000	30,0**	7,5	29,1**	7,3	30,7**	7,0	29,8**	7,24	29,2**	8,0	28,7**	7,1
MIRSB-ESM	4.9	.001	35,8**	7,4	38,4**	6,0	33,7**	6,9	36,5**	5,25	36,4	8,2	35,6	5,6
MIRSB-RSWB	10.6	.000	183,1**	34,0	190,8**	32,4	178,6**	28,9	176,0**	24,09	185,3**	31,8	185,3**	25,6
Religiosity	8.3	.001	2,8**	1,4	2,3**	1,5	2,9	1,6	2,4	1,42	3,1**	1,7	3,2**	1,5
Spirituality	14.7	.000	3,7**	1,5	3,2**	1,6	3,8	1,6	3,7	1,44	4,1**	1,6	4,3**	1,4

***= Significant Differences* at the *p< .001 level (2-tailed) ; *= Significant Differences* at the *p< .01 level (2-tailed); GR = “General Religiousness”; FO = “Forgiveness”; HI = “Hope Immanent”; HT = “Hope Transcendent”; CO = “Connectedness”; SM = “Experiences of Sense and Meaning”; RSWB = Religious /Spiritual Well-Being*

4.5 Regressions

For data reduction and causality purposes we conducted backward stepwise regressions, *R* -squared. The first two regressions were conducted on the clinical sample and included the independent variables (predictors) which, until now, showed significant effects on Suicide as: “Depression”, “Anxiety”, “Age”, “Neuroticism”, “Extraversion”, “Spirituality”, “Religiosity”, “Hope Immanent”, “Forgiveness” and “Global Mental Impairment”. We included “Suicide Ideation” from the Columbia-Suicide Severity Rating Scale as a dependent variable. After the first linear regression, there remained only two graded coefficients of determination; “Depression” accounted for 13% of explained variance (R^2=.132, β=.36, p=.000) and “Spirituality” with 0.9% (R^2=.009, β=.09, p=.041). Together both variables explained 14% of the variance and also presented a positive correlation with “Suicidal Ideation”. “Suicidal behaviour” was the second dependent variable to be analyzed with the same predictors as mentioned previously. Also in this case the graded predictors were “Depression” (R^2 =.116, β=.34, p=.000) and “Spirituality” (R^2 =.002, β=.08, p=.076).

In order to investigate the explained variance of the predictors mentioned above regarding our total sample, we conducted a second linear regression with the SCL-90 psychiatric symptom “Suicide Scl-90” as the dependent variable. Four graded predictors explained 43% of the total variance: “Depression” (R^2 =.402, β=.63, p=.000), “Age” (R^2=.018, β=.13, p=.000), “Neuroticism” (R^2=.010, β=-.14, p=.000) and “Hope Immanent” (R^2= 007, β=-.09, p=.000). The last two predictors revealed a negative causality to “Suicide SCL-90”

We repeated the same procedure on our total sample with “Global mental impairment” as a dependent variable and we found similar results. The four graded predictors explaining 92% of the entire variance of “Global mental impairment” were: “Depression” (R^2=.840, β=.50, p=.000), “Anxiety” (R^2=.077, β=.48, p=.000), “Forgiveness” (R^2=.006, β=-.28, p=.000), “Age” (R^2=.001, β=-.03, p=.000) and “Religiosity” (R^2=.001, β=.02, p=.004). “Depression” remained the strongest predictor of both dependent variables with 40% or 84% explained variance; “Hope Immanent” as well as “Forgiveness” were negatively correlated to “Suicide SCL-90” and to the “Global Mental Impairment”.

A final model was subjected to linear regressions with only the spiritual variables as independent variables (comprising Religiosity, Spirituality, Hope Immanent, Forgiveness, Experience of Sense and Meaning, Hope Transcendent, General Religiousness, Connectedness, Existential Well-being [MIRSWB_EWB], Religious/Spiritual Well-being [MIRSWB_RWB]) and “Suicide SCL-90” as dependent variable. We decided to conduct linear regressions with only the spiritual variables as we aimed to avoid the “Depression” psychiatric symptom. Due to the high explained variance, “Depression” represented a

confounding factor for the better understanding of the relationship between Spirituality and Suicide/Mental health. The same procedure was used for the total student, total clinical and total samples. In the total student sample, the four graded predictors that explained 9% of the entire variance were: “Hope Immanent” (R^2=.054, β=-.25, p=.000), “Forgiveness” (R^2=.012, β=-.10, p=.008), “Connectedness” (R^2=.014, β=.19, p=.000) and “Spirituality” (R^2=.009, β=-.12, p=.011). “Connectedness” was the only predictor positively correlated to “Suicide SCL-90”. In the total student sample the other variables represented a rather protective factor against “Suicide SCL-90”. In our total clinical sample the graded predictors that explained 10% of the entire variance were different from the student sample: “Existential Well-being” (R^2=.083, β=-.34, p=.000) negatively related to “Suicide SCL-90” and “General Religiousness” (R^2 =.022, β=.15, p=.002) positively related to “Suicide-SCL90”. The total sample presented similar results. “Existential Well-being” (R^2=.085, β=-.25, p=.000) and the associated religious/spiritual dimension of “Hope Immanent” (R^2=.008, β=-.14, p=.002) correlated negatively with “Suicide SCL-90”. “General Religiousness” (R^2=.029, β=.11, p=.001) and “Connectedness” (R^2=.009, β=.12, p=.001) correlated positively with “Suicide SCL-90” (see Table 8).

Table 8- Regressions, Scl-90_Suicide & Spiritual dimension

	Total Student Sample				Total Clinical Sample				Total Sample			
	Suicide SCL-90											
	r	R²	β	p	R	R²	β	p	r	R²	β	P
MIRSB_EWB	-	-	-	-	-,28**	,083	-,347	,000	-,291**	,085	-,256	,000
MIRSB_GR	-	-	-	-	,03*	,022	,159	,002	,075**	,029	,114	,001
MIRSB_CO	,05**	,014	,199	,000	-	-	-	-	,058**	,009	,120	,001
MIRSB_HI	-,23**	,054	-,250	,000	-	-	-	-	-,287**	,008	-,142	,002
MIRSB_FO	-,15*	,012	-,105	,008	-	-	-	-	-	-	-	-
Spirituality	-,05	,009	-,124	,011	,080	-	,076	,165	-	-	-	-
Religiosity	-	-	-	-	-	-	-	-	-	-	-	-
Total		**,090**				**,105**				**,131**		

***= Significant Explained Variance* at the *p< .001 level (2-tailed) ; *= Significant Explained Variance* at the *p< .01 level (2-tailed); GR = “General Religiousness”; HI = “Hope Immanent”; CO = “Connectedness”; FO =“Forgiveness”; EWB = “Existential Well-being”*

4.6 Post Tests

As mentioned above, neuroticism (as a personality characteristic) and depression (as a psychiatric symptom) were significantly related to suicide. For a better understanding of this relationship we investigated this connection further. Initially we researched the correlation between both variables and "Suicide SCL-90". Neuroticism and depression initially revealed a significant positive relation to suicide (r=.24, p<.001) (r=.63, p<.001 respectively). However when we conducted a partial correlation without the variable "Depression" the results were totally different. Neuroticism correlated negatively to "Suicide SCL-90" (r=-.14, p<.001) and consequently represented a protective factor against suicide.

In order to gain an overview concerning differences in the interaction between "Region" and so far the most important predictors in the student sample and in the clinical sample, we further examined these interactions by independent two -sample *T-test*. In Styria the student sample differed from the clinical sample in all analyzed predictors. For the Styrian student sample the interaction between "Region" and "Forgiveness" (*M*=35.00, *SD=8.3),* "Hope immanent" (*M*=36.05, *SD=7.3)*, "Hope Transcendent" (*M*=34.13, *SD=7.3)* and "Experience of sense and meaning" (*M*=38.48, *SD=6.3)* revealed higher values as the psychiatric patients. The clinical sample revealed the highest values in all other predictors (see Group Statistic Table 9, 10, 11). In South Tyrol/Veneto the student sample differed significantly from the clinical sample showing higher values in "Hope Immanent" (*M*=31.70, *SD=6.2)* and in "Experience of sense and Meaning" (*M*=36.50, *SD=5.2*). The clinical sample showed higher values in "Suicide" (*M*=2.32, *SD=2.4)*, "Global mental Impairment" (*M*=1.18, *SD=.57)*, "Depression" (*M*=21.60, *SD=11.3)*, "Religiosity" (*M*=2.92, *SD=1.62)* and in "General Religiousness" (*M*=25.72, *SD=11.53)*. The interaction between "Region" and each predictor were more significant for the clinical sample than for the student sample except for the predictors "Hope immanent" and ""Experience of sense and Meaning" where the student sample revealed higher values. In Lazio the student sample differed the least from the clinical sample. The differences were found in "Suicide (SCL-90)" (*M*=1.00, *SD=1.69)*, "Global Mental Impairment" (*M*=.73, *SD=.45)* and "Hope immanent" (*M*=31.7, *SD=5.73)* whereby the differences in "Suicide (SCL-90)" and in "Hope immanent" were tendencies. The student sample presented higher levels in "Global mental impairment" and in "Hope immanent", the clinical sample in "Suicide (SCL-90)".

Generally the more southern the sample, the fewer the differences between the student sample and the clinical sample (see Table 9, 10, 11) .

Table 9: Post Tests – Pairwise Comparissons of Samples -Styria

Group Statistic

	klin_State	N	Mean	SD	Standard error of Mean	Sig. (2-Tailed)
Suicide	1 Student	221	,74	1,230	,083	,000
	2 Patient	138	2,62	2,675	,228	
GSI	1 Student	221	,524	,4149	,0279	,000
	2 Patient	132	1,320	,7231	,0629	
Depr	1 Student	221	9,86	8,689	,584	,000
	2 Patient	137	23,70	12,316	1,052	
BFI_N	1 Student	217	23,63	5,981	,406	,000
	2 Patient	138	27,99	6,176	,526	
Spirituality	1 Student	221	3,29	1,634	,110	,007
	2 Patient	138	3,76	1,540	,131	
Religiosity	1 Student	221	2,36	1,512	,102	,004
	2 Patient	138	2,83	1,424	,121	
MIRSB_GR	1 Student	221	21,49	12,352	,831	,002
	2 Patient	138	25,59	12,282	1,045	
MIRSB_FO	1 Student	221	35,00	8,327	,560	,012
	2 Patient	138	32,56	9,802	,834	
MIRSB_HI	1 Student	221	36,05	7,331	,493	,000
	2 Patient	138	31,73	10,196	,868	
MIRSB_CO	1 Student	221	25,67	9,489	,638	,080
	2 Patient	138	27,45	9,238	,786	
MIRSB_HT	1 Student	221	34,13	7,357	,495	,000
	2 Patient	138	30,00	7,546	,642	
MIRSB_ESM	1 Student	221	38,48	6,016	,405	,000
	2 Patient	138	35,82	7,425	,632	

Table 10: Post Tests – Pairwise Comparisons of Samples -South Tyrol/Veneto

Group Statistik

	klin_State	N	Mean	SD	Standard error of Mean	Sig. (2-Tailed)
Suicide	1 Student	320	,60	1,411	,079	,000
	2 Patient	145	2,32	2,451	,204	
GSI	1 Student	318	,766	,4898	,0275	,000
	2 Patient	143	1,185	,5750	,0481	
Depr	1 Student	319	13,18	8,730	,489	,000
	2 Patient	143	21,60	11,306	,945	
BFI_N	1 Student	320	26,92	5,940	,332	,177
	2 Patient	145	27,70	5,525	,459	
Spirituality	1 Student	320	3,73	1,437	,080	,501
	2 Patient	146	3,84	1,598	,132	
Religiosity	1 Student	320	2,43	1,419	,079	,001
	2 Patient	146	2,92	1,625	,135	
MIRSB_GR	1 Student	320	19,80	10,750	,601	,000
	2 Patient	146	25,72	11,537	,955	
MIRSB_FO	1 Student	320	33,08	7,698	,430	,416
	2 Patient	146	33,80	9,340	,773	
MIRSB_HI	1 Student	320	31,72	6,257	,350	,007
	2 Patient	146	29,51	8,783	,727	
MIRSB_CO	1 Student	320	25,04	6,851	,383	,904
	2 Patient	146	25,14	9,287	,769	
MIRSB_HT	1 Student	320	29,84	7,235	,404	,202
	2 Patient	146	30,75	7,040	,583	
MIRSB_ESM	1 Student	320	36,54	5,250	,293	,000
	2 Patient	146	33,73	6,990	,578	

Table 11: Post Tests – Pairwise Comparisons of Samples -Lazio

Group Statistic

	klin_State	N	Mean	SD	Standard error of Mean	Sig. (2-Tailed)
Suicide	1 Student	92	,65	1,386	,145	,098
	2 Patient	125	1,00	1,694	,152	
GSI	1 Student	91	,735	,4508	,0473	,005
	2 Patient	121	,552	,4771	,0434	
Depr	1 Student	92	12,37	8,507	,887	,211
	2 Patient	125	10,84	9,144	,818	
BFI_N	1 Student	92	26,17	6,414	,669	,428
	2 Patient	125	26,90	6,776	,606	
Spirituality	1 Student	92	4,37	1,458	,152	,294
	2 Patient	125	4,14	1,630	,146	
Religiosity	1 Student	92	3,23	1,591	,166	,796
	2 Patient	125	3,17	1,768	,158	
MIRSB_GR	1 Student	92	27,20	12,115	1,263	,692
	2 Patient	125	27,90	13,342	1,193	
MIRSB_FO	1 Student	92	34,85	7,791	,812	,147
	2 Patient	125	33,14	9,100	,814	
MIRSB_HI	1 Student	92	31,79	5,735	,598	,098
	2 Patient	125	29,93	10,615	,949	
MIRSB_CO	1 Student	92	27,14	7,146	,745	,210
	2 Patient	125	28,59	9,854	,881	
MIRSB_HT	1 Student	92	28,76	7,132	,744	,632
	2 Patient	125	29,26	8,003	,716	
MIRSB_ESM	1 Student	92	35,64	5,687	,593	,375
	2 Patient	125	36,48	8,216	,735	

5 Discussion

The intent of our study was to further investigate the relationships between suicide, various religious/spiritual dimensions, and the “Big Five” dimensions of personality, as well as the relationship with parameters of mental health (SCL-90) in psychiatric patients and young Austrian and Italian adults. As hypothesized, we discovered profound geographical differences between the three regions and also differences between the clinical and the student sample.

5.1 Regional differences

As Table 3 reveals, there were substantial regional differences between the clinical samples, regarding the most frequently diagnosed mental disorders. In central Italy the frequency of the diagnosed “Major recurrent depressive disorder” and “Depression disorder” was lower than in north Italy or south-eastern Austria. The same results were also found by collecting the psychiatric symptoms with our SCL-90-S survey (see “Depression” values in Table 7). Conversely central Italy showed the highest frequency in “Mental and behavioural disorders due to psychoactive substances use” (See Table 3). In accordance with the findings of experts in this field, such as Pompilli (2008) and Kapusta & Niederkrotenthaler (2009), “Depression disorder” in our study was found to be the most important predictor for suicide as the regression analysis revealed (Table 5, 7, Regressions). This finding could represent one of the main determinats of the regional differences on suicide seen in our clinical samples.

Furthermore the regional differences also concerned socio-demographic variables or others, such as “believers” and “nonbelievers”, the intensity of the participant’s belief and a number of variables that will be discussed below. In our clinical sample in middle Italy we had the highest percentage of unemployed (47%) and in South Tyrol the lowest (15.8%) (Table 1). Nevertheless, in contrast to most previous cross-cultural studies (e.g. Nordt et al 2015, Boseley et al. 2015, Caba 2015 etc) middle-eastern Austria and north Italy, despite the high percentage of “employees”, presented the highest values in “Depression” and “Suicide” , as mentioned above.

The middle-eastern Austrian clinical sample also revealed the highest percentage of “believers” (in a divine dimension) and the South Tyrol/Veneto sample the lowest (see Table

1.1). Lazio with Rome as the principal city, ranked second, although its student sample, revealed the highest percentage of “Believers” compared to the other student samples across regions (see Table 1.1). The Styrian patients who defined themselves as “Believers” also presented the highest values in “Suicidal ideation” and “Suicidal behavior” but not in “Actual suicide attempts”. Similar results were found in the South Tyrolean/ Venetian clinical sample. The “Nonbeliever” patients from central Italy revealed the highest values in “Actual suicide attempts” (see Table 6). We found these results interesting because if the Styrian and the South Tyrolean/Venetian “Believers” patients revealed higher “Suicide ideation” this doesn’t necessary mean that the lethality of this suicide behavior is also grave or “extremist”. In Lazio conversely the “nonbelievers” patients, despite lower values in “Suicide Ideation” and “Suicide behavior” demonstrates higher suicide lethality.

Contrary to Durkheim`s “Integration theory” and also to “The Network Theory*”,* from Pescosolido & Georgianna (1989) in two of our analyzed regions (Styria and South Tyrol/Veneto), the Roman Catholic patients who defined themselves as “Churchgoers” (Theists) presented high levels of suicide ideation and suicide behaviour. In Lazio the “Integration Theory” and the “The Network Theory” were supported due to the high values we found in “Suicide behavior” by “Pantheists” and “Agnostics” (see Table 6). The patients from Styria who defined themselves as “Deists” revealed the highest percentage in “Suicidal behavior”. In South Tyrol/Veneto and Lazio the “Deists” presented also higher values in “Suicidal behavior” (see Table 6). Although our results in this case are based on nominal differences and were not highly significant, we may generally assume that in all three clinical samples, “Pantheists” presented high levels in “Suicide behavior”. In central and in northern Italy, they presented even higher levels (see Table 6).

In Styria and South Tyrol/Veneto the clinical sample also revealed higher values in the other spiritual dimensions compare to the student sample regarding the MI-RSB dimensions (“Hope Immanent”, “Connectedness”, “Hope Transcendent”) and also in “Religiosity” and “Spirituality” (see Table 7). The dimensions “Hope Immanent”, “Hope transcendent” and “Experience of sense and meaning” were found to be negatively related to the suicide dimensions and to the global mental impairment in almost all samples (see Table 5). Conversely the MI-RSB dimensions of “General religiousness”, “Connectedness” and also “Spirituality” were positively related to suicide and to global mental impairment (see Table 5). Surprisingly, in central Italy the student sample presented higher values than the clinical sample in religiosity and spirituality. The linear regression analysis also revealed that, in the student sample, the four graded predictors which explained 9% of the entire variance were: “Hope Immanent”, “Forgiveness”, “Connectedness” and “Spirituality” whereby “Connectedness” was the only predictor to have a positive correlation to “Suicide SCL-90”. In the total student sample, the other variables represented a rather protective factor against

"Suicide SCL-90". In our clinical sample the graded predictors which explained 10% of the entire variance were different from the student sample: "Existential Well-being" (R^2=.083, β=-.34, p=.000) with a negative relation to "Suicide SCL-90", and "General Religiousness" (R^2=.022, β=.15, p=.002) with a positive relation to "Suicide-SCL90". The total sample presented similar results. "Existential Well-being" (R^2=.085, β=-.25, p=.000) and the associated religious/spiritual dimension of "Hope Immanent" (R^2 =.008, β= -.14, p=.002) correlated negatively with "Suicide SCL-90". "General Religiousness" (R^2 =.029, β= .11, p=.001) and "Connectedness" (R^2=.009, β=.12, p=.001) correlated positively with "Suicide SCL-90" (see Table 8).

Based on these results, we can assume that generally "Spirituality", "Religiosity" and also some spiritual dimensions of MI-RSB such as "Connectedness" and "General Religiousness" (see Table 5) represent differently risk factors for suicide and mental health. However, the risk factor concerned principally the psychiatric samples in middle-eastern Austria and north Italy but also the student sample in central Italy, due to the high levels in the spiritual dimensions which represented a risk factor and the low levels in other spiritual dimensions which represented a protective factor.

However, for some of these "dangerous" spiritual dimensions such as "Connectedness", Unterrainer, Huber, Sorgo, Collicutt and Fink (2011), demonstrated that there might be facets of "Connectedness" that could be associated with psychopathological symptoms. In the present study, "Connectedness" was found to be positively correlated with a higher amount of "Magical Thinking," one of the predominant symptoms of schizotypy. In our Study "Connectedness" was related positively to "Global Mental Impairment" and almost all the other psychiatric symptoms in the total student sample and with "Paranoid ideation" in our total clinical sample (see Appendix, Correlation Table 1, 2).

Other dimensions such as "Hope Immanent", "Forgiveness" and "Experience of sense and meaning", which represent the values of experiential spirituality, were found to be protective factors for suicide and mental health in almost all samples. "Hope transcendent" presented also the same relationships (Table 5, Appendix, Correlation Table 1, 2).

5.2 Gender Differences

Regarding the gender differences (see Table 4.1), excepting for the "Big Five" personality characteristics and "Spirituality" we did not find significant differences in the suicide dimensions and or in the "Global mental impairment". Therefore we didn't include gender as a factor in all further analysis. We are conscious that this exclusion means less

information, but conversely, we then avoid further subdivisions of our subsamples and thereby circumvent non-significant results due to the small number of participants in every subsample.

5.3 The role of the Big Five personality characteristics

As revealed in Table 5, in both samples (total clinical sample and total student sample) the Big Five personality trait “Extraversion” was negatively associated with “Suicidal ideation”, “Intensity of suicidal Ideation”, “Global mental impairment” and all the other dimensions of psychiatric symptoms (see Table 5, see Appendix- Table of correlation 1,2,3). The student sample in all three regions showed higher values in “Extraversion” compared to the clinical sample. In particular the Styrian student sample presented the highest percentage of “Extraversion” (see Table 7). The same pattern but with a weaker relationship was found also for “Agreeableness” (see table 7). Moreover the psychiatric patients who participated in our study revealed higher “Agreeableness” levels than the student sample (see Table 7). Conversely “Neuroticism” represented a significant risk factor for all suicide dimensions (see table 5). We also noted that “Neuroticism” correlated significantly with “Depression”, “Anxiety” and all the other dimensions of psychiatric symptoms including “Global mental Impairment (GSI)” (see Appendix, Table of correlation 1, 2, 3). In all three regions, the clinical sample revealed higher values in “Neuroticism” than the student sample due to the higher levels of “Depression” and “Anxiety”. Once again, the highest values in “Neuroticism” were exhibited in the Styrian clinical sample. The student samples from northern Italy revealed the highest values in “Neuroticism” (see Table 7).

Furthermore at the first appearance “Neuroticism and “Depression” represented a risk factor for suicide but as we thoroughly investigated the relationship between neuroticism, depression and suicide in our post tests we discovered, to the best of our knowledge, something completely new in this field. “Neuroticism” in combination with “Depression” represents a significant risk factor for suicide but without the involvement of “Depression”, “Neuroticism” turned out to be a protective factor against suicide (see Regressions, see Post tests). This implies that the previously found positive relationship between “Neuroticism” and suicide was for the most part influenced by other psychiatric symptoms such as ”Depression”. In our study, we might assume that “Depression” represented at the beginning of our calculations a confounding factor that prevented the better understanding of the relationship between Suicide and the Big Five personality characteristics. However we could confirm our hypothesis by demonstrating that the personality characteristics played an important role in the triangular relationship suicide/mental health, –spirituality, -personality.

Corresponding with Saraglou (2002), three of the Big Five personality dimensions, namely “Agreeableness”, “Conscientiousness” and “Extraversion”, turned out to be significantly associated in both samples (clinical and student sample) with all MI-RSB sub-dimensions and with “Religious/Spiritual wellbeing” total score. Furthermore, a negative association could be demonstrated between “Neuroticism” and all MI-RSB sub-dimensions (see Appendix, Correlation Table 1, 2, 3) which mirrors the results of Stefa-Missagli et al. (2014) and Unterrainer et al. (2011).

5.4 Psychiatric symptoms, Suicide and Religious/Spiritual dimensions

In conformity with our theoretical assumptions all dimensions of the psychiatric symptoms measured with the Symptom Checklist 90-S were found to be positively related to all suicide dimensions measured with the Columbia-Suicide Severity Rating Scale -B. “Depression” showed the strongest correlation to Suicide and to the “Global mental Impairment” in all samples (see Table 5). As previously mentioned the clinical sample in Styria and South Tyrol/Veneto revealed the highest values in “Depression”. The student samples from the South Tyrolean/Venetian areas were the ones which presented the highest “Depression” values (see Table 7). “Anxiety” was the second most significant psychiatric symptom to correlate with the suicide dimensions (see Table 5). The Styrian clinical sample revealed also in this case the highest values. Surprisingly the student sample from Lazio presented the highest values of “Anxiety” and “Global mental Impairment GSI” (see Table 7). However, the patients diagnosed with “Anxiety disorder” in all three regions, revealed the lowest values in “Suicide ideation”, “Suicide behavior” and also in “Spirituality” and in “Religiosity” (see Graphic 4) with no significant difference to the other diagnoses (except for Obsessive-Compulsive disorder). We presume that this contradiction arises because of the difference between the diagnosed “Anxiety disorder” and the elevated SCL-90 psychiatric symptom of “Anxiety”. Although they overlap, they are not the same. The psychiatric symptoms of “Anxiety” constitute only a part of “Anxiety disorder”. Secondly, we examined the clinical diagnosis from the clinical files, found in the archives of each hospital and we can only assume that all criteria used for the diagnosis were fulfilled.

Showing important similarities to previous studies (e.g. Unterrainer et al., 2011; Stefa-Missagli et al., 2014 etc) the religious/spiritual dimensions of MI-RSB (“Forgiveness”, “Hope Immanent”, “Hope Transcendent” as well as the global score “RSWB”) were found to be negatively correlated with the parameters of “Global mental impairment” measured by the

“Global Severity Index” in *Symptom Checklist 90* (SCL90) (see Appendix, Correlation Table 1,2,3).

Resonating with Freud’s theory of religion as “A collective compulsion neurosis” recently supported by Maltby (1999) and Kelly et al. (2014) our study also revealed that in the total clinical and student sample, the third most significant psychiatric symptom to correlate with the suicide dimensions (and also in our student sample with “Spirituality” and “Connectedness”), were the “Obsessive-Compulsive” psychiatric symptoms (see Figure 4, see Table 5, see Appendix, Correlation Table 1).

6 Study Limitations

Notably the data collection took place in different regions of Europe and we might assume there were substantial differences, not only in the approach to suicide but also in dimensions such as religiosity or spirituality based on different cultural backgrounds. This could be the cause for an additional variability. Unfortunately the number of tested students in the three different regions, Styria (south-eastern Austria), South Tyrol/Veneto (north Italy) and Lazio (central Italy), was not equally distributed. In south-east Austria we included 221 students, in north Italy 320, and in central Italy 94 students. Moreover our comparative sample was not subjected to diagnostic tests, consequently, the student sample could not be considered as a healthy sample. In particular the student sample from Lazio and South Tyrol/Veneto revealed high levels in “Global mental Impairment”, “Anxiety” and “Depression” (see Table 7). Also our failure to require the students to complete a questionnaire similar to the Columbia Suicide Severity Rating Scale Baseline prevented further analyzes of suicide dimensions such as “Suicide behavior” and “Actual suicide attempts”. The dimension Suicide taken from the Symptom Checklist -90 Standard (Suicide SCL-90) was the only survey instrument used to collect the suicide ideation and the intensity of suicidal ideation throughout the entire sample. The suicidal dimension (Suicide SCL-90) included two sub-dimensions (based on two items): “Suicidal Ideation”, and “Intensity of Suicidal Ideation”.

Furthermore the region of Styria (according to Statistik Austria) presented the highest suicide rates in Austria and for Italy the highest rates were to be found in South Tyrol (according to Istituto nazionale di statistika ISTAT). We might assume that our results were influenced by these psycho-social backgrounds.

Our results could also be influenced by the fact, that females were overrepresented in our student sample. Our student data set were 72% female. Moreover, based on the obtained data, the student sample was too homogenous to reveal any effects that “Age” might have on suicide or on spirituality and religiosity. Nevertheless we found that the spirituality dimensions increased in older people in general (see Appendix, Correlation Table 1,2,3), which mirrors the results of Unterrainer et al. (2011). Furthermore in our total clinical sample age represented a risk factor for “Suicide Behavior” (see Table 5). Thus variable might be considered for further analysis, using comparison groups with the same age and gender differences. Within our resources, it was unfortunately impossible to provide such comparison groups.

Data collection was conducted by doctors of medicine or psychologists, who received training in the administration of our questionnaires and were generally prepared to answer the subsequent questions, but they were many, and this may represent another confounding

factor. However the distribution of data collection to a number of specialists protected against the "*Rosenthal effect"* also known as the "Experimenter-expectancy effect".

The measuring instruments were not always the most appropriate for identifying the variables we wished to analyze. The Columbia Suicide Severity Rating Scale -Baseline, cannot be used in a large student sample by many individuals at the same time without a medical or psychologist supervisor being present for each person. Secondly the measure doesn't collect widely enough the reasons for "Suicidal Ideation" by considering thoroughly the wide range of culturally tolerated or untolerated suicide motivations. Further analysis of the relationship between these motivations and the religious/spiritual dimensions would have been interesting to pursue. Furthermore the valid MI-RSB questionnaire contains some non-strictly religious/spiritual dimensions as: "Hope Immanent", "Forgiveness", "Experience of Sense and Meaning". These three dimensions represented the values of experiential spiritual well being and compose the "Immanent over-dimension" which was also difficult to interpret.

7. Conclusions and clinical implications

The relationship between suicide, personality and various religious/spiritual dimensions seems to be significantly moderated by regional differences and clinical state. It appears that it is not only the psychiatric disease which affects the association between religious/spiritual dimensions and suicide but also factors such as the culture in which the persons live and their personality characteristics. We also found intra-cultural differences and similarities between "Believers", "Nonbelievers" as well as within the five groups of intensity of belief (by self-assessed categories as Atheist, Agnostic etc.) and their impact on the suicide dimensions, although "Region" and "Age" significantly moderated these intra-cultural differences.

By considering suicide and spirituality as multidimensional constructs, the results seem to branch out. If "Spirituality", "Religiosity" but also some spiritual dimensions of MI-RSB such as "Connectedness" and "General Religiousness" represent differently a risk factor for suicide and mental health, other religious/spiritual dimensions such as "Hope Immanent", "Hope transcendent" and "Experience of sense and meaning" were found to be negatively related to the suicide dimensions and to global mental impairment. The risk factor, or the protective factor was significantly influenced by regional differences and clinical states.

The psychiatric patients from central Italy were definitely less affected by suicide than the middle-eastern Austrian sample. Furthermore we learned from this data that an increased amount of "healthy" dimensions of spirituality/religiosity may prevail in the central part of Italy.

Our linear regression revealed that "Depression" was the most important predictor for suicide and for global mental impairment. According to our findings we generally noted an increasing tendency on depression values the further north the inpatients lived, and the further south the student lived.

Initially, "Neuroticism and "Depression" seemed to be a risk factor for suicide but as we further investigated the relationship between neuroticism, depression and suicide in our post tests we found that "Neuroticism" without the involvement of "Depression" turned out to be a protective factor against suicide. The clinical implications of this finding should be considered in the future by assessing the suicide risk in people with depression, or more generally in psychiatric patients.

In conclusion, as previously mentioned there are many contradictory findings in this field. Most research has illustrated a tendency toward negative correlations between spiritual/religious dimensions and suicide. Our study could not confirm these findings but rather found the opposite to be true. We hope that the results of this cross-cultural scientific survey in the field of suicide, spirituality and personality offer some interesting options for further cross-cultural research.

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Appendix A

Test in German

Sehr geehrte Dame, sehr geehrter Herr!

Vorab möchte ich mich recht herzlich für Ihre Teilnahme an unserer Untersuchung bedanken.

In Zusammenarbeit mit der Medizinischen Universität Graz, Karl Franzenz Universität Graz, dem psychiatrischen Dienst in Bozen, der Universität Padua und der Medizinischen Universität La Sapienza, Rom führen wir, MMag. Stefan Stefa Missagli, Univ.-Prof. DDr.Hans-Peter Kapfhammer, Univ.-Prof. DDr. Maurizio Pompilli, Assoz. Prof.in Dr.in Wallner-Liebmann S.J., Dr. Giupponi G., Assoz. Prof.in Dr.in Sarlo M., Priv. Doz. DDr. Human-Friedrich Unterrainer im Rahmen meiner Doktorarbeit eine Forschung zum Thema:“ Suizid und die Wechselbeziehung zur Religiös/Spirituelle Dimensionen und Persönlichkeit: Eine österreichisch –italienische Multicenterstudie“ durch.

Insgesamt werden aus den drei Städten Graz (Österreich), Bozen (Italien) und Rom (Italien) zwischen 1000 und 1050 Personen teilnehmen.

Um korrekte Vergleiche zu ermöglichen ist es wichtig, dass Ihre Muttersprache österreichisch ist und Sie in Graz und Umgebung aufgewachsen sind. Die Testung besteht aus sechs Fragebögen mit einer Gesamtdauer von ca. 45 Minuten.

Im ersten Teil der Untersuchung bitte ich Sie einige Fragen zu Ihrer Person zu beantworten. Ihre Daten werden durch einen Code anonymisiert und streng vertraulich behandelt. Bitte beantworten Sie alle Fragen gewissenhaft und korrekt um Fehler in den Ergebnissen zu vermeiden.

Ich wird die ganze Zeit anwesend sein und stehe für Fragen gerne zur Verfügung.

Falls Sie noch Fragen oder Anmerkungen im Nachhinein haben bitte kontaktieren sie mich oder meine Kollegin unter der E-Mailadresse stefan.stefa@stud.medunigraz.at

Mit freundlichen Grüßen

MMag. Stefan Stefa-Missagli

Anhang nr.1

Informationsschreiben und Einwilligung zur Verarbeitung personenbezogener Daten

Rechtsinhaber der Datenverarbeitung und entsprechender Zweck

Das Forschungszentrum Uni-Klinik für Psychiatrie Medizinische Universität Graz in zusammenarbeit mit dem Psychiatrischen Dienst in Südtiroler Sanitätsbetrieb Bozen und der Uni-Klinik für Psychiatrie Sant Andrea, La Sapienza Rom, der die Ihnen beschriebene Studie in Auftrag gegeben hat, werden beide ihre personenbezogenen Daten, insbesondere die Daten bezüglich Ihrer Gesundheit und andere Daten in Bezug auf Ihre Herkunft und Ihren Lebensstil nur in dem Ausmaß, das zur Realisierung der Studie und zu klinischen Zwecken unbedingt notwendig ist, im Rahmen ihrer Zuständigkeiten und entsprechend der von den Regeln der guten klinischen Praxis vorgeschriebenen Verantwortung in Italien (GD, 211/2003) und die von American Psychological Association (APA) und World Medical Association (WMA, „Declaration of Helsinki“) verarbeitet.

Zu diesem Zweck werden die bezeichneten Daten vom Forschungszentrum erfasst und an den Förderer und die Personen, die in dessen Namen handeln, nur in anonyme und aggregierter Form übertragen.

Die Verarbeitung der personenbezogenen Daten in Bezug auf Ihre Herkunft und Ihren psychologischen Merkmalen oder Erfahrungen ist zur Durchführung der Studie unbedingt notwendig: Sollten Sie sich weigern, diese zu erteilen, wird Ihnen die Teilnahme an der Studie nicht gestattet.

Art der Daten

Der Arzt, der Sie während der Studie begleitet, identifiziert Sie mit einem Code: Die Sie betreffenden, in der Studie erfassten Daten, ausgenommen Ihr Name, werden dem Förderer zusammen mit diesem Code, Ihrem Geburtsdatum, dem Geschlecht, Ihrer Herkunft und Ihre psychologischen Merkmalen oder Erfahrungen übermittelt, registriert, bearbeitet und gespeichert. Nur der Arzt und die befugten Subjekte können diesen Code mit Ihrem Namen verbinden.

Modalitäten der Datenverarbeitung

Die Daten, die auch mit elektronischen Instrumenten verarbeitet werden, werden ausschließlich in anonymer und aggregierte Form verbreitet, zum Beispiel in wissenschaftlichen Veröffentlichungen, in Statistiken und auf wissenschaftlichen Kongressen. Ihre Teilnahme an der Studie bringt es mit sich, dass das Personal der Klinik die die Überwachung und die Überprüfung der Studie durchführen, die Ethikkommission und die italienischen und ausländischen Gesundheitsbehörden in Übereinstimmung mit den Vorschriften für klinische Bedingungen in Kenntnis der Sie betreffenden Daten gelangen

können, die auch in Ihrer originalen klinischen Dokumentation enthalten sind, dass die Vertraulichkeit Ihrer Identität garantiert ist.

Wahrnehmung der Rechte

Sie können Ihre Rechte in Bezug auf Art. 7 des Gesetzes ausüben (z.B. Zugang zu den eigenen Daten verlangen, um sie zu ergänzen, zu aktualisieren, Korrekturen oder Änderungen anbringen zu lassen oder im Falle von gesetzwidriger Behandlung sich ihrer Benutzung zu widersetzen) und sich dabei direkt an das oben angegebene Forschungszentrum oder über Ihren Vermittler wenden. **(Ansprechpersonen: MMag. Stefa-Missagli e-mail** stefan.stefa@stud.medunigraz.at, Dr. Giupponi giancarlo.giupponi@asbz.it, Prof. Dr. Pompilli maurizio.pompili@uniroma1.it)

Sie können jederzeit und ohne Angabe einer Rechtfertigung Ihre Teilnahme an der Studie abbrechen: In diesem Fall werden die mit Ihnen zusammenhängenden Daten vernichtet. Es werden überdies keine weiteren Daten erfasst, die Sie betreffen, unbeschadet der Verwendung jener bereits erfassten Daten, um, ohne sie dabei zu ändern, die Ergebnisse der Forschung festzulegen.

Einwilligung

Ich stimme der Verarbeitung meiner personenbezogenen Daten zu Forschungszwecken mit den im Informationsblatt genannten Einschränkungen und Modalitäten, die mir mit dem gegenständlichen Dokument beigestellt wurden, durch meine Unterschrift auf diesem Formular zu.

Vor- und Nachname der betroffenen Person (in Blockschrift) _____

Unterschrift der betroffenen Person _____

Datum _____

Code _____ _____

Alter _____

Geschlecht ☐ weiblich ☐ männlich
(bitte ankreuzen)

abgeschlossene Ausbildung ☐ Hauptschule/ Neue Mittelschule
(bitte ankreuzen) ☐ Matura
☐ Lehre
☐ Bachelor
☐ Master/ Mag.
☐ Doktor

Beruf ☐ berufstätig
(bitte ankreuzen) ☐ in Ausbildung (Uni, FH, Lehre etc.)
☐ arbeitslos

Familienstand ☐ verheiratet
(bitte ankreuzen) ☐ in einer Beziehung/Partnerschaft
☐ ledig
☐ geschieden

geboren& aufgewachsen in… ……☐

Glaubensbekenntnis: _____

Sind Sie gläubig?

☐ ja ☐ nein

Wie definieren Sie ihre Glaubensrichtung?
(z.B. römisch-katholisch, Agnostiker, Atheist, Theist, Deist, Pantheist)

_____

Wie hoch würden sie ihre Religiosität einschätzen? (bitte ankreuzen)

(Religiosität = Zugehörigkeit zu einer Religionsgemeinschaft)

nicht religiös | 1 | 2 | 3 | 4 | 5 | 6 | sehr religiös

Wie hoch würden Sie Ihre Spiritualität einschätzen? (bitte ankreuzen)

(Spiritualität = ein Konzept, welches zusätzlich zur materiellen Welt eine spirituelle Ebene der Existenz mit einbezieht, aus der das Leben hervorgeht; dies muss jedoch nicht unbedingt an ein religiöses Glaubenssystem gekoppelt sein)

nicht spirituell | 1 | 2 | 3 | 4 | 5 | 6 | sehr spirituell

COLUMBIA – BEURTEILUNGSSKALA ZUR SUIZIDALITÄT (C-SSRS)

Baseline

Version 14. 1. 2009

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

SUIZIDGEDANKEN	
Stellen Sie die Fragen 1 und 2. Wenn beide mit „Nein" beantwortet werden, machen Sie bitte mit dem Abschnitt „Suizidales Verhalten" weiter. Wenn Frage 1 mit „Ja" beantwortet wird, gehen Sie bitte weiter zum Abschnitt „Intensität der Suizidgedanken". Wenn Frage 2 mit „Ja" beantwortet wird, stellen Sie auch die Fragen 3, 4 und 5.	Bisheriges Leben: Zeit, in der er/sie am stärksten suizidal war
1. Wunsch, tot zu sein Person hegt den Wunsch, tot oder nicht mehr am Leben zu sein, oder den Wunsch, einzuschlafen und nicht wieder aufzuwachen. ***Haben Sie sich gewünscht, tot zu sein, oder den Wunsch gehabt, Sie könnten einschlafen und müssten nicht mehr aufwachen?*** Wenn Ja, bitte beschreiben:	**Ja** ☐ **Nein** ☐
2. Unspezifische, aktive Suizidgedanken Allgemeine, unspezifische Gedanken daran, seinem Leben ein Ende machen/Suizid begehen zu wollen (z. B. *„Ich habe daran gedacht, mich umzubringen"*), ohne Gedanken über die Art der Selbsttötung/damit zusammenhängende Methoden, Vorsatz oder Plan. ***Haben Sie tatsächlich daran gedacht, sich umzubringen?*** Wenn Ja, bitte beschreiben:	**Ja** ☐ **Nein** ☐
3. Aktive Suizidgedanken mit Überlegungen zur Methode (nicht zu einem Plan), aber ohne Vorsatz zu handeln Person hegt Suizidgedanken und hat im Einschätzungszeitraum über mindestens eine Methode der Selbsttötung nachgedacht. Das (z. B. Gedanken über eine Methode der Selbsttötung, aber kein spezifischer Plan) ist etwas anderes als ein spezifischer Plan, in dem Zeit, Ort und Methode ausgearbeitet wurden. Dazu gehört z. B. jemand, der sagt: *„Ich dachte daran, eine Überdosis zu nehmen, habe aber noch nie einen genauen Plan gemacht, wann, wo oder wie ich das tatsächlich tun würde ... außerdem würde ich das nie durchziehen."* ***Haben Sie darüber nachgedacht, wie Sie das tun könnten?*** Wenn Ja, bitte beschreiben:	**Ja** ☐ **Nein** ☐

4. Aktive Suizidgedanken mit einem gewissen Vorsatz zu handeln, aber ohne spezifischen Plan Aktive Suizidgedanken, und Person berichtet, dass sie einen gewissen Vorsatz habe, solche Gedanken in die Tat umzusetzen, im Gegensatz zu: *„Ich denke zwar daran, aber ich werde diese Gedanken ganz sicher nicht in die Tat umsetzen."* ***Haben Sie solche Gedanken gehabt und eine gewisse Absicht, diese in die Tat umzusetzen?*** Wenn Ja, bitte beschreiben:	**Ja** ☐ **Nein** ☐
5. Aktive Suizidgedanken mit spezifischem Plan und Vorsatz Gedanken an Selbsttötung und detaillierter Plan, der ganz oder teilweise ausgearbeitet ist, und die Person hat einen gewissen Vorsatz, den Plan auszuführen. ***Haben Sie die Einzelheiten, wie Sie sich töten wollen, angefangen auszuarbeiten oder bereits ausgearbeitet? Haben Sie vor, diesen Plan auszuführen?*** Wenn Ja, bitte beschreiben:	**Ja** ☐ **Nein** ☐
INTENSITÄT DER SUIZIDGEDANKEN	
Die folgenden Merkmale sollen für die stärkste Art von Suizidgedanken bewertet werden (d.h. 1 - 5 aus dem Abschnitt oben, wobei 1 am wenigsten stark und 5 am stärksten ist). Fragen Sie nach dem Zeitraum, in dem er/sie am stärksten suizidal war. ***Stärkster Suizidgedanke:*** _____ *Art Nr. (1-5)* _____ *Beschreibung des Suizidgedankens*	Am stärksten
Häufigkeit ***Wie oft hatten Sie diese Gedanken?*** (1) Weniger als einmal pro Woche (2) Einmal pro Woche (3) 2-5-mal pro Woche (4) Täglich oder fast täglich (5) Jeden Tag viele Male	
Dauer ***Wenn Sie diese Gedanken haben, wie lange dauern sie an?*** (1) Flüchtig - wenige Sekunden oder Minuten (2) Weniger als 1 Stunde/eine Weile (3) 1-4 Stunden/lange Zeit (4) 4-8 Stunden/fast den ganzen Tag (5) Mehr als 8 Stunden/durchgehend oder andauernd	

Kontrollierbarkeit

Konnten/Können Sie aufhören, daran zu denken sich umzubringen oder sterben zu wollen, wenn Sie es wollten?

(1) Kann die Gedanken leicht kontrollieren
(2) Kann die Gedanken ohne große Schwierigkeiten kontrollieren
(3) Kann die Gedanken mit einigen Schwierigkeiten kontrollieren
(4) Kann die Gedanken mit großen Schwierigkeiten kontrollieren
(5) Kann die Gedanken nicht kontrollieren
(0) Versucht nicht, die Gedanken zu kontrollieren

Hinderungsgründe

Gibt es Personen oder Dinge (z. B. Familie, Religion, Schmerzen beim Sterben), die Sie davon abhielten, sterben zu wollen oder Selbstmordgedanken in die Tat umzusetzen?

(1) Das hat Sie ganz sicher davon abgehalten, sich das Leben zu nehmen
(2) Das hat Sie wahrscheinlich davon abgehalten
(3) Nicht sicher, ob Sie das abgehalten hat
(4) Das hat Sie höchstwahrscheinlich nicht davon abgehalten
(5) Das hat Sie ganz sicher nicht davon abgehalten
(0) Trifft nicht zu

Gründe für Suizidgedanken

Welche Art von Gründen hatten Sie, dass Sie daran dachten, sterben oder sich umbringen zu wollen? Wollten Sie Ihren Schmerzen oder der Art, wie Sie sich fühlten, ein Ende bereiten (mit anderen Worten: Sie konnten mit den Schmerzen oder so, wie Sie sich fühlten, nicht weiterleben), oder wollten Sie auf sich aufmerksam machen, sich rächen oder eine Reaktion von anderen Menschen bekommen? Oder beides?

(1) Ausschließlich, um auf sich aufmerksam zu machen, sich zu rächen oder eine Reaktion von anderen Menschen zu bekommen.
(2) Überwiegend, um auf sich aufmerksam zu machen, sich zu rächen oder eine Reaktion von anderen Menschen zu bekommen.
(3) Um auf sich aufmerksam zu machen, sich zu rächen oder eine Reaktion von anderen Menschen zu bekommen und in gleichem Maße, um die Schmerzen zu beenden.
(4) Überwiegend, um die Schmerzen zu beenden (Sie konnten mit den Schmerzen oder so, wie Sie sich fühlten, nicht weiterleben).
(5) Ausschließlich, um die Schmerzen zu beenden (Sie konnten mit den Schmerzen oder so, wie Sie sich fühlten, nicht weiterleben).
(0) Trifft nicht zu

SUIZIDALES VERHALTEN

(Kreuzen Sie alle zutreffenden Punkte an, solange es sich um separate Ereignisse handelt; gefragt werden muss nach allen Arten suizidalen Verhaltens)

Bisheriges Leben

Tatsächlicher Suizidversuch:

Eine potenziell selbstschädigende Handlung, die zumindest mit einem gewissen Wunsch durchgeführt wurde, *durch diese Handlung* zu sterben. Verhalten war zum Teil als Methode der Selbsttötung gedacht. Vorsatz muss nicht 100 % sein. Wenn mit der Handlung ***irgendein*** Vorsatz/Wunsch zu sterben verbunden war, kann sie als tatsächlicher Suizidversuch betrachtet werden. ***Es muss keine Verletzung oder körperlicher Schaden aufgetreten sein***, lediglich die Möglichkeit einer Verletzung oder eines körperlichen Schadens. Wenn die Person auf den Abzug drückt, während sie sich die Schusswaffe in den Mund hält, diese aber defekt ist und deshalb keine Verletzung verursacht, wird diese Handlung als Suizidversuch betrachtet.
Schluss auf einen Vorsatz: Selbst wenn das Individuum den Vorsatz/Wunsch zu sterben bestreitet, kann klinisch aus dem Verhalten oder den Umständen darauf geschlossen werden. Beispielsweise kann bei einer mit großer Wahrscheinlichkeit tödlich ausgehenden Handlung, die eindeutig kein Unfall ist, auf Suizid geschlossen werden (z. B. Schuss in den Kopf, Sprung aus einem in großer Höhe befindlichen Fenster). Auch wenn jemand den Vorsatz der Selbsttötung bestreitet, aber glaubt, dass seine Handlung hätte tödlich sein können, kann auf Vorsatz geschlossen werden.

Haben Sie einen Selbstmordversuch unternommen?
Haben Sie etwas unternommen, um sich zu verletzen?
Haben Sie irgendetwas Gefährliches getan, bei dem Sie hätten sterben können?
Was haben Sie getan?
Haben Sie _____ als einen Weg gesehen, Ihr Leben zu beenden?
Hatten Sie (auch nur den leisen) Wunsch zu sterben, als Sie _____?
Versuchten Sie, Ihrem Leben ein Ende zu machen, als Sie _____?
Oder hielten Sie es für möglich, dass Sie hätten sterben können, als Sie____?
Oder handelten Sie aus ganz anderen Gründen/ohne JEGLICHE Absicht, sich umzubringen (etwa um sich von Stress zu befreien, sich wohler zu fühlen, Mitleid zu erregen oder damit etwas anderes geschieht)? (Selbstschädigendes Verhalten ohne Vorsatz der Selbsttötung)
Wenn Ja, bitte beschreiben:

Anzahl Suizidversuche insgesamt

Ja ☐ **Nein** ☐

Hat die Person nichtsuizidales selbstschädigendes Verhalten gezeigt?

Ja ☐ **Nein** ☐

Unterbrochener Suizidversuch:

Wenn die Person (durch einen äußeren Umstand) von der potenziell selbstschädigenden Handlung abgehalten wird *(wenn dies nicht geschehen wäre, hätte ein tatsächlicher Suizidversuch stattgefunden)*.Überdosis: Person hat Tabletten in der Hand, wird aber davon abgehalten, sie einzunehmen. Sind die Tabletten bereits eingenommen, gilt dies als Suizidversuch und nicht als unterbrochener Suizidversuch. Schießen: Person hat die Schusswaffe auf sich gerichtet, die dann aber von jemandem weggenommen wird, oder Person wird irgendwie daran gehindert, den Abzug zu drücken. Hat die Person auf den Abzug gedrückt, auch wenn die Schusswaffe nicht losgeht, gilt dies als Suizidversuch. Springen: Person ist im Begriff zu springen, wird aber gepackt und vom Rand weggezogen. Erhängen: Person hat die Schlinge um den Hals, hat aber mit der Strangulierung noch nicht angefangen - wird daran gehindert.
Haben Sie schon einmal etwas unternommen, um Ihrem Leben ein Ende zu machen, aber jemand oder etwas hat Sie davon abgehalten, bevor Sie zur Tat geschritten sind?
Wenn Ja, bitte beschreiben:

Anzahl unterbrochener Suizidversuche insgesamt

Ja ☐ **Nein** ☐

Abgebrochener Suizidversuch:

Wenn die Person Schritte zu einem Suizidversuch unternimmt, ihre Handlung aber einstellt, bevor sie selbstzerstörerisches Verhalten tatsächlich ins Werk setzt. Ähnliche Beispiele wie bei unterbrochenen Suizidversuchen, außer dass das Individuum den Versuch selbst abbricht und nicht durch etwas anderes davon abgehalten wird.
Haben Sie schon einmal etwas unternommen, um Ihrem Leben ein Ende zu machen, aber Sie haben den Versuch abgebrochen, bevor Sie zur Tat geschritten sind?
Wenn Ja, bitte beschreiben:

Anzahl abgebrochener Suizidversuche insgesamt

Ja ☐ **Nein** ☐

Vorbereitende Handlungen oder vorbereitendes Verhalten:

Handlungen oder Vorbereitungen, die auf einen bevorstehenden Suizidversuch gerichtet sind. Dazu kann alles zählen, was über suizidale Äußerungen oder Gedanken hinausgeht, z. B. sich auf eine bestimmte Methode der Selbsttötung vorbereiten (z. B. Tabletten kaufen, sich eine Schusswaffe besorgen) oder Maßnahmen zur Vorbereitung seines Freitods treffen (z. B. Dinge weggeben, einen Abschiedsbrief schreiben).
Haben Sie Schritte unternommen, um einen Selbstmordversuch zu machen oder Vorbereitungen getroffen, sich umzubringen (z. B. Tabletten gesammelt, sich eine Schusswaffe besorgt, Wertsachen weggegeben oder einen Abschiedsbrief geschrieben)?
Wenn Ja, bitte beschreiben:

Ja ☐ **Nein** ☐

Suizidales Verhalten: Lag im Einschätzungszeitraum suizidales Verhalten vor?	**Ja**	**Nein**
	☐	☐

Beantwortung nur für tatsächliche Suizidversuche	Jüngster Versuch Datum:	Letalster Versuch Datum:	Erster Versuch Datum:
Tatsächliche Letalität/körperlicher Schaden: 0. Kein körperlicher Schaden oder sehr geringer körperlicher Schaden (z. B. oberflächliche Schrammen). 1. Geringer körperlicher Schaden (z. B. lethargisches Sprechen, Verbrennungen ersten Grades, leichte Blutung, Verstauchungen). 2. Mäßiger körperlicher Schaden; medizinische Behandlung erforderlich (z. B. bei Bewusstsein, aber schläfrig, einigermaßen ansprechbar, Verbrennungen zweiten Grades, Blutung aus einem Hauptblutgefäß). 3. Mäßig schwerer körperlicher Schaden; Krankenhausaufenthalt und wahrscheinlich Intensivversorgung erforderlich (z. B. komatös bei erhaltenen Reflexen, Verbrennungen dritten Grades an weniger als 20 % des Körpers, beträchtlicher Blutverlust, der aber kompensiert werden kann, schwere Frakturen). 4. Schwerer körperlicher Schaden; Krankenhausaufenthalt mit Intensivversorgung erforderlich (z. B. komatös bei nicht erhaltenen Reflexen, Verbrennungen dritten Grades an über 20 % des Körpers, beträchtlicher Blutverlust und instabile Vitalfunktionen, schwere Verletzung an einem lebenswichtigen Organ). 5. Tod	*Code eintragen*	*Code eintragen*	*Code eintragen*
Potenzielle Letalität: Nur beantworten, wenn tatsächliche Letalität = 0 Wahrscheinliche Letalität des tatsächlichen Suizidversuchs, wenn kein körperlicher Schaden entstanden ist (die folgenden Situationen bleiben zwar ohne medizinische Beeinträchtigung, haben aber das Potenzial, mit sehr großer Wahrscheinlichkeit zum Tode zu führen: Person steckt sich die Schusswaffe in den Mund und drückt auf den Abzug, aber die Waffe geht nicht los, sodass kein körperlicher Schaden entsteht; legt sich vor einem herannahenden Zug auf die Schienen, rollt sich aber weg, bevor sie überfahren wird). 0 = Verhalten führt wahrscheinlich nicht zu Verletzungen 1 = Verhalten führt wahrscheinlich zu Verletzungen, aber wahrscheinlich nicht zum Tod 2 = Verhalten führt wahrscheinlich trotz vorhandener medizinischer Versorgung zum Tod	*Code eintragen*	*Code eintragen*	*Code eintragen*

MI-RSB 48

(Unterrainer, Ladenhauf & Huber, 2005)

Bevor Sie an die Beantwortung der Fragen gehen, bitte ich Sie folgende Dinge zu beachten:

Sie werden zum großen Teil Fragen bezüglich Ihres religiösen Glaubens finden. Auch werden Sie bei der Bearbeitung der einzelnen Fragen öfters auf den Begriff „Gott" stoßen.

Dazu ist wichtig anzumerken:

- Die hier gemachten Angaben dienen ausschließlich der wissenschaftlichen Forschung und werden **vollkommen anonym** ausgewertet.
- Diese Untersuchung wurde von keiner religiösen Vereinigung oder Gemeinschaft gefördert, noch werden Daten an eine solche weitergegeben.
- Der Begriff „Gott" **kann, muss aber nicht** im christlich– konfessionellen Sinne verstanden werden.
- Falls Sie den Begriff „Gott" als unpassend empfinden, können Sie diesen gedanklich durch eine Formulierung wie „höhere Macht" ersetzen.
- Die Beantwortung des Fragebogens ist trotz der völligen Ablehnung eines religiösen Glaubens möglich. Diese Haltung wird im Fragebogen berücksichtigt.

Bitte beantworten Sie die Fragen spontan und halten Sie sich gedanklich nicht zu lange bei einer Frage auf.

Weiters bitte ich Sie jede Frage zu beantworten, da nur so eine korrekte Auswertung möglich ist.

1. Mein Glaube gibt mir ein Gefühl von Sicherheit.	*Trifft gar nicht zu* 1 2 3 4 5 6 *Trifft völlig zu*
2. Es gibt Dinge, die ich nicht verzeihen kann.	*Trifft gar nicht zu* 1 2 3 4 5 6 *Trifft völlig zu*
3. Ich blicke mit Optimismus in die Zukunft.	*Trifft gar nicht zu* 1 2 3 4 5 6 *Trifft völlig zu*
4. Ich habe eine Erfahrung gemacht, in der meine Person in etwas Größerem aufzugehen schien.	*Trifft gar nicht zu* 1 2 3 4 5 6 *Trifft völlig zu*
5. Ich denke oft daran, dass ich die von mir geliebten Menschen zurücklassen werden muss.	*Trifft gar nicht zu* 1 2 3 4 5 6 *Trifft völlig zu*
6. Ich habe die Erfahrung der Echtheit von Gefühlen gemacht.	*Trifft gar nicht zu* 1 2 3 4 5 6 *Trifft völlig zu*
7. Es ist für mich möglich, Zufriedenheit im vertraulichen Gespräch mit Gott zu finden.	*Trifft gar nicht zu* 1 2 3 4 5 6 *Trifft völlig zu*
8. Es gibt Menschen, die ich hasse.	*Trifft gar nicht zu* 1 2 3 4 5 6 *Trifft völlig zu*
9. Ich denke, dass es in Zukunft aufwärts gehen wird.	*Trifft gar nicht zu* 1 2 3 4 5 6 *Trifft völlig zu*
10. Ich glaube, nach meinem Tod wiedergeboren zu werden.	*Trifft gar* 1 2 3 4 5 6 *Trifft völlig*

	nicht zu *zu*
11. Ich würde alles daran setzen, das Leben geliebter Menschen zu verlängern.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig* *Nicht zu* *zu*
12. Ich habe die Erfahrung tiefer Zuneigung gemacht.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig* *nicht zu* *zu*
13. Ich werde mit Gottes Hilfe alle Probleme bewältigen können.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig* *nicht zu* *zu*
14. Es gibt Menschen, denen ich niemals verzeihen werde können.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig* *nicht zu* *zu*
15. Ich glaube, mein Leben entwickelt sich in die richtige Richtung.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig* *nicht zu* *zu*
16. Es gibt Menschen, zu denen ich eine übersinnliche Verbindung verspüre.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig* *nicht zu* *zu*
17. Es fällt mir schwer daran zu denken, dass von mir geliebte Menschen einmal nicht mehr leben werden.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig* *nicht zu* *zu*
18. Ich habe wahre Freundschaft erfahren.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig* *nicht zu* *zu*
19. In gewissen Momenten in meinem Leben fühle ich mich Gott ganz nah.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig* *nicht zu* *zu*
20. Es gibt Dinge, die man nicht verzeihen soll.	

	Trifft gar nicht zu **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
21. Ich glaube, dass ich in Zukunft mehr positive Erlebnisse haben werde als negative.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
22. Ich habe Dinge erfahren, durch die mir bewusst wurde, dass nichts je richtig tot ist.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
23. Ich habe Angst davor, nach meinem Tod vergessen zu werden.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
24. Ich habe oftmals die Erfahrung von Offenheit und Ehrlichkeit gemacht.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
25. Ich werde mit Gottes Hilfe noch einmal glücklich sein.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
26. Wenn mich jemand verletzt hat, versuche ich in der Regel es ihm heimzuzahlen.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
27. Ich glaube, dass ich in Zukunft so leben werde, wie ich mir das vorstelle.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
28. Ich glaube an eine Weiterexistenz nach dem Tode.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
29. Ich würde alles daran setzen, mein Leben zu verlängern.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*

30. Ich habe Dinge erfahren, die ich immer wieder erleben möchte.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
31. Ich weiß, dass Gott barmherzig ist.	*Trifft gar Nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
32. Der Gedanke daran meine Feinde leiden zu sehen, befriedigt mich.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
33. Ich habe eine genaue Vorstellung davon, wie meine Zukunft aussehen soll.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
34. Ich habe Dinge erfahren, die sich nicht in Worte ausdrücken lassen.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
35. Ich habe Angst davor, was nach meinem Tod mit mir geschieht.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
36. Ich habe oftmals eine Erfahrung gemacht, die mich zutiefst betroffen zurückließ.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
37. Ich gehe gerne zu einer Veranstaltung einer Glaubensgemeinschaft.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
38. Es gibt Menschen, die es verdienen schlecht behandelt zu werden.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
39. Meine Zukunft erscheint mir als sehr unsicher.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig*

	nicht zu *zu*
40. Ich habe erfahren, dass es Gegenstände gibt, von denen eine ganz besondere Kraft ausströmt.	*Trifft gar* **1** **2** **3** **4** **5** **6** *Trifft völlig* *nicht zu* *zu*

41. Mit dem Tod endet alle Hoffnung.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
42. Ich habe erfahren, dass ich mich so in eine Sache vertiefen kann, dass ich alles um mich herum vergesse.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
43. In der freien Natur spüre ich die Gegenwart Gottes.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
44. Ich habe denjenigen verziehen, die mich verletzt haben.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
45. Ich glaube, dass die Zukunft spannende Aufgaben für mich bereithält.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
46. Ich glaube in Zukunft Erfahrungen zu machen, die vielen Menschen verwehrt sind.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
47. Ich habe Angst davor, nach meinem Tod für meine Verfehlungen zur Verantwortung gezogen zu werden.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*
48. Ich habe eine oder mehrere Erfahrungen gemacht, durch die mir der Sinn des Lebens bewusst wurde.	*Trifft gar nicht zu* **1** **2** **3** **4** **5** **6** *Trifft völlig zu*

BFI Deutsch-44

Im folgenden finden Sie eine Reihe von Beschreibungen, die auf Sie zutreffen können oder nicht. Zum Beispiel, trifft es zu, dass sie jemand sind, der gerne Zeit mit anderen verbringt? Bitte schreiben Sie eine Zahl neben jede der aufgeführten Beschreibungen, um anzuzeigen, wie sehr diese Aussage auf Sie zutrifft oder nicht zutrifft.

Trifft überhaupt nicht zu	Trifft wenig zu	Trifft teils/teils zu	Trifft gut zu	Trifft sehr gut zu
0	**1**	**2**	**3**	**4**

Ich sehe mich selbst als jemand, der ...

___ 1. gesprächig ist, sich gerne unterhält

___ 2. dazu neigt, andere zu kritisieren.

___ 3. Aufgaben gründlich erledigt

___ 4. deprimiert, niedergeschlagen ist

___ 5. originell ist, neue Ideen entwickelt

___ 6. eher zurückhaltend und reserviert ist

___ 7. hilfsbereit und selbstlos gegenüber anderen ist

___ 8. etwas achtlos sein kann

___ 9. entspannt ist, sich durch Stress nicht aus der Ruhe bringen lässt

___ 10. vielseitig interessiert ist

___ 11. voller Energie und Tatendrang ist

___ 12. häufig in Streitereien verwickelt ist

___ 13. zuverlässig und gewissenhaft arbeitet

___ 14. leicht angespannt reagiert

___ 15. tiefsinnig ist, gerne über Sachen nachdenkt

___ 16. begeisterungsfähig ist und andere mitreißen kann

___ 17. nicht nachtragend ist, anderen leicht vergibt

___ 18. dazu neigt, unordentlich zu sein

___ 19. sich viele Sorgen macht

___ 20. eine lebhafte Vorstellungskraft hat, phantasievoll ist

___ 21. eher still und wortkarg ist

___ 22. anderen Vertrauen schenkt

___ 23. bequem ist und zur Faulheit neigt

___ 24. ausgeglichen ist, nicht leicht aus der Fassung zu bringen

___ 25. erfinderisch und einfallsreich ist

___ 26. durchsetzungsfähig und energisch ist

___ 27. sich kalt und distanziert verhalten kann

___ 28. nicht aufgibt ehe die Aufgabe erledigt ist

___ 29. launisch sein kann, schwankende Stimmungen ha

___ 30. künstlerische und ästhetische Eindrücke schätzt

___ 31. manchmal schüchtern und gehemmt ist

___ 32. rücksichtsvoll und einfühlsam zu anderen ist

___ 33. tüchtig ist und flott arbeitet

___ 34. ruhig bleibt, selbst in angespannten Situationen

___ 35. routinemäßige und einfache Aufgaben bevorzugt

___ 36. aus sich herausgeht, gesellig ist

___ 37. schroff und abweisend zu anderen sein kann

___ 38. Pläne macht und diese auch durchführt

___ 39. leicht nervös und unsicher wird.

___ 40. gerne Überlegungen anstellt, mit Ideen spielt

___ 41. nur wenig künstlerische Interessen hat

___ 42. sich kooperativ verhält, Zusammenarbeit dem Wettbewerb vorzieht

___ 43. leicht ablenkbar ist, nicht bei der Sache bleibt.

___ 44. sich gut in Musik, Kunst und Literatur auskennt.

	überhaupt nicht	ein wenig	ziemlich	stark	sehr stark
	⓪	①	②	③	④

Wie sehr litten Sie in den vergangenen sieben Tagen unter ...

1	Kopfschmerzen	⓪ ① ② ③ ④
2	Nervosität oder innerem Zittern	⓪ ① ② ③ ④
3	immer wieder auftauchenden unerwünschten Gedanken, Worten oder Ideen, die Ihnen nicht mehr aus dem Kopf gehen	⓪ ① ② ③ ④
4	Ohnmachts- und Schwindelgefühlen	⓪ ① ② ③ ④
5	Verminderung Ihres Interesses oder Ihrer Freude an Sexualität	⓪ ① ② ③ ④
6	allzu kritischer Einstellung gegenüber anderen	⓪ ① ② ③ ④
7	der Idee, dass irgendjemand Macht über Ihre Gedanken hat	⓪ ① ② ③ ④
8	dem Gefühl, dass andere an den meisten Ihrer Schwierigkeiten schuld sind	⓪ ① ② ③ ④
9	Gedächtnisschwierigkeiten	⓪ ① ② ③ ④
10	Beunruhigung wegen Achtlosigkeit und Nachlässigkeit	⓪ ① ② ③ ④
11	dem Gefühl, leicht reizbar oder verärgerbar zu sein	⓪ ① ② ③ ④
12	Herz- und Brustschmerzen	⓪ ① ② ③ ④
13	Furcht auf offenen Plätzen oder auf der Straße	⓪ ① ② ③ ④
14	Energielosigkeit oder Verlangsamung in den Bewegungen oder im Denken	⓪ ① ② ③ ④
15	Gedanken, sich das Leben zu nehmen	⓪ ① ② ③ ④
16	Hören von Stimmen, die sonst keiner hört	⓪ ① ② ③ ④
17	Zittern	⓪ ① ② ③ ④
18	dem Gefühl, dass man den meisten Leuten nicht trauen kann	⓪ ① ② ③ ④
19	schlechtem Appetit	⓪ ① ② ③ ④
20	Neigung zum Weinen	⓪ ① ② ③ ④
21	Schüchternheit oder Unbeholfenheit im Umgang mit dem anderen Geschlecht	⓪ ① ② ③ ④
22	der Befürchtung, ertappt oder erwischt zu werden	⓪ ① ② ③ ④
23	plötzlichem Erschrecken ohne Grund	⓪ ① ② ③ ④
24	Gefühlsausbrüchen, denen gegenüber Sie machtlos waren	⓪ ① ② ③ ④
25	Befürchtungen, wenn Sie alleine aus dem Haus gehen	⓪ ① ② ③ ④
26	Selbstvorwürfen über bestimmte Dinge	⓪ ① ② ③ ④
27	Kreuzschmerzen	⓪ ① ② ③ ④
28	dem Gefühl, dass es Ihnen schwerfällt, etwas anzufangen	⓪ ① ② ③ ④
29	Einsamkeitsgefühlen	⓪ ① ② ③ ④
30	Schwermut	⓪ ① ② ③ ④

	überhaupt nicht ⓪	ein wenig ①	ziemlich ②	stark ③	sehr stark ④

Wie sehr litten Sie in den vergangenen sieben Tagen unter ...

31	dem Gefühl, sich zu viele Sorgen machen zu müssen	⓪ ① ② ③ ④
32	dem Gefühl, sich für nichts zu interessieren	⓪ ① ② ③ ④
33	Furchtsamkeit	⓪ ① ② ③ ④
34	Verletzlichkeit in Gefühlsdingen	⓪ ① ② ③ ④
35	der Idee, dass andere Leute von Ihren geheimsten Gedanken wissen	⓪ ① ② ③ ④
36	dem Gefühl, dass andere Sie nicht verstehen oder teilnahmslos sind	⓪ ① ② ③ ④
37	dem Gefühl, dass die Leute unfreundlich sind oder Sie nicht leiden können	⓪ ① ② ③ ④
38	der Notwendigkeit, alles sehr langsam zu tun, um sicher zu sein, dass alles richtig ist	⓪ ① ② ③ ④
39	Herzklopfen oder Herzjagen	⓪ ① ② ③ ④
40	Übelkeit oder Magenverstimmung	⓪ ① ② ③ ④
41	Minderwertigkeitsgefühlen anderen gegenüber	⓪ ① ② ③ ④
42	Muskelschmerzen (Muskelkater, Gliederreißen)	⓪ ① ② ③ ④
43	dem Gefühl, dass andere Sie beobachten oder über Sie reden	⓪ ① ② ③ ④
44	Einschlafschwierigkeiten	⓪ ① ② ③ ④
45	dem Zwang, wieder und wieder nachzukontrollieren, was Sie tun	⓪ ① ② ③ ④
46	Schwierigkeiten, sich zu entscheiden	⓪ ① ② ③ ④
47	Furcht vor Fahrten in Bus, Straßenbahn, U-Bahn oder Zug	⓪ ① ② ③ ④
48	Schwierigkeiten beim Atmen	⓪ ① ② ③ ④
49	Hitzewallungen oder Kälteschauern	⓪ ① ② ③ ④
50	der Notwendigkeit, bestimmte Dinge, Orte oder Tätigkeiten zu meiden, weil Sie durch diese erschreckt werden	⓪ ① ② ③ ④
51	Leere im Kopf	⓪ ① ② ③ ④
52	Taubheit oder Kribbeln in einzelnen Körperteilen	⓪ ① ② ③ ④
53	dem Gefühl, einen Klumpen (Kloß) im Hals zu haben	⓪ ① ② ③ ④
54	einem Gefühl der Hoffnungslosigkeit angesichts der Zukunft	⓪ ① ② ③ ④
55	Konzentrationsschwierigkeiten	⓪ ① ② ③ ④
56	Schwächegefühl in einzelnen Körperteilen	⓪ ① ② ③ ④
57	dem Gefühl, gespannt oder aufgeregt zu sein	⓪ ① ② ③ ④
58	Schweregefühl in den Armen oder den Beinen	⓪ ① ② ③ ④
59	Gedanken an den Tod und ans Sterben	⓪ ① ② ③ ④
60	dem Drang, sich zu überessen	⓪ ① ② ③ ④

	überhaupt nicht	ein wenig	ziemlich	stark	sehr stark
	⓪	①	②	③	④

Wie sehr litten Sie in den vergangenen sieben Tagen unter ...

61	einem unbehaglichen Gefühl, wenn Leute Sie beobachten oder über Sie reden	⓪ ① ② ③ ④
62	dem Auftauchen von Gedanken, die nicht Ihre eigenen sind	⓪ ① ② ③ ④
63	dem Drang, jemanden zu schlagen, zu verletzen oder ihm Schmerz zuzufügen	⓪ ① ② ③ ④
64	frühem Erwachen am Morgen	⓪ ① ② ③ ④
65	zwanghafter Wiederholung derselben Tätigkeit wie Berühren, Zählen, Waschen	⓪ ① ② ③ ④
66	unruhigem oder gestörtem Schlaf	⓪ ① ② ③ ④
67	dem Drang, Dinge zu zerbrechen oder zu zerschmettern	⓪ ① ② ③ ④
68	Ideen oder Anschauungen, die andere nicht mit Ihnen teilen	⓪ ① ② ③ ④
69	starker Befangenheit im Umgang mit anderen	⓪ ① ② ③ ④
70	Abneigung gegen Menschenmengen, z.B. beim Einkaufen oder im Kino	⓪ ① ② ③ ④
71	einem Gefühl, dass alles sehr anstrengend ist	⓪ ① ② ③ ④
72	Schreck- oder Panikanfällen	⓪ ① ② ③ ④
73	Unbehagen beim Essen oder Trinken in der Öffentlichkeit	⓪ ① ② ③ ④
74	der Neigung, immer wieder in Erörterungen oder Auseinandersetzungen zu geraten	⓪ ① ② ③ ④
75	Nervosität, wenn Sie allein gelassen werden	⓪ ① ② ③ ④
76	mangelnder Anerkennung Ihrer Leistungen durch andere	⓪ ① ② ③ ④
77	Einsamkeitsgefühlen, selbst wenn Sie in Gesellschaft sind	⓪ ① ② ③ ④
78	so starker Ruhelosigkeit, dass Sie nicht stillsitzen können	⓪ ① ② ③ ④
79	dem Gefühl, wertlos zu sein	⓪ ① ② ③ ④
80	dem Gefühl, dass Ihnen schlimme oder eigenartige Dinge passieren werden	⓪ ① ② ③ ④
81	dem Bedürfnis, laut zu schreien oder mit Gegenständen zu werfen	⓪ ① ② ③ ④
82	der Furcht, in der Öffentlichkeit in Ohnmacht zu fallen	⓪ ① ② ③ ④
83	dem Gefühl, dass die Leute Sie ausnutzen, wenn Sie es zulassen würden	⓪ ① ② ③ ④
84	sexuellen Vorstellungen, die ziemlich unangenehm für Sie sind	⓪ ① ② ③ ④
85	dem Gedanken, dass Sie für Ihre Sünden bestraft werden sollten	⓪ ① ② ③ ④
86	Vorstellungen und Gedanken, die Ihnen Angst einflößen	⓪ ① ② ③ ④
87	dem Gedanken, dass etwas ernstlich mit Ihrem Körper nicht in Ordnung ist	⓪ ① ② ③ ④
88	dem Eindruck, sich einer anderen Person nie so richtig nahe fühlen zu können	⓪ ① ② ③ ④
89	Schuldgefühlen	⓪ ① ② ③ ④
90	dem Gedanken, dass irgendetwas mit Ihrem Verstand nicht in Ordnung ist	⓪ ① ② ③ ④

Test in Italian

Gentile Signore/a !

In una collaborazione con l'Università di Medicina Graz, il servizio Psichiatrico Pubblico di Bolzano e l´Università di Medicina Roma sto svolgendo una ricerca scientifica nell'ambito del Dottorato di Ricerca in Medicina con il tema:

I rapporti tra il suicidio e le dimensioni della spiritualità/religiosità: Uno studio multicenter austro-italiano sui casi clinici.

Nel territorio italiano ci sono attualmente scarsi e insignificanti dati rilevati da statistiche scientifiche riguardo a questo tema. Per questa ragione si richiede una Vostra seria collaborazione in questa ricerca.

La ricerca avrà luogo in tre città culturalmente e geograficamente diverse: Graz (Austria), Bolzano (Italia) e Roma (Italia) con un numero complessivo di 600-800 Persone. La ricerca sarà tutelata dall'anonimità.

Il sondaggio è composto da sei test di lunghezza diversa di durata complessiva di circa 45 min. Per compilare tali test è necessario che l'italiano sia la Vostra madrelingua.

La prima parte del test riguarderà alcune informazioni su voi
stessi. Tali dati verranno trattati rigorosamente in maniera
anonima.

Vi preghiamo inoltre di rispondere a tutte le domande, in caso contrario le risposte date da Voi in precedenza diverrebbero non valide.

Tante grazie per il vostro impegno!

Per domande o altre osservazioni vi preghiamo gentilmente di contattarci sotto l'indirizzo e-mail stefan.stefa@stud.medunigraz.at

Tel. 0043/69981578180

Cordiali Saluti,

Stefan Stefa Missagli

Età

(Accerchiare la risposta giusta)
Sesso

femminile

maschile

Educazione (finita)

scuola secondaria

maturità

laurea breve

laurea magistrale

dottorato di ricerca

Occupazione

impiegato/autonomo

in formazione

disoccupato

Stato di famiglia

sposato

non sposato, convivente

non sposato, single

divorziato

.....

La Città dove sono nato e cresciuto è

Affiliazione spirituale o religiosa?

sì

no

Se sì, a quale affiliazione?……..

Come si definirebbe?

(p.es. cristiano-cattolico, teista, agnostico, panteista, ateo ecc.)

La pregheremmo di stimare l'intensità della sua religiosità. Segni con una crocetta il numero più adatto alla Sua posizione.

(Religiosità= Appartenente ad una comunità religiosa, osservante)

Non religioso affatto | 1 | 2 | 3 | 4 | 5 | 6 | estremamente religioso

La pregheremmo di stimare l'intensità della sua spiritualità. Segni con una crocetta il numero più adatto alla Sua posizione.

(Spiritualità= un concetto secondo il quale oltre alla materia tangibile esiste un livello spirituale di esistenza, dal quale la materia tragga vita, non implica necessariamente che la persona pratichi una religione)

Non spirituale affatto | 1 | 2 | 3 | 4 | 5 | 6 | estremamente spirituale

Tante grazie per il Suo impegno!

Cephalon INSIGHTS INTO MEDICINE	Codice ID del paziente						Iniziali del paziente			Iniziali del valutatore		
ID della visita (Screening, Basale, Settimana n., Interruzione anticipata, Non pianificata)												

SCALA DELLA COLUMBIA UNIVERSITY PER LA VALUTAZIONE DELLA GRAVITÀ DEL RISCHIO DI SUICIDIO (C-SSRS)

Dall'ultima visita

Versione 14/01/09

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

IDEAZIONE SUICIDARIA *Porre le domande 1 e 2. Se la risposta ad entrambe è negativa, passare alla sezione "Comportamento suicidario". Se la risposta alla domanda 2 è "sì", porre le domande 3, 4 e 5. Se la risposta alle domande 1 e/o 2 è "sì", compilare la sezione qui sotto "Intensità dell'ideazione".*	Dall'ultima visita
1. Desiderio di essere morto/a Il soggetto ammette di avere pensieri che riguardano il desiderio di essere morto o non più vivo oppure vorrebbe addormentarsi e non svegliarsi più. ***Ha desiderato di essere morto/a o di potersi addormentare e non svegliarsi più?*** Se sì, descriva:	Sì ☐ No ☐
2. Pensieri suicidari attivi non specifici Pensieri generici non specifici di voler mettere fine alla propria vita/di suicidarsi (ad es. *"Ho pensato di uccidermi"*) senza pensieri sui modi di uccidersi/sui corrispondenti metodi, intenzione o piano durante il periodo di valutazione. ***Ha pensato veramente di uccidersi?*** Se sì, descriva:	Sì ☐ No ☐
3. Ideazione suicidaria attiva con qualsiasi metodo (nessun piano) senza l'intenzione di agire Il soggetto ammette di avere pensieri di suicidio e ha pensato ad almeno un metodo durante il periodo di valutazione. Questo è diverso da un piano specifico con dettagli sul tempo, sul luogo o sul metodo (ad es. ha pensato al metodo per uccidersi, ma senza un piano specifico). Sono incluse le persone che dicono, *"Ho pensato di prendere un'overdose di farmaci, ma non ho mai fatto un piano specifico su quando, dove o come lo farei veramente.....e non lo porterei mai a termine"*. ***Ha pensato a come potrebbe farlo?*** Se sì, descriva:	Sì ☐ No ☐
4. Ideazione suicidaria attiva con qualche intenzione di agire, senza un piano specifico Pensieri suicidari attivi di uccidersi con il soggetto che dichiara di avere qualche intenzione di metterli in pratica, al contrario di *"Ho questi pensieri ma certamente non farei niente in tal senso"*. ***Ha avuto questi pensieri e qualche intenzione di metterli in pratica?*** Se sì, descriva:	Sì ☐ No ☐
5. Ideazione suicidaria attiva con un piano specifico e con intenzione Pensieri di uccidersi con dettagli di un piano completamente o in parte organizzato e con il soggetto che ha qualche intenzione di realizzarlo. ***Ha iniziato ad organizzare o ha già organizzato i dettagli di come uccidersi? Ha intenzione di realizzare questo piano?*** Se sì, descriva:	Sì ☐ No ☐

INTENSITÀ DELL'IDEAZIONE	
I seguenti aspetti dovrebbero essere valutati per le tipologie di ideazione più gravi (cioè, in base alle risposte qui sopra da 1 a 5, dove 1 sta per la meno grave e 5 per la più grave). ***Ideazione più grave:*** _____ *N° tipo (1-5)* _____ *Descrizione dell' ideazione*	Più grave
Frequenza ***Quante volte ha avuto questi pensieri?*** (1) Meno di una volta la settimana (2) Una volta la settimana (3) 2-5 volte la settimana (4) Ogni giorno o quasi ogni giorno (5) Molte volte al giorno	____
Durata ***Quando ha questi pensieri quanto tempo durano?*** (1) Passeggeri - pochi secondi o pochi minuti (2) Meno di 1 ora/un po' di tempo (3) 1-4 ore/molto tempo (4) 4-8 ore/la maggior parte della giornata (5) Più di 8 ore/persistenti o continui	____
Controllabilità ***Se voleva/vuole, riusciva/riesce a smettere di pensare ad uccidersi o a voler morire?*** (1) Riesce facilmente a controllare i pensieri (2) Riesce a controllare i pensieri con poca difficoltà (3) Riesce a controllare i pensieri con qualche difficoltà (4) Riesce a controllare i pensieri con molta difficoltà (5) Non riesce a controllare i pensieri (0) Non cerca di controllare i pensieri	____
Deterrenti ***Ci sono delle cose - qualcuno o qualcosa (ad es. la famiglia, la religione, il dolore della morte) - che le hanno impedito di voler morire o di mettere in atto i suoi pensieri di suicidarsi?*** (1) I deterrenti le hanno certamente impedito di tentare il suicidio (2) I deterrenti gliel'hanno probabilmente impedito (3) È incerto/a che i deterrenti gliel'abbiano impedito (4) I deterrenti molto probabilmente non gliel'hanno impedito (5) I deterrenti non gliel'hanno certamente impedito (0) Non pertinente	____
Motivi dell'ideazione ***Che tipo di motivi aveva per pensare di voler morire o di uccidersi? Era per mettere fine al dolore o al modo in cui si sentiva (in altre parole, non riusciva a continuare a vivere con quel dolore o nel modo in cui si sentiva) o era per attirare l'attenzione, per vendetta o per suscitare una reazione da parte degli altri? O entrambe le cose?*** (1) Esclusivamente per attirare l'attenzione, per vendetta o per suscitare una reazione da parte degli altri. (2) Soprattutto per attirare l'attenzione, per vendetta o per suscitare una reazione da parte degli altri. (3) Sia per attirare l'attenzione, per vendetta o per suscitare una reazione da parte degli altri, che per mettere fine al dolore. (4) Soprattutto per mettere fine al dolore (non poteva continuare a vivere con quel dolore o nel modo in cui si sentiva). (5) Esclusivamente per mettere fine al dolore (non poteva continuare a vivere con quel dolore o nel modo in cui si sentiva). (0) Non pertinente	____

COMPORTAMENTO SUICIDARIO *(Segni tutto ciò che è pertinente, purché si tratti di eventi separati; deve porre le domande su tutte le tipologie)*	Dall'ultima visita
Tentativo concreto: Un atto potenzialmente autolesivo commesso con almeno qualche desiderio di morire *in seguito a tale atto*. Il comportamento era stato pensato in parte come metodo per uccidersi. L'intenzione non deve essere necessariamente del 100%. Se c'è ***una qualsiasi*** intenzione/***un qualsiasi*** desiderio di morire associato all'atto, allora può essere considerato un tentativo concreto di suicidio. ***Non devono prodursi necessariamente lesioni o danni fisici***, ma basta che ci sia la possibilità di lesioni o danni fisici. Se una persona preme il grilletto mentre ha la pistola in bocca, ma la pistola è rotta e perciò non si determina una lesione, questo è considerato un tentativo. Intenzione implicita: anche se un individuo nega l'intenzione/il desiderio di morire, lo si può dedurre clinicamente dal comportamento o dalle circostanze. Per esempio, da un atto altamente letale che chiaramente non è un incidente, non si può dedurre altra intenzione se non quella di suicidarsi (ad es. colpo di pistola alla testa, lanciarsi dalla finestra da un piano alto). Inoltre, se una persona nega l'intenzione di morire, ma pensa che quello che ha fatto poteva essere letale, si può dedurre comunque l'intenzione. ***Ha tentato il suicidio?*** ***Ha fatto nulla per farsi del male?*** ***Ha fatto qualcosa di pericoloso che avrebbe potuto causare la sua morte?*** ***Che cosa ha fatto?*** ***Ha_____ come modo per mettere fine alla sua vita?*** ***Voleva (anche solo un po') morire quando ha_____?*** ***Stava tentando di mettere fine alla sua vita quando ha_____?*** ***Oppure pensava che sarebbe potuto/a morire quando ha_____?*** ***Oppure l'ha fatto semplicemente per tutt'altre ragioni/senza NESSUNA intenzione di uccidersi (come ad esempio, per alleviare lo stress, per sentirsi meglio, per suscitare comprensione o per far succedere qualcos'altro)?*** (Comportamento autolesivo senza intenzione suicida) Se sì, descriva:	Sì ☐ No ☐ N° totale di tentativi ____
Il soggetto ha manifestato un comportamento autolesivo non suicidario?	Sì ☐ No ☐
Tentativo interrotto: Quando la persona viene fermata (da una circostanza esterna) dall'iniziare l'atto potenzialmente autolesivo *(se non fosse stato per quello, si sarebbe attuato un tentativo concreto)*. Overdose di farmaci: la persona ha in mano delle pillole, ma le viene impedito di ingerirle. Una volta che abbia ingerito delle pillole, questo diventa un tentativo piuttosto che un tentativo interrotto. Spararsi: la persona ha la pistola puntata contro se stessa, ma qualcuno gliela toglie o le viene in qualche modo impedito di premere il grilletto. Una volta premuto il grilletto, anche se la pistola non spara, si tratta di un tentativo. Buttarsi: la persona è pronta a buttarsi, ma viene presa e portata via dal bordo. Impiccarsi: la persona ha il cappio attorno al collo, ma non si è ancora impiccata e le viene impedito di farlo. ***Le è mai capitato di iniziare a fare qualcosa per mettere fine alla sua vita, ma qualcuno o qualcosa glielo ha impedito prima che lei potesse farlo veramente?*** Se sì, descriva:	Sì ☐ No ☐ N° totale di tentativi interrotti ____

Tentativo fallito: Quando una persona inizia a mettere in atto un tentativo di suicidio, ma si ferma prima di aver effettivamente dato inizio ad un comportamento autolesivo. Gli esempi sono simili a quelli dei tentativi interrotti, ma in questo caso il soggetto si ferma da solo, invece di essere fermato da qualcos'altro. ***Le è mai capitato di iniziare a fare qualcosa per mettere fine alla sua vita e di essersi fermato/a prima di averlo fatto veramente?*** Se sì, descriva:	**Sì** ☐ **No** ☐ N° totale di tentativi falliti: ____
Comportamenti o atti preparatori: Atti o preparativi per mettere in atto un tentativo di suicidio imminente. Questo può includere qualsiasi cosa che vada oltre la verbalizzazione o l'ideazione, come ad esempio procurarsi il necessario per il metodo specifico (ad es. comprare le pillole, acquistare una pistola) o prepararsi a morire tramite suicidio (ad es. regalando le proprie cose, scrivendo un biglietto di addio). ***Ha fatto qualche cosa per mettere in atto un tentativo di suicidio o per prepararsi a uccidersi (come mettere da parte le pillole, procurarsi una pistola, regalare oggetti di valore o scrivere un biglietto di addio)?*** Se sì, descriva:	**Sì** ☐ **No** ☐
Comportamento suicidario: Il comportamento suicidario era presente durante il periodo di valutazione.	**Sì** ☐ **No** ☐
Suicidio riuscito:	**Sì** ☐ **No** ☐

Rispondere solo nel caso di tentativi concreti	**Data del tentativo con la più alta probabilità di esito letale:**
Effettiva letalità/danni fisici: 0. Nessun danno fisico o danni fisici molto lievi (ad es. graffi superficiali). 1. Danni fisici lievi (ad es. eloquio rallentato, ustioni di primo grado, lieve sanguinamento, slogature). 2. Danni fisici moderati, necessaria l'assistenza medica (ad es. cosciente ma assonnato/a, parzialmente reattivo/a, ustioni di secondo grado, sanguinamento dai vasi sanguigni principali). 3. Danni fisici abbastanza gravi; necessario il *ricovero* ospedaliero e probabilmente la terapia intensiva (ad es. stato comatoso con riflessi intatti, ustioni di terzo grado su meno del 20% del corpo, forte perdita di sangue con possibilità di recupero, fratture importanti). 4. Danni fisici gravi; necessari il *ricovero* ospedaliero e la terapia intensiva (ad es. stato comatoso senza riflessi, ustioni di terzo grado su più del 20% del corpo, forte perdita di sangue con instabilità dei segni vitali, danni gravi a organi vitali). 5. Morte	*Inserire il codice* ____
Letalità potenziale: rispondere solo in caso di letalità effettiva=0 Probabile letalità per tentativi concreti in assenza di danni fisici (gli esempi seguenti, in assenza di effettivi danni fisici, avevano una letalità potenzialmente molto elevata: mettersi la pistola in bocca e premere il grilletto ma la pistola non spara, cosicché non provoca danni fisici; stendersi sui binari con un treno in arrivo ma spostarsi prima di essere investiti). 0 = Comportamento che difficilmente causerà lesioni 1 = Comportamento che può causare lesioni, ma che difficilmente può causare la morte 2 = Comportamento che può causare la morte nonostante le cure mediche disponibili	*Inserire il codice* ____

MI-RSB 48

(Unterrainer, Ladenhauf & Huber, 2005)

Nel rispondere alle domande, tenga presente, per favore, quanto segue:

1. In gran parte troverà domande relative alle Sue credenze religiose/spirituali e incontrerà spesso il termine "Dio".

2. Questa indagine non è sponsorizzata da nessun gruppo religioso e i dati non verranno, neppure in minima parte, trasmessi a organizzazioni del genere.

3. Se trova inadeguato il termine "Dio", è libero di sostituirlo con un termine che considera più adatto, per esempio "potenza soprannaturale".

4. Il questionario può essere compilato anche da chi è agnostico o ateo - il questionario tiene conto anche di questi orientamenti.

La preghiamo di rispondere nel modo più immediato e spontaneo e di non soffermarsi troppo sulle domande. Per una corretta valutazione del questionario, è importante che Lei risponda a tutte le domande.

Appendix B Korrelationstabelle 1 (Studenten)

	Religiosität	Spiritualität	MIRSB_AR	MIRSB_VB	MIRSB_HI	MIRSB_AL	MIRSB_HT	MIRSB_EBS	MIRSB_RSB	MIRSB_TRANS	MIRSB_IMA	BFI_E	BFI_V	BFI_G	BFI_N	BFI_O
Alter	-,042	-,008	,068	,148**	,172**	,048	,199**	,102*	,199**	,146**	,204**	,170**	,107**	,164**	-,187**	,056
Religiosität		,519**	,794**	,238**	,079*	,358**	-,089*	,068	,507**	,626**	,195**	,140**	,208**	,172**	,008	-,098*
Spiritualität			,601**	,227**	,084*	,599**	-,043	,181**	,527**	,625**	,236**	,193**	,203**	,115**	,045	,109**
MIRSB_AR				,318**	,169**	,555**	-,055	,196**	,727**	,857**	,332**	,181**	,276**	,188**	-,040	-,008
MIRSB_VB					,180**	,139**	,322**	,150**	,613**	,396**	,696**	,211**	,547**	,233**	-,214**	,080*
MIRSB_HI						,239**	,235**	,420**	,579**	,308**	,740**	,385**	,222**	,371**	-,445**	,128**
MIRSB_AL							-,122**	,421**	,661**	,737**	,356**	,213**	,215**	,104**	,021	,194**
MIRSB_HT								-,066	,346**	,324**	,264**	,169**	,076	,123**	-,366**	,106**
MIRSB_EBS									,527**	,280**	,675**	,280**	,294**	,148**	-,113**	,257**
MIRSB_RSB										,893**	,820**	,389**	,463**	,326**	-,300**	,185**
MIRSB_TRANS											,475**	,277**	,301**	,216**	-,167**	,122**
MIRSB_IMA												,409**	,522**	,363**	-,374**	,206**
BFI_E													,235**	,205**	-,203**	,216**
BFI_V														,226**	-,173**	,068
BFI_G															-,179**	,020
BFI_N																-,094*

**. Die Korrelation ist auf dem Niveau von 0,01 (2-seitig) signifikant. *. Die Korrelation ist auf dem Niveau von 0,05 (2-seitig) signifikant.

	Soma	Zwan	Unsi	Depr	Angst	Aggre	Phobie	Parano	Psych	Suizid
Alter	-,128**	-,146**	-,184**	-,160**	-,200**	-,116**	-,128**	-,186**	-,166**	-,081*
Religiosität	,087*	,034	,057	,039	,042	-,037	,020	,076	,052	-,032
Spiritualität	,156**	,079*	,102*	,077	,106**	-,002	,044	,108**	,070	-,050
MIRSB_AR	,054	,054	,030	,034	,031	-,063	-,007	,044	,051	-,015
MIRSB_VB	-,168**	-,219**	-,267**	-,233**	-,208**	-,315**	-,204**	-,337**	-,205**	-,150**
MIRSB_HI	-,291**	-,427**	-,376**	-,491**	-,377**	-,301**	-,289**	-,350**	-,370**	-,231**
MIRSB_AL	,161**	,121**	,073	,100*	,153**	,089*	,062	,115**	,116**	,050
MIRSB_HT	-,292**	-,352**	-,364**	-,347**	-,370**	-,288**	-,260**	-,386**	-,304**	-,143**
MIRSB_EBS	,001	-,066	-,117**	-,060	-,004	-,040	-,064	-,094*	-,117**	-,051
MIRSB_RSB	-,129**	-,217**	-,254**	-,248**	-,194**	-,248**	-,195**	-,252**	-,199**	-,139**
MIRSB_TRANS	-,016	-,058	-,099*	-,079*	-,066	-,120**	-,084*	-,081*	-,042	-,047
MIRSB_IMA	-,231**	-,350**	-,372**	-,386**	-,296**	-,333**	-,275**	-,389**	-,335**	-,213**
BFI_E	-,089*	-,215**	-,294**	-,252**	-,171**	-,124**	-,193**	-,185**	-,199**	-,128**
BFI_V	-,125**	-,141**	-,232**	-,163**	-,154**	-,321**	-,165**	-,280**	-,174**	-,128**
BFI_G	-,152**	-,393**	-,261**	-,300**	-,211**	-,224**	-,114**	-,256**	-,293**	-,141**
BFI_N	,445**	,502**	,540**	,603**	,593**	,414**	,403**	,429**	,434**	,231**
BFI_O	,029	-,045	-,067	-,054	-,008	,026	,001	-,001	-,043	,087*
Soma		,586**	,528**	,607**	,708**	,536**	,495**	,543**	,555**	,306**
Zwan			,688**	,777**	,710**	,578**	,494**	,665**	,704**	,421**
Unsi				,782**	,693**	,588**	,597**	,790**	,738**	,365**
Depr					,800**	,652**	,584**	,705**	,759**	,525**
Angst						,621**	,603**	,653**	,694**	,440**
Aggre							,470**	,629**	,580**	,399**
Phobie								,533**	,563**	,434**
Parano									,747**	,375**
Psych										,477**

**. Die Korrelation ist auf dem Niveau von 0,01 (2-seitig) signifikant. *. Die Korrelation ist auf dem Niveau von 0,05 (2-seitig) signifikant.

Korrelations Table 2 (clinical Sample)

	Religiosität	Spiritualität	Suizidgedanken	Intensität_der_Suizidgedanken	Suizidales_Verhalten	Suizidversuche_insg	Suizidversuche_u	Suizidversuche_a	Letalität_LV	Letalität_EV	PotentielleL_LV	PotentielleL_EV
Alter	,294**	,225**	,024	,059	,047	,122*	,020	,059	,033	,002	,082	,084
Religiosität		,430**	,037	,019	,097	,086	-,032	,108*	,069	,055	,071	,064
Spiritualität			,118*	,118*	,107*	,107*	-,083	,033	,060	,082	,082	,074
Suizidgedanken				,820**	,689**	,524**	,297**	,320**	,535**	,467**	,539**	,555**
Intensität_der_Suizidgedanken					,617**	,504**	,279**	,373**	,530**	,462**	,521**	,537**
Suizidales_Verhalten						,659**	,423**	,446**	,665**	,603**	,610**	,619**
Suizidversuche_insg							,472**	,596**	,618**	,540**	,592**	,612**
Suizidversuche_u								,116*	,433**	,406**	,440**	,441**
Suizidversuche_a									,275**	,275**	,419**	,410**
Letalität_LV										,897**	,626**	,644**
Letalität_EV											,624**	,611**
PotentielleL_LV												,983**

**. Die Korrelation ist auf dem Niveau von 0,01 (2-seitig) signifikant. *. Die Korrelation ist auf dem Niveau von 0,05 (2-seitig) signifikant.

	MIRSB_AR	MIRSB_VB	MIRSB_HI	MIRSB_AL	MIRSB_HT	MIRSB_EBS	MIRSB_RSB	MIRSB_TRANS	MIRSB_IMA
Alter	,328**	,222**	-,015	,058	-,030	,007	,201**	,227**	,110*
Religiosität	,678**	,032	,134**	,271**	-,146**	,163**	,402**	,511**	,159**
Spiritualität	,501**	,039	,043	,462**	-,001	,278**	,426**	,548**	,161**
Suizidgedanken	,038	-,109*	-,187**	,034	,053	,013	-,050	,062	-,153**
Intensität_der_Suizidgedanken	-,001	-,116*	-,275**	,012	,059	-,007	-,105*	,028	-,214**
Suizidales_Verhalten	,053	-,096	-,127**	,093	,036	,040	-,001	,094	-,103*
Suizidversuche_insg	,029	-,096	-,101*	,068	,022	-,005	-,024	,061	-,108*
Suizidversuche_u	-,041	-,011	-,110*	,020	-,015	-,025	-,057	-,023	-,077
Suizidversuche_a	,026	-,128**	-,100*	,049	-,066	,042	-,050	,015	-,104*
Letalität_LV	,014	-,086	-,099*	,052	,022	-,004	-,031	,043	-,101*
Letalität_EV	,009	-,097	-,110*	,067	,003	,016	-,035	,040	-,104*
PotentielleL_LV	,013	-,039	-,196**	,014	,031	-,022	-,061	,027	-,137**
PotentielleL_EV	,011	-,029	-,194**	,019	,050	-,015	-,051	,035	-,128**
MIRSB_AR		,092	,315**	,556**	-,181**	,358**	,726**	,843**	,371**
MIRSB_VB			,139**	-,112*	,266**	-,082	,386**	,107*	,563**
MIRSB_HI				,337**	-,010	,450**	,683**	,364**	,809**
MIRSB_AL					-,167**	,555**	,683**	,783**	,359**
MIRSB_HT						-,191**	,147**	,191**	,053
MIRSB_EBS							,617**	,428**	,625**
MIRSB_RSB								,858**	,835**
MIRSB_TRANS									,435**

**. Die Korrelation ist auf dem Niveau von 0,01 (2-seitig) signifikant. *. Die Korrelation ist auf dem Niveau von 0,05 (2-seitig) signifikant.

	BFI_E	BFI_V	BFI_G	BFI_N	BFI_O	Soma	Zwan	Unsi	Depr	Angst	Aggre	Phobie	Parano	Psych	Suizid
Alter	,071	,226**	,141**	-,062	-,016	,002	-,021	-,140	,014	-,004	-,162**	-,009	-,079	-,009	,072
Religiosität	,090	,153**	,159**	-,057	,076	,031	-,010	-,022	-,002	,008	-,037	,022	,038	,067	,097
Spiritualität	,136**	,126*	,090	-,041	,240**	,040	-,020	-,023	,016	,038	-,021	,005	,063	,010	,080
Suizidgedanken	-,116*	,039	,022	,149**	,015	,191**	,255**	,250**	,360**	,255**	,228**	,227**	,191**	,223**	,555**
Intensität_der_Suizidgedanken	-,132**	-,004	,016	,245**	-,013	,253**	,293**	,269**	,407**	,309**	,237**	,260**	,230**	,268**	,525**
Suizidales_Verhalten	-,038	,111*	,059	,099*	,020	,187**	,210**	,211**	,328**	,251**	,209**	,243**	,176**	,272**	,502**
Suizidversuche_insg	-,012	,090	,064	,033	,064	,097	,047	,042	,174**	,112*	,082	,064	,057	,108*	,370**
Suizidversuche_u	-,059	,071	,034	,035	-,023	,024	,070	,061	,099*	,058	,042	,055	,045	,089	,185**
Suizidversuche_a	,012	,014	,022	,087	,065	,085	,083	,063	,142**	,111*	,129**	,105*	,073	,097*	,208**
Letalität_LV	,003	,079	,089	,056	,043	,073	,096	,094	,211**	,159**	,132**	,132**	,090	,139**	,417**
Letalität_EV	,009	,067	,093	,074	,058	,103*	,119*	,129**	,231**	,193**	,133**	,161**	,136**	,149**	,390**
PotentielleL_LV	-,032	,121*	,012	,073	,041	,033	,093	,003	,153**	,100*	,082	,063	,067	,098*	,382**
PotentielleL_EV	-,044	,121*	,014	,073	,034	,029	,085	-,011	,147**	,095	,069	,051	,049	,091	,384**
MIRSB_AR	,158**	,209**	,181**	-,151**	,147**	,003	-,026	-,061	-,081	-,008	-,058	-,018	,053	,021	,030
MIRSB_VB	,044	,429**	,002	-,211**	,041	-,223**	-,163**	-,305**	-,174**	-,203**	-,461**	-,194**	-,393**	-,238**	-,169**
MIRSB_HI	,458**	,201**	,338**	-,516**	,256**	-,156**	-,239**	-,239**	-,364**	-,257**	-,143**	-,202**	-,216**	-,248**	-,260**
MIRSB_AL	,301**	,135**	,142**	-,159**	,250**	,064	,001	,025	-,035	,051	,104*	,012	,126**	,078	,021
MIRSB_HT	,132**	,059	,074	-,236**	,140**	-,175**	-,170**	-,212**	-,130**	-,172**	-,112*	-,256**	-,194**	-,278**	-,080
MIRSB_EBS	,351**	,206**	,205**	-,112*	,353**	,006	-,025	-,113*	-,090	,000	,042	-,017	-,052	-,069	-,135**
MIRSB_RSB	,424**	,375**	,286**	-,414**	,342**	-,134**	-,179**	-,259**	-,260**	-,169**	-,189**	-,190**	-,184**	-,199**	-,164**
MIRSB_TRANS	,301**	,223**	,214**	-,267**	,272**	-,034	-,081	-,109*	-,119*	-,047	-,029	-,106*	,020	-,056	-,001
MIRSB_IMA	,421**	,421**	,273**	-,440**	,310**	-,200**	-,227**	-,338**	-,329**	-,247**	-,301**	-,220**	-,346**	-,289**	-,288**
BFI_E		,233**	,379**	-,436**	,403**	-,185**	-,248**	-,285**	-,291**	-,199**	-,087	-,257**	-,154**	-,253**	-,142**
BFI_V			,339**	-,196**	,172**	-,108*	-,132**	-,305**	-,084	-,102*	-,363**	-,100*	-,300**	-,244**	,000
BFI_G				-,275**	,287**	-,035	-,196**	-,168**	-,122*	-,072	-,103*	-,092	-,159**	-,193**	-,011
BFI_N					-,203**	,377**	,440**	,405**	,466**	,458**	,371**	,381**	,303**	,360**	,220**
BFI_O						-,151**	-,189**	-,195**	-,213**	-,174**	-,060	-,283**	-,068	-,183**	-,121*
Soma							,669**	,642**	,668**	,785**	,557**	,641**	,527**	,611**	,388**
Zwan								,755**	,809**	,797**	,594**	,676**	,601**	,695**	,461**
Unsi									,771**	,757**	,680**	,672**	,742**	,733**	,469**

Depr										,813**	,532**	,681**	,584**	,690**	,635**
Angst											,622**	,756**	,605**	,727**	,500**
Aggre												,503**	,644**	,558**	,350**
Phobie													,477**	,611**	,425**
Parano														,673**	,394**
Psych															,488**

**. Die Korrelation ist auf dem Niveau von 0,01 (2-seitig) signifikant. *. Die Korrelation ist auf dem Niveau von 0,05 (2-seitig) signifikant.

Correlations Table 3 (Total Sample)

	Religiosität	Spiritualität	MIRSB_AR	MIRSB_VB	MIRSB_HI	MIRSB_AL	MIRSB_HT	MIRSB_EBS	MIRSB_RSB	MIRSB_TRANS	MIRSB_IMA	BFI_E	BFI_V	BFI_G	BFI_N	BFI_O
Alter	,215**	,146**	,288**	,100**	-,093**	,091**	-,022	-,071*	,127**	,219**	-,024	,001	,160**	,101**	,036	-,081**
Religiosität		,486**	,751**	,137**	,080*	,325**	-,121**	,092**	,456**	,585**	,151**	,105**	,191**	,166**	,002	-,034
Spiritualität			,562**	,140**	,050	,540**	-,032	,212**	,482**	,597**	,186**	,161**	,175**	,104**	,021	,157**
MIRSB_AR				,203**	,197**	,557**	-,118**	,237**	,711**	,854**	,305**	,150**	,254**	,183**	-,053	,037
MIRSB_VB					,163**	,015	,299**	,039	,508**	,258**	,629**	,140**	,490**	,128**	-,217**	,066*
MIRSB_HI						,271**	,127**	,449**	,619**	,302**	,781**	,424**	,196**	,345**	-,484**	,212**
MIRSB_AL							-,146**	,472**	,668**	,757**	,338**	,243**	,182**	,121**	-,044	,209**
MIRSB_HT								-,111**	,262**	,258**	,178**	,159**	,065*	,102**	-,322**	,127**
MIRSB_EBS									,565**	,324**	,656**	,320**	,239**	,172**	-,129**	,318**
MIRSB_RSB										,869**	,816**	,403**	,424**	,308**	-,344**	,258**
MIRSB_TRANS											,423**	,271**	,273**	,214**	-,183**	,171**
MIRSB_IMA												,421**	,457**	,314**	-,416**	,273**
BFI_E													,228**	,277**	-,307**	,309**
BFI_V														,274**	-,172**	,108**
BFI_G															-,215**	,142**
BFI_N																-,157**

**. Die Korrelation ist auf dem Niveau von 0,01 (2-seitig) signifikant. *. Die Korrelation ist auf dem Niveau von 0,05 (2-seitig) signifikant.

	Soma	Zwan	Unsi	Depr	Angst	Aggre	Phobie	Parano	Psych	Suizid	GSI
Alter	,138**	,143**	-,056	,197**	,183**	-,033	,226**	,017	,137**	,258**	,153**
Religiosität	,089**	,048	,030	,061*	,067*	-,023	,068*	,075*	,091**	,082**	,073*
Spiritualität	,114**	,049	,051	,068*	,092**	-,003	,044	,096**	,057	,044	,082**
MIRSB_AR	,074*	,066*	,002	,041	,073*	-,039	,058	,072*	,082**	,075*	,058
MIRSB_VB	-,201**	-,195**	-,287**	-,206**	-,208**	-,390**	-,194**	-,367**	-,226**	-,165**	-,282**
MIRSB_HI	-,247**	-,349**	-,309**	-,445**	-,342**	-,227**	-,269**	-,293**	-,328**	-,287**	-,389**
MIRSB_AL	,127**	,077*	,055	,053	,119**	,104**	,055	,129**	,112**	,058	,103**
MIRSB_HT	-,246**	-,271**	-,300**	-,251**	-,279**	-,211**	-,248**	-,306**	-,295**	-,123**	-,308**
MIRSB_EBS	-,029	-,077*	-,122**	-,114**	-,045	-,010	-,080**	-,089**	-,120**	-,140**	-,096**
MIRSB_RSB	-,129**	-,191**	-,256**	-,241**	-,173**	-,218**	-,173**	-,219**	-,193**	-,143**	-,236**
MIRSB_TRANS	,007	-,031	-,093**	-,050	-,011	-,063*	-,037	-,017	-,014	,026	-,038
MIRSB_IMA	-,245**	-,314**	-,360**	-,384**	-,304**	-,327**	-,274**	-,381**	-,337**	-,291**	-,390**
BFI_E	-,152**	-,243**	-,293**	-,282**	-,202**	-,114**	-,235**	-,180**	-,238**	-,155**	-,262**
BFI_V	-,099**	-,115**	-,259**	-,097**	-,101**	-,331**	-,090**	-,278**	-,186**	-,033	-,178**
BFI_G	-,090**	-,281**	-,217**	-,196**	-,130**	-,164**	-,086**	-,208**	-,231**	-,060	-,209**
BFI_N	,427**	,483**	,482**	,544**	,534**	,399**	,387**	,383**	,411**	,250**	,545**
BFI_O	-,092**	-,147**	-,137**	-,168**	-,129**	-,030	-,205**	-,050	-,143**	-,074*	-,150**
Soma		,654**	,584**	,664**	,765**	,553**	,607**	,546**	,610**	,403**	,803**
Zwan			,711**	,810**	,777**	,589**	,635**	,637**	,718**	,490**	,879**
Unsi				,750**	,704**	,636**	,595**	,767**	,723**	,413**	,850**
Depr					,827**	,584**	,675**	,642**	,739**	,632**	,917**
Angst						,616**	,726**	,629**	,733**	,531**	,914**
Aggre							,478**	,640**	,571**	,375**	,715**
Phobie								,489**	,617**	,496**	,770**
Parano									,709**	,398**	,777**
Psych										,523**	,848**
Suizid											,599**

**. Die Korrelation ist auf dem Niveau von 0,01 (2-seitig) signifikant. *. Die Korrelation ist auf dem Niveau von 0,05 (2-seitig) signifikant.