

Common Suicide Misconceptions

Misconception: “Talking openly about suicide will put the idea into their head.”

Response: It is a myth that a caring adult talking openly about suicide in an informative, nonjudgmental, and scientifically accurate way, or inquiring into a person’s possible suicidal ideation, will make that person consider suicide for the first time. When you talk more about suicide, it helps youth understand mental health and be more likely to get help for themselves or recognize the warning signs of mental illness and suicidality in someone else.

Misconception: “If they ask me to promise not to share, then I am obligated to stay silent.”

Response: It is important that you never promise that you will not share someone’s suicidal thoughts. Even mental health clinicians give clients disclosure when they begin treatment that everything said is confidential *except* an intention to hurt others or kill or hurt themselves. So, even if you were a medical professional, imminent suicidal or homicidal ideation would not be bound by doctor-client confidentiality.

Misconception: “Only trained professionals, or case managers, can provide this kind of support.”

Response: Everyone should be trained in suicide warning signs. Mental health professionals are not often immediately accessible in the onset of a crisis or in the critical period when a supportive person might be able to address distress before a crisis begins. The warning signs of suicidal ideation are displayed most often to friends, family, teachers, and community and, therefore, it is your responsibility to be knowledgeable enough to refer them to a professional if needed.

Misconception: “A youth will go to their parents and friends with their thoughts, not me.”

Response: Youth program staff may assume they will not be the first person to whom a participant expresses suicidal ideation. Statistics show that youth quite often go to unexpected people to share their suicidal ideation including teachers, coaches, bus drivers, and janitors, rather than intimate family and friends. Many times, they go to people they can relate to by way of identity or personality and with whom they feel a sense of safety.

Misconception: “Every suicide death is preventable.”

Response: Sometimes people with suicidal ideation display very few warning signs and, in some cases, it’s their intention to hide their thoughts so that no one can intervene. It is important that grieving youth program staff members do not place blame on themselves for a suicide death. With a suicide death, we most look to the future—in preventing more deaths, addressing survivor trauma, and limiting suicide contagion. Rather than ruminating on a past we cannot change, we can turn that energy into future action!

Language Do's and Don'ts

Below are lists of commonly used phrases you should avoid saying when discussing suicide to reduce hurt and stigma, and phrases you are *encouraged* to say to show respect and compassion, and to maintain scientific accuracy.

Don't Say

- x “Committed suicide”
- x “Failed” or “successful” attempt
- x “A selfish act”

Do Say

- ✓ “Died by suicide”
- ✓ “Ended their life”
- ✓ “Killed themselves”
- ✓ “Suicide attempt” or “death by suicide”



You might wonder why using appropriate suicide terminology is so important. Much of the historical use of suicide terminology is fundamentally inaccurate to the medical nature of suicide. Educating others about suicide using accurate terms is critical for encouraging help-seeking, raising awareness in groups with high risk, and advocating for new crisis interventions and prevention strategies for those experiencing distress. When suicide is talked about safely and precisely, we can help reduce the likelihood of its occurrence because, when we open up and connect, it is *conversation* that saves lives.

Where can I find more information?

This information is sourced from “An Introduction to Youth Suicide Prevention”, a Technical Assistance Webcast from the U.S. Department of Labor Division of Youth Services on [WorkforceGPS](#).