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An Empowerment Approach to Family Caregiver Involvement in Suicide Prevention: Implications for Practice

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Abstract

Family members are often intimately involved in the suicidal crisis of a loved one but receive few resources and little support from the mental health community. As a result, these families can experience significant feelings of caregiver burden and powerlessness. This review outlines the experience of caring for a loved one at suicide risk, including potential barriers to involvement, risk and protective factors, and impact on the caregiver. One way to facilitate a caregiver's sense of self-efficacy when working with a suicidal client is to implement an empowerment-based family approach in treatment planning. In this piece, we propose an existing caregiver empowerment model, Creativity, Optimism, Planning and Expert information (COPE), that can be applied to any existing suicide prevention model to assist families in the treatment of clients who are at risk for suicide.

Keywords

empowerment, suicide prevention, caregivers, family

The estimated prevalence of suicidal ideation for adults living in the United States is 3.7% among the general population and 20.7% among individuals with a psychiatric diagnosis (National Survey on Drug Use and Health, 2012). An estimated 75% of individuals who die by suicide communicate their suicidal thoughts, plans, or intent to another person prior to their death (Rich, Fowler, Fogarty, & Young, 1988; Intent, 2002). In many cases, these thoughts are heard by family members and friends (Prabhu, Molinari, Bowers, & Lomax, 2010; Nirui & Chenoweth, 1999). Cerel, Currier, and Conwell (2006) found that over a third of patients were with a family member at the time of their suicide attempt. In sum, families are witnesses to or involved in the suicidal crisis with their loved ones.

Families often function "as the first and last resort" for relatives living with mental illness (Marsh & Johnson, 1997, p. 229). The National Alliance for Caregiving (2009) defines a family caregiver as an individual over the age of 18 who provides care to a relative with a disability or serious illness. This care can include psychological, physical, or financial support to an individual in addition to the dual role of being a family member. There are an estimated 36.5 million households in the United States in which a person fills the role of a family caregiver, and approximately 32% of those caregivers report that their family member has an emotional or mental health problem (National Alliance for Caregiving, 2009). As it is estimated that 90% of individuals who go onto die by suicide have a psychiatric diagnosis (Conwell et al., 1996), there is a critical overlap between those individuals living with psychiatric illnesses and individuals at suicide risk.

The difficulties associated with caring for a person with a mental illness have been studied extensively since the 1950s. Caregiver burden is conceptualized in the literature as the objective and subjective effects of providing ongoing care to a person with an illness (Reinhard, 1994). Objective burden includes observable direct impacts on the family such as financial strain, household disruption, increased physical responsibilities, and impaired interpersonal relations within the family and social network (Platt, 1985). Subjective burden of caring for a person with mental illness may include painful feelings such as shame, stigma, grief, worry, and resentment (Thompson & Doll, 1982).

Caregiver burden in the context of mental illness refers to the adverse consequence of a person's psychiatric disorder for family members (Gubman & Tessler, 1987). Research has demonstrated that caregiver burden is significantly higher for those caring for a person with a mental illness versus caring

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for someone with a physical illness (Ampalam, Gunturu, & Padma, 2012; Magliano, Fiorillo, DeRosa, Malangone, & Maj, 2005). Possible explanations for this burden include a lack of information about a loved one's mental health status, tenuous relationships with professionals about the care of the client (van de Bovenkamp & Trappenburg, 2010), and limited to no familial involvement in the client's mental health treatment (Magne-Ingvar & Öjehagen, 1999).

Results from a 2009 survey by the National Alliance of Caregiving revealed that 78% of family caregivers desire more information on topics related to caregiving. Caregivers are consistently described in the literature as feeling unprepared with inadequate knowledge to properly care for an ill family member; family caregivers receive very little help from professionals (Reinhard, Given, Petlick & Bemis, 2008). Specifically, family members of individuals living with mental illness report a lack of connection with mental health providers, a limited understanding of mental health disorders (Hatfield, 1994; van de Bovenkamp & Trappenburg, 2010), and a lack of education about how to recognize signs of when their relative's mental health condition may be deteriorating (Perreault et al., 2005). Compounding the problem is evidence that formal treatment engagement with health professionals is low among individuals who experience suicidal ideation (Matthews, Milne, & Ashcroft, 1994; Michelmore & Hindley, 2012; Pagura, Fotti, Katz, Sareen, & Swampy Cree Suicide Prevention Team, 2009), due in part to attitudinal barriers to seeking professional help (Bruffaerts et al., 2011).

The purpose of this article is twofold. First, we review the extant literature regarding family involvement in suicide prevention, with a focus on the impact of caring for a suicidal individual on the family. We examine current approaches, potential barriers to involvement, risk and protective factors, and the impact of a suicide crisis on the health of the caregiver. Second, we suggest a new approach to involving the family in suicide prevention using a model from the caregiver empowerment literature. We believe that families who provide care for individuals at risk for suicide benefit from educational and clinical supports to help them cope with their roles as caregivers and to pro-actively engage in suicide prevention efforts with their loved ones. For the purpose of this article, we focus on family caregiving between two adults (one of whom has a known psychiatric illness), with the acknowledgment that there are many different constellations of families that may include relatives as well as close friends.

Current Approaches to Family Involvement in Suicide Prevention

The inclusion of the family in suicide prevention efforts for adults remains conspicuously absent from the literature. Research on family involvement in suicide prevention focuses predominately on parents caring for a child or adolescent. Evidence-based approaches that include family in the treatment of a child who is suicidal include Multisystemic Therapy (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), Attachment-based Family Therapy (Diamond et al., 2010), and Cognitive Behavior Therapy for Suicide Prevention (Stanley et al, 2009). However, therapeutic approaches tailored for adolescents may have limited ability to be transferred without modification to adult clients due to psychosocial and legal factors such as living arrangements and confidentiality concerns as well as the psychological, physical, financial dependence and power dynamics inherent in a parent–minor child relationship.

Currently, there are three family-focused interventions listed in the Substance Abuse and Mental Health Services Administration National Registry of Evidence-based programs and practices (Substance Abuse and Mental Health Services Administration [SAMHSA] National Registry of Evidence Based Programs and Practices, 2014) for suicide prevention with adults: Kognito Family of Heroes (limited to military families affiliated with specific base locations), the United States Air Force Suicide Prevention Program (also for military families only), and Question, Persuade, and Refer Gatekeeper Training for Suicide Prevention (a fee-based program). Although there are clear strengths and benefits to these programs, each has limited access for the general public. These suicide prevention programs are broad approaches to raise community awareness about suicide and are not specifically designed to provide concrete, problem solving based information to families who are caring for a loved one at risk for suicide. In addition to the broad prevention approaches, a unique tailored focus on strategies or education to empower families caring for a suicidal loved one is needed.

Barriers to Family Involvement in Caring for the Suicidal Client

The National Institute of Mental Health and the National Alliance for the Mentally Ill (NAMI) have identified families for decades as allies in the treatment of persons living with mental illness (Lefley & Johnson, 1990). Practice guidelines across disciplines typically recommend family involvement in a client's mental health treatment. From a medicolegal (medical and legal) perspective, the U.S. Health Insurance Portability and Accountability Act of 1996 includes a Privacy Rule that permits health information to be shared with family or friends when the information is directly related to the family member's involvement in the client's care as long as the client does not object to sharing this information (US Public Law 45 C.F.R. §§ 164.502(g)).

Even with these practice guidelines, mental health providers do not typically involve families of adult clients in the treatment process (Bernheim & Switalski, 1988; Hatfield, Firestein, & Johnson, 1982) and research in this area is sparse (Meis et al., 2012). Providers have acknowledged a lack of time to work with family members (Kass, Lee & Peitzman, 2003) and confusion over confidentiality and ethics of family involvement (Szmukler, 1999). Other researchers have suggested that mental health providers are the biggest barrier to involving families (Nicholls & Pernice, 2009). There is also evidence that clients refuse to involve their families in mental health care (Perreault et al., 2005). Since the client has the right to refuse family involvement in their treatment at any time, collaboration can be a moving target and families may receive inconsistent information about their loved one's treatment over time. As such, practices that involve family members can be difficult to utilize with adult clients who have weak or strained family connections or when family conflict is a contributing factor for suicide risk.

Caring for a relative with a psychiatric illness can elicit experiences of powerlessness and alienation when a person become suicidal, highlighting the gap in knowledge between mental health professionals and lay family members. For example, families have reported a lack of communication with health care providers following a suicide attempt by a loved one (Cerel, Currier & Conwell, 2006) and dissatisfaction with their level of involvement during their family member's discharge from a psychiatric unit, especially in regard to how to intervene during future crisis situations (Perreault et al., 2005). At the same time, a crisis can bring together all parties involved in the care of the loved one in one location. A recent pilot study of family-centered brief intensive treatment for individuals with acute suicide risk has demonstrated positive improvements for clients compared to treatment when family is not involved (Anastasia, Humphries-Wadsworth, Pepper, & Pearson, 2014). Therefore, a crisis may be an opportunity for increased communication, education, and understanding between the family, the client, and providers with the potential to increase collaborative opportunities for involvement in suicide prevention efforts.

Families as Protective and Risk Factors

Families have historically been identified as both a risk and a protective factor for suicide (McLean, Maxwell, Platt, Harris, & Jepson, 2008). Beyond genetic risk for suicide including familial aggregation of impulsive/aggressive behaviors (McGirr et al., 2009), there are environmental effects of familial suicidal behavior (e.g., Wilcox, Kuramoto, Brent, & Runeson, 2012). Families, without appropriate education or knowledge about mental health, have been known to minimize, shun, or demean the individual, placing the client at greater risk of despair (Busch, 1996). Negative life events related to family have been demonstrated to precede suicidal behavior, particularly events related to romantic relationships (Yen et al, 2005; Bagge, Glenn, & Lee, 2013). Not surprisingly, suicide autopsies reveal that family discord is very common preceding suicide (Conwell, Duberstein, & Caine, 2002).

On the other hand, families can provide a powerful function in protecting against suicide risk. A feeling of responsibility to family is a known reason for living in suicide risk assessment (Linehan, Goodstein, Nielsen & Chiles, 1983), and the Interpersonal Theory of Suicide posits that decreased social connectedness (also known as thwarted belongingness) is a key risk factor for the desire for suicide (Joiner, 2005). Similarly, some suicidal individuals choose not to harm themselves to avoid indirect emotional harm to their family members (Jordan et al., 2012). In one study of clients' views of suicide prevention, more than half of participants who had social supports available to them reported that a family or friend was the "most helpful factor" in suicide prevention efforts (Eagles, Carson, Begg, & Naji, 2003, p. 262).

The Impact of a Suicide Crisis on the Caregiver

A suicide crisis by a loved one has been found to be the most challenging aspect for caregivers of psychiatric patients (Dore & Romans, 2001), and has a known negative impact on the caregiver's overall health (Chessick et al., 2007). Parents of individuals who go on to die by suicide have increased depression, physical health problems, and lower income than parents of individuals who die in motor vehicle accidents (Bolton et al., 2013). Caregivers may require psychological support themselves related to the role of caring for someone with suicidal thoughts or behaviors (Magne-Ingvar & Öjehagen, 1999). Relatives have expressed feelings of worry, shame, and anxiety about how to provide care to a person who is suicidal (Tzeng & Lipson, 2004). Other feelings known to be associated with providing care for a person living with mental illness (regardless of the presence of suicidal thought) include guilt, anger, resentment, and frustration, as well as compassion, and empathy (Karp & Watts-Roy, 1999). Caregivers have also been described as experiencing persistent stress (Boynkin & Winland-Brown, 1995), anxiety symptoms, depression, and a lack of understanding about their loved one's mental illness (Rose, 1997). This cacophony of emotions and experiences most commonly influences the presence of caregiver burden.

As shown in Figure 1, the family caregiver has many experiences unique to caring for a person with a mental illness. Of note, caregiver burden may be exacerbated by a family's limited resources or knowledge about a suicide crisis; however, caregiver strengths often include a contextualized understanding of the person experiencing a suicide crisis. Most significantly, the family may have increased access to the client and firsthand knowledge of the individual's development, family and experiences. Likewise, a mental health professional will have a depth of knowledge in some areas (e.g., an understanding of suicide crisis and mental health disorders), but may require collaboration with the family to learn more about the client's history and symptoms over time. As depicted in Figure 1, communication between family members and mental health providers can be of great mutual benefit to both parties.

A New Approach: Family Caregiver Empowerment in Suicide Prevention

A family caregiver's response to a suicide crisis will vary in relation to available social and personal resources, knowledge, problem-solving skills, as well as prior experiences. Providing suicide prevention education to families may help decrease caregiver burden and may have an indirect impact on the

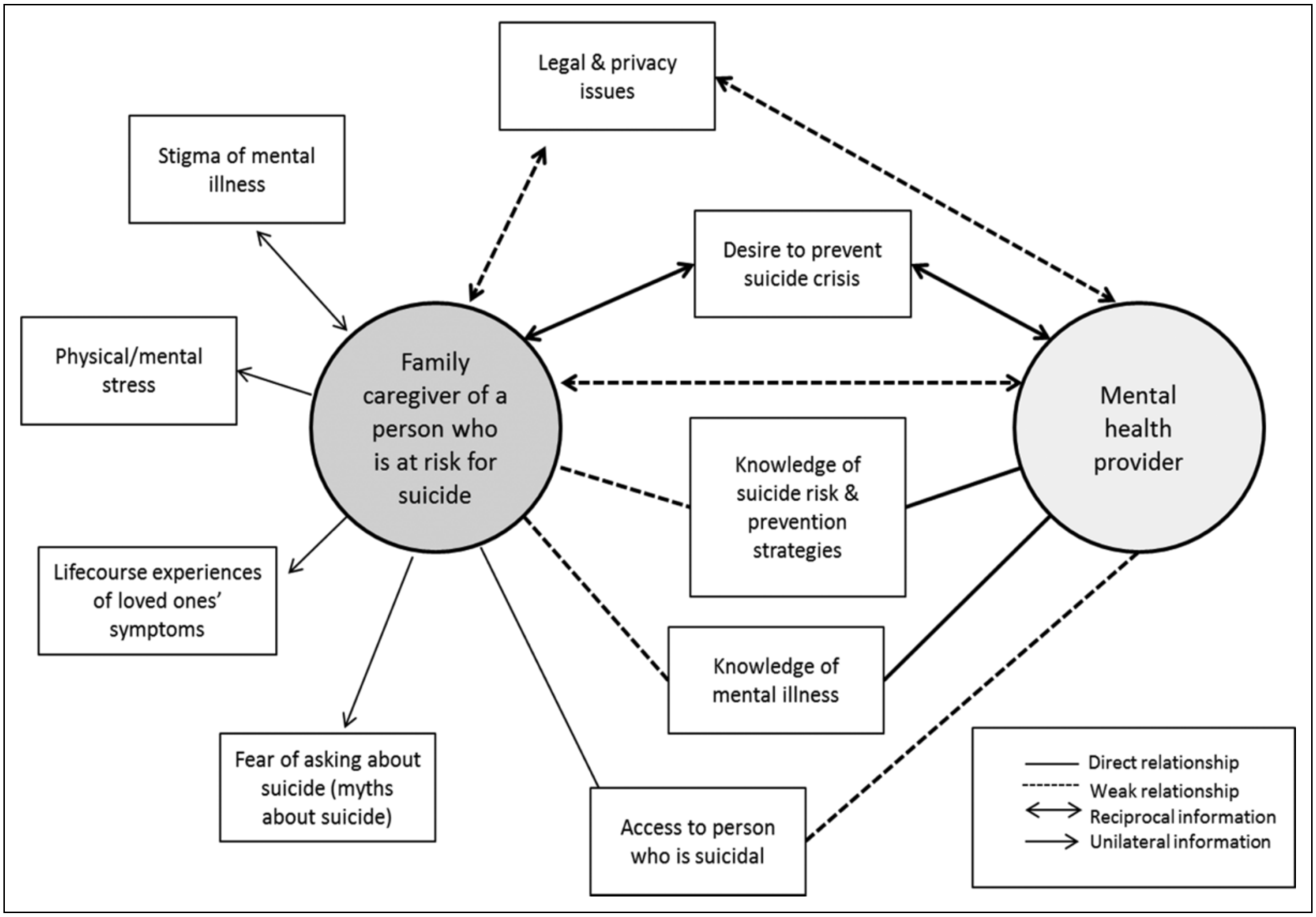

Figure 1. Family-provider issues associated with caring for a person at risk for suicide.

individual at risk for suicide. Pro-active family involvement and preparation for suicide crises can shift the caregiving experience from a perceived position of powerlessness to one that may simultaneously positively benefit the individual who is suicidal as well as his or her caregiver. We believe family caregivers can be empowered to cope with suicidal thoughts and behaviors expressed by their loved one by reframing the problem of suicide risk as a situation in which the family can have some control and agency.

An empowerment approach focuses on the process and outcomes of collaboration with others to achieve goals and to gain access to resources (Simon, 1994). In clinical practice, the process of empowering individuals (in this case, the family caregiver) involves partnership between the provider and the family to identify the family's abilities, resources, and strengths. These strengths are harnessed as a way to promote change and transformation within the environment. Empowered outcomes are measured by the family's "situation-specific perceived control and resource mobilization skills" (Perkins & Zimmerman, 1995, p. 570). Thus, the process of recognizing the family's unique strengths, accessing resources, working with a mental health provider, and gaining some control over a situation are all necessary elements for a caregiver faced with the suicidal crisis of a loved one.

In empowerment practice, family caregivers are considered experts on their own lives (Simon, 1994). Caregivers have intimate knowledge and extensive experiences regarding the needs and desires of their family members, including a loved one's disclosure of suicidal ideation or exposure to suicide behaviors. The empowerment tradition relies on the family to identify and utilize resources as a way to make meaning of their situations, relationships, and problems (Saari, 1991). Family caregivers require education to understand the warning signs and nature of a suicide crisis in order to harness resources. They need knowledge of recovery, treatment outcomes, and to believe that suicide prevention is possible. If this can be accomplished, the combination of education and collaboration with the provider may increase the personal and interpersonal power of the caregiver.

Caregiver education has many benefits. First, caregiver education helps the caregiver to more successfully solve logistical caregiving problems as they arise. Concrete resources and collaboration with health and social work professionals can help address these needs. Providing families with a more comprehensive understanding of suicide risk may have the dual benefit of helping the caregiver and the family member. Second, education teaches the caregiver how to cope with their emotional reactions to caregiving and may decrease caregiver burden (Houts, Nezu, Nezu, & Bucher, 1996). Normalizing the

Table 1. Suicide Prevention Education From an Empowerment Perspective.

1. Develop suicide prevention education programs in response to the preferences and needs of family caregivers. Provide education in small groups that promote solidarity, decrease stigma, and permit discovery of the unique needs of each family.
2. Be sure that programs are convenient and accessible for family caregivers. Consider delivery of education in online formats available in multiple languages; structure prevention programs in a single visit or during evening sessions that can be completed without additional burden of care to the family.
3. Ensure that all education programs are collaborative between mental health providers and family caregivers. Approach the problem of the risk of suicide as a collective issue that involves the individualized experience of families, providers, and the client.
4. Whenever possible, use a problem solving model (e.g., COPE) to build on existing strengths, resources, and prior experiences of the family. Teach families to recognize their capabilities and problem-solving skills based on their intimate knowledge of their loved ones.
5. Attend to the unique needs of each family caregiver while also recognizing the universality of suicide risk among those caring for a person living with a mental illness. Allow families members attending education programs to problem solve among themselves and with others in a similar situation.
6. Build alliances between mental health providers and family caregivers; promote a common goal of suicide prevention; provide support and make resources available to families and their loved ones during times of suicide crisis.
7. Remember that empowerment is a process; be patient with one another while continuing to instill hope. Trust may develop as barriers are broken down between families, clients, and providers.
8. Mental health providers cannot predict death by suicide (Wortzel, Matarazzo and Homaifar, 2013), neither can family caregivers. Providers and families must be aware of their own powerlessness in suicide prevention.

Note. COPE = Creativity, Optimism, Planning and Expert information.

experience of suicide risk, building solidarity with other families in similar situations, and learning coping strategies for self-care have the potential to directly support the caregiver. Finally, educating caregivers may offer an indirect way to improve the care provided to a person who is living with an illness. Based on a problem-solving framework for caregiver empowerment developed by Houts, Nezu, Nezu, and Bucher (1996), we believe that education can and should be targeted toward the family caregiver in suicide prevention efforts.

Shifting Provider Perspectives Toward Families

Mental health providers have a key role in eliminating the systematic barriers between families and professionals. Providers should make efforts, when clinically appropriate, to involve family in the care of a client who is at risk for suicide. Providers are encouraged to use an empowerment approach by tailoring problem-solving suicide prevention programs in ways that not only will support family caregivers themselves but may also promote each family's ability to provide support for the suicidal client.

An application of eight guidelines of clinical practice in the empowerment tradition is applied to suicide prevention education for family caregivers in Table 1. Each of these guidelines is drawn from the work of social worker Barbara Simon (1994).

If feasible, approaches to suicide prevention education constructed in the empowerment tradition should include local knowledge (Geertz, 1983) combined from the mental health provider, the family caregiver, and the client. The knowledge that family caregivers have developed over time based on their own experiences with their loved ones needs to be valued and respected. Mental health professionals who have expertise in suicide risk and psychiatric illness can contribute this expertise as a way to provide education to the family caregiver and the client. Thus, the empowerment approach is both a theoretical and practical approach that can be applied to family education models related to suicide prevention.

A Family Empowerment Model: COPE

Houts et al. (1996) developed a conceptual model for a prepared family caregiver course called COPE. The COPE caregiver preparedness model includes education on problem-solving techniques associated with COPE information, and emphasizes collaboration between caregivers and providers. Full details about the COPE model are available in the second edition of the *American Cancer Society Complete Guide to Family Caregiving* (Bucher, Houts, & Ades, 2011).

Briefly, *creativity* involves the need for caregivers to think creatively about how to overcome a challenge in caring for a family member. There is a focus on brainstorming, improving on prior problem-solving ideas, managing expectations, and exploring solutions to the problem with a person outside of the situation. In addition, realistic *optimism* is encouraged. Caregivers are taught to be prepared for inevitable challenges and to set reasonable goals for both the family member and the caregiver. Caregivers are empowered to believe in their ability to succeed in helping their family member by recognizing that they have a history of effective problem solving in their own lives. *Planning* includes obtaining facts about a situation (often before it arises), identifying a problem in detail, and clarifying what makes the situation a problem. Once this information is available, the caregiver works with the family member and a provider to cocreate a caregiving plan that can be carried out and adjusted as needed. The concept of obtaining *expert information* includes gathering reliable resources (usually from health care providers), being able to recognize what the caregiver can and cannot do, and knowing when professional intervention will be needed.

COPE is typically taught by a health professional and a mental health provider using didactic material in a manual with case examples and/or video supplements. The participants have the opportunity to practice the COPE techniques and to develop plans tailored to their individual situation (Nezu, Nezu, Friedman, Faddis, & Houts, 1999). The course is typically offered to small groups of caregivers who have family members or friends

Table 2. An Application of COPE to Suicide Prevention Within the Family.

Caregiver Empowerment Education Approach[a]	Suicide Prevention Example Strategies
Creativity: • Talk to someone about the problem or imagine what another person would do about the problem • Improve on an idea that worked to some extent in the past • Try a smaller goal • Brainstorm	• Families can reduce the stigma of mental illness by talking with others in a NAMI Family to Family support group to learn about the frequency of suicidal ideation among people with a mental illness. • Families can talk to a mental health professional, a clergy member, or a friend about the experience of caregiving. • Families could plan one small fun activity together each week, such as a family dinner in order to have a small, obtainable goal. • Families can develop their own language and communication around suicide risk, which does not have to involve traditional modes to check-in about mood and perceptions of safety.
Optimism • Set reasonable goals • Expect to succeed • Take breaks from caregiving • Accept that problems are inevitable • Realize that you are already an effective problem solver • Try different ways of staying optimistic	• Families can assess their strengths as a cohesive family system. If it helps, families may need visual reminders, such as pictures, poems or letters in their house to remind them of the importance and power of their family. • Discussing what has worked in the past, both as a family and with a mental health professional, can further cement these approaches to coping. • A history of suicidal thoughts and behaviors is a suicide risk factor across the lifespan. Therefore, suicide prevention is a "marathon," not a "sprint," and may require adjusting familial expectations for the suicidal loved one. • As suicide prevention is a lifelong endeavor, caregivers will need respite at times to tend to their own health. Scheduling these breaks often and in advance, rather than in response to a crisis, could improve feelings of caregiver burden.
Planning • Getting the facts • Breaking the problem into specific details • Identify what makes situation a problem • Develop your plan • Carry out, evaluate and adjust your plan	• Family members are often best positioned to notice changes in behaviors that may signal warning signs for suicide. Families can ask the relative directly if he or she is suicidal if warning signs are present. Families are then empowered by asking questions rather than avoiding the subject. • Families members are often essential in means restriction, meaning that weapons and potential methods of harm should securely locked away or removed from the home. • Families can collaborate with their relative to create a suicide safety plan. The safety plan should be concrete and specifically written for the relative and family system. All emergency numbers, including mental health professionals and hotlines should be included. The safety plan can be posted in a visible location (e.g., the refrigerator, the bathroom mirror).
Expert information • Seek out reliable resources • Consider whether professional help is needed • Identify what you can do	• Families can participate in a suicide education programs offered in their community or online. List-serves or support groups may be helpful. • Families can decide when to contact psychiatric services ahead of a future suicidal crisis. There are many levels of professional involvement, from leaving a message for a patient's therapist, calling a crisis line or bringing the loved one for emergency evaluation. Proactively deciding what to do in the event of a crisis, in collaboration with both the mental health profession and loved one, can avoid additional stress and conflict.

Note. NAMI = National Alliance for the Mentally Ill.
[a] Adapted from Bucher et al. (2011).

experiencing the same type of physical illness. Originally designed for families caring for someone with cancer (Houts et al., 1996), the model has since been applied to other medical problems such as end of life care (McMillan et al., 2006; Meyers, et al., 2011), transplant (Bevans, et al., 2010), and pain management (Loscalzo & Bucher, 1999). According to one of the lead authors of COPE, this is the first time the model has been applied to suicide prevention efforts (Julia Bucher, personal communication, March 21, 2014).

The goals of the COPE model are to improve caregiving effectiveness and to increase self-efficacy (Nezu et al., 1998); two constructs that align with empowerment theory. Research outcomes on the impact of COPE educational approaches have demonstrated an increase in caregiver efficacy (Hendrix, Landerman, & Abernethy, 2013), a positive impact on caregiver quality of life, and decreased caregiver burden (McMillan et al., 2006).

Application of COPE to Suicide Prevention

A caregiver empowerment educational approach such as the COPE model offers a flexible framework for how to manage a problem. While this approach to educating families on the problem of suicide risk is not intended to be a theoretical model or a means of training families in suicide risk assessment, we maintain that this framework could be incorporated into suicide awareness programs or in clinical treatment with the family. Thus, the COPE pedagogical and conceptual approach can be infused into the existing suicide prevention program that is already in place at the local level.

The COPE approach is based on the assumption that family caregivers want to help and be engaged in suicide prevention efforts with their relatives, and that their relatives have given permission for their families to be involved in treatment We also assume that families have varying knowledge of suicide prevention strategies and diverse levels of connection with mental health service providers. This conceptual approach suggests that family caregivers can aid in suicide prevention efforts with empowerment-based education and training.

Table 2 provides an outline of the COPE framework adapted from Bucher, Houts, and Ades (2011) and how its components could be applied to any suicide prevention model. We have included concrete examples of potential suicide prevention strategies that could be used by family caregivers when faced with a crisis, but the list is in no way instructive or exhaustive. These clinical examples of suicide prevention strategies are based on prevention approaches from the suicide treatment literature that can be used to educate family caregivers. This approach allows for a personalized application of the COPE model in relation to the unique experience of each individual who is at risk of suicide.

A key requirement to implement the COPE model will involve the integration of this model into existing suicide prevention strategies. Suicide prevention programs are made available for the public in a number of different settings, including hospitals, schools, churches, county health departments, human service programs, mental health advocacy organizations (especially the National Alliance for the Mentally Ill), law enforcement, and community mental health centers. In addition, the educational background of the trainers may differ, whether by mental health professionals or passionate lay workers. In our region of the country, we have seen an increase in community-based education for Signs of Suicide, Question, Persuade and Respond, and Mental Health First Aid. We envision the dissemination of the COPE model to individuals who conduct these trainings in our community, who can then infuse this additional layer of family support into their suicide prevention education.

Next Steps

There has been no research to date in the United States to study suicide prevention education for family caregivers, despite growing recognition of the stressors faced by families caring for individuals with mental health problems (National Research Action Plan, 2013). Following participation in family suicide prevention education programs that have been infused with a COPE approach, researchers can evaluate changes in caregiver concepts such as efficacy, competency, satisfaction, and burden, as well as how family involvement in suicide prevention may aid individuals at risk for suicide. Comparative studies can be conducted to explore qualitative differences in the family experience of suicide prevention when COPE has been integrated into an existing suicide prevention program and when it is not. Research is needed to understand the family experience of caring for a relative who has experienced suicidal thoughts or behaviors, and the collaboration (or lack thereof) between family and mental health providers. Additionally, further study of the development of suicide prevention strategies for families using the COPE model may facilitate greater collaboration between practitioners, families, and the client.

On a practical level, clinicians are encouraged to apply empowerment-based best practice approaches to suicide prevention strategies that are tailored to meet the unique needs of family caregivers. Rappaport wrote that the goal of the empowerment process is “to enhance the possibility for people to control their own lives” (1981, p. 15). We can think of no stronger desire than for a family member to have the knowledge (and perhaps power) to engage in suicide prevention during a suicide crisis of a loved one.

Behavioral health providers have a key role in eliminating the systemic barriers that may exist between families and professionals. When clinically appropriate, professionals can make efforts to involve family in the care of the client who is at risk for suicide. Education programs that are collaborative, promote empowerment of family members, and are sensitive to the unique needs of each person who may be at risk of suicide are consistent with the necessary conditions of successful prevention program in mental health care (Felner, Jason, Moritsugu, & Farber, 1983). Caregiver education provided through an empowerment approach, such as COPE, is one promising way to increase a caregiver’s ability and resources to provide care.

Authors’ Note

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy, position or views of the Department of Veteran Affairs, the National Institutes of Health, the Department of Health and Human Services or the U.S. Government.

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