Miguel Guerrero-Díaz[a].
Emilio Andrade-Conde[a].
Joaquín Peláez-Cherino[b].
José Antonio Rodríguez-Montalvo[b].
Eugenio Contreras-Fernández[c,d].
Francisco Rivas-Ruiz[c,e].

Attitudinal beliefs concerning suicidal behavior among healthcare professionals in the Western Costa del Sol healthcare district (Spain)

[a]Community Mental Health Unit of Marbella, Andalusian Health Service, Málaga, Spain.
[b]Emergency Department, Costa del Sol Hospital, Málaga, Spain.
[c]Health Prevention, Promotion, and Monitoring Clinical Management Unit, Costa del Sol Healthcare District, Andalusian Health Service, Mijas, Málaga, Spain.
[d]Chronic Diseases Research Network in Health Services (REDISSEC), Spain.
[b]Emergency Department, Costa del Sol Hospital, Málaga, Spain.

ABSTRACT

Introduction. Suicide continues to be the leading external cause of death in Spain, according to the latest report on deaths by cause of death published by the National Statistics Institute (INE, for its initials in Spanish) in December 2019[1]. According to this report, there were 3,539 deaths by suicide recorded in 2018. Ten people voluntarily ending their lives each day. Málaga province recorded 134 deaths by suicide in 2018, being therefore one of the provinces with the highest incidence in the autonomous community of Andalucía and the eighth nationally.

Method. This descriptive, cross-sectional survey of healthcare professionals was carried out in one healthcare district in Málaga (Spain). The main outcome variable was attitudinal beliefs, which were evaluated using the Questionnaire on Attitudinal Beliefs Regarding Suicidal Behavior (CCCS-18). The questionnaire includes four factors: legitimization of suicide, suicide in terminally ill patients, moral dimension of suicide, and suicide itself, each measured via an average of responses to different items on a scale of 1 to 7 points. Stigmatizing attitudes or beliefs are defined as those with average scores of less than 3.5.

Results. 135 health professionals completed the questionnaire: 58.5% were nurses, 25.9% were physicians, and 15.6% were medical social workers. The mean score on the CCCS-18 scale was 3.6 (SD: 1.17) points, with significant differences depending on the profession (p = .043). A mean of 3.22 (SD: 1.17) was found among physicians, 3.66 (SD: 1.02) among nurses, and 3.99 (SD: 1.52) among medical social workers. In an analysis by factors, mean scores below 3.5 were found for "legitimization of suicide" (mean: 2.59; SD: 1.28) and "suicide itself" (mean: 2.9; SD: 1.47).

Conclusions. Healthcare professionals in the Western Costa del Sol Health District expressed unfavorable attitudes and beliefs in dimensions related to legitimization of suicide and suicide itself, with worse overall attitudes found among physicians.

Key words. Attitudinal beliefs, suicidal behavior, suicide prevention, healthcare professionals, stigma.

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CREENCIAS ACTITUDINALES SOBRE LA CONDUCTA SUICIDA EN PROFESIONALES SANITARIOS DEL ÁREA SANITARIA DE LA COSTA DEL SOL OCCIDENTAL

RESUMEN

Introducción. El suicidio sigue siendo la primera causa de muerte externa en España como describe el último informe de defunciones según la causa de muerte publicada por el Instituto Nacional de Estadística (INE) en diciembre de 2019[1]. Según este informe los fallecimientos por suicidio registrados en el año 2018 se situaron en 3.539 fallecimientos. Diez personas se quitan la vida de forma voluntaria diariamente. La provincia de Málaga registró 134 muertes por suicidio en el mismo año, siendo por tanto una de las provincias con mayor incidencia en la comunidad autónoma de Andalucía y la octava a nivel nacional

Metodología. La muestra del estudio fueron de 135 profesionales. Se trata de un estudio transversal descriptivo de periodo mediante encuesta, realizado entre los profesionales sanitarios de un Área Sanitaria de Málaga. Las creencias actitudinales fueron valoradas a través del Cuestionario de Creencias Actitudinales sobre Comportamiento Suicida (CCCS-18) que incluye cuatro factores: legitimización del suicidio, suicidio en enfermos terminarles, dimensión moral

Corresponding Author. Miguel Guerrero Díaz.
Address: Community Mental Health Unit of Marbella. C/ Las Albarizas s/n.
Email: miguel.psico1982@gmail.com (M. Guerrero-Díaz).

y propio suicidio, medidas con una escala de respuesta en promedio de 1 a 7 puntos, identificando creencias estigmatizantes aquellas puntuaciones promedias inferiores a 3,5.

Resultados. Un total de 135 profesionales completaron el cuestionario, siendo un 58,5% enfermeras, 25,9 % facultativos y 15,6 % trabajadores sociosanitarios. La puntuación media de la escala CCCS-18 fue de 3,6 (DE: 1,17) puntos, hallándose diferencias significativas en función de la profesión (p: 0,043), con una media 3,22 (DE: 1,17) en facultativos, 3,66 (DE: 1,02) en enfermeras, y 3,99 (DE: 1,52) en trabajadores sociosanitarios. En análisis por factores, se hallaron puntuaciones promedias en la muestra inferior a 3,5, tanto en factor "legitimación del suicidio" (media: 2,59; DE: 1,28), como en factor "propio suicidio" (media: 2,9; DE: 1,47).

Conclusiones. Los profesionales sanitarios del Área Sanitaria de la Costa del Sol Occidental han manifestado actitudes y creencias desfavorables en dimensiones relacionadas con legitimación del suicidio y el propio suicidio, determinándose peores actitudes globalmente en el colectivo médico.

Palabras clave. Creencias actitudinales, conducta suicida, prevención del suicidio, profesionales sanitarios, estigma.

INTRODUCTION

Suicide continues to be the leading external cause of death in Spain, according to the latest report on deaths by cause of death published by the National Statistics Institute (INE, for its initials in Spanish) in December 2019[1]. According to this report, there were 3,539 deaths by suicide recorded in 2018. Ten people voluntarily ending their lives each day. Málaga province recorded 134 deaths by suicide in 2018, being therefore one of the provinces with the highest incidence in the autonomous community of Andalucía and the eighth nationally.

Despite these worrying figures, the phenomenon of suicide continues to be surrounded by institutional, social, and political silence; it is a taboo topic[2]. More research on the social and cultural aspects surrounding suicide must be carried out in to identify the beliefs and image that suicide has in each community[3]. Furthermore, healthcare professionals' knowledge about suicide has been extensively studied and it has been consensually agreed that it is insufficient and manifestly an area for improvement[4].

One of the main reasons indicated by mental health patients for not seeking specialized, professional help is the perception of healthcare personnel as agents that contribute to stigma and discrimination[5]. However, little attention is paid to studying this stigma and how these discriminatory attitudes affect patients at risk of suicide. The manifestation of intolerant attitudes and/or beliefs towards suicidal behavior by healthcare professionals could negatively influence various aspects that are considered essential for the proper healthcare of patients who present with suicidal behavior[6]. These manifestations represent a barrier to the provision of healthcare services and can be explained by a lack of specific training, low motivation, or the presence of negative emotional reactions that could be projected to the patient. There is a risk that these beliefs could lead to iatrogenic actions that could later affect the therapeutic process for these users, such as disruption of continuity of care, refusal to consult a mental health specialist, or withdrawal or concealment of his or her personal situation due to shame or guilt. In addition, these beliefs emotionally affect the person's subjective well-being, acting as a considerable obstacle to seeking out help, accessing treatment, and the adherence to and efficacy of that treatment[7].

Fredman et al. concluded that there was prejudice towards patients with suicidal behavior among healthcare professionals, who attribute suicidal motivations to a call for attention with manipulative and instrumental purposes with a clearly pejorative connotation[8]. Studies analyzing the attitudes that healthcare professionals show towards patients with medical diseases compared to those who manifest suicidal behavior have corroborated the existence of more hostile attitudes on the part of the healthcare professionals towards the latter group of patients[9].

In view of the foregoing, the social stigma associated with suicide is an issue of seminal importance at present, given that it can represent a barrier to patients' recovery, compromise the accessibility of the healthcare system, delay the start of specialized treatment, and thus increase the risk of suicide attempts or reattempts. Professionals who display favorable attitudes and behaviors towards suicidal behavior offer better healthcare to patients with suicidal behavior, encouraging them to comprehend the necessity of seeking help in the community mental health services and find the conviction to do so, thus guaranteeing continuity of care. This preventative measure not only contributes to reducing the risk of suicide in patients who have suicidal ideation or have attempted suicide, but also to alleviating the associated psychological suffering in a time of enormous personal vulnerability. On the contrary, healthcare professionals who manifest unfavorable beliefs and attitudes towards suicidal behavior have a greater probability of incurring in poor healthcare practices and having a negative influence on these patients' understanding of the need to seek help, their distrust in the healthcare system, and therefore a disruption in continuity of care. This situation could increase the risk of suicide among these patients[10]. Professionals who show themselves to be more tolerant regarding suicide have a greater probability of providing more respectful, personable healthcare to suicidal patients[11].

The purpose of this study was to learn the attitudes and beliefs about suicidal behavior among healthcare professionals in primary care and hospital emergency department units as well as to explore the correlation between these attitudes and the sociodemographic, occupational, and social desirability characteristics of said professionals.

METHODOLOGY

Study design, scope, and population

This work is a cross-sectional, descriptive study performed by means of a questionnaire administered to healthcare professionals in the Costa del Sol Primary Care District (CS-PCD) and the Costa del Sol Hospital (CSH) Critical Care and Emergency Department. The study population included all healthcare professionals (physicians, nurses, and medical social workers) belonging to the Albarizas, Leganitos, and San Pedro Alcántara Health Centers of the CS-PCD and the Critical Care and Emergency Department of the CSH.

Instruments

The questionnaire was sent to the professional email addresses of all healthcare professionals belonging to the participating centers. For this task, the SurveyMonkey program was used, which allowed for designing a questionnaire on the platform, generating a web link to the questionnaire, and then managing the results once the information gathering period ended (12 weeks – September to December 2018 with two reminders per month for those who had not yet responded). The professional email addresses were provided by the management of the participating centers. In the survey, which was sent electronically, the study's aim was explained and it indicated that informed consent for participating in the study was implicit with the completion of the questionnaire.

Prior to launching, the project received approval from the Costa del Sol Research Ethics Committee (76-07-2018, dated July 26, 2018). All information was collected anonymously in strict accordance with current national data protection laws (Organic Law 3/2018, of December 5, on Personal Data Protection and the Guarantee of Digital Rights).

Study variables

The primary outcome variable was the attitudinal beliefs evaluated through the *Questionnaire on Attitudinal Beliefs Regarding Suicidal Behavior* (CCCS-18)[12]. The questionnaire contains 18 items. It can be considered a subject-centered additive scale, given that the variation in responses corresponds to individual differences related to the beliefs and attitudes that healthcare professionals have about suicide. The questionnaire is in a Likert scale format, with seven response options that indicate the level of agreement or disagreement regarding the statement posed in each item. The questionnaire is divided into four factors. The first factor, called *"Legitimization of Suicide,"* seeks to measure beliefs about the legitimacy of the act of suicide in certain life circumstances. The second factor, *"Suicide in Terminally Ill People,"* seeks to learn if suicide can be conceived as a viable method of dying for people who suffer from terminal illnesses. The third factor, *"Moral Dimension of Suicide,"* refers to the judgment of suicide as moral or immoral according to one's beliefs and, in addition, analyzes if it is inherent in said beliefs. Lastly, the fourth factor focuses on *"Suicide Itself,"* and seeks to determine if the act of suicide could arise as a possibility in light of different situations that generate emotional disturbances. The items, factors, and total score of the CCCS-18 scale are evaluated with mean scores on a scale of 1 to 7, with average scores of less than 3.5 indicating stigmatizing attitudes or beliefs. Items 3, 7, 9, 12, and 16 are scored inversely.

On the other hand, social desirability bias was evaluated in the study population using the Marlowe–Crowne Social Desirability Scale (MC–SDS)[13,14]. There is general consensus on using this scale to control whether responses to a psychological questionnaire could be biased due to a tendency to respond in a socially desirable manner.[15] The scale consists of 33 items in which the survey respondent must indicate if they are true or false to him or her, scoring direct items that a person considers true or the inverse items that a person considers false as 1 and scoring the opposite as 0. The direct sum of scores yields a number between 0 and 33, in which higher scores indicate greater social desirability bias.

The remaining independent variables were the sociodemographic and occupational characteristics of the participating healthcare professionals; the presence of stigmatizing behaviors observed (in other medical professionals or their own behavior); the degree of self-perception and competence in approaching suicidal patients effectively; and the level of need for receiving specific, formal training in order to address suicidal behavior in a healthcare setting. All were measured on a scale of 0 to 100 points (from lesser to greater need). Each of these variables was evaluated through questions formulated *ad hoc* by the research team.

Statistical analysis

A descriptive analysis was performed using measurements of central tendency, dispersion, and position for quantitative variables and distribution of frequency for qualitative variables. A bivariate analysis was performed using the scores on the four factors as well as the total score on the CCCS-18 scale as outcome variables versus the social

and occupational characteristics of the sample of healthcare professionals. Student's t-test (or the Mann–Whitney U test in the case of non-normal distribution) was used for independent dichotomous variables and the one-way ANOVA test (or Kruskal-Wallis test) in the case of independent variables with three categories. Pearson's correlation coefficient was used to evaluate the correlation between social desirability scores and the factors and total score on the CCCS-18 scale. Statistical significance was established as $p < .05$.

RESULTS

Of the 350 healthcare professionals who were eligible to participate (all received the questionnaire by email), 156 responses were received. Of them, 21 were discarded due to a lack of thorough completion of the CCCS-18 questionnaire. Therefore, the final study sample comprised 135 respondents (38.6% response rate of the population eligible to participate).

Table 1 Description of the sample of healthcare professionals evaluated

Variables		n	%
Sex			
	Male	39	28.9
	Female	96	71.1
Age (years)			
	25 – 35	14	10.4
	> 35 – 45	65	48.1
	> 45 – 55	35	25.9
	> 55	21	15.6
Workplace			
	Primary Care	74	54.8
	Hospital Emergency Department	61	45.2
Profession			
	Physician	35	25.9
	Nurse	79	58.5
	Medical social worker	21	15.6
Years worked			
	< 10	23	17.0
	10 – 20	66	48.9
	> 20	46	34.1
Formal mental health training			
	Absence	69	51.1
	Presence	66	48.9
Specific suicidal behavior training			
	No	124	91.9
	Yes	11	8.1
Experience with suicide in one's personal life			
	No	79	58.5
	Yes	56	41.5
Stigmatizing behavior in healthcare – Other healthcare professionals' behavior[1]			
	No	53	39.6
	Yes	81	60.4
Stigmatizing behavior in healthcare – One's own behavior			
	No	97	71.9
	Yes	38	28.1
Degree of self-perception and competence for approaching and managing suicidal patients in an effective way (0 – 100)[2]	Median (IR)	30 (46)	
Level of need for receiving specific, formal training on the approach to and management of patients with suicidal behavior (0 – 100)	Median (IR)	81 (80)	

n = frequency; IR: Interquartile Range
[1]: one loss; [2]: two losses

Of the final study sample, 71.1% were female, 58.5% were 45 years of age or younger, 54.8% worked in a primary care setting, 58.5% were nurses, and 25.9% were physicians. 48.9% of the sample reported formal mental health training and 8.1% reported specific training on suicidal behavior. Furthermore, 60.4% of respondents reported having identified stigmatizing behaviors towards suicide in other healthcare professionals and 28.1% reported perceiving them in themselves (Table 1).

The mean score on the CCCS-18 scale was 3.6 (SD: 1.17) points. In the evaluation broken down by factors, the mean score was greater than 4 points on factor II – suicide in terminally ill patients (mean: 4.02; SD: 1.87) and factor III – moral dimension of suicide – (mean: 5.38; SD: 1.37). The mean score was less than 3 points on factor I – legitimization of suicide – (mean: 2.59; SD: 1.28) and on factor IV – suicide itself – (mean: 2.9; SD: 1.47) (Table 2).

On the comparative analysis between scores on the CCCS-18 scale and the social and occupational characteristics of the study sample, differences were found based on profession, with lower scores found among physicians versus nurses and medical social workers both on factor II ($p = .024$) and on the total score ($p = .043$). Differences were also identified among professionals who had experience with suicide in their personal lives, with higher scores on factor I, factor III, and the total score among those with experience in their personal lives versus those without experience (Table 3).

The mean social desirability score found on the Marlowe-Crowne scale was 16.7 (SD: 5.9) out of a maximum of 33 points, with a significant negative correlation on each of the four factors and on the total score of the CCCS-18 scale. Pearson's correlation coefficient was -0.255 ($p < .01$) on factor I, - 0.272 ($p < .01$) on factor II, -0.19 ($p < .032$) on factor III, -0.288 ($p < .01$) on factor IV, and -0.32 ($p < .01$) on the total score on the CCCS-18 scale (Figure 1).

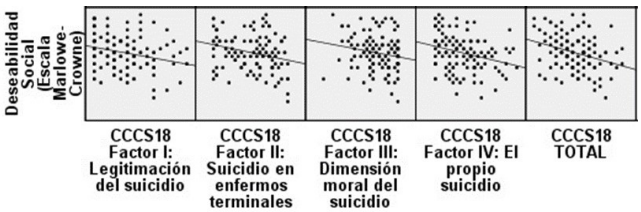

Figure 1 Correlation of Social Desirability against factors and total score of beliefs about suicide.

Table 2 Descriptive data of the CCCS-18 scale with scores by items, factors, and the total score

Factor	Items	Mean	SD
I. Legitimization of suicide	**Factor I**	**2.59**	**1.28**
	10. I would accept suicide in the elderly.	2.79	1.87
	05. If someone wants to attempt suicide, that is their business and we should not intervene.	1.72	1.35
	14. There should be clinics so that suicidal people can take their lives privately and with less suffering.	2.47	1.83
	01. I would accept certain forms of suicide (example: overdosing on pills).	2.68	2.09
	08. Suicide should be a legitimate way of dying.	3.64	2.09
	18. Suicide would be a normal thing in an ideal society.	2.27	1.77
II. Suicide in terminally ill people	**Factor II**	**4.02**	**1.87**
	02. Suicide in a dignified manner should be allowed for people with incurable diseases.	4.58	2.24
	15. I would accept suicide in people who have little time left to live.	3.77	2.05
	06. Suicide is an acceptable way to want to end an incurable disease.	3.68	2.10
	11. Helping a terminally ill person commit suicide is understandable.	4.04	2.12
III. Moral dimension of suicide	**Factor III**	**5.38**	**1.37**
	07. Suicide is an immoral act.	5.49	1.75
	03. Suicide goes against morality.	4.84	1.97
	16. Suicide should be prohibited because it is murder.	5.33	1.82
	12. People who commit suicide are a threat to society.	5.87	1.70
IV. Suicide itself	**Factor IV**	**2.90**	**1.47**
	13. If I felt very alone and depressed, I would try to commit suicide.	2.13	1.53
	17. Sometimes, suicide is the only way to escape life's problems.	2.36	1.76
	04. It is possible that I would commit suicide if I were in an extreme situation.	3.49	2.18
	09. I would never commit suicide under any circumstances.	3.64	2.17

SD = Standard deviation

Table 3 Bivariate analysis between the score per factor and total score on the CCCS-18 scale and occupational characteristics

Variables		Factor I: Legitimization of suicide			Factor II: Suicide in terminally ill people			Factor II: Moral dimension of suicide			Factor IV: Suicide itself			Total		
		Mean	SD	p	Mean	SD	p	Mean	SD	p	Mean	SD	p	Mean	SD	p
Sex	Male	2.69	1.45	0.589	3.75	2.11	0.331	5.32	1.61	0.736	3.00	1.69	0.630	3.58	1.36	0.897
	Female	2.56	1.22		4.13	1.77		5.41	1.27		2.86	1.38		3.61	1.08	
Age	≤ 45	2.60	1.13	0.940	4.16	1.88	0.309	5.43	1.42	0.660	2.80	1.36	0.336	3.62	1.06	0.813
	> 45	2.58	1.49		3.82	1.86		5.32	1.31		3.05	1.62		3.57	1.32	
Workplace	Primary care	2.61	1.40	0.870	3.89	1.88	0.396	5.19	1.46	0.070	2.96	1.53	0.651	3.55	1.25	0.558
	Hospital emergency department	2.57	1.14		4.17	1.87		5.62	1.23		2.84	1.41		3.66	1.06	
Profession	Physician	2.27	1.11	0.092	3.30	1.94	**0.024**	5.18	1.48	0.491	2.61	1.50	0.270	3.22	1.17	**0.043**
	Nurse	2.62	1.20		4.20	1.72		5.41	1.34		2.94	1.31		3.66	1.02	
	Medical social worker	3.03	1.73		4.51	2.05		5.62	1.31		3.26	1.93		3.99	1.52	
Years worked	< 10	2.61	1.25	0.974	4.00	1.95	0.750	5.03	1.44	0.362	2.60	1.49	0.309	3.45	1.19	0.810
	10 – 20	2.57	1.11		4.13	1.81		5.51	1.33		2.84	1.34		3.63	1.02	
	> 20	2.62	1.54		3.86	1.95		5.38	1.40		3.15	1.63		3.63	1.36	
Formal mental health training	Absence	2.77	1.30	0.089	4.26	1.84	0.139	5.40	1.49	0.562	2.95	1.49	0.746	3.72	1.20	0.128
	Presence	2.41	1.25		3.77	1.89		5.37	1.25		2.86	1.46		3.47	1.13	
Specific suicidal behavior training	No	2.60	1.26	0.806	4.07	1.86	0.371	5.33	1.40	0.122	2.90	1.47	0.990	3.60	1.16	0.791
	Yes	2.58	1.57		3.45	1.98		6.00	0.85		2.95	1.63		3.62	1.28	
Personal experience with suicide	No	2.37	1.18	**0.016**	3.82	1.88	0.147	5.08	1.38	**0.002**	2.80	1.39	0.336	3.39	1.08	**0.013**
	Yes	2.91	1.37		4.29	1.85		5.81	1.24		3.05	1.59		3.89	1.23	

SD = Standard deviation

DISCUSSION AND ANALYSIS OF THE RESULTS

The healthcare professionals included in this study showed a generally unfavorable attitude toward suicidal behavior. More than half of the sample studied did not have formal training on mental health or specific training on suicidal behavior, despite being aware of the great need to receive specific, formal training and recognizing a low degree of self-perception and competence for the proper approach to and management of patients with suicidal behavior. Overall, physicians showed more unfavorable attitudes towards suicidal behavior compared to nursing personnel and medical social workers, with the suicide of terminally ill patients the most rejected by physicians. Healthcare professionals who had experience with suicide in their personal lives showed more favorable and legitimizing attitudes and beliefs towards suicidal behavior and greater moral acceptance of suicide. In the sample we analyzed, having formal training in mental health and specifically on suicidal behavior, was not associated with having more favorable beliefs and attitudes towards suicidal behavior *per se*.

The stigmatizing beliefs and behaviors that healthcare professionals may manifest to people who have attempted suicide can have serious repercussions and consequences both for the patient and for his or her family. Therefore, we must be aware of them[16]. This is especially true given that the study sample comprises workers from different professional categories who work in primary care and hospital emergency department units, which are both units where suicidal patients traditionally enter into the healthcare system network. Good professional care in outpatient and hospital health centers; warm, welcoming, and deeply respectful care for the patient; transmitting understanding of the psychological suffering; and recognizing the moment of great personal vulnerability that a suicidal patient is going through will in large part determine the patient's trust in the healthcare system and access to the specialized community mental health service resources where psychotherapeutic treatment is offered for reducing the risk of suicidal behavior. Access to telematic interventions through the use of e-health resources[17] or crisis hotline intervention services[18] can be useful additional tools along with the care of a healthcare professional.

In regard to this study's limitations, in addition to obtaining a relatively low response rate, there are difficulties in extrapolating the results to other healthcare professionals in different health areas. Additionally, the study was performed in an urban context in which, though there are high rates of suicide, they are lower than those recorded in the rural areas of our province.

The social desirability values of the sample of healthcare professionals was within the range of the general population of Spain (median of 16.5 (P25 – P75: 12.2 – 20) in our sample versus a somewhat higher median of 18 in a sample of the general population (P25 – P75: 15 – 22))[19]. The social desirability scores significantly negatively correlated with all factors and the total score on the CCCS-18 scale. This translates into a possible bias in beliefs about suicide expressed by the sample of healthcare professionals, though it is possible they are not different to what would be reflected in the general population, given that similar desirability thresholds have been found.

The results of this study are generally similar to those found in the work carried out by Carmona-Navarro and Pichardo-Martínez at the University of Granada. That work demonstrated that healthcare professionals had similar values on attitudinal beliefs towards suicidal behavior independently of sex, time worked, place of work, and/or having formal training[20]. In our study, no significant differences were found based on sex, mental health training, or the place of work.

CONCLUSIONS

Healthcare professionals who show a greater degree of acceptance, tolerance, and inclusive attitudes with respect to suicidal behavior have a greater probability of providing effective and more authentic clinical care to patients with suicidal tendencies[21-24].

Given the current lack of similar studies on the national and international level, further exploration of these belief and attitudes is warranted. We consider the need for further study on the stigma of suicide among healthcare professionals and in the different healthcare units which attend to patients with suicidal behaviors to be essential. Likewise, it is necessary to know what training content positively modifies and produces change in beliefs and a reduction in the associated social stigma. In future studies, it will be necessary to measure the efficacy of these programs and identify what specific variables play a role in the relationship between having personal experience with suicide and manifesting more favorable attitudinal beliefs towards suicidal behavior.

We believe that training aimed at educating healthcare professionals on the management of and approach to suicide must include not only the acquisition of technical knowledge on the management of suicide prevention (evaluation of suicidal behavior, risk/protective factors, evaluation of suicide risk, etc.), but also must transmit knowledge that influences attitudes and personal beliefs, promotes empathetic understanding, and improves the doctor-patient relationship. Along these lines, this training must be expanded to include the largest number of professionals in the healthcare district, but most of all to those who directly intervene in the healthcare process of a patient with suicidal behavior. In addition to psychological educational training,

as mentioned above, a change in behavior and attitudes that improves the quality of clinical care and professionals' ability to cope with the management of suicidal behavior is vital.

This work's analysis of the healthcare professionals of the Western Costa del Sol Healthcare District confirms the existence of unfavorable attitudes and beliefs towards suicidal behavior, regardless of whether they work on primary care teams or in hospital emergency department units and independently of sex, age, prior training, or the number of years worked. The only variables that correlated with a greater acceptance of suicidal behavior were professional category and personal experience related to suicide. If a social desirability bias does indeed exist, it does not differ from what could be manifested by the rest of the population.

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