Understanding the Importance and Relationship Between Coping and Resiliency When Dealing With a Death From Suicide

A Paper

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for

The Degree of Master of Arts in

Adlerian Counseling & Psychotherapy

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September 2015
Abstract

The aim of this paper was to review the literature concerning the relationship between a person’s degree of resilience and their ability to use emotion or problem-focused coping methods, when they are dealing with a death from suicide. The writer is interested in the topic of suicide, as it seems to be one of the hardest issues for those who have suicidal thoughts and feelings, those who have lost someone to this type of death, and even for those who are trying to help in a professional capacity (medical, mental health, EMT, etc.) The writer is going to provide an overview of suicide (statistics, beliefs, causes, risks, effects) as well as some research on common coping strategies that might be used to deal with this type of loss and information about resiliency, so it can be assessed and fostered in people dealing with a death from suicide.
Acknowledgements

This paper is dedicated to all those lost to suicide and those dealing with this devastating type of loss. First, I would like to thank, Derek, for his love, support, and patience through this long graduate school journey. I would also like to thank the many faculty members at Adler, who have contributed their knowledge and experiences to help me to complete my Master’s program.

To my internship supervisor, Claire Stuckey, your dedication and level of care for your students and clients is unwavering and remarkable. Thank you for allowing me to be part of an amazing integrative care clinic and providing so much encouragement and invaluable insight to my learning and growth as a therapist.

To my project chair and reader, I owe you many thanks for this project and for all of your contributions to my learning throughout my time at Adler. Dr. Premo, I thank you for your incredible research and analytic skills that really helped me to focus my topic and inspired me to achieve even more than I imagined. Herb, I thank you for your ever-calm presence, amazing stories, and sense of humor that always managed to explain and reframe an issue into a manageable and exciting learning experience. These two faculty members are a great team and I could not have done it without them both.
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Understanding the Importance and Relationship Between Coping and Resiliency When Dealing With a Death From Suicide

**Suicide**

Everyone will experience death in some manner during their lifetime, especially as people progress into the later stages of life and lose family and friends to age-related causes. Although death is a natural part of life, it can be extremely difficult for people to deal with the death of a loved one, even when that death may have been anticipated, such as those due to old age or a terminal illness. Death is not easy to cope with, even for the most well prepared individual or family.

Deaths from suicide can be particularly difficult for people, as those deaths can be unexpected, sudden, and violent as well as a person’s choice to end their life. This type of death can create a sense of confusion for those left behind, as a person may struggle with why the suicidal person chose this option and the guilt of what he or she could have done to stop it. Although suicide is a choice, that choice is often seen as limited or non-existent and is usually a choice to end the immediate and unbearable pain (physical or emotional).

Many people (approximately 69.0%) will be exposed to at least one traumatic event in their lifetime, including death (Ozer, Best, Lipsey, & Weiss, 2003). Death from suicide can be extremely hard to deal with or accept, as the death can be a shocking and traumatic loss, especially if a person witnesses the event (suicide) or finds the body of the deceased person after his or her death. These traumatic events can cause a wide range and variety of reactions that can impact a person’s life. Each person’s reaction to a traumatic event will be unique, as his or her life experiences, ability to cope with the event and resiliency will be different. For some, death can be devastating or even debilitating, where they will suffer greatly and may never recover or
overcome the loss. Others may have less distress (or show less) and recover more quickly on their own or with the help of others. Suicide will be discussed in more detail, including current statistics, beliefs about the topic, causes or risk factors of suicide, and the emotional and psychological effects for a person dealing with a loss from suicide.

**Suicide Statistics**

Suicide was the 10th leading cause of death in the United States in 2012, with about 40,600 total suicides or about one death every 13 minutes (Center for Disease Control and Prevention, 2013). The Center for Disease Control and Prevention (CDC) also reported that between 2000 and 2012, the percentage of deaths from suicide had increased from 10.4% (2000) to 12.5% (2012). Of the 40,600 deaths, 31,780 (78.3%) of the deaths were male and 8,820 (21.7%) were female (CDC, 2013). Suicide rates were highest among whites (14.1%) and American Indian/Alaska Natives (10.8%) and the most common method of suicide happened via firearms (50.9%) suffocation or hanging (24.8%) and poisoning (16.6%) (CDC, 2013). The American Association on Suicidology (2014) estimated, that as of 2012, there were 4.9 million suicide survivors (family or friends who have lost someone to suicide), which is about 1 out of every 64 Americans.

**Beliefs about Suicide**

Individual and societal beliefs about and the causes of suicide are varied, intense, and can have a powerful influence on a person’s ability to cope with this type of loss. These varied beliefs can have both a positive or negative impact for someone dealing with suicide, as the survivor’s support system’s (family, friends, co-workers, spiritual groups, etc.) beliefs may become a frequent support or a constant conflict.
Some of the negative influences may come from people who believe that suicide is wrong, selfish, or argue the spiritual consequences of such an action. Although differences in opinions on suicide do not have to become a negative influence, it can when this type of response becomes an argument or is the only response for the survivor, putting the moral implications above all else. The survivor may never feel that this person, who is arguing the morals of the action, does not truly understand the survivor’s perspective and pain, or care about the person who has died. This continued moral argument or focus may create a temporary or permanent wedge between survivors and their support system.

There are also people who can have a positive impact on the survivors of a death from suicide, as they have immense understanding and empathy for someone dealing with suicide, because of their beliefs or past experiences. These individuals may believe in a person’s right to die, no matter the circumstance or may have experienced a suicide in their family or social circles. As stated in the statistics section, 1 out of 64 Americans has been affected by suicide (through 2012), so there is a large group of individuals that understand or have experience with this type of loss and could be a support to someone who has recently lost a loved one to suicide. Although some individuals may focus on the positive, rightness or justification of the act of suicide, focusing on the reasons for suicide, whether good or bad may not be truly helpful for a recent survivor, although it may be less hurtful than focusing on the negatives.

Any conflict between an individual’s beliefs, their support system’s beliefs, and societal beliefs can cause additional distress in a person’s emotions and relationships after a suicide. The survivor may feel additional or intense emotions (such as shame or guilt), may not be able to get support or empathy from people or groups with differing or extreme beliefs, and have additional conflicts in relationships.
**Emotional and Psychological Impacts for Survivors of Suicide**

“While an individual suicide is often a solitary act, family and friends are almost always left behind to grieve,” trying to understand the reasons behind the death, looking for ways they could have prevented the death, and how to proceed with life after the death (Cerel, Jordan, & Duberstein, 2008, p. 38). There are many emotional and psychological effects for survivors of suicide, which can manifest in different combinations or severities.

**Emotional Effects**

The American Association of Suicidology (2010) states that the following list of emotions are common after experiencing a death and may not follow a linear path or forward direction. These emotions may be experienced individually or in combination:

- Shock
- Denial
- Pain
- Helplessness
- Guilt
- Anger
- Shame
- Depression
- Despair
- Disbelief
- Confusion
- Hopelessness
- Stress
- Sadness
- Self-blame
- Numbness
- Rejection
- Loneliness
- Anxiety
- Abandonment

*Figure 1. Emotions*

Currently, there is not sufficient evidence to show that grief from suicide is any more pathological than other forms of death, even in those that are sudden or violent (Jordan & McIntosh, 2011, pg. 30). Although research does not prove the severity or uniqueness of pathology of this type of grief, Jordan & McIntosh (2011) stated that there are some common reactions (features) that frequently occur after a suicidal death. Some of these reactions are supported by research and others are supported by clinical experience.
Emotions Supported by Research:

- Abandonment and Rejection
- Shame and Stigma, including concealment of the cause
- Blaming
- Increased self-destructive behavior or suicidality

Emotions Unsupported by Research, but Supported by Clinical Experience:

- Guilt
- Anger
- Search for answers
- Relief
- Shock and Disbelief
- Family and social system issues
- Activism

**Psychological Effects**

Emotions after a death can be complicated, overwhelming, and debilitating. Although intense emotions are a normal part of the process, some individuals will experience distress that may cause extreme negative impacts in their lives and their ability to cope or recover. Someone who reaches this point may experience more than just intense or short-term emotional distress and may require assistance from medical or mental health professionals. Although there may be many psychological effects and possible diagnosis resulting from a death, this section will focus on two common issues: depression and grief as well as their similarities and differences.
Depression

Depression is a serious mental state that, if left untreated, can lead to numerous negative impacts in a person’s life, such as a loss of enjoyment of activities, a deterioration in quality of life and relationships, health issues, job loss, as well as self-harm, including suicide. According to The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) depression is a part of a myriad of depressive disorders that include: disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. These disorders all have common features of “the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function” (American Psychiatric Association, 2013, p. 155).

Many of the above depressive disorders carry a risk of suicide, especially major depressive disorder and substance/medication-induced depressive disorder. A depressive episode can always create the possibility of suicidal behavior and the DSM-5 (2013) states that the risk can increase with being of the “male sex, being single or living alone, and having prominent feelings of hopelessness” as well as the “presence of borderline personality disorder” (American Psychiatric Association, 2013, p. 167). Substances, including medications can also significantly increase the risk of mood changes and suicidal behavior, as the chemicals change a person’s thoughts, feelings, and behaviors, from his or her normal state (or baseline).
Grief

Grief is a universal, natural, and expected human response or process that can happen before, during, and after a loss or separation. People can start grieving in anticipation of a loss or separation, such as with terminal illness or a family member moving away. Although grief is commonly associated with the death of a loved one (bereavement) it can also include the loss or separation from:

- Relationships (divorce, separation, child leaving home, or end of a friendship)
- Things (lost sentimental or heirloom object, like a ring)
- Places (a foreclosure, a home destroyed by a tornado or fire, relocation)
- Jobs (change in hours or responsibilities, layoff, or retirement)
- Physical (chronic or terminal illness, rape, loss of a limb, or control over body)
- Financial (inability to buy necessities or change in financial state, such as bankruptcy)
- Legal (violations, impending court date/decision, detainment, or incarceration)

Although grief can be caused by different types of losses, such as people, objects, and abilities, bereavement is a more specific type of grief. Bereavement is “defined as the objective situation one faces after having lost an important person via death,” with mourning being “the public display of grief” (National Cancer Institute, 2014, Bereavement).

According to the DSM-5 (2013) grief becomes persistent complex bereavement after 12 months (6 months for children) and includes significant issues within the reactive distress of the death and social/identity disruptions. Bereavement can be complicated further by a traumatic element (bereavement due to homicide or suicide) and can be particularly more painful and difficult to recover from, as there is the element of surprise, trauma, and confusion about the death. These bereavement factors can put the survivor at risk of suicide, as “individuals with
persistent complex bereavement disorder frequently report suicidal ideation,” and a may have a “desire to die in order to be with the deceased” (American Psychiatric Association, 2013, p. 791).

**Grief Theories and Models**

Grief theory has a long history, starting with early ideas from Freud, who thought grief was a “solitary process, whereby mourners withdrew from the world so that detachment from the deceased could be a gradual process” and primarily focused his researched on depressed persons (Buglass, 2010, p. 44).

Lindermann identified normal and pathological grief or bereavement, including five characteristics based on clinical experience with people dealing with grief from disasters. These characteristics included: somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, and loss of patterns of conduct. Linderman believed that process of coping “required the bereaved person to become emotionally detached from the deceased person and adapt to a new environment in which the deceased was not included,” which has been confirmed in subsequent research (Buglass, 2010, p. 45).

Kubler-Koss was a pioneer in near-death studies and developed a model of five stages of grief (Elisabeth Kubler-Ross Foundation, 2015). These stages include: denial, anger, bargaining, depression, and acceptance and were developed while she attended to dying patients (Buglass, 2010, p. 45). This model is probably one of the most well-known and widely used models for grief and loss.

Bowlby developed an attachment theory that emphasized “the importance of human attachments and bonds that are developed early in life” and his grief theory included attachment
to the deceased person and “four overlapping, flexible phases” (Buglass, 2010, p. 45). These stages include: shock, yearning and protest, despair, and recovery.

Parkes (1998, as cited in Burglass, 2010), who studied under/with Bowlby, expanded on early theories to find that grief was a unique experience from person to person, was a more dynamic experience than originally thought. He also noted the process could be long-lasting, such as with a situational experience, like visiting a grave site. Parkes’ stages, similar to Bowlby’s included: shock and numbness, yearning and pining, disorganization and despair, and recovery.

Worden’s theory “extended bereavement theory by emphasizing the role that counselors and therapists play in offering care and comfort to grieving clients” and included four tasks of grieving (Wright & Hogan, 2008, p. 352). These tasks include: to accept the reality of the loss, to work through the pain of grief, to adjust to the world without the deceased, and to find an enduring connection with the deceased in the midst of embarking on a new life.

Many of these theories have common themes or stages of grief. It is important to note that each individual’s process of grieving is different and complex, including the order of stages, time in each stage, and the movement to another stage or back to a previous stage, making it difficult to understand the progress toward recovery. Society’s limitations (i.e., 3 days off to grieve) and understanding of bereavement, especially when associated with a death from suicide, can add additional stress and time for those grieving a loss.

**Similarities and Differences for Depression and Grief**

Although grief and depression can look similar, a person who experiences sadness, sleep or appetite changes, or loss of pleasure may not be suffering from depression. According to
Ferszt and Leveillee (2006), there are characteristics more common for grief, more common for depression as well as some shared characteristics.

- **Grief:** variable mood shifting between anger, sadness, and normal states in one day, preoccupied with a loss, responds to warmth and reassurance from others, and stays connected with family and friends.

- **Depression:** Feeling immobilized or stuck, withdrawal, despondency, and hopelessness, persistent, overwhelming guilt, preoccupied with negative, distorted self-view, unable to feel comforted by the support of others, loss of connection with self and others.

- **Shared characteristics:** sadness, fatigue, loss of energy, inability to focus, not interested in the rest of the world, anxiety, somatic disturbances, anger, fear of losing one’s mind, spiritual estrangement, alteration in relationships, impaired function, and longing for end of pain.

**Causes or Risk Factors of Suicide**

Understanding the causes of suicide are vital in preventing suicide and helping those who are dealing with a death from suicide and are wanting answers about why their loved one would resort to such an extreme choice. The causes are diverse, as each individual is unique and has their own struggles, experiences, and reasons for ending their life. Although there is a lot of focus on the internal risk factors (psychological, emotional, or biological) there are also external factors (environmental, familial, or societal) that can influence a person’s choice to contemplate or take their life.

**Psychological or emotional risks.** It is estimated that approximately 90% of people who commit suicide have been diagnosed with a mental illness, including “bipolar disorder,
schizophrenia, personality disorders (including borderline personality disorder), anxiety disorders (including posttraumatic stress disorder and panic attacks) and eating disorders” (National Alliance on Mental Illness, 2015). Some studies indicate that the risk of suicide can be 10 to 20 times higher in persons with mental illness (Baldessarini & Hennen, 2004, p. 1). In addition to a mental health diagnosis, a history of suicide attempts can also significantly increase the risk and likelihood of another attempt.

Although a mental health diagnosis may be present in many cases, the mental health diagnosis may not be the only or main reason for the act of suicide. There can be contributing factors such as emotional turmoil from a temporary or situational crisis that can create a perceived unbearable or inescapable situation that the person is not able to handle on their own. A mental health diagnosis may make it harder for a person to cope with this intense or sudden situation, but the diagnosis may not be the reason for the death. For example, a person with an anxiety disorder, who recently lost their ability to walk, may take their life due to the sudden changes and loss of mobility and not the anxiety that he or she may feel about most other issues in life. A mental health diagnosis does not have to be present for a person to become suicidal, as emotions can be extremely intense and overwhelming for people with and without a mental health diagnosis.

**Biological or physiological risks.** Biological causes included genetic and physiological factors. Research suggests that there may be a genetic or biological component to suicide, as seen in multiple studies of monozygotic (identical) twins and dizygotic (non-identical) twins, where there were higher rates of suicidal behaviors or death (Joiner, Brown, & Wingate, 2005, pg. 288). Multiple family studies also “strongly and consistently report increased risks of suicidal behavior among relatives of suicidal index cases compared to relatives of nonsuicidal
controls” (Baldessarini & Hennen, 2004, p. 2). Included in the biological component is substance abuse and dependence, which is also a heritable trait or diagnosis that can greatly impact the risk for suicide, especially when it is co-occurring with a mental health diagnosis such as major depressive and bipolar disorders (Baldessarini & Hennen, 2004, p. 1).

Although a lot of information is focused on the psychological risk factors, physiological factors are as important. Illnesses, especially those that are terminal and or cause chronic pain, can increase the risk of suicide. A terminal illness can cause intense emotional and physical suffering and a desire to end life before the illness does, which some term with phrases such as ‘death with dignity’ or ‘the right to die.’ This choice is available in several states and has been legal since 1997. According to the Oregon Public Health Division (2014), since 1997, 1,327 people have received a prescription, of which 859 people ingested the drug to end their life.

Chronic pain is another serious risk factor, as it can be a long-term and intolerable issue for many. According to research done by Gilbert et al. (2009), studies have found that chronic pain can increase the risk of depression, suicidal thoughts, and suicide rates. This type of pain “is frequently a lifelong condition that cannot be cured but only managed” and is complicated by the use, debate, and regulations over potent and addictive pain management medications (Gilbert et al., 2009 p. 1969). According to Webster (2014), the result leaves patients caught in a system between regulation (government and law enforcement) and physicians who have to make difficult ethical decisions. This includes the patient’s ability to adhere to the prescription as well as have “fewer, and less effective, tools available to treat patients whose pain approaches levels unimaginable by most people” (Webster, 2014, p. 345).

**Environmental risks.** Environmental risk factors can include both natural occurring environmental factors and social factors. Some studies have analyzed natural environmental
factors such as air temperatures, sunlight duration, and precipitation. A few studies have found a positive correlation, including a German study that found suicide rates increased with the rising air temperatures and global radiation in the late spring and early summer months (Müller et al., 2011, p. 949). Another study that focused on clinical and social environmental factors found that environmental factors such as victimization, prosocial behavior, and social supports were impactful to suicidal risk. They found that those with “higher relational victimization, and those indicating on being or having a low recipient of prosocial score, were significantly associated with higher levels of suicidal ideation” (Shtayermman, Reilly, & Knight, 2012, p. 63).

**Familial risks.** Certain family systems can put an individual at greater risk of suicide. Familial factors can relate to some of the biological and environmental risk factors mentioned previously, as a person can inherit family genetics or traits and can also be exposed to an unhealthy family environment (natural or social.) This section however, will specifically focus on some research that shows that a family history of suicide and how the childhood family system can increase a person’s risk for suicide.

A family with a history of suicide can increase an individual’s or family’s risk of suicide. Evidence that suicide risk increases with a family history of the issue has been found in multiple studies. This history may be more impactful to an individual’s risk than a psychological history, as a study by Qin (2003) states that, “suicide clusters in families are independent of familial cluster of psychiatric disorders… while a family history of completed suicide significantly increases suicide risk in its own right” (Risk Associated with Family History, para. 3).

The family system can also have a significant impact on an individual’s risk of suicide. Families with an unhealthy system where abuse (physical, emotional, or sexual), substance abuse, mental health diagnosis, or other traumas have been found to increase a person’s risk by 2
to 5 times higher than those without adverse childhood experiences (Perales, Gallaway, Forys-Donahue, & Millikan, 2012, p. 1034). This study, by Perales et al. (2012), of army soldiers, who had either attempted or completed suicide found that attempt cases (64.7 &%) had a higher occurrence of childhood trauma than suicide cases (43.3%). They also found that 61.2% of the soldiers with suicidal behavior had a history of childhood trauma and “the most prevalent forms of childhood trauma across both groups were abuse and family problems” (Perales et al., 2012, p. 1035).

A review of studies, by Roy and Janal (2005), found that three risk factors at least double the risk of suicide: childhood trauma, family history of suicidal behavior, and female gender. Although each is a non-interacting and independent variable to the risk, female gender and high childhood trauma are both risk factors for “an early onset of first attempting suicide and for making more attempts” (Roy & Janal, 2005, p. 367).

Although each of these familial risk factors can independently increase the risk, the severity, number or length of occurrences, or combinations of these factors could impact a person’s well-being, resilience, and risk for suicide. It should also be noted that an individual’s own history of suicide attempts is “the most commonly described risk factor,” but that “most completed suicides are not preceded by unsuccessful attempts” (American Psychiatric Association, 2013, p. 167).

**Societal risks.** Societal influences are varied and include things such as cultural or religious beliefs, pressures to conform or meet norms or expectations for behavior, gender, ideas, appearance, life style, etc. These pressures can be intense and even consequential, especially during the early part of the life cycle, when adolescents have a strong desire to belong in a static group of people. Social pressures last throughout the entire life cycle though and can contribute
to a person’s risk for suicide. Some of these pressures are quite common and some are rare, but have been seen more recently as terrorism increases.

One societal influence, which is quite problematic for younger individuals in the United States is substance abuse and dependence. Drinking and drug use has been glorified in the music and movie industries as well as the general media as something that ‘cool’ people do. There is a day, songs, and a myriad of products dedicated to marijuana culture and lifestyle. Although substance abuse and dependence can be considered a family trait, as there is evidence of genetic implications increasing the risk through generations of families, it will be discussed under the social factors, but isn’t limited to this topic.

Substance abuse or dependence can contribute to suicidal outcomes, especially in younger individuals, where suicide was the second leading cause of death (in 2012) for those 15-24 years of age (American Association on Suicidology, 2014). Research suggests that “suicide attempts are common in adolescents with SUD (substance use disorder)” and that the risk for suicide is four times higher for men and five times higher for women with alcohol-related disorders (Pompili et al., 2012, p. 479). Chemical use, whether frequent or rare, can affect a person’s ability to make good decisions, worsen some emotions, or change normal behaviors, thoughts, and abilities. One study found that 66% of suicide cases had some type of substance (alcohol, pharmaceutical, illicit or multiple drugs) detected during a toxicology screening (Darke, Duflou, & Torok, 2009, p. 1003).

There are some other societal or external factors that can contribute to suicide: financial, bullying, military, or protest. For example, a financial or economic crisis is a serious contributing factor to suicide, especially for men during times of high unemployment (Chang, Stuckler, Yip,
& Gunnell, 2013). A gambling addiction is another financial issue that could also put a person into a financial crisis, where they feel they have no escape or are ashamed of the monetary issue.

Bullying has become a major concern in recent years, as this behavior can affect children’s long-term well-being and increase suicide risk. According to a study by Dickerson Mayes et al. (2014), victimization by bullying was found to occur in 60% of a psychiatric sample of children and 28% in a general population sample. Research mentioned in this study, has found suicidal ideation to be as high as 42% for bully/victim, 26% for victims, 23% for bullies, and 10% for neither (Dickerson Mayes et al., 2014, p. 302).

In addition to some of the external reasons listed above, there are influences such as the military (or the like), that can cause deaths, seen as either heroic or cowardice. Military duty can create a death that may be seen as a dutiful suicide for the greater good or to save a life. Some of these deaths however, may be seen in a less heroic manner, such as a suicide attack on an enemy or one that involves innocent bystanders. Other reasons may include personal beliefs (religious, cult, delusion, etc.) as well as in defiance or protest to an important issue or to avoid prosecution or disgrace for some action or behavior.

**Suicide Summary**

Suicide was the 10th leading cause of death in 2012, which implies that these types of deaths affect many more people than most probably realize. There are many varying and strong beliefs about suicide, on a personal and cultural level, both for and against this type of death, making it sometimes more difficult for people to get the support they want or need. For those who are dealing with this type of death, there are many emotional effects supported by research, such as: abandonment, rejection, shame, stigma (including concealment of the cause), blaming, and increased self-destructive behavior (including suicide). Psychology effects are also common,
with grief and depression being two of the most common outcomes. Suicide is difficult to understand for those grieving this type of death, so understanding some of the causes may benefit their grieving process. These risks or causes include: psychological or emotional (mental health diagnosis or situational crisis), physical or physiological (twins studies, terminal illness, chronic pain), environmental (air temperatures, sunlight duration, and precipitation), familial (history of suicide, unhealthy family atmosphere, including abuse), and societal (culture, religion, norms, financial pressures/failures, etc.) Suicide is a complex and emotion-inducing topic for many people, even professionals trained to help with this very topic. People suffering from a death from suicide will have many varying and complex ways of responding and coping, as described in the next section.

**Coping Strategies**

Coping skills, including defense mechanisms, are a unique selection of actions or non-actions that an individual chooses, to deal with high levels of distress (physical, emotional, or psychological). These activities vary from event to event, but are usually a protective function, learned during childhood (or adulthood), to manage distress before, during, and after a stressful experience.

Every person copes with stress differently and can do this in a positive (adaptive) way, a negative (maladaptive) way, or a combination of these depending on the situation and the distress level. An individual’s perception of his or her ability to evaluate and manage a situation may be related to the level of psychological distress during and after that situation and their knowledge and ability to implement effective coping strategies. “Fewer coping skills may be associated with higher levels of psychological distress under stressful events,” which may in turn create more distress, as the individual is not able to handle the initial distress in an effective or
tolerable manner (Wang, Nyutu, & Tran, 2012, p. 459). The less able an individual is at using adaptive coping skills, the more likely they are to have additional distress or negative impacts in their daily functioning.

Adaptive coping facilitates positive functioning while reducing the individual’s actual or perceived thoughts or feelings about the event causing distress. This type of coping may help an individual explore or implement solutions or be able to better manage or tolerate a stressful situation. These types of skills may include: relaxation, exercise, journaling, prayer, or mindfulness exercises.

Maladaptive coping does not facilitate positive functioning and may include avoidance or even destructive or dangerous activities. This type of behavior may delay or increase the severity of distress for the individual dealing with the emotions from a stressful event. These types of skills may also worsen a situation, not only for the person using the maladaptive skill, but also for those around them who are trying to implement adaptive coping. Maladaptive skills may include: manipulation, dishonesty, aggressiveness, or self-indulgent behaviors (excessive drinking, drug use, eating, etc.). It is important to understand coping skills, to gain insight into people’s positive and negative reactions (emotions, decisions, thoughts, and behaviors) to distress and trauma. These coping skills can either facilitate awareness and recovery or hinder it, using avoidance or even engaging in dangerous behaviors.

Defense Mechanisms

Defense mechanisms “(or coping styles) are automatic psychological processes that protect the individual against anxiety and from the awareness of internal or external dangers or stressors” (American Psychiatric Association, 2000, p. 807). These defenses are often automatic mediators of a person’s reaction to stress, that an individual is often unaware of. The Diagnostic
and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000) categorizes 31 types of defenses into the following 7 levels: high adaptive, mental inhibitions (compromise formation) minor image-distorting, disavowal, major image-distorting, action, and defensive dysregulation. Although there are varied lists and sources of defense mechanisms available, this section will focus on the following 10 mechanisms that are usually found in psychology text books (Table 1): compensation, denial, displacement, identification, projection, rationalization, reaction formation, regression, repression, and sublimation (Corey, 2013, p. 68).
Table 1

*Defense Mechanisms*

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<thead>
<tr>
<th>Mechanism</th>
<th>Description</th>
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<tbody>
<tr>
<td>Compensation</td>
<td>Masking perceived weaknesses or developing certain positive traits to make up for limitations.</td>
</tr>
<tr>
<td>Denial</td>
<td>‘Closing one’s eyes’ to the existence of a threatening aspect of reality.</td>
</tr>
<tr>
<td>Displacement</td>
<td>Directing energy toward another object or person when the original object or person is inaccessible.</td>
</tr>
<tr>
<td>Identification</td>
<td>Identifying with successful causes, organizations, or people in the hope that you will be perceived as worthwhile.</td>
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<tr>
<td>Projection</td>
<td>Attributing to others one’s own unacceptable desire and impulses.</td>
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<tr>
<td>Rationalization</td>
<td>Manufacturing ‘good’ reasons to explain away a bruised ego.</td>
</tr>
<tr>
<td>Reaction Formation</td>
<td>Actively expressing the opposite impulse when confronted with a threatening impulse.</td>
</tr>
<tr>
<td>Regression</td>
<td>Going back to an earlier phase of development when there were fewer demands.</td>
</tr>
<tr>
<td>Repression</td>
<td>Threatening or painful thoughts and feelings are excluded from awareness.</td>
</tr>
<tr>
<td>Sublimation</td>
<td>Diverting sexual or aggressive energy into other channels.</td>
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Defense mechanisms have been categorized into many functions or levels based on their use or usefulness to the individual implementing the skill. One common way to categorize these
skills has been the use of emotion-focused versus problem-focused coping skills, which was originally devised by Richard Lazarus and Susan Folkman in their 1984 book, *Stress, Appraisal, and Coping*. The following section will define these terms as they were originally conveyed and how the writer intends for these coping style categories to be understood for this research.

**Emotion-Focused Coping**

Lazarus and Folkman (1984) originally defined emotion-focused coping to mean that individuals applied skills to usually lessen (using avoidance, minimization, distancing, etc.) but sometimes to increase (using self-blame, self-punishment, etc.) emotional distress and was better matched to events that were perceived as uncontrollable (Lazarus & Folkman, 1984, p. 150). The original focus is on how one uses skills to respond or cope specifically to external emotions or emotional distress. The researcher’s intent is to show the difference in coping skills based on an individual’s use of internal emotions to deal with the emotional distress, instead of just a focus on the type or cause of the distress itself (external).

The writer’s focus on the emotional process used to cope with the stressor, instead of the type of stressor, puts the following defense mechanisms into the emotion-focused category: repression, projections, reaction formation, displacement, and regression. Included with the categorization, is an example of each defense mechanism as it might pertain to someone who is dealing with a death from suicide.

**Repression.** Repressed memories are usually unconsciously blocked memories and individuals using this process, may have little or no control over the repression or emotional response. These memories, although inaccessible, are not gone and are just out of conscious awareness. Even without an awareness of the memory, it will continue to influence a person’s
thoughts, emotions, and behaviors. Someone dealing with a death from suicide may speak about different emotions or the type or outcome of the death, than actual reality.

Example: A spouse, whose husband died by suicide, while on a business trip, still speaks of her husband being away on a business trip. Although the wife learned months ago that her husband has died from suicide, she is unconsciously protected from the painful truth. She believes and tells other people a false truth, based on her protected awareness and emotions.

Using repression may increase a person’s resiliency, as he or she is sheltered from a painful memory, thought, emotion or behavior, until he or she is ready to deal with it or even acknowledge it. This defense may allow the individual to continue functioning in a stressful environment or keep them safe until they can leave that environment or situation. Although this defense mechanism could be useful in times on immense stress or pain, it may hinder an individual’s ability to cope or heal in the long-term, as the true memory, emotion, or behavior is kept away from his or her awareness, but may still be negatively affecting thoughts, emotions, behaviors or progress (healing).

**Projection.** Projection is the process of shifting one’s own unacceptable thoughts, beliefs, or behaviors to other people. Projection may be combined with other defenses, such as denial and therefore may seem similar to repression, as an individual appears unaware or in denial about their own traits. This process may allow an individual to express or discuss a difficult or painful emotion, thought or behavior, without having to be accountable for it in his or her own life.

Example: A daughter may tell her father, who is not feeling hateful, that he hates his wife for dying from suicide, when it is really the daughter who is feeling anger and hate toward her mother.
Projection may increase resiliency, as it allows people to discuss difficult emotions, thoughts, behaviors or topics before they are ready to accept responsibility for or the presence of them in their own life. This may be a safer way for the person to process something painful or shameful, as it allows them to initially disconnect from it on a personal level. This process could be detrimental to a person’s ability to understand his or her own personality traits, if it is used as a long-term process to keep from dealing with an issue. It could damage relationships, as blame or criticism may be shifted to a loved one.

**Reaction formation.** Reaction formation happens when a person converts their thoughts or feelings into the opposite of how he or she actually feels or thinks. This process can seem somewhat manic in nature. It tends appear ‘exaggerated, compulsive, and inflexible’ and it may not appear to correspond to a person’s usual personality, so it ‘may therefore appear to be groundless, irrational, or idiosyncratic’ (Burton, 2012).

Example: A friend, who has lost her best friend to suicide, says she is happy her friend is not suffering anymore and that she thinks she is in a better place. In reality she is really angry at her friend and thinks she was selfish to take her own life and hurt the friend’s daughter.

Reaction formation may be tied to societal or familial norms, where an individual feels or perceives that he or she must act, react, or behave in a certain manner. This process may help an individual’s resiliency, as they are able to control their behavior, especially in public, in an appropriate, acceptable, or useful manner. The individual may have an awareness of his or her negative thought or behavior, that they are now able to form into a more positive thought or behavior, therefore increasing their ability to cope or find effective solutions to issues or distress. This process could be an unfavorable tool, if it is used to avoid valid and healthy emotions and thoughts that are simply uncomfortable or unexplored. This type of process may also be in
contrast to being authentic and may cause a person additional distress, as they are not able to be themselves around others.

**Displacement.** Displace is the process of directing emotions (frustration, anger, jealousy, etc.) on other people or objects that did not cause the initial emotion or distress. Displacement is usually used when an individual does not know how or cannot express their feelings to the person or situation that the feeling should be directed toward. This process can usually be easily identified, as the topic or emotion does not match the current situation or severity of an issue. Example: *A man who has recently lost his childhood best friend to suicide, starts yelling at his wife and children, who are quietly watching TV. The man is extremely angry at the friend, but he does not know how to express his emotions about the friend, who is longer there to hear how he feels about his death.*

Displacement may be used to increase or help resiliency as it may keep an individual safe from harm (i.e., not fighting) or keeping consequences to a minimum (i.e., breaking a vase, instead of yelling or hitting someone else). This process may help maintain important relationships that could have otherwise been damaged by inappropriate or negative behaviors or emotions. Displacement can be detrimental to the individual or his or her relationships, if negative emotions or behaviors are always being avoided or are directed at other people, who are then negatively impacted by the interaction.

**Regression.** Regression is the process of returning to an earlier stage of development (i.e., childhood) when faced with severe distress. This process is an emotional response to protect oneself and may cause individuals to abandon learned or previously used defense mechanisms to connect to a safer time in their lives. This process may be easy to recognize, as people may act childish or immature, when compared to their normal behavior.
Example: A child who recently lost his older brother to suicide reverts back to bedwetting and sucking his thumb, which he had a hard time overcoming in an earlier developmental stage (2 years ago).

Using regression can help a person’s resiliency, as it can be a protection process to endure an intense stressful or painful situation. Regression can allow a person time to retreat from the distress, in order to accept or acknowledge it later, in a healthy or useful manner. Regression can be problematic for people if it is continually used to avoid or shift responsibility. Relationships may suffer, as others may tire of the retreating behavior and being the one responsible for the person (or his or her actions) that is using regression.

**Problem-Focused Coping**

Problem-focused coping was originally defined as a problem-solving coping skill that individuals used to deal with a specific stressor (external). Individuals use an “analytic process that is focused primarily on the environment,” where strategies are focused outward (external) and may be better matched with events that are perceived as controllable (Lazarus & Folkman, 1984, p. 152). Riley and Park (2014) found “problem-focused coping generally has better outcomes than does emotion-focused coping” because problem-focused coping was more “positively related to adjustment” (p. 588). The writer’s intent is again to show the difference in coping based on an individual’s use of internal problem-solving (logic) responses to deal with distress, instead of a focus on the external cause of the problem being faced.

The writer’s focus on the problem-focused or logical response process used to cope with the stressor, instead of the type of stressor, puts the following defense mechanisms into the problem-focused category: denial, rationalization, identification, compensation, and sublimation.
Included with the categorization, is an example of each defense mechanism as it might pertain to someone who is dealing with a death from suicide.

**Denial.** Denial is a process of not admitting a truth about a situation or person and acting as if it is not or did not happen. This is a protective role similar to repression, but “it operates at a preconscious or conscious level” (Corey, 2013, p. 67). Denial does not influence an individual’s behavior as repression does, but is a logical response that may help alleviate an individual’s anxiety.

Example: A sister who has recently learned that her younger sister died, may deny the fact that it was from suicide, even though she knows and understands that the sister has died and how it happened. The sister had recently spoken to her younger sister about her suicidal thoughts and now has intense guilt about her lack of actions, so she denies the truth to protect her from the guilt.

Denial is a process that can be used to increase resiliency, as it can alleviate anxiety during distress. A person using denial in a positive way may be using the process, as a short-term solution, to keep him or herself from being overwhelmed or to reduce anxiety. This may allow the person to keep making progress or be productive at what needs to be achieved. Denial may be problematic when it is used in the long-term to deny emotions, thoughts, or behaviors that need to be dealt with or have become a hindrance in the tasks of life or relationships.

**Rationalization.** Rationalization is a process of explaining a situation, behavior, or emotion that is perceived to be unacceptable to that individual or to other people. This process may be used by individuals to find logical reasons for a situation or to soften disappointments, failures, bad decisions, and rejections. Rationalization may be used to avoid intense feelings of
guilt, shame, or embarrassment. This process may be easy to recognize when a person thinks someone else is making excuses for his or her emotions or behaviors.

Example: A young boy, whose abusive father has recently died from suicide, is confronted by a bully, at school about his father’s death. This bully laughs and taunts the boy about how his father died and although the boy is really hurt by it, tells the bully that his Dad was mean and deserved to die before he did anything else wrong.

Using rationalization may help or increase a person’s resiliency by temporarily using a logical process, to analyze a situation or reaction, to find possible causes or solutions, with or without emotions being addressed. This tactic may help a person see the event, thought, emotion, or behavior in a more simplified or less emotional way, so that he or she can better handle it or make progress. This process, when used long-term may damage relationships or become problematic, as the person may appear unaccountable or uncaring (unemotional) about their actions or the events he or she is a part of.

Identification. Identification is a process of improving self-esteem by forming an alliance with a person or group to “enhance self-worth and protect one from a sense of being a failure” (Corey, 2013, p. 68). An individual may not find actual individuals or groups to align with and may possibly find a symbolic strength, such as a fantasy to engage in (i.e., a fanatical devotion to a science fiction character or story). This alliance with others could be both a positive (helping a cause) or negative (gang or cult) alignment for individuals seeking to improve their self-worth or to contribute to something outside of themselves.

Example: A woman who has recently found her long-time boyfriend dead from suicide, and who also has trouble socializing, joins a cause to help hungry children in a foreign country.
Identification may help a person’s resiliency, as it may help to increase a person’s self-worth through a positive contribution (social interest) and socialization with others who may support a healthy state of mind, cause, or lifestyle. This process may also be used as a way to temporarily escape or relax from problems, in order to come back to them stronger and more resilient later. This supportive environment may increase a person’s self-image, confidence, and resilience, as these traits are modeled by others and learned or mastered over time. Of course, this process could backfire or cause harm, if the group or person the individual aligns with, has malevolent or manipulative behaviors or aspirations in the world or toward others.

Compensation. Compensation is a logical process of attempting to overcome or to counterbalance a perceived weakness or limitation by achieving or overachieving at something else. In Adlerian theory, this helps an individual move from a felt minus to a perceived plus. This process may be identified when someone is trying to make up for a mistake (i.e., being overly nice or bringing gifts) or when perfectionism is present.

Example: A man who recently lost his friend to suicide from a heroin overdose, decides to get training in suicide prevention and is considering a career as a Licensed Alcohol and Drug Counselor (LADC).

Compensation may be useful in building resiliency, as it allows a person to find alternative successes (maybe with the use of adaptability and resourcefulness) in life that would not have been possible if he or she only focused on the one thing they were not able to or could not accomplish. Compensation may provide a person with some increased hope, as he or she starts to realize and achieve some success, even if it was not as originally intended. Although compensation can be a positive process to help improve feelings of inferiority, overcompensation can be detrimental and impossible to achieve or maintain long-term.
**Sublimation.** Sublimation is the logical process of taking unacceptable emotions, thoughts, or behaviors and channeling them into “socially acceptable and sometimes even admirable” ones (Corey, 2013, p. 68). This process is similar to identification, but is not tied to finding self-worth through the identity or actions of other people and groups. Sublimation may be tied more to personal satisfaction and approval, in response to some new or different emotion, thought or behavior to compensate for a negative one.

Example: A man, who is angry with his father for committing suicide, starts to train for 5K runs and hopes to be able to run a full marathon within six months.

Sublimation may help increase resiliency, as the shift in emotions or behavior may prove to be more useful and productive, as it allows individuals to exert energy on tasks that might have been lost or used in an inappropriate or harmful manner. A person may find an admirable or positive social contribution which may help increase his or her own acceptance (belonging) and personal satisfaction. Again, sublimation can become damaging if it is used to avoid emotions or is done with less than true intentions (guilted or forced into it).

**Coping Strategies Summary**

Coping skills are important to understand for both the people experiencing distress and those trying to help them. Coping skills used in a positive (adaptive) way may help an individual recover or be more able to live with the effects (including emotions) from a suicide death. Some people may have a harder time using their coping skills after this type of death, as depression and grief can narrow people’s ability to take action or problem solve. They may feel hopeless and lessen communications, having a reduced sense of perspective, resourcefulness, concern, optimism, and hope.
Emotional responses take longer to understand and deal with than logical responses, so emotional coping may be more difficult, especially if the trauma or death is recent. Although it is difficult and uncomfortable to deal with painful emotions, it may be more effective (long-term) to deal with emotional reactions and their impact, before logical reactions. This may ensure the onset of a healthy awareness of the emotions and healing from their impact.

Problem-Focused (logical) coping may facilitate quicker responses and solutions, but may neglect an awareness or a focus on painful emotions that may be negatively impacting thoughts, feelings, and behaviors. A focus on problems or logic may be more appropriate under circumstances where there is a lower level of short-term distress, or when there is a need to facilitate a focus on safety and survival. Time is a real and limited factor in grieving and recovery in our society, as many people are only given a few days off from work to deal with their grief. Logical coping may be a necessary first step to meet and deal with limited time to cope and return to the task of work.

Coping skills can be learned and improved, through education and practice, so it is important to assess and focus on these skills when helping clients find their reasons for distress and continued pain. The use of coping skills may increase a person’s ability to deal with distress in both the short-term and long-term, as there are both immediate and long-lasting effects from stress, trauma, and grief. The next section will focus on resiliency and the factors that may help people withstand and recover from distress.

Resiliency

Resiliency, especially as it relates to loss or trauma, “pertains to the ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event, such as the death of a close relation or a violent or life-threatening situation, to maintain
relatively stable, healthy levels of psychological and physical functioning” (Bonanno, 2004, p. 20). Resiliency is a universal concept that can be seen in every walk of life: race, culture, class, socioeconomic, gender, sexual preference, religion, and age. Resilient people are not free from emotional turmoil, but they do appear to be better equipped to handle, recover, and even prosper from it. Resiliency “teaches us not to empower ideas, but to use ideas to empower ourselves” (Warschaw & Barlow, 1995, p. 18).

**Resiliency in Early Life**

Stress is a part of life, even from the earliest moments of life and dealing with the uncertainty of the new surroundings and people. Perry (2006) found that some resiliency characteristics start early in life, where some children seem to have a natural ability to “survive and thrive in the face of heartbreaking trauma.” There are a lot of unknowns about negative short and long-term effects of childhood stress on a child or on that child as an adult. The “mastery of relatively minor adversity by children is important for developing resilience to later challenges” (Herrman et al., 2011, p. 259). Herman et al. (2011) also reported that in groups, where childhood emotional abuse occurred, 60% of that group developed a major depression in their lifetime. So what was different for the 40%, who also experienced abuse, but did not develop that type of disorder?

Studies have found that childhood resiliency is a dynamic process that “emerges from complex interactions among a myriad of systems in a person’s life” (Holmes, Yoon, Voith, Kobulsky, & Steigerwald, 2015, p. 178). Holmes et al. (2015) also mentioned how protective factors, for maltreated children, promote childhood resiliency and that those factors can outweigh or even cancel out the negative or stressful environmental risks. These factors may include: pro-social skills, child internalizing well-being, caregiver well-being, attachment to caregivers, a
child’s temperament or disposition, opportunities to practice skills, cognitive abilities (i.e., intelligence, quick learner, etc.), a sense of coherence, independent problem-solver, adaptability, and hope.

**Lifelong Resiliency**

Although there are many factors that contribute to childhood resiliency and foster a positive start to an individual’s ability to cope with distress in the long-term, protective factors during childhood do not ensure lifelong resiliency. It also does not necessarily keep people from become resilient even if those protective factors are lacking or missing in early life. Resiliency is a dynamic process that changes over time, with experience and knowledge, and also during differing situations and distress levels. Each person’s resiliency level is unique and can increase, decrease, or remain consistent, as more or less distress is experienced. This next section will include characteristics of resilient people as well as how these factors might relate to an individual’s ability to learn and apply coping strategies (skills).

**Resiliency Characteristics and Possible Stages**

Resiliency is comprised of many personal and cultural characteristics. Personal characteristics may be influenced by cultural factors such as: cultural identity, knowledge, survival, and collaboration within the culture and with other cultures. Each culture has its own unique practices, beliefs, strengths, weaknesses, and other factors, that will influence each of its individuals in some manner.

Resiliency is often compared to recovery and survival, but is quite different. Recovery, especially in the context of mental health, is defined as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles” (Anthony, 1993, Recovery: The Concept, para. 2). Resiliency aids in the acceptance, process, and success of recovery, but is
not recovery itself. Survival can also be confused with resiliency, and although resiliency may play a part of survival, it may also be attributed to luck or avoidance of danger. Survivors may appear mentally healthy since they got through the distress and may be using coping strategies to avoid the pain and suffering they are truly feeling. Resiliency is more than just making it through a situation; it is an intentional awareness and processing of reality and the emotions, thoughts, and behaviors that come from those situations.

Resiliency can increase or decrease during an individual’s lifespan, as distress increases, decreases, or accrues to an uncontrollable or unbearable level. So what characteristics do people with strong resiliency possess that allows them to better tolerate or recover from significant life events? There are some inherent traits (i.e., temperament, intelligence, optimism, etc.,) but research seems to suggest that resilient people, use a multitude of varying and dynamic factors or skills, both inherent and learned (Benard, 1991; Thomas, 2012; Warschaw & Barlow, 1995).

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<th>Adaptability</th>
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Although there are many personal and unique factors that contribute to resiliency, 10 will be addressed in this section. The factors below are of interest and importance to the writer, as these traits have been witnessed in people who appear resilient. These factors will include: adaptability, communication skills, hope, no ambivalence about living, perspective, personal responsibility, resourcefulness, self-efficacy, risk-taker, and sense of humor. Many of these characteristics can work independently, but usually require some interaction or combination to increase or maintain resiliency over time and in the face of distress.

**Adaptability.** Being adaptable means to be “able to change or be changed in order to fit or work better in some situation or for some purpose” (Adaptable, n.d.). Adaptability is a crucial life skill, especially in today’s fast-paced, ever-changing, and technological environment. Adaptable people are usually “cooperative people who elicit helpful responses from family, friends, and co-workers” (Warschaw & Barlow, 1995, p. 3). This skills also includes an individual’s ability to be flexible and agile, while using resources and creativity to meet or exceed the change or distress being faced from situations or people.

Example: A *family that has recently lost their wife and mother to suicide learns to do tasks that were usually handled by the deceased. The family decides to take a cooking class together, so they can learn how to make meals together.*

An individual’s acceptance and use of adaptability, may be related to their ability to quickly and effectively use coping skills to understand change and his or her need to make changes before, during, or after an event or change. A death from suicide can be very disruptive to an individual’s or family’s life, so being adaptable to the changes after a death is an important trait, to ensure ongoing stability, recovery, and future well-being.
Communication skills. Communication is probably one of the most important skills that an individual must be able to utilize in almost every aspect of life, as it is used to convey information, thoughts, feelings, and meaning in both a verbal and non-verbal manner. Being good at communication is not always about just conveying something to others and also includes the ability to listen and adapt to changes in context, feedback, mood, body language, etc. A person with good communication skills may be more resilient, as he or she is able to listen and clearly convey his or her emotions to or about others in an effective and meaningful manner. 

Example: A girl, whose mother has died from suicide, tells her best friend that she is feeling depressed and suicidal and that her thoughts and feelings are sometimes overwhelming. She and her friend discuss her feelings and make a plan for her to see a school counselor to talk about it.

An individual’s ability to use communication in or about their coping skills may help them use those skills more effectively. A person, with good communication skills, who is also aware of his or her use of displacement (a defense mechanism to project emotions or actions toward a non-causal object or person) may have a more successful outcome when they discuss its use and meaning with others who might have been affected by the action.

Hope. “Our hopes provide essential navigational information, a direction to head in that feeds our sense of purpose, [while] our fears and concerns alert us to danger, telling us what we might want to avoid or address” (Johnstone, 2014, p. 5). Hope, above all other characteristics covered, seems most important, as it gives a person a future direction or plan toward change or to overcome distress, including bereavement. Hopes can pertain to major live changes or simply small interactions or events where a person may hope that something will not happen again or will happen differently. Hope can generate perceived control or movement, in the face of hopelessness and despair. Hope offers a starting place for choices and creativity in the journey
toward recovery and well-being. Even if hope just plants the seed of an idea, instead of initial action, it can set in motion an entirely new way thinking and outcomes.

Example: A man, who has recently lost his terminally ill wife to suicide, talks about this hope of traveling and exploring after he spends some time grieving. He openly admits that he is not ready to travel yet, but plans to save money and create a travel plan over the next year.

When an individual has hope, he or she has possibilities and may assess the probability of and move toward these new options. An individual may initially have ambivalence about these options, but that may create an environment or mental state to explore and create new choices or a tolerance of new risks necessary to achieve those options. Hope can create a desire to act or feel better (or different) and a want or need to use or stop using coping skills, depending on how that skill is serving that person. An avoidant defense mechanism may impede a person’s hopes and dreams, so learning to find a healthy way of coping with reality, may be necessary to find hope and reach his or her goals. It is important to know that resiliency is “always grounded in reality and infused with hope” (Warschaw & Barlow, 1995, p. 19).

No ambivalence about living. Ambivalence is the “simultaneous and contradictory attitudes or feelings (as attraction and repulsion) toward an object, person, or action” (“Ambivalence,” n.d.). For resilient people, a lack of ambivalence does not mean they lack emotion about the topic of living, it means they have decided and are committed to the idea that they want to live. Ambivalence can be a positive sign when working with someone who has suicidal thoughts and feelings. The person is still contemplating reasons to live or not, and has not decided to die, which offers time and hope that he or she will choose life. “The common core of resilient people is this transcendent attitude or belief which gives them the passion and
courage to bounce back” and they do not spend time agonizing about life being worth it or not (Warschaw & Barlow, 1995, p. 3).

Example: A man talks about his recent and severe depression, after losing his wife to suicide. He states that although he is miserable at times, he has no intent or desire to die. He says that he has a lot to live for and mentions how life is hard, but worth every minute.

People without ambivalence about life, may work hard to use, learn, or improve their coping skills to improve their quality of life, since they have a real desire to live life and probably want that time to be meaningful. These individuals may use this lack of ambivalence in other areas of their life, such as confronting new challenges or dealing with stress, trauma, or bereavement. Ambivalence can be used to avoid feelings and emotions, as no action is still a choice or course of action.

**Perspective.** Perspective is a person’s view of life and the world around him or her. It can be developed early in life and is a system of core beliefs and values that bring unique meaning, purpose, and comfort to each person. Perspectives provide a foundation that allows people to quickly, effectively, and positively apply their beliefs and values to a situation. It guides people’s wants and needs, their identity, what matters to them, and how to live life. Perspective must be developed over time and is especially useful, when developed, in times of crisis and uncertainty.

Example: A teenage girl, who recently lost her best friend to suicide, says that she has a new appreciation for life and the importance of her friends and family. She says that she used to be easily irritated with certain people, like her mother, but is trying to be more patient and understanding.
Perspective allows resilient people to be “possibility thinkers who refuse to fall into belief systems that support negativity, failures, and hopelessness” (Warschaw & Barlow, 1995, p. 26). Resilient people will institute resourcefulness (coping skill) and support systems until they regain their perspective. A lack of or a negative perspective may inhibit useful coping skills, leaving a person “confused, disoriented, and despairing” (Warschaw & Barlow, 1995, p. 32).

**Personal responsibility.** “Personal responsibility is concerned with people taking individual accountability for their decisions and actions, together with the outcomes they create and their impacts on others” (Lopez, 2009, Abstract). Responsibility can be seen in both a large context, such as social responsibility, and in a smaller context at a personal level. Responsibility can also be both retrospective, taking responsibility for things that have already happened as well as prospective, understanding and accepting responsibility for possible future emotions, decisions, and behaviors.

Example: *A man, who recently lost his wife to suicide, drank heavily, crashed his car, and killed another person. He willingly goes with the police at the scene and takes full responsibility for his emotions, decisions, and consequences.*

Resilient people do not ‘makes excuses’ or ‘claim victim status,’ as they are willing to own their mistakes and “turn them into positive learning experiences” (Warschaw & Barlow, 1995, p. 4). Resilient people are willing to accept and work on the outcome of their choices, including the corresponding emotions and behaviors. People, who do not have an awareness or acceptance of their responsibility for their impact or reaction to a situation, may not be able to implore healthy coping skills and may hinder their recovery by shifting the real responsibility to others.
Resilience.

Resourcefulness. Resourcefulness is a person’s ability to find what he or she needs or wants either in a specific situation or as way to accomplish larger or long-term aspirations. Resilient people know what resources they need, where to find them, and who to ask (for resources or help). Resourceful people may know how to bend the rules, make sacrifices, make multiple plans, apply their past experiences, and adapt to get what they need or want, while still maintaining their integrity.

Example: A man, who lost his wife to suicide, notices that his young son is having some behavioral problems (aggression toward other children and his teachers). The father starts to research what would be useful and offers his son a chance to talk about how he feels. He also offers some activity options that the son might enjoy to reconnect him socially with other children, in a healthy way.

Being resourceful is especially helpful for people dealing with distress, as they have accumulated the experience and coping skills to be “creative and imaginative in the way they use resources to solve problems” (Warschaw & Barlow, 1995, p. 4). A person without the ability to be resourceful, may find it hard or even impossible to deal with or find solutions to challenges. This inability to find needed resources may cause the use of unhealthy or avoidant coping skills, as the person may be overwhelmed with problems and not have many possible solutions.

Self-Efficacy. Self-efficacy is people’s belief in their competence and capabilities, either for a specific task or as an overall attitude toward life’s tasks and challenges. A person’s self-efficacy may be tied to his or her past success or failures as well as his or her perspective about life and the world around them. A world that seems positive and full of possibilities and potential successes, may foster optimism, strength, hope, and self-confidence about life’s challenges. Self-efficacy includes the idea of self-confidence, which provides a ‘positive mental attitude’ that
allows people to “strive for their aspirations while retaining a sense of integrity” (Warschaw & Barlow, 1995, p. 3).

Example: A young male you recently met lost his mother and only family member to suicide, talks about having the confidence to face the world on his own and still leaving for college in a few months to pursue a career in medicine.

Self-efficacy and confidence can be useful when a person faces distress and feels capable of handling that stress and impact to his or her life. A lack of these traits may inhibit the use of coping skills or only the use of unhealthy types of coping, as the person may see situations as “threats and burdens to be avoided” (i.e., denial or regression) or “shifted to someone else” (i.e., projection or displacement) (Warschaw & Barlow, 1995, p. 3).

**Risk-Taker.** Risk is defined as “the possibility that something bad or unpleasant (such as an injury or a loss) will happen,” but also includes the possibility that something good or enjoyable may happen as well (Risk, n.d.). People, who are risk-takers, vary greatly and range in the amount of risk they are willing to assume to reach a desired outcome. Resilient people take “intelligent risks grounded in real possibilities and with a good chance of success” (Warschaw & Barlow, 1995, p. 4). Risk-taking may be based on many of the resiliency factors already covered, such as a person’s level of hope, perspective, personal responsibility, and self-efficacy, as these may allow someone to properly and successfully assess and manage risks.

Example: A woman, who recently lost her brother to suicide, decides she is going to start a business that her and her brother had always talked about. She understands the risks, but also sees the potential benefits for her and the surrounding community.

Risk-taking can bring positive outcomes, if managed properly. A resilient person may risk being emotionally uncomfortable, by using a new coping skill or mastering an existing one.
This type of person understands the potential reward (recovery or emotional healing) from the risk of being in temporary emotional discomfort or pain. Someone who is not willing to take risks may limit their chance of movement toward coping, resiliency, and healing.

**Sense of humor.** Humor and laughter seem opposite on an emotional spectrum to grief and may seem inappropriate, in response to grief, yet “laughter facilitates the adaptive response to stress by increasing the psychological distance from distress and by enhancing social relations (Keltner & Bonanno, 1997, p. 687). According to Kelter and Bonanno (1997) laughter, when applied in a positive context during bereavement, can reduce negative emotions (i.e., anger), increase positive emotions, and enhance social bonds. Kelter and Bonanno (1997) also found a positive correlation between smiling and a decrease in distress and fear. Humor or laughter can be a useful tool to reframe a situation, ease tension, or even learn to find a balance between perfection and mistakes. Laughter does not just help express or relieve emotions, but according to the Mayo Clinic, can help a person physically: stimulate organs (increase oxygen intake, heart rate, etc.,) increases endorphins, activates or relieves the stress response, stimulates circulation, aids muscle relaxation, improves the immune system (release neuropeptides,) and relieves pain (Mayo Clinic, 2013).

Example: A man, who recently lost his brother to suicide, tells funny and positive stories about his brother, so that he can share many of the fun and humorous things they did and experienced together. He has experienced and accepted the pain, but also wants to connect with the good feelings he has about his brother.

Humor can be misunderstood, especially during bereavement and when taken out of context, by those who process grief and suicide differently. In the above example, the individual is using humor as a healing tool and not as a defense mechanism, such as reaction formation,
avoid his true feelings about his brother’s death. Humor has been targeted as a maladaptive defense mechanism of avoidance, in many social outlets, such as movies or TV shows. Humor, just like other skills, could be used to avoid true feelings, but each person’s use of this trait is unique and would need to be compared to times when he or she is less stressed, to know its true use in a case of high distress or bereavement.

**Weak Resiliency**

Resiliency can become low or weak, as an accumulation of negative events corrode a person’s ability to withstand increased, constant, or multiples stressful or painful situations. For example, a woman may be able to deal with a home foreclosure as a single event, but may become unable to cope or function when another stressful event is added to her distress (her mother dies from suicide). Weak resiliency may be attributed to a complete lack of or limited use of the factors covered above, but may also be attributed to an overwhelming situation that causes a person to panic with a fear response (fight, flight, or freeze). A person may have hope, but without resourcefulness or self-efficacy, may not have the fortitude to withstand or recover from distress or trauma. A person’s mastery of one skill, may not ensure resilience if he or she is unaware or deficient in another skill that is needed. Resiliency also takes into account the use and application of coping skills. Someone with low resiliency may not use coping in a healthy way, avoiding or displacing his or her emotions and behaviors.

**Stages of Resiliency**

Although resiliency may assist in a faster or more effective recovery from distress, it does not guarantee an individual’s immediate acceptance of a situation or emotion or his or her recovery. Recovery is a complicated and unique process, of which resiliency can play a vital and positive role in its success. According to Warschaw and Barlow (1995), resiliency occurs in three
stages: holding on, letting go, and moving on, which requires people need to learn “what to hold, when to let go, and how to move on.” Although resiliency is dynamic and can change according to the situation and the growing maturity and experience of the individual, the writer views these possible resiliency stages more as a recovery process, with the use of resiliency skills.

The holding on stage can be used in both a positive and a negative manner, depending on how it serves that person. An individual should not hold on to things, thoughts, emotions, behaviors, and habits that do not serve them well, such as excessive alcohol use or taking their frustrations out on someone who does not deserve it (displacement). However, “holding fast to your deepest beliefs in the face of a setback is the first requirement of resiliency” (Warschaw & Barlow, 1995, p. 17). It is essential for individuals to understand their core beliefs, so they can make decisions in times of crisis, without a loss of integrity or authenticity.

The second stage, letting go, can be the most difficult stage for people. An individual may have a sense of emptiness during this stage and may be tempted to go back to previous, useless, or detrimental thoughts, behaviors, emotions, habits, coping strategies, etc., because of the anxiety created by change and the unknown.

The last stage, moving on, happens after a person deals with the anxiety of the pause (letting go) between holding on and moving on. Individuals in this phase may spend time processing what kept them in a holding pattern and how they feel in this new stage of life, which probably has become their new and enjoyable reality.

The process of grief, is also more complicated than simply moving through 3 stages, so a more complex and flexible model may be more appropriate, not that some of factors and observations of this model could not be applied to grief (bereavement). This process however, could be quite helpful in less traumatic or complex cases of change and stress.
How to Tell if Someone is Resilient

Resiliency and its characteristics are not something that can be applied universally to people or situations: it is complex. Even highly resilient people, who have experienced the same traumatic event, will each react, process, and recover differently, using their own personal set of experiences and skills. So if each person is different, how can you tell if a person is resilient?

The writer found that although there is a uniqueness to the actual process or set of skills, there are similarities in resilient people that happen both internally and externally, given there is time to witness and understand the person’s reaction, change, and recovery.

Time is a great gauge of resiliency and a necessary factor in being resilient. Some people never recover from life’s tragedies and cease to function, enjoy life, or choose to end their lives. Others, however, seem to be knocked down temporarily, only to get back up quicker and stronger than the last time they were knocked down. These people seem different each time, as the distress adds to their skills and experiences making them seem stronger, more determined, and even inspired. There is no time restriction for recovery, but resilient people take the time they need to accept, adapt, and heal from distress, without lingering too long in the space between the event and the process of recovery.

Aside from the factor of time, resilient people understand their internal processes and have an awareness of their own feelings, thoughts, behaviors, personal responsibility, and skills that allows them to guide their responses and recovery. These people understand their strengths and weaknesses and know how to focus, adapt, and apply their skills to a situation in a useful manner. Of course, mistakes can always be made, especially in times of high distress and grief, but mistakes are to be expected in life. A resilient person, however, will take that mistake, separate it from their self-worth and find meaning in it and a way to apply that meaning in the
future, if given the chance. Boundaries are also an important aspect in their awareness, as it allows people to understand the cause of the temporary distress, while keeping it from becoming their entire identity.

People, who are resilient, also understand and know how to interact with their external environment effectively. These people understand when they need help and ask for it. They also know which people can help them with what they need (i.e., someone who listens versus someone who problem solves.) They also know if they have what they need and seek it out if they are missing it. Communication, adaptation, and resourcefulness are key factors to their movement toward self-care and authenticity with their external support networks. The external environment also consists of an existential component, which assists people in finding meaning in their life and to understand and apply their spiritual beliefs.

Resiliency is a dynamic set of skills, used uniquely to meet the challenges in life. Resilient people are able to adapt and recover from distress and trauma, using their awareness and understanding of internal and external factors that influence their and other’s emotions, decisions, and behaviors.

A Story of Amazing Resiliency

In 1971, W. Mitchell (known as Mitchell) was a young, healthy, and athletic 28-year old man with a bright future and an interest in flying planes. In July of that year, his life changed forever, when he struck the side of a truck, while driving his motorcycle. Although he sustained minor injuries from the crash, fuel had leaked from his motorcycle and the heat from his engine ignited that fuel, burning him over 65% of his body. A bystander helped put out the flames, but Mitchell’s face and hands were burned so bad, that he lost much of his face and fingers in the fire. He recovered from his injuries and would walk to the hospital to visit patients in the burn
unit. He used humor, saying things like “Man, you’re the only guy in this place who’s as funny-looking as I am,” trying to add some perspective to the patient’s lives (Mitchell, 2012, How I started …, para. 1). He adjusted to his new body and abilities, learned to be resourceful and creative around other people (especially those that were cruel or insensitive about his looks,) and developed a new philosophy: “Do whatever it takes” (Mitchell, 2012, How it started …, para. 8).

Mitchell had moved on, moving to a new state and even learning to fly a plane again, but life was not done challenging him. In 1975, he was piloting a plane of people on a routine flight, when things went wrong. It was a cold morning and Mitchell had not noticed that ice had accumulated on the wings of the plane. This prevented the plane’s assent, causing a stall and crash back onto the runway. The accident crushed his spine, paralyzing him from the waist down. This was a difficult and long set back, but it still didn’t stop Mitchell or change his attitude toward the negative. He did have feelings of loss and defenselessness, especially in times of adversity with other’s insensitive comments or actions. These people did not defeat him, they motivated him to teach them about their misperceptions, overcoming adversity, and to share his concept of: “It’s not what happens to you, it’s what you do about it” (Mitchell, 2012, para. 1).

**Can Resiliency be Changed and How?**

A person’s resiliency may naturally be a part of who that person is or has become, but can continue to be changed and improved. Even those who appear highly resilient can find ways to nuance their skills to improve their responses and interactions with others and to stressful situations. So how does one build or help someone else build resiliency? First, it’s important that the person understands the important of resiliency and how it can impact and transform their life, so that he or she is dedicated to the process. A good place to start is by focusing on the resiliency characteristic that were mentioned previously: adaptability, communication skills, hope, no
ambivalence about living, perspective, personal responsibility, resourcefulness, self-efficacy, risk-taker, and sense of humor. If someone has ambivalence about living, that area should be a main concern and focus, to prevent possible suicidal behavior. According to Henderson (2014) some other possible areas to focus on are: building relationships, service to others (social interest), increasing life skills (decision making, impulse control, etc.), continual learning, self-motivation, finding strengths, self-esteem, spirituality, creativity, and perseverance as well as the previously covered topic of coping skills. While it is not necessary to have all of the above characteristics to be resilient, it is helpful to learn and develop as many as necessary to tolerate and process distress and trauma. The more skills a person has, the more options he or she will have and be able to apply to a difficult situation.

**Resiliency Summary**

Resiliency is an important trait to have in the face of distress and although it can develop in early childhood, it can be learned and fostered at any time during the life cycle. Characteristics such as: adaptability, communication skills, hope, no ambivalence about living, perspective, personal responsibility, resourcefulness, self-efficacy, risk-taker, and sense of humor are just some of the traits that create resiliency in people and cultures. Many of these characteristics can work independently, but usually require some interaction or combination of these to increase or maintain resiliency in the face of distress. Not all characteristics are required to create resiliency, but each person will have to develop a unique set of skills that allow them to tolerate, manage, and recover from distress, including death. A person dealing with a death from suicide may face many challenges, including: emotional, psychological, physical, and social, in which resiliency may help him or her deal with and overcome such a traumatic death.

**Overall Discussion**
Suicide is a difficult and devastating topic for almost anyone dealing with it: those who are feeling suicidal, those who know someone who is currently dealing with suicidal thoughts and behaviors, those who are dealing with a death from suicide, and even for the professionals trained or trying to help with suicide. The topic itself, can instill instant fear, confusion or even anger in people, so having an understanding of the current statistics, beliefs, causes or risk factors, and the emotional and psychological effects for a person dealing with a loss from suicide, can help people understand and better deal with this topic at many levels.

People dealing with a death from suicide are going to have many reactions to and difficulties from this type of death, depending on the circumstances of the death and how well they knew the person who died. These reactions and difficulties will depend on a person’s ability to cope (use coping skills), his or her resiliency (inherent or learned) as well as the experience and success or failure the person has had with both of these types of skills in the past.

Coping and resiliency interact with each other, where being able to positively and temporarily use or learn one type of these skills may help facilitate or develop the use of the other set of skills. Those who learn to positively cope with a situation may become more resilient and those who are resilient may be able to use new or more positive coping skills. It does not appear to matter which type of skill is used or developed first, although it seems possible that resilient people may have a higher tolerance for distress and, therefore, the ability to more effectively use coping skills in a positive manner. There is also the possibility that either type of skill may increase a person’s ability to tolerate, process, and recover from distress as well as possibly foster skills in the other area. It does matter, however, how a skill is used: positively (adaptive/healthy) or negatively (maladaptive/unhealthy).
People’s positive use of coping skills, where they temporarily use a skill (i.e., rationalization) to protect themselves from or to process distress and trauma, may feel or be more resilient to the situation, as the successful use of coping skills may increases his or her knowledge and self-efficacy (resiliency skill). People possessing strong resiliency skills may also be able to better use and learn coping skills, such as rationalization (coping skill) by their use of creative or critical thinking, resourcefulness and adaptability as well as their ability to use or modify their perspective to better fit the situations. This may in turn increase their hope about the situation or outcomes and allow them to take responsibility for their thoughts, feelings, and behaviors. A person with positive and effective skills in either skill area may be better able to use or develop skills in the other area. A person with strong resiliency, may be more able to understand and use emotional coping, where they are willing and able to process and own painful emotions as well as find ways to adapt (recover or move past) to the distress or loss.

People with negative coping skills, such as those that use avoidance or destructive behavior may not only have a hard time coping in the short and long-term, but may not be as resilient or able to recover from distress, including grief. Avoiding painful thoughts and emotions may seem helpful in the moment, but may influence a person’s behaviors, relationships, and ability to be authentic. A person may be able to negatively use coping, but still be resilient, as resiliency can be a combination of natural and learned traits that can keep a person moving through or around distress. A person can continue on in a resilient manner, even if he or she may not be as emotionally or psychologically healthy, as a person who is able to use both coping and resiliency in a positive manner. A person with limited or negative coping skills or limited resiliency, may have an easier time using or learning problem-focused (logical)
coping, as they may not be able or ready to deal with painful emotions or coping that requires emotional awareness or maturity.

**Conclusion**

Each person dealing with grief, especially suicide, will have a unique experience and reaction, with a unique set and application of coping and resiliency skills, making it hard to determine the outcome of his or her emotional or psychological health. A person who is able to deal with many low to moderate distressful situations, may not necessarily have the skills to be able to tolerate a high level of distress. The level or accumulation of distress may require different or new skills, which a person may or may not possess. It appears important to access a person’s current understanding and application of coping and resiliency skills, to determine how to help them develop and more positively use these skills to recover from or tolerate a traumatic death, such as suicide. Strong resiliency may help a person better cope in an emotional manner, which can take time and be painful. Low resiliency may cause a person to have difficulty with emotional coping and may have an easier time, at least initially, with problem-focused (logical) coping. Each person must be assessed individually for their current understanding and use of coping and resiliency skills, to better help them accept and recover from a death from suicide.

Suicide is a painful topic, with lasting and impactful effects for those who have lost someone in this manner. Each person’s experience will be vastly unique and so will his or her reactions. Recovery from this type of death will be painful and slow, with no clear end to the distress and emotions. The loved one will never be forgotten, but there is hope of moving past the pain and trauma by developing a person’s coping and resiliency skills, that may allow him or her a healthier and more positive outlook, in their new existence without the loved one who died.
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