

BEATRIZ MARIA CAÇÃO DIAS

**Families of young people who self-harm: A systematic review
of their experiences and needs**



UNIVERSIDADE DO ALGARVE
Faculdade de Ciências Humanas e Sociais

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their experiences and needs**

Dissertação para obtenção do grau de Mestre em Psicologia Clínica e da Saúde

Trabalho efetuado sob orientação de:

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UNIVERSIDADE DO ALGARVE

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Declaro ser autora deste trabalho, que é original e inédito. Autores e trabalhos consultados estão devidamente citados no texto e constam da listagem de referências incluídas.

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(Beatriz Maria Cação Dias)

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“Suicide is not selfish

Characterising suicide as selfish simply adds to the stigma around it. And when stigma increases, help-seeking declines, ignorance flourishes and deaths soar.”

Rory O’Connor in *When It Is Darkest*

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Abstract

Youth self-harm is increasingly recognized as a significant issue with far-reaching effects on families. Although often framed as an individual problem, it disrupts the psychological well-being and dynamics of the family, underscoring the urgent need to understand its broader impact on family systems. This systematic review aims to provide a comprehensive understanding of the experiences and needs of families of young people who self-harm. A systematic search was conducted in PsycINFO, PubMed, Web of Science, and Scopus, along with forward tracking of references from the included studies, up to July 2024. Methodological quality was assessed using the MMAT and the GRADE-CERQual approach. Quantitative data were synthesized through narrative synthesis, while qualitative data were analyzed using thematic synthesis. The review included 29 studies, with quantitative findings identifying two key themes: (1) Self-harm Repercussions in the Family, and (2) Support and Being Supported. Qualitative analysis revealed four analytical themes: (1) Emotional and Psychological Burden; (2) Biographical Disruption and Parenting Shifts; (3) Impact on Family Dynamics; and (4) Seeking and Accessing Support. The synthesis highlights the profound emotional, psychological and relational effects of youth self-harm on families, emphasizing the need for improved health systems, trained professionals, and more readily available resources.

Keywords: Self-harm; Families; Youth; Experiences; Systematic Review

Resumo

Os comportamentos autolesivos nos jovens são reconhecidos como um problema significativo com impacto extensivo na família. Embora frequentemente enquadrado como um problema individual, a autolesão perturba o bem-estar psicológico e as dinâmicas familiares, sublinhando a necessidade urgente de compreender o seu impacto nos sistemas familiares. A presente revisão sistemática visa proporcionar uma compreensão aprofundada das experiências e das necessidades das famílias de jovens com comportamentos autolesivos. Foi realizada uma pesquisa sistemática nas bases de dados PsycINFO, PubMed, Web of Science e Scopus, bem como um rastreio das referências bibliográficas dos estudos incluídos, até julho de 2024. A qualidade metodológica foi avaliada através das ferramentas MMAT e GRADE-CERQual. Os dados quantitativos foram sintetizados através de uma síntese narrativa e os qualitativos através de uma síntese temática. A revisão incluiu 29 estudos. Os resultados quantitativos revelaram dois temas principais: (1) Repercussões da Autolesão na Família e (2) Apoiar e ser Apoiado. A análise qualitativa identificou quatro temas analíticos: (1) Carga Emocional e Psicológica, (2) Disrupção Biográfica e Mudanças na Parentalidade, (3) Impacto nas Dinâmicas Familiares e (4) Procura e Acesso ao Apoio. A síntese destaca o impacto emocional, psicológico e relacional dos comportamentos autolesivos nas famílias, destacando a necessidade de melhorias dos sistemas de saúde, profissionais qualificados e uma maior disponibilidade de recursos.

Palavras-chave: *Comportamentos Autolesivos; Famílias; Jovens; Experiências; Revisão Sistemática*

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List of Acronyms and Abbreviations

CERQual: Confidence in the Evidence from Reviews of Qualitative Research

CRD: Centre for Reviews and Dissemination

DGS: *Direção Geral de Saúde*

DSH: Deliberate Self-harm

FTR: Forward Tracking References

GRADE: Grading of Recommendations Assessment, Development, and Evaluation

INE: *Instituto Nacional de Estatística*

MeSH: Medical Subject Headings

MMAT: Mixed-Method Appraisal Tool

NICE: National Institute for Health and Care Excellence

NSSI: Non-suicidal Self-Injury

PICO: Population, Intervention, Comparison, Outcome

PICo: Population, Phenomena of Interest, Context

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PRISMA-P: Preferred Reporting Items for Systematic Reviews and Meta-Analysis
Protocols

SA: Suicide Attempt

SH: Self-harm

ScoR: Scoping Review

SR: Systematic Review

SRB: Suicide-related Behaviors

WHO: World Health Organization

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CHAPTER 1: INTRODUCTION

1.1. Conceptualization of the Phenomenon

1.1.1. Suicide and Self-Harm: Definition and Prevalence

Although the fundamental instinct for self-preservation inherently assumes that any life is too precious to be ended, suicide remains a major social and public health concern, causing devastating consequences for individuals, their families, and communities alike. Epidemiological data suggest that approximately 700,000 lives are lost to suicide annually worldwide (World Health Organization [WHO], 2021). In Portugal, the mortality rate due to intentionally self-inflicted injuries (suicide) was 9.0 per 100,000 inhabitants (Instituto Nacional de Estatística [INE], 2023).

Among these individuals, adolescents represent a particularly vulnerable group due to the drastic and transient physical, psychological, and social changes they undergo (Christie & Viner, 2005). However, the difficulties do not end with adolescence. As young adults, they continue to face new challenges, including increased responsibilities and uncertainty about the future (Lowe et al., 2013). WHO (2019) defines “Adolescents” as individuals aged 10-19 years and “Youth” as those aged 15-24. The term “Young People” encompasses the broader age range of 10-24 years.

Suicide can be defined as a “*death caused by an act carried out by the individual with the intention of ending their life, including psychopathological intentionality*” (Direção Geral de Saúde [DGS], 2013). Suicidal behavior, self-harm, and non-suicidal self-injury (NSSI) serve as significant precursors to suicide in young people (Aggarwal et al., 2017; Hamza et al., 2012). These behaviors exist along a continuum, ranging from NSSI, characterized by the intentional destruction of one’s body tissue without suicidal intent (Nock, 2009), to a suicide attempt (SA), defined as an act performed with the intention of ending one's own life that does not result in death due to being unsuccessful or thwarted (DGS, 2013).

Despite the distinction between NSSI and SA, determining the presence of suicidal intent behind these behaviors can be challenging, making it difficult to differentiate them (Farkas et al., 2023; Klonsky et al., 2003; Klonsky, 2007; Nock et al., 2006). Due to the lack of consensus in the literature regarding the terminology, this study will adopt the term “self-harm” defined by the National Institute for Health and Care Excellence (NICE, 2022) as “*intentional self-poisoning or injury, irrespective of the apparent purpose*”, to provide clarity within the research framework.

Self-harm is recognized as a significant and growing concern among adolescents worldwide (Townsend et al., 2022). It often manifests as a repetitive behavior (Hawton et al., 2012) and stands as one of the most substantial risk factors for suicide (Hawton et al., 2020), which ranks as the *fourth* leading cause of death among individuals aged 15-29 (WHO, 2023). Self-harm is found in 40–60% of suicides (Hawton et al., 2003).

Globally, it is estimated that 16%–18% of individuals will engage in self-harm at some point in their lives (Muehlenkamp et al., 2012; Zhao et al., 2023). Across many countries, self-harm is more prevalent among females than males, with a sex ratio as high as 6:1 between the ages of 12 and 15 years (Hawton et al., 2012). Additionally, repeated instances of self-harm are common among adolescents, with almost two-thirds of those who engage in self-harm reporting having done so more than four times (Curtis et al., 2018; Lawrence et al., 2015).

There is a direct link between self-harm and SA, with more than nine in ten adolescents who attempt suicide also reporting a history of self-harm (Duarte et al., 2020). In a study by Nock et al. (2006), among those with a history of self-harm, 70% had attempted suicide at least once, and 55% had attempted suicide multiple times. According to WHO (2023), SA occurs much more frequently than completed suicides, with an estimated 20 SA for each suicide death.

1.1.2. Risk Factors and Complexity of Self-Harm

The phenomenon of self-harm is marked by a complex interplay of numerous risk factors that contribute to its occurrence (Barzilay & Apter, 2014), often stemming from severe distress (Zadravec et al., 2006). Young individuals engaging in self-harm report a range of motives, including intrapersonal and interpersonal reasons (Klonsky et al., 2015), with the most common being *to gain relief from a mental state, to escape, or to seek help* (Madge et al., 2008).

Psychiatric disorders, such as major depression, anxiety disorders, eating disorders, impulse-control disorders, addictions, and psychotic and personality disorders pose a higher risk for engaging in self-harm and suicidal behaviors (Apter & Wasserman, 2006; Bridge et al., 2006; Hawton et al., 2015; Mangnall & Yurkovich, 2008; O'Connor, 2007).

Having multiple hospital admissions, and previous episodes of self-harm or suicide attempts are strong indicators of elevated risk for future self-harm (Bridge et al., 2006; de

Kloet et al., 2011; Hawton & Harriss, 2008; Krysiniska et al., 2006). The consumption of alcohol and substances also contributes to the risk of self-harming behaviors. Moreover, a family history of psychiatric disorders, low self-esteem, and feelings of hopelessness or pessimism, along with the suicide of a relative or friend further exacerbate vulnerability (McEvoy et al., 2023; Miranda-Mendizabal et al., 2019).

Other demonstrated predictors include a history of trauma, neglect, or (physical/sexual) abuse in childhood, as well as experiencing major life events such as bullying, interpersonal losses, and academic stress, all of which can significantly impact their vulnerability (Bilsen, 2018; Spirito & Esposito-Smythers, 2006). Poor family relationships, social isolation, being a victim of dating/relationship violence, or experiencing a breakup in a relationship also contribute to increased risk (Evans et al., 2017). Environmental factors like the contagion effect and access to means also heighten the risk (Bilsen, 2018; Gould, 2001).

1.2. Vulnerability in Adolescence and Young Adulthood

1.2.1 Cognitive and Emotional Development in Adolescence

Adolescence is a crucial stage marked by significant cognitive growth, notably the emergence of abstract thinking (Sanders, 2013). This developmental milestone often leads adolescents to engage in risky behaviors, driven by a sense of invincibility and a preference for immediate rewards over long-term consequences. During this phase, the brain tends to prioritize rewarding stimuli, making adolescents more inclined toward behaviors offering instant gratification, even if they entail risks. Compared to adults, adolescents tend to exhibit higher levels of impulsivity and have a distinct time perspective, often prioritizing immediate rewards without considering long-term consequences (Reyna & Farley, 2006).

Young individuals face significant decision-making challenges as they navigate identity construction and strive for independence (Bilsen, 2018). However, not all adolescents face these challenges in the same way. Those who engage in risky behaviors, including self-harm, often exhibit impairment in decision-making abilities (Bridge et al., 2012). They may display a greater attraction to short-term, high-reward solutions and have difficulty adapting strategies to avoid long-term consequences, with the frequency of self-harm episodes appearing to be directly related to the severity of decision-making impairments (Oldershaw et al., 2008).

Emotionally, adolescence is characterized by heightened emotional reactivity, sensitivity, and instability (Ahmed et al., 2015). Adolescents often experience intense emotions more frequently and with greater intensity than adults (Bailen et al., 2018). This period involves significant emotional turmoil, partly due to hormonal changes and the ongoing development of the brain regions responsible for emotional regulation, such as the prefrontal cortex and the amygdala (Casey et al., 2008). Greater emotional reactivity and sensitivity during adolescence may play a role in the higher incidence of affective disorder onset during this developmental period (Steinberg, 2005).

Emotional regulation plays a critical role during adolescence. Adolescents with poor emotional regulation skills may struggle to cope with stress and negative emotions, often resorting to maladaptive coping mechanisms such as self-harm (Sim et al., 2009). This struggle can manifest in various ways, including increased irritability, anxiety, and depressive symptoms. The inability to regulate emotions can exacerbate feelings of helplessness and hopelessness, which are common precursors to self-harming behaviors (Voon et al., 2013).

Moreover, one's risk-taking propensity may be also influenced by their self-regulatory competence, which encompasses the ability to control, modify, and adapt one's emotions, impulses, or desires (Murtagh & Todd, 2004). Decisions made in an affective context, where emotions play a role, are further affected by cognitive limitations in understanding and labeling emotions, as well as by maladaptive psychological functioning (Lauriola et al., 2022; Valle et al., 2023). This developmental stage becomes critical, signifying a period when self-destructive behaviors can erupt, potentially leading to an epidemic of self-harm for the first time (Orbach, 2003).

1.2.2 Transition to Adulthood: Challenges and Pressures

By young adulthood the locus of achievement and belonging transitions from adolescence to adult domains, encompassing the adoption of adult roles. This transition is typified by pervasive shifts in social contexts and connections, coupled with reduced structure and social support (Hooven et al., 2012).

As individuals transition into adulthood, the conditions that foster social integration and regulation (Durkheim, 1897, 1951) are changing, leaving many young adults without a blueprint for assuming adult roles (Hooven et al., 2012). This struggle is particularly

challenging for those with a history of vulnerability to suicide, including experiences of emotional distress or self-harm behaviors during earlier life stages (Fergusson et al., 2005; Lewinsohn et al., 2001).

Success in this stage is characterized by the attainment of various adult milestones, such as autonomy, intimacy, pursuing higher education, securing employment, and establishing familiar bonds (Hooven et al., 2012). However, alongside these achievements, young adults often encounter high expectations from significant family members and peers, which inevitably lead to feelings of powerlessness, insecurity, stress, and a sense of losing control (Patton et al., 2016).

Furthermore, the transition to university life represents a significant challenge for many young adults. Moving away from home, adjusting to academic demands, and forging new social connections are critical aspects of this phase that can exacerbate existing vulnerabilities (Gençöz & Or, 2006; Haas et al., 2003; Owusu-Ansah et al., 2020).

1.3. Family (Dys)Function and Self-Harm in Young People

1.3.1. Parent-child Relationship

No other family factors are as important as parent-child relationships (Steinberg & Morris, 2001). Understanding youth self-harm within the family context requires acknowledging the dynamic nature of the relationship (Townsend et al., 2021).

Normal development during this tumultuous period is heavily influenced by parental interest and emotional involvement, as well as parenting styles, which largely determine the overall climate and communication within the family (Fong et al., 2021). Parental support encompasses behaviors expressing love, appreciation, warmth, acceptance, affection, emotional availability, or support for autonomy and independence (Skinner et al., 2005). Such warm, supportive, and involved parenting can have a profound impact on children's social communication and mental health as they grow (Connor & Rueter, 2006; Flouri & Buchanan, 2002; Tao et al., 2020).

However, existing empirical research has identified numerous associations between the poor quality of early parent-child attachment relationships in childhood, disruptions in parent-child bonds, and experiences of separation and loss that may increase the incidence of self-harming behaviors in youth (Bureau et al., 2009; Conterio & Lader, 1998; Honglei et al., 2018; Suyemoto, 1998; van der Kolk et al., 1991; Walsh, 2006).

The lack of support and closeness coupled with a sense of alienation in the parent-child relationship increases the risk of depression and suicidal behaviors in adolescents. This stems from an invalidating and rejecting caregiving environment characterized by parental criticism (Baetens et al., 2013; Fonagy et al., 2000; Sofronoff et al., 2005; Tao et al., 2020; Yates et al., 2008).

Adequate parenting style is considered one of the best protective factors against self-harm, and conversely, inadequate parenting style is a reliable positive predictor of its occurrence (Baetens et al., 2013). The families of adolescents engaged in self-harm are often characterized by inflexibility and overly controlling parenting styles, rigid problem-solving behaviors, patriarchal leadership, and intolerance to developmental changes. Parents also tend to be overly protective and intrusive, promoting lower levels of self-esteem, an internal locus of control, high levels of stress, anomie, and depression; all of these factors are related to suicidal ideation (de Man & Leduc, 1995; Van Renen & Wild, 2008).

Furthermore, in university students, the developmental transitions (Arnett, 2015) and academic pressures (Beiter et al., 2015) when coupled with parental behaviors that impede their sense of autonomy and competence, can be particularly dysregulating during this period (Guérin-Marion et al., 2021).

1.3.2. Family Structure and Conflicts

While families typically serve as vital sources of support and stability, changes within the family structure can have profound effects, particularly on vulnerable members. These changes, such as separation, divorce, or death, can disrupt the support networks and resources that families provide, leaving vulnerable individuals at increased risk (Amoateng et al., 2004).

Numerous studies have consistently linked youth self-harm and suicidal behavior to various factors associated with family dynamics and structure (Brent & Mann, 2003). Families of suicidal adolescents often exhibit higher levels of conflict compared to average families (Henry et al., 1993; Tomori & Zalar, 2000; van Renen & Wild, 2008). Marital discord and exposure to parental conflicts may elevate the risk of self-harm and suicidal behavior among adolescents. Overhearing parents' arguments, threats, or

violence can be highly stressful for children, and parents in unhappy relationships may be less emotionally available to their children (Bilsen, 2018; Wagner, 1997).

Poor conflict resolution within the family may exacerbate the situation, leading to poor problem-solving skills and increased feelings of hopelessness in the adolescent (Sofronoff et al., 2005). Additionally, poor family communication, including an inability to openly discuss feelings and worries, has also been linked to self-harm behavior in youth (Bilsen, 2018) and acute conflicts with parental figures (Soole et al., 2015).

Furthermore, evidence suggests that suicidal youth are more likely than their non-suicidal counterparts to have a family history of suicide or psychiatric disorders (Portzky et al., 2005), as well as family members with alcohol, drug, or emotional problems (Yoder, 1999). Adolescents from divorced families are more likely to report suicidal thoughts and self-harming behaviors compared to those from intact families (Gould et al., 1998; Sofronoff et al., 2005). Parental divorce may increase an adolescent's vulnerability to self-harm due to its connection between divorce and parental psychiatric disorders or by increasing the adolescent's vulnerability to depression, which is a recognized risk factor for suicide (Sofronoff et al., 2005). Moreover, self-harm can stem from unresolved attachment issues related to a deceased parent or caregiver, manifesting as feelings of guilt or an inability to cope with the loss (Wagner, 1997).

1.3.3. Theories of Self-Harm and Suicide in Young People: Family Dynamics

As previously mentioned, families of young individuals who engage in self-harm behaviors often experience high levels of conflict (Mathew et al., 2021). Using attachment (Bowlby, 1980) and family coercion (Patterson, 1982) theories, Wagner and colleagues (2000) reasoned that certain self-harm behaviors among adolescents could be shaped and perpetuated by relational patterns within the family, serving as a temporary means to suppress conflicted or hostile behavior of other family members.

Bowlby (1980) suggests that youth self-harm behaviors seek to influence a caregiver to whom the child is insecurely attached. This is done either to punish the caregiver, thereby potentially compelling them to be more attentive or to express distress powerfully to signal the need for attention. Patterson (1982) proposed that aggressive children's aversive behaviors serve as a form of coercion, motivating other family members to put an end to them. Parents often respond with their aversive behaviors, creating a cycle of negative

reinforcement. This dynamic can lead to contingencies in which family members shape and reinforce each other's engagement in high levels of aversive behavior.

Other family models are based on the Circumplex Model of Family Systems, developed by Olson (2000), which relates to the family's cohesion and adaptability (Butler & Spencer, 2018; Olson et al., 1979). Cohesion refers to the emotional links established between family members, while adaptability refers to the capability of the family system to reorganize and address stress. This model proposes that a balanced level of both cohesion and adaptability is the most functional family development (Olson et al., 1979). Some studies relate these unbalanced family functional models to mental health problems (Birmes et al., 2009; Joh et al., 2013; Kashani et al., 1995; Wallin & Kronvall, 2002), however, few have provided empirical data related to self-harm and suicidal behavior (Alvarez-Subiela et al., 2022; Sheftall et al., 2013).

1.3.4. Consequences of Self-Harm in the Family

Family is a fundamental aspect of life and the structure of every society, providing individuals, from birth until adulthood, membership and a sense of belonging, economic support, nurturance, education, and socialization (Canary & Canary, 2013). Nonetheless, despite the anticipation of this commitment, unforeseen life events can disrupt familial harmony, with a child's self-harm presenting one such challenge. The consequences of a young person's self-harm extend far beyond the individual involved; they resonate within the family unit, affecting not only parents but also siblings and other close relatives (Frey & Cerel, 2013; Lindqvist et al., 2008), therefore jeopardizing family stability (Chi et al., 2014).

The increasing prevalence of self-harm among young individuals has prompted a growing demand for understanding and preventing this phenomenon, which has directed research attention towards the impact of self-harm on the adolescent (Ball, 2010). However, family involvement is recognized as an important factor in the child's prognosis (Byrne et al., 2008). Relatives play an important role in the prevention of further self-harm behavior; however, suicide and self-harm affect the relatives' lives profoundly, both emotionally and socially (Cerel et al., 2008; Krug et al., 2002). Living with a family member who engages in self-harm has a devastating effect on all members. When the family member is a child, the situation creates a unique crisis, especially in the mother's life (Daly, 2005).

Following a self-harm act of a young individual, the family members not only have to confront the stigma associated with self-harm but also take on a caregiving role for the individual who self-harmed, who may be perceived as a source of social injury to the family (Asare-Doku et al., 2017). Parents often describe the incident of self-harm by their child as extremely traumatic, experiencing what some authors describe as a “*double trauma*” – first, the shock and distress of discovering the self-harm, and second, the ongoing anxiety and vigilance required to support and protect their child (Buus et al., 2014; Hickey et al., 2019; Klein, 2016; Raney et al., 2022). This double trauma can lead to feelings of helplessness and concerns about how it affects their parent-child relationship (Morgan et al., 2013).

This experience is compounded by a sense of isolation and difficulties in communicating with their child about self-harm, leaving them uncertain about how to address the topic (Ferrey et al., 2015) and doubting their ability to provide support (Hughes et al., 2016). The stigma also prevents parents and other family members from seeking much-needed information and support (Kelada et al., 2016).

Emotionally, parents express a range of emotions including shock, disappointment, guilt, fear, frustration, and anger (Byrne et al., 2008; Oldershaw et al., 2008), along with self-blame (Raphael et al., 2006). They also report experiencing somatic and psychological symptoms, including depression and insomnia, which disrupt their daily routines, such as being unable to attend work. The perceived lack of information and/or support from healthcare services further heightened their feelings of hopelessness and confusion (Morgan et al., 2013). While every family’s experience is unique, there are universal needs that they often share, particularly in terms of support and assistance for both them and their young person (de Miranda Trinco et al., 2017).

1.4. Research Justification and Objectives:

1.4.1 Existing Literature and Gaps

Lavers et al. (2022) conducted a systematic review focused on the experiences of informal caregivers of people who self-harm. Additionally, the systematic review conducted by Mughal et al. (2022) specified the focus on informal caregivers of young people. The last database search for these two systematic reviews ended in 2021; since then, additional studies have been published in the field due to the emerging need for attention in this area.

Rheinberger et al. (2023) conducted a scoping review focusing on parents' experiences with adolescent suicidal phenomena; however, it did not adhere to the meticulous methodology typically employed in systematic reviews, lacking features such as comprehensive data synthesis and rigorous quality assessments.

1.4.2. Rationale for the Current Study

Over the past years, there has been a growing recognition of the profound and enduring impact that self-harm by young individuals can have on the family system. These families, who were previously silenced not only by the stigma but also by clinicians and researchers who overlooked their perspective, only began to receive attention later (Henry-McAllister, 2011).

Due to sample accessibility issues, there is limited literature available on this subject, primarily consisting of qualitative research that has explored the impact, needs, perspectives, and responses of parents and close relatives to their teenager's self-harm (Aiken et al., 2019; Ball, 2010; Boussat et al., 2022; Buus et al., 2014; Greene-Palmer et al., 2015; Henry-McAllister, 2010; Raney et al., 2022; Wagner et al., 2000).

There is a lack of a comprehensive systematic review that synthesizes data exploring the entire family dynamic, addressing the experiences, needs, difficulties, resources, and obstacles exclusively of parents and other family members.

The present systematic review was designed to specifically investigate the experiences and needs of families of youth with self-harming behaviors. The decision to opt for a systematic review, rather than a scoping review, was deliberate and based on the nature of our research questions and objectives.

Scoping reviews aim to identify and map the available evidence in a general manner, particularly when the topic is still underexplored and it is unclear what evidence exists and what other specific questions can be investigated (Anderson et al., 2008; Arksey & O'Malley, 2005; Armstrong et al., 2011; Munn et al., 2018). On the other hand, systematic reviews allow for the careful selection of relevant international evidence to investigate specific questions through a structured and predefined process with rigorous methods aimed at minimizing biases and providing more reliable and meaningful results that can guide practices, policies, and sometimes future research (Aromataris & Pearson, 2014; Green & Higgins, 2011; Liberati et al., 2009; Munn et al., 2018; Pearson, 2004).

In this regard, the present study opted for the methodology of systematic review. The specific nature of the questions posed about the experiences and needs of family members of young individuals with self-harm behaviors requires a structured and careful methodological approach, allowing for the systematic identification, selection, and evaluation of these experiences and needs. This process will enable a robust and unbiased systematic synthesis of the extracted results, which is imperative for facilitating the development of a practical guide for parents and family caregivers, as envisioned by the objectives of our study and a unique feature of this methodology.

1.4.3. Objectives

Our study aims to fill this gap by providing a thorough understanding of the impact, experiences, and needs of the families affected by young people who engage in self-harm. We aim that our results will inform future research and facilitate the development of a manual guide tailored to parents and caregivers of these young individuals, offering practical strategies to address their experiences and challenges.

Specific objectives:

- 1) to explore the experiences of family members of young individuals who engage in self-harm.
- 2) to identify the psychosocial effects (including emotional, relational, among others) of a young person's self-harm on the family.
- 3) to evaluate the needs and difficulties faced by family members in the aftermath of self-harm.

CHAPTER 2: METHODS

2.1. Type of study

This study constitutes a Systematic Review (SR), which is a methodical approach to secondary research aimed at gathering all relevant empirical evidence that meets predetermined eligibility criteria to address a specific research question. It employs rigorous and systematic methods designed to minimize bias, thereby providing more reliable findings from which conclusions can be drawn and decisions made (Higgins et al., 2019). High-quality SRs, described as the most reliable source of evidence to guide clinical practice (Clarke, 2011), should be impartial, transparent, and replicable (Donato & Donato, 2019). SRs can be invaluable for identifying research gaps; scarcity of publications; recognizing the limitations of individual studies; and discussing future needs and recommendations (Robinson et al., 2011).

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) is a methodological guideline designed for the clear and structured presentation of systematic reviews and meta-analyses. The PRISMA is presented as a checklist, specially created to standardize the steps to be followed in a systematic review (Donato & Donato, 2019; Liberati et al., 2009).

The first step should be to formulate the research question, based on the model defined by the acronym PICO which stands for Population, Intervention, Comparison, and Outcome of interest (Donato & Donato, 2019). In a more qualitative context, the PICo mnemonic stands for the Population, the Phenomenon of Interest, and the Context (Joanna Briggs Institute, 2020).

Once the research question has been defined, it must follow a) a clearly stated set of objectives with an explicit, reproducible methodology; (b) a systematic search that attempts to identify all studies that would meet the eligibility criteria; c) an assessment of the validity of the findings of the included studies, for example through the assessment of risk of bias; and (d) systematic presentation, and synthesis, of the characteristics and findings of the included studies (Liberati et al., 2009).

It is intended that the SR be registered in advance on the PROSPERO platform. Registration will create a public record of the study's protocol, methods, and planned analyses, enhancing transparency and minimizing bias. This process will optimize the quality and impact of the review (Page et al., 2018).

2.2. Procedure

2.2.1. Identification of the research question

This systematic review aims to provide a comprehensive and systematic overview of the empirical knowledge concerning the experiences and needs of families of young people who have engaged in self-harm. The goal is to serve as a reference to facilitate the development of a manual guide tailored to the family members of these young individuals, offering practical strategies to address their experiences and challenges.

To this end, the proposed systematic review will answer the following question, according to the **PICo** (Joanna Briggs Institute, 2020) approach:

- What are the experiences and needs reported in the literature by families of young people who self-harm?

Structured Question

- *Population*: families of young people who self-harm
- *Phenomenon of Interest*: experiences and needs
- *Context*: self-harm

2.2.2. Protocol

A protocol for this systematic review was preregistered with PROSPERO on 29th February 2024, under registration number CRD42024497809, following the guidelines outlined in the Preferred Reporting Items for Systematic Reviews and Meta-Analysis Protocols (PRISMA-P; Shamseer et al., 2015). The systematic review followed the PRISMA 2020 guidelines (Page et al., 2021; see **Annex A**), the MMAT (Mixed-Method Appraisal Tool; Hong et al., 2018), and the GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative Research) framework, with results reported accordingly.

2.2.3. Eligibility criteria

Following the PICo approach, the bibliographic search was conducted adhering to predefined inclusion and exclusion criteria as outlined in **Table 1**.

Review Question	What are the experiences and needs reported in the literature by families of young people who self-harm?	
	Inclusion Criteria	Exclusion Criteria
Population	Families of young people (10-24 years) who self-harm.	Young people who self-harm due to intellectual disabilities or other behaviors (e.g. eating disorder, substance abuse)
Phenomenon of Interest	Impact, experiences, perspectives, needs, and difficulties.	Primarily focusing on aspects other than the detailed analysis of families' experiences and needs in the aftermath of a young person's self-harm behavior.
Context	Self-harm	Cases of fatal suicidal behavior or suicide ideation.
Design	Primary research studies of a qualitative, quantitative, or mixed-method nature.	
Consulted sources	International databases recognized for their high-quality standards	Grey literature; and unpublished studies, reviews, and studies that do not fall into the research category (e.g. study protocols, editorials, theses, conference abstracts).
Language	English, Portuguese, French, and Spanish	
Time frame	Since 1980	
Setting	No restrictions	

Table 1. Inclusion and exclusion criteria following the PICo approach

2.2.4. Search strategy and information sources

The studies were searched in the following bibliographic databases: PsycINFO, PubMed/MEDLINE, Scopus, and Web of Science. A search string using keywords/Medical Subject Headings (MeSH) was developed around four key concepts: self-harm; family; experiences; and young people (see **Appendix A**). Additional searches were conducted before the final analysis to identify any further studies for inclusion. **Table 2** below illustrates the search strategy for each concept.

Concepts	Search Strategy
<i>Self-harm</i>	“Self Injurious Behavior” OR “Intentional Self Injur*” OR “Intentional Self Harm” OR “Self Destructive Behavior” OR “Deliberate Self Harm” OR “Self Injur*” OR “Self Harm” OR “Non-suicidal Self Injur*” OR “Suicide Attempt*” OR “Parasuicide” OR “Self-mutilation” OR “Suicide Survivor” OR “Suicid* Behavior”
<i>Family</i>	AND (famil* OR career OR caregiver* OR “informal caregiver*” OR parent* OR mother OR father OR sibling* OR grandparent*)
<i>Experiences</i>	AND (experiences OR impact OR perspectives OR needs OR difficulties OR views)
<i>Young People</i>	AND (youth OR adolescent* OR teenager* OR child* OR “young adult*” OR “young people” OR “young person*” OR “young individual” OR “emerging adult*” OR son* OR daughter* OR grandchild* OR sibling*)

Table 2. Search strategy

2.2.5. Study screening and selection

The selection studies began by extracting the search results using the Mendeley® reference manager. Duplicate studies were removed through Mendeley's automatic duplicate detection process. The selection took place in three phases:

1. **Screening of titles and abstracts:** The process of selecting eligible studies was illustrated using the PRISMA flow diagram (PRISMA, 2020). One author (BD) read the titles and abstracts of the identified studies to assess their relevance and compliance with the predetermined inclusion criteria (Centre for Reviews and Dissemination [CRD], 2009). Articles that were not related to the subject of our research or did not meet the inclusion requirements were excluded.
2. **Full-text selection:** The full text of studies that appeared to meet the inclusion criteria was reviewed when a definitive decision could not be made based solely on the title and/or abstract (CRD, 2009). One author (BD) reviewed the full texts, while the second author (MB) verified the accuracy of the decisions made. Any discrepancies were resolved through discussion. Study authors were contacted if it was necessary to clarify information or obtain the full text of an article.
3. **Forward tracking references (FTR):** The bibliographic references of the studies included in the systematic review were analyzed manually to identify potentially relevant studies not detected by electronic searches.

2.2.6. Data extraction

The study characteristics and key findings from the included studies were compiled in a Microsoft Office Excel™ spreadsheet through the following data items: Author, year, and country; study design; family members characteristics; youth demographics; self-harm concept; data collection; formal resources/setting; objective(s); experiences; needs; and barriers.

2.2.7. Study risk of bias assessment

The MMAT (Hong et al., 2018) was employed to assess the quality of the included studies. The tool allows for the concurrent critical appraisal of quantitative, qualitative, and mixed-methods primary research within mixed-methods systematic reviews (Hong et al., 2018).

The MMAT applies five criteria specifically tailored to five study design types: qualitative, quantitative randomized controlled trials, quantitative non-randomized, quantitative descriptive, and mixed-methods studies (Hong et al., 2018).

Each study is assigned an overall quality score by dividing the number of positive criteria met by 5 (Hong et al., 2018). Quality scores range from 20% (*; Low), representing one criterion met, to 100% (****; High), where all are met, based on a system adapted from Pearce et al. (2022). Quality scores were independently assigned by one author (BD) using the MMAT checklist (see **Appendix C**), with the second author (MB) verifying accuracy of the decisions made. Any discrepancies were resolved through discussion. No studies were excluded based on quality.

2.2.8. Synthesis

The heterogeneity of the studies prevented the performance of meta-analyses. For the quantitative studies, we performed a narrative synthesis focusing on the experiences and needs of the families of young people who self-harm.

The qualitative analysis employed a thematic synthesis approach as outlined by Thomas and Harden (2008). This method was chosen for its ability to provide an in-depth and systematic analysis of qualitative data. It involves three stages: (1) coding text line-by-line; (2) developing descriptive themes; and (3) generating analytical themes.

The NVivo 14® software was used for the qualitative analysis. Following Egan et al. (2022) and Ludvigsen et al. (2016), we were “third-order interpreters”, and data extracts were included from participants “first-order interpreters” and observations by authors (“second-order interpreters”).

An inductive coding approach was applied resulting in a total of 70 primary codes, derived from identified similarities and patterns within the data in the results section of the eligible studies, and 823 data extracts (stage one). These primary codes contributed to the generation of 26 descriptive themes (stage two; see **Appendix D**). The final analysis consisted of themes and subthemes within these, representing the analytical themes, which will be presented below (stage three). The analytical themes were discussed and agreed upon by both authors.

References follow APA 7th edition; however, citations in the results section are numbered according to the IDs in **Table 3** for easier reading.

2.2.9. Confidence in the evidence: The GRADE-CERQual approach

One author (BD) used the GRADE-CERQual approach to assess the confidence in the findings for each theme of the qualitative evidence synthesis. The second author (MB) verified the accuracy of this assessment, and any discrepancies were resolved through discussion. The evaluation was based on four components: (1) methodological limitations, (2) coherence, (3) adequacy of data, and (4) relevance. The GRADE-CERQual approach results in a final classification of confidence in each theme, categorized as “high”, “moderate”, “low” or “very low” (Lewin et al., 2018; See **Appendix E**).

2.2.10. Ethics and Dissemination

As this study involves a secondary analysis with no primary data collection, it did not require ethical approval from the Ethics Committee. The findings of this study aim to contribute by (1) enhancing understanding of the impact, experiences, and needs of families affected by young people who engage in self-harm, (2) facilitating the development of a tailored manual guide for parents and caregivers, offering practical strategies to address their experiences and challenges.

CHAPTER 3: RESULTS

The systematic search process, detailed in **Appendix B** and illustrated in the PRISMA 2020 flow diagram below (see **Figure 1**), began with a systematic search across the databases that identified 3903 potentially relevant studies. After removing 2016 duplicates, the remaining 1887 articles underwent screening based on titles and abstracts. Subsequently, 62 full-text articles were assessed for eligibility, with 36 excluded for not meeting the inclusion criteria.

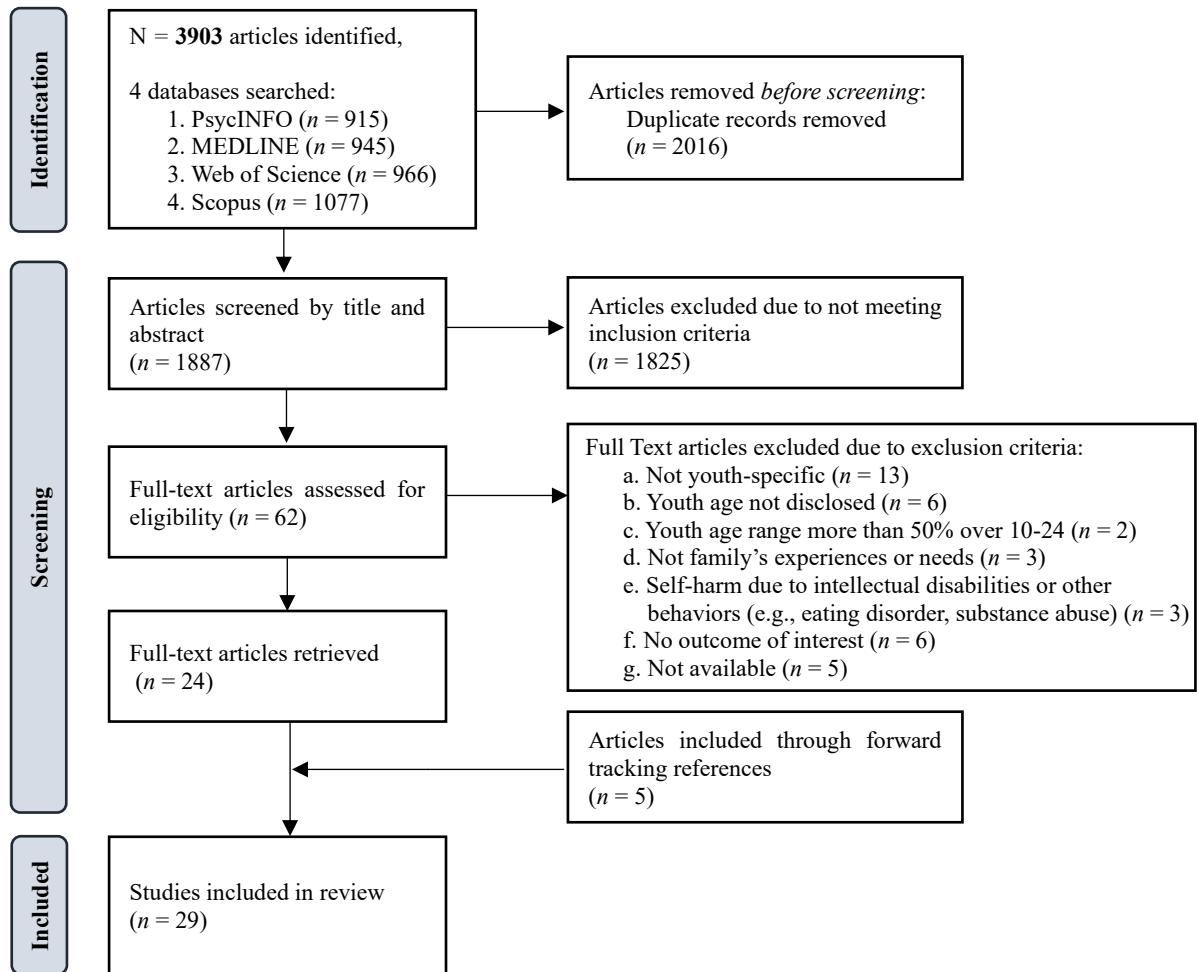


Figure 1. PRISMA 2020 flow diagram (adapted from Page et al., 2021)

The reasons for exclusion were categorized as follows: **(a)** Not youth-specific ($n = 13$); **(b)** Youth age not disclosed ($n = 6$); **(c)** Youth age range more than 50% over 10-24 ($n = 2$); **(d)** Not family experiences or needs ($n = 2$); **(e)** Self-harm due to Intellectual disabilities/Other behaviors (e.g. eating disorders, substance abuse) ($n = 3$); **(f)** No outcome of interest ($n = 6$); **(g)** Not available ($n = 5$). Efforts to obtain the full text of unavailable articles were mostly unsuccessful, except for one.

To ensure comprehensive inclusion without compromising quality, we adopted the criteria outlined by Rheinberger et al., (2023) for the abovementioned (c) criteria. This approach allowed for the inclusion of studies involving youth participants outside the designated age range of 10-24 years, provided these additional age groups did not exceed 50% of the sample within 10 to 24 years. As a result, 5 additional articles met our inclusion criteria. This process resulted in 24 articles being selected.

Additionally, 5 studies were included through forward tracking of references from the included studies, resulting in a final sample of 29 articles.

3.1. Study characteristics

The systematic review included 29 studies, comprising 3 quantitative studies, 3 mixed-methods studies, and 23 qualitative studies. Quantitative data were primarily collected through self-report measures ($n = 6$) and qualitative data were obtained through semi-structured interviews ($n = 17$), in-depth semi-structured interviews ($n = 2$), semi-structured narrative interviews ($n = 2$), unstructured interviews ($n = 2$), in-depth narrative interview ($n = 1$), and conversational interview ($n = 1$).

Studies were conducted in the United Kingdom ($n = 7$), Australia ($n = 6$), China ($n = 6$), United States of America ($n = 4$), France ($n = 2$), Canada ($n = 1$), Denmark ($n = 1$), Germany ($n = 1$), Portugal ($n = 1$), and Sweden ($n = 1$); across a range of settings: community settings ($n = 13$), psychiatry settings ($n = 11$), general hospital settings ($n = 3$), and pediatric settings ($n = 2$). The publications spanned from 2005 to 2024, with the following distribution: 4 articles from 2005 to 2008, 2 articles from 2011 to 2015, 8 articles from 2016 to 2019, and 15 articles from 2020 to 2024.

The sample ranged from 10 to 65 years and comprised mothers ($n = 613$), fathers ($n = 155$), foster parents ($n = 3$), siblings ($n = 74$), and grandmothers ($n = 7$) of young individuals who engaged in self-harm ($n = 867$).

The quality of the included studies was predominantly rated as medium-high ($n = 12$; 80%), followed by high ($n = 11$; 100%), medium ($n = 5$; 60%), and medium-low ($n = 1$; 40%). Several issues contributed to studies not meeting all the criteria: (a) small sample size ($n = 5$); (b) incomplete outcome or missing data ($n = 5$); (c) lack of methodological detail ($n = 3$); (d) inappropriate methods ($n = 2$); (e) confounders not accounted ($n = 1$).

A summary of the study's characteristics and key findings can be found in **Table 3**.

Table 3. Summary of included studies ($n = 29$)

ID	Author, Year; Country	Sample		Data Collection	SH Concept	Formal Resources/ Setting	Objective	Main Results			MMAT Score
		Family Members	Youth					Experiences	Needs	Barriers	
<i>Quantitative Studies</i>											
1	Czyz et al. (2018); USA	N = 162 Mothers ($n=129$) Fathers ($n=27$) Grandm ($n=4$) Guardians ($n=2$)	N = 165 Females ($n=93$) Males ($n=69$) Age _{range} = 13-17 Age _{mean} = 15.41	Self-report measures	SA	Psychiatric Emergency Department Services	To investigate parents' perceptions of self-efficacy in engaging in suicide prevention activities and to explore the association between parental self-efficacy and youth suicide-related outcomes.	Parents endorsed high self-efficacy in engaging in suicide prevention activities. However, they reported low confidence in their ability to identify suicide warning signs, communicate effectively, obtain the teen's commitment to refrain from suicide, encourage their teen to cope, and keep them safe to prevent future SAs.	* Parents may benefit from additional education, support and outreach.	* Low parental confidence in their ability to keep the child safe could undermine their efforts to implement suicide prevention strategies.	Medium High (****)
2	Greene Palmer et al. (2015); USA	N = 130 Mothers ($n=81$) Fathers ($n=49$)	N = 85 <i>Gender not reported</i> Age _{range} = 13-18 Age _{mean} =	Self-report measures	SA	Private Psychiatric Hospitals	To examine parental reactions to adolescents' SA and the association of reactions with future suicidal self-directed violence.	From pre- to post-attempt, mothers reported increased feelings of sadness, caring, anxiety, guilt, fear, and being overwhelmed; fathers reported increased feelings of sadness, anxiety, and fear.	* A psychoeducation program focusing on emotional reactions, communication skills, and understanding youth depression and suicidal behaviors.	* Parents lack understanding of self-harm.	Medium (***)
3	Tschan et al. (2019); Germany	N = 73 Sisters ($n=44$) Brothers ($n=29$) Age _{range} = 10-28 Age _{mean} = 16.88	N = 139 <i>Gender not reported</i> Age _{range} = 13-20 Age _{mean} = 16.18	Self-report measures	NSSI	Child and Adolescent Psychiatric Inpatient Clinics	To examine the sibling relationship quality of adolescents (1) with NSSI, (2) with other mental disorders without NSSI, and (3) without current or past experience of mental disorders.	Siblings reported negative emotional and familial consequences, such as feeling isolated with their sister's issues or a distressing family situation, after their sister's NSSI. They experienced more coercion in their relationship compared to the other siblings groups from the study.	Siblings expressed an need for help to better cope with their sister's NSSI.	Siblings felt alone with their sister's issue and experienced a lack of understanding.	Medium High (****)

Table 3. Continued

ID	Author, Year; Country	Sample		Data Collection	SH Concept	Formal Resources/ Setting	Objective	Main Results			MMAT Score
		Family Members	Youth					Experiences	Needs	Barriers	
<i>Mixed-Methods Studies</i>											
4	Kelada et al. (2016); Australia & USA	N _{Study 1} : 16 Mothers (n=15) Father (n=1) Age _{range} = 36-56 Age _{mean} = 45.44 N _{Study 2} : 22 Mothers (n=18) Father (n=14)	N _{Study 1} : 16 Females (n=10) Males (n=6) Age _{range} = 14-17 Age _{mean} = 15.38 N _{Study 2} : 22 Females (n=19) Males (n=3) Age _{range} = 15-24	Self-report survey (w/ open-ended questions) Semi-structured interviews	NSSI	Community	To assess the impact SH has on parent health, parent responses, and interactions with professional help.	Parents suffered emotional and psychological symptoms, lacked knowledge about NSSI, and underestimated its severity. They lost trust, became hypervigilant, lived in fear, and felt emotionally unequipped to help. Negative experiences with healthcare professionals were also reported.	Parents need professionals to be empathetic and nonjudgmental toward adolescents engaging in NSSI, to receive better training in NSSI, and to provide feedback about their child's progress in treatment. A need for services that offer follow-up was also reported.	Difficulties in finding a professional specialized in NSSI treatment.	Medium Low (**)
5	Townsend et al. (2021); Australia	N = 37 Mothers (n=34) Fathers (n=2) Foster Carer (n=1) Age _{mean} = 45.70	N = 37 <i>Gender not reported</i> Age _{range} = 12-18 Age _{mean} = 16.89	Self-report survey (w/ open-ended questions)	SH	Community	To understand how parent stress response styles to their child's self-harm affect their well-being and functioning and the wider family.	Parents experienced significant distress and functional impairment. They face distress and fear, coupled with hypervigilance, anticipatory dread, and a decline in their mental health. Family dynamics changed, with members becoming hypersensitive to the child.	Parents request support to maintain their mental health.	Access to mental health support for themselves.	High (****)
6	Townsend et al. (2023); Australia	N = 37 Mothers (n=34) Fathers (n=2) Foster Carer (n=1)	N = 37 Female (n=28) Male (n=9) Age _{range} = 12-18 Age _{mean} = 15.41	Online survey (open-ended questions) Semi-structured interviews	SH	Community	To understand the experiences of parents supporting and seeking help for their child who is self-harming within the family context.	Parents reported a range of initial feelings and responses, including distress, shock, anger, and confusion while also trying to remain calm. They continue to experience feelings of helplessness, misunderstanding and uncertainty where to seek help.	Parents need health professionals to provide appropriate referrals, meaningfully connect and validate their experiences, work collaboratively, include them in the process, and offer education, as well as practical and psychological support that is affordable and accessible. They also want parent support groups.	Parents face difficulties in finding appropriate support for their child, along significant financial and time burdens.	Medium High (****)

Table 3. Continued

ID	Author, Year; Country	Sample		Data Collection	SH Concept	Formal Resources/Setting	Objective	Main Results			MMAT Score
		Family Members	Youth					Experiences	Needs	Barriers	
<i>Qualitative Studies</i>											
7	Boussat et al. (2022); France	N = 13 Mothers (n=8) Fathers (n=5)	N = 10 Female (n=8) Male (n=2) Age _{range} = 11-17 Age _{mean} = 14.70	Semi-structured interviews	SA	Adolescent Psychiatry Departments	To analyze the experience of parents after the suicidal attempt of their adolescent.	After being informed of their child's SA, parents felt deep sadness and initial distress as part of the grieving process regarding their self-image as idealized parents. They felt anger toward their child, the wider family, and the healthcare professionals/system. Given the uncertainty, they doubted their educational, caring, and empathy skills.	Parents expressed the need for support in understanding and managing the suicide risk, dealing with the emotional turmoil they felt, and reinforcing their competencies as carers to keep their children safe.	Parents reported a lack of communication from healthcare professionals and perceived the health system as ineffective and unhelpful.	High (****)
8	Daly (2005); Canada	N = 6 Mothers (n=6) Age _{range} = 32-45	N = 6 Gender not reported Age _{range} = 12-16	Unstructured interviews	SB	Paediatric Health facility	To describe the experiences of mothers living with suicidal adolescents.	Mothers reported feelings of failure as good mothers, doubting their parenting skills. They felt rejected and lost trust due to the multiple SB repetitions. They constantly lived in fear, feeling alone, helpless, and powerless, experiencing multiple losses and anticipatory grief.	Mothers reported needing to be hypervigilant about their children's safety and expressed a need for a compassionate understanding from health professionals.	Mothers reported the stigma of suicide and the accompanying callous and hurtful remarks, as well as a lack of understanding and knowledge from others.	Medium High (****)
9	de Miranda Trinco et al. (2017); Portugal	N = 38 Mothers (n=34) Fathers (n=4)	N = 38 Gender not reported Age _{range} = 13-18 exclusive	Semi-structured interviews	SH	Paediatric Hospital	To identify the experiences and needs of parents of adolescents who self-harm were admitted to the emergency department of a pediatric hospital.	Parents expressed ambivalent emotions, describing sadness, suffering, worry, pain, disorientation, despair, and apathy. However, they also saw this as a potential opportunity to resolve the situation.	They desired to speak with a nurse about what was happening and sought guidance on how to handle their child, but, above all, they wanted to avoid feeling criticized and stigmatized.	Lack of information and emotional support.	High (****)
10	Dempsey et al. (2019); Australia	N = 8 Mothers (n=7) Fathers (n=1) Age _{range} = 46-56 Age _{mean} = 52.50	N = 8 Gender not reported Age _{range} = 15-25 Age _{mean} = 20.50	Semi-structured interviews	SH	Youth Mental Health Clinic	To explore clinician and caregiver reflections regarding YMC service provision for caregivers of young people attending the clinic.	Caregivers experienced emotional turmoil, anxiety, guilt, shame, and isolation. They felt unskilled to manage suicide risk and struggled with communication and setting boundaries. Balancing caregiving with personal life was challenging, with concerns over the deterioration of family relationships.	Caregivers sought more information, specific to their child's needs, as well as greater support and guidance in managing the young person's safety.	Barriers to obtain information included service resource limitations, the complexity of the caregiver needs, and confidentiality.	Medium High (****)

Table 3. Continued

ID	Author, Year; Country	Sample		Data Collection	SH Concept	Formal Resources/ Setting	Objective	Main Results			MMAT Score
		Family Members	Youth					Experiences	Needs	Barriers	
11	Ferrey et al. (2016); United Kingdom	N = 37 Mothers (n=32) Fathers (n=5)	N = 35 Female (n=29) Male (n=6) Age _{range} = 14-28 Age _{mean} = 19.40	In-depth interviews	SH	Community	To explore how the discovery of a child's self-harm affects parenting behavior.	After discovering a child's SH, family dynamics and parenting strategies often changed, with adjustments in support, control, and monitoring of the child.	Parents need information about the nature of SH and guidance on possible parenting strategies to manage it. The need for forums or peer support groups was also expressed.	Parents reported difficulties in obtaining referrals to mental health professionals and experienced long waiting times for services.	High (****)
12	Ferrey et al. (2016); United Kingdom	N = 37 Mothers (n=32) Fathers (n=5)	N = 35 Female (n=29) Male (n=6) Age _{range} = 14-28 Age _{mean} = 19.40	Semi-structured narrative interviews	SH	Community	To explore the effects of a young person's self-harm on parents and family and to generate information to aid them in providing care.	Parents felt emotional turmoil, and social isolation. Siblings were often upset, and balancing caregiving with work was challenging, yet they remained hopeful for their child's future.	Parents need information about SH, what to expect, and contact with other parents whose children have also self-harmed.	Parents may neglect other children due to the lack of time and resources. They also reported financial strains due to the costs associated with their child's care.	High (****)
13	Fu et al. (2020); China	N = 20 Mothers (n=16) Fathers (n=4)	N = 20 Female (n=17) Male (n=3) Age _{range} = 12-18 Age _{mean} = 14.20	In-depth semi-structured interviews	NSSI	Child Psychiatric Ward of a Tertiary Hospital	To investigate the parents' attitudes toward and perceptions of adolescents who have engaged in NSSI behaviors, and the impact on their parents.	Parents lack knowledge about SH and its treatment, leading to significant emotional stress. After learning about it, they altered their parenting and communication styles out of fear of repeated SH. They also faced financial burden.	* Need to increase parents' knowledge about SH and its treatment and to encourage seeking professional support.	Some parents feared receiving negative reactions when seeking help, as well as concerns about disrupting academic achievement, employment, and marriage prospects.	Medium High (****)
14	Fu et al. (2021); China	N = 15 parents Mothers (n=11) Fathers (n=4)	N = 15 Gender not reported Age _{range} = 12-18 Age _{mean} = 14.20	In-depth semi-structured interviews	SRB	Psychiatric Departments	To explore parents' and the front-line medical staff's experience of an adolescent with suicide-related behaviors admitted to the psychiatry department of a general hospital in China.	Parents expressed doubt and dissatisfaction with hospitalization treatments. They reported that medical staff were often too busy to communicate effectively, perceived inequalities in treatment, and were concerned about medication side effects and challenges in accessing mental health services.	Parents desired an increase in psychotherapy as part of the treatment plan and wanted medical staff to communicate more effectively with their children.	Lack of professional mental healthcare institutions in their area of residence and the lack of social recognition and acceptance of psychiatric patients.	Medium High (****)

Table 3. Continued

ID	Author, Year; Country	Sample		Data Collection	SH Concept	Formal Resources/ Setting	Objective	Main Results		Barriers	MMAT Score
		Family Members	Youth					Experiences	Needs		
15	Griffiths et al. (2023); <i>United Kingdom</i>	N = 5 Mothers (n=3) Fathers (n=2) Age _{range} = 36-65 Age _{mean} = 52.40	N = 6 Female (n=5) Male (n=1) Age _{range} = 14-17 Age _{mean} = 16.33	Semi-structured interviews	SH	Children and Young People's Mental Health Services	To understand the views of CYP, parents, and staff on how staff should respond to incidents of self-harm carried out by CYP in mental health inpatient settings.	Parents expressed distress over their children's SH and concerns for their immediate safety. They reported feeling frustrated by access implements used for SH, as well as the apparent reluctance of staff to remove these items.	Parents expressed the need to substantially lower the threshold for implementing restrictive interventions to ensure their children's immediate safety. They also require a caring, empathetic approach towards their children.	Gaps between parents' and staff's agreement on the appropriate threshold for using restrictive interventions, along with inadequate communication between the two parties.	Medium (***)
16	Juel et al. (2023); <i>Denmark</i>	N = 21 Mothers (n=17) Fathers (n=4) Age _{range} = 40-60	N = 21 Female (n=18) Male (n=3) Age _{range} = 10-25	Semi-structured interviews	SB	Suicide Preventing Clinics and Centers for Child and Adolescent Psychiatry.	To explore how parents re-constructed and negotiated their parental identity after realizing that their offspring was suicidal.	The offspring's SH significantly impacted the parents' sense of identity. All parents went through a stage of disrupted parental identity; some were able to rebuild this identity through social interactions, while others struggled to do so.	Parents described the need to adjust their parenting approaches.	Administrative delays within the system. Perception of professionals ignoring their insights and not involving them.	High (****)
17	Krysinska et al. (2020); <i>Australia</i>	N = 19 Mothers (n=16) Fathers (n=3)	N = 19 <i>Gender not reported</i> Age _{range} = 12-25	Semi-structured interviews	SH	Community	To explore the experiences of parents of a young person who self-harms and their psycho-educational needs.	When confronted with SH, parents often struggle with their distress and feel ill-equipped to provide the necessary support for their adolescents. SH can also lead to changes in the adolescent-family relationship.	Parents voiced the need for psychoeducation on SH and its management, as well as a desire for peer support and self-care strategies.	Gaps in available information resources, noting that they are often difficult to access or do not meet their needs.	Medium High (****)
18	Lantto et al. (2023); <i>Sweden</i>	N = 17 Mothers (n=13) Fathers (n=3) Foster P. (n=1) Age _{range} = 38-60 Age _{mean} = 48.00	N = 17 Female (n=13) Male (n=3) Age _{range} = 14-18	Semi-structured interviews	SH	University Hospital, Inpatient Clinic	To explore parents' lived experiences of their teenagers' use of BAs and elucidate the essential meaning of the BA phenomenon for the parent.	Parents experience heightened vigilance, chronic stress, fear, and a constant state of preparedness to respond to crises. Feelings of anxiety, despair, and hopelessness are prevalent among parents and siblings. They also feel profound loss and distrust toward the psychiatric system, perceiving it as inadequate and lacking proper care.	Parents expressed a need for professionals to communicate openly, transparently, and collaboratively, validating their concerns and efforts to keep their children safe. They seek inclusion in their child's care and assistance in balancing boundaries with openness.	Parents perceive that professionals often do not involve them in the care process or community-based alternatives to inpatient psychiatry.	High (****)

Table 3. Continued

ID	Author, Year; Country	Sample		Data Collection	SH Concept	Formal Resources/ Setting	Objective	Main Results			MMAT Score
		Family Members	Youth					Experiences	Needs	Barriers	
19	Mcdonald et al. (2007); Australia	N = 6 Mothers (n=6)	N = 8 Female (n=6) Male (n=2) Age _{range} = 12-21	Conversational interviews	SH	Community	To examine the experiences of mothers dealing with self-harming adolescents and how it affects their well-being and of their families.	Mothers felt intense guilt and shame over their children's SH, often attributing it to family events or relationship issues. They became hypervigilant, and experienced embarrassment and isolation. They struggled with neglecting their roles at home and work while caring for their child.	Mothers need healthcare providers to normalize their feelings of guilt and shame and consider their well-being. They expressed a need to understand self-harm, support strategies, and access to judgment-free support groups.	Work and financial strain, as well as guilt and shame, isolated mothers from traditional support networks of family and friends.	Medium High (****)
20	Oldershaw et al. (2008); United Kingdom	N = 12 parents Mothers (n=9) Fathers (n=2) Grandm (n=1)	N = 12 Female (n=12) Age _{range} = 13-18 Age _{mean} = 14.83	Semi-structured interviews	SH	Community Child and Adolescent Mental Health Service	To explore the perspective of parents related to health service provision, making sense of self-harm, its impact, their skills as carers, and hope for the future.	Parents often noticed signs of SH, experienced emotional turmoil, and struggled to understand the reasons behind it. Awareness of self-harm led to altered parenting styles, such as becoming hypervigilant, and posed challenges in balancing the needs of their child with their personal life. However, some parents felt this strengthened the parent-child relationship.	Parents expressed a need for accessible support services for both their child and the family, as well as improved communication with schools and healthcare providers.	Negative or dismissive responses from external agencies can delay or hinder parents from seeking timely help.	High (*****)
21	Qin et al. (2023); China	N = 18 parents Mothers (n=16) Fathers (n=2) Age _{range} = 34-55 Age _{mean} = 44.94	N = 18 Female (n=15) Male (n=3) Age _{range} = 13-18 Age _{mean} = 14.94	Semi-structured interviews	NSSI	Mental Health Center of a Tertiary Hospital	to investigate the perspectives of parents of adolescents with repeated non-suicidal self-injury on sharing their caretaking experiences with peers as well as the motivations for and barriers to this behavior	Parents experienced initial negative emotions, a low sense of self-identity, and viewed themselves as failures. They recognized the importance of manage emotions by focusing on understanding rather than punitive measures and fostering a supportive family environment. Sharing experiences with others provided support and alleviated isolation.	Parents reported a need to reflect on SH, manage their negative emotions, diversify the support of the whole family, and emotionally communicate their experiences with peers.	Barriers to sharing included inadequate knowledge, a low sense of self-identity, and concerns for children's negative attitudes.	High (*****)
22	Raphael et al. (2006); United Kingdom	N = 9 Mothers (n=5) Fathers (n=4)	N = 7 Female (n=4) Male (n=1) Age _{range} = 17-24 Age _{mean} = 18.67	In-depth Unstructured interviews and biographical accounts	DSH	Emergency Medical Unit	To understand parents' concerns, expectations and experiences following an episode of deliberate self-harm in young people to identify their support needs.	Parents reported deep distress and feelings of helplessness. They were concerned about coping with their child after discharge and were worried about future recurrence.	Parents need support and information to understand and accept SH and to provide appropriate care.	Barriers to seeking help included fear of stigma and a lack of advice and information.	Medium High (****)

Table 3. Continued

ID	Author, Year; Country	Sample		Data Collection	SH Concept	Formal Resources/ Setting	Objective	Main Results			MMAT Score
		Family Members	Youth					Experiences	Needs	Barriers	
23	Rose et al. (2011); United Kingdom	N = 5 Mothers (n=5) Age _{range} = 41-52 Age _{mean} = 45.80	N = 5 Female (n=5) Age _{range} = 15-16	Semi-structured interviews	SH	Children and Adolescent Mental Health Services	To explore how parents experience their relationships with services following an episode of their child's self-harm.	Mothers reported self-blame and shame, questioning their competence and anticipating scrutiny from mental health professionals. The feelings of shame and blame led to exclusion and isolation, worsened by professionals withholding knowledge due to confidentiality requirements. They felt frustrated and inadequate in their roles.	Mothers expressed a need to know more information and greater inclusion in the care process.	Barriers included a sense of exclusion from services, lack of communication, knowledge sharing, scrutiny and judgment from professionals, and social stigma.	Medium High (****)
24	Spiers et al. (2020); France	N = 15 Mothers (n=9) Fathers (n=6)	N = 11 Female (n=10) Male (n=1) Age _{range} = 14-18 Age _{mean} = 15.67	Semi-structured interviews	DSH	Adolescent Psychiatry Departments	To explore the function of self-harm in parent-adolescent relationships.	Parents described their child's SH as "extremely violent" upon discovery. They experienced shock, helplessness, sadness, anxiety, guilt, and anger towards their child and third parties (such as education/healthcare institutions or even potential attackers). They reported a profound reorganization of the family with material and psychological protection.	Parents need rational explanations for SH behaviors.	Parents reported communication barriers with their adolescents and felt that the school did not listen or act quickly enough.	High (****)
25	Stewart et al. (2018); United Kingdom	N = 37 Mothers (n=32) Fathers (n=5)	N = 35 Female (n=29) Male (n=6) Age _{range} = 14-28 Age _{mean} = 19.40	Semi-structured narrative interviews	SH	Community	To explore parents' experiences of treatment and support for the young person and themselves.	Parents felt unprepared to care for a young person following self-harm and appreciated support in navigating this unfamiliar world.	Parents need nonjudgmental professionals, who take SH seriously and engage sincerely with their children. They require prompt access to intensive help, involvement in care, practical strategies, and peer support.	Access to intensive care was often delayed and appointments were difficult to arrange. Parents perceived that the GP as judgmental toward their child.	Medium High (****)
26	Wang et al. (2022); China	N = 24 Mothers (n=18) Fathers (n=6) Age _{mean} = 42.50	N = 24 Female (n=21) Male (n=3) Age _{range} = 12-18 Age _{mean} = 15.00	Semi-structured interviews	NSSI	Child and Adolescent Psychiatric Ward	To explore parents' cognition, behaviors, and adolescent-parent reciprocal interaction during repeated NSSI.	Initially, parents perceived SH as a manifestation of puberty, a way of meeting needs, or a coping strategy, but gradually realized that it required psychological assistance. Parents' coping behaviors were divided into 4 stages: denial, dissuasion, reflection and adaptation, and teamwork.	* Need for increasing parents' awareness of SH and overcoming stigma.	Parents reported a lack of knowledge about SH and how it should be treated.	Medium Low (**)

Table 3. Continued

ID	Author, Year; Country	Sample		Data Collection	SH Concept	Formal Resources/ Setting	Objective	Main Results		Barriers	MMAT Score
		Family Members	Youth					Experiences	Needs		
27	Wang et al. (2024); China	N = 15 Mothers (n=8) Fathers (n=4) Grandm (n=2) Sister (n=1) Age _{range} = 28-65	N = 15 Females (n=11) Males (n=4) Age _{range} = 12-19	Semi-structured interviews	SA	Psychiatric Hospital	To explore the information needs of family caregivers of adolescents who have attempted suicide.	Family caregivers experience complex negative emotions upon learning about a teenager's SH. Throughout the caregiving process, they faced numerous challenges, with A noticeable lack of external support.	* Efforts should be made to provide education on various coping mechanisms and support strategies, as well as assist them in better understanding how to manage the stress and challenges of caregiving.	Communication barriers.	High (*****)
28	Wang et al. (2024); China	N = 21 Mothers (n=16) Fathers (n=5) Age _{range} = 35-60 Age _{mean} = 42.60	N = 21 Females (n=16) Males (n=5) Age _{range} = 10-19	Semi-structured interviews	NSSI	Tertiary Psychiatric Specialized Hospital	To gain insights into the internal experiences of parents while caring for their adolescents with NSSI during the social isolation of the COVID-19 pandemic.	Parents of adolescents dealing with SH during the COVID-19 pandemic underwent different internal experiences, which could be classified into four themes: negative experience, high caregiving burden, lack of caregiving capacity, and resilience.	They expressed a desire for professional help to better understand and cope with their adolescent patients and to prevent the recurrence of the behavior.	Stigma attached to the illness, lengthy treatment programs, lack of care due to inadequate staffing, and financial burdens were significant challenges.	Medium Low (**)
29	Weissinger et al. (2023); USA	N = 18 Mothers (n=16) Father (n=1) Grandm (n=1) Age _{mean} = 48.00	N = 18 Females (n=9) Males (n=7) Non-binary (n=2) Age _{range} = 12-18 Age _{mean} = 14.10	Semi-structured interviews	SA	Community	To understand parents' experience of adolescent suicide crises and its impact on themselves and the family system.	Parents experienced these events as traumatic, with feelings of helplessness and failure damaging their sense of self. They endured long periods of fear and loneliness. Conversely, they also found the potential for healing and growth through reconnection and healing within and outside the family system.	Parents expressed the need for a support network of others facing similar issues and a "mental health doula" to help them during the initial weeks.	Social support.	Medium Low (**)

Note:

* **Quality Control [MMAT Tool]:** (*****) – High; (***) – Medium High; (***) – Medium; (**) – Medium Low; (*) – Low

** **Author, Year; Country:** USA – United States of America

*** **Sample:** Grandm – Grandmother; Foster P. – Foster Parents

**** **Self-harm Concept:** DSH – Deliberated Self-Harm; NSSI – Non-suicidal Self-Injury; SA – Suicide Attempt; SRB – Suicide-Related Behaviors; SH – Self-Harm

***** (*) - The study's authors identified the summarized needs/barriers; the sample did not directly express them

3.2. Quantitative data findings

Theme 1. Self-harm Repercussions in the Family

Quantitative data demonstrate that self-harm affects family emotional well-being and life [1-6]. Townsend et al. [5], found that two-thirds of parents were likely to have mental ill-health according to the MHI-5. Parents often experience intense negative emotions, distress and functional impairment upon discovering self-harm [1, 5]. Similarly, Tschan et al. [3], reported that siblings experience distress, sadness, desperation, helplessness, and anger.

Relationship dynamics within families often suffer [1-3, 5]. Greene-Palmer et al. [2] suggested that self-harm may function to increase positive emotions among parents (attachment theory; Bowlby, 1980) and reduces parental anger (family coercion theory; Patterson, 1982). Siblings reported feeling isolated in managing their sister's self-harm and reported a relationship ruled by their sibling's dominance, control, and lower boundary maintenance [3].

Families frequently struggled to understand self-harm [3-4] and have concerns about their coping abilities and the potential for recurrence [1, 3]. Additionally, some parents lack confidence in their ability to ensure their child's safety [1].

Theme 2. Support and Being Supported

Family members play a critical role in providing emotional and practical support for young people who self-harm [1, 3]. Nonetheless, they also face challenges and require support themselves [1-2, 4, 6].

A clear need for comprehensive psychoeducation and mental health support is expressed by both parents and siblings to better understand and cope with a young person's self-harm [1, 3, 6]. Townsend et al. [6], identified variability in support effectiveness: while services such as psychiatrists and private psychologists are generally viewed as helpful, others, like CAMHS and inpatient units, show mixed results. Greene-Palmer et al. [2] proposed that psychoeducation should include communication skills to reduce hostile comments and a program addressing depression and suicidal behaviors in adolescents. Additionally, Czyz et al. [1] also emphasized that parents would benefit from additional education, support, and outreach to improve how parents manage self-harm.

3.3. Qualitative data findings

The descriptive themes (see **Appendix D**) informed the generation of the following four analytical themes reported in **Table 1**: (1) Emotional and Psychological Burden; (2) Biographical Disruption and Parenting Shifts; (3) Impact on Family Dynamics; and (4) Seeking and Accessing Support.

Analytical Themes	Subthemes
<i>1. Emotional and Psychological Burden</i>	1.1. Emotional Distress and Trauma
	1.2. Anticipatory Grief and Overwhelming Sadness
<i>2. Biographical Disruption and Parenting Shifts</i>	2.1. Perceived Failure and Distrust in Parenting
	2.2. Safety Concerns and Changes in Parenting
	3.1. Balancing Caregiving with Life
	3.2. Impact on Partner Relations
<i>3. Impact on Family Dynamics</i>	3.3. Impact on Siblings
	3.4. Impact on Extended Family Relations
	4.1. Information and Practical Support
<i>4. Seeking and Accessing Support</i>	4.2. Prompt and Easy Access to Specialized Care
	4.3. Healthcare Professionals' Approach
	4.4. Emotional and Psychological Support for Families

Table 4. Analytical themes derived from the qualitative analysis

Figure 2 below provides a visual summary of the analytical themes and qualitative findings.

Theme 1: Emotional and Psychological Burden

This theme explores the emotional and psychological impact of a young person's self-harm on families. It encompasses two key subthemes: (1.1.) emotional distress and trauma, and (1.2.) anticipatory grief and overwhelming sadness (GRADE-CERQual confidence level: high).

1.1. Emotional Distress and Trauma

Parents often endure profound emotional distress when confronted with their young person's self-harm [4-7, 9-12, 15-20, 22, 24], frequently characterizing their experience as 'traumatic' [5, 12, 18, 22-23, 26-27, 29]. This distress manifests in diverse forms, including shock [4-7, 9-12, 15, 17, 20-23, 24, 26-27, 28], horror [4-5, 7, 12, 24, 29], panic [9, 11-12, 17, 23, 27] and anger [4-7, 11-12, 17, 20-23, 24, 26]. One mother mentioned [12]:

"At first, when you see these marks on your child's beautiful skin, you're just filled with every emotion that you can possibly think of - fear, anxiety, disbelief, anger and just not knowing what to do."

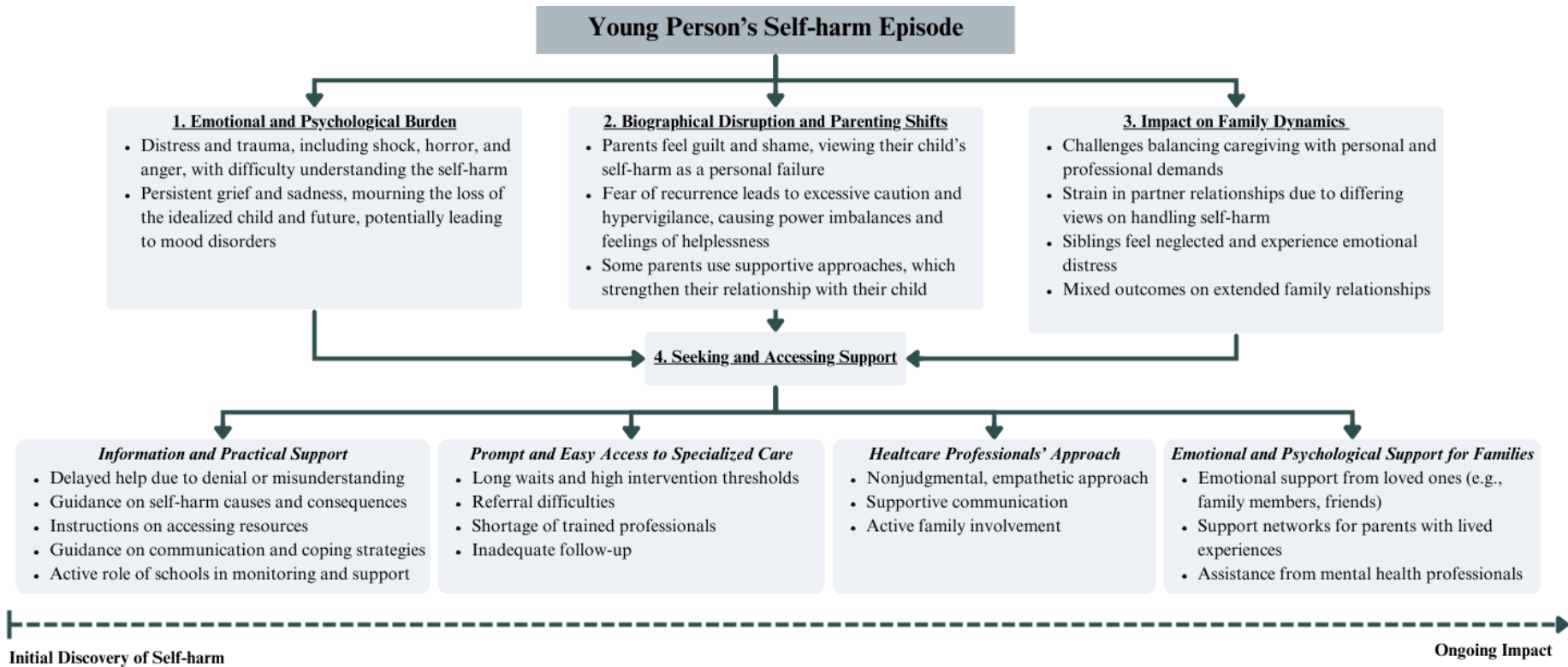


Figure 2. Visual summary of analytical themes and qualitative findings.

In this stage, there's also an urgent need to understand the underlying reasons for self-harm, yet many parents find themselves unable to do so, adding to their distress [7, 14, 17, 20, 24, 27-29].

1.2. Anticipatory Grief and Overwhelming Sadness

Parents often experience anticipatory grief [4-5, 7-9, 11, 16, 20, 22-24, 27, 29] when coping with their young person's self-harm, marked by feelings of devastation and insecurity. They mourn their idealized parental image, the child they once knew [8, 20], and the loss of a hopeful future [5, 8, 10, 13, 18, 27]. As one parent remarked [20]:

"She was the loveliest little girl. It's like erm a bereavement really because that person's not there anymore."

This grief is not a one-time event but a recurring, unresolved process that affects their mental health, in some cases, leading to mood disorders, including depression [4-5, 7, 9, 12-13, 22] and anxiety [4-5, 7-8, 10, 12, 22-23, 24, 27]. Few studies reported that the situation also led some parents to contemplate self-harm or experience a relapse [12, 16], or even to wish that their young person had never been born [7-8, 16]. One mother shared [8]:

"I even said to my husband, 'If only we had stopped at one...if only she had never been born. Imagine if we never had her? Wouldn't things be great? Wouldn't life be wonderful?' You're saying this and thinking what kind of mother am I? I hate my child, so I must be the worst mother."

Theme 2: Biographical Disruption and Parenting Shifts

This theme examines how a young person's self-harm alters parental biographical identity and parenting styles. It contains two key subthemes: **(2.1.)** perceived failure and distrust in parenting, and **(2.2.)** safety concerns and changes in parenting styles (GRADE-CERQual confidence level: high).

2.1. Perceived Failure and Distrust in Parenting

Parents often perceive a deep sense of failure [5, 7-9, 12, 16-17, 19, 22, 27, 29] and guilt [4, 10, 12-13, 16-22, 24, 27-29], upon discovering their child's self-harm. They internalize their child's distress as a personal failing, believing they could have done more or acted differently to prevent the situation. The realization that their child was suffering shakes their primary role of keeping their child safe. As one parent shared [5]:

“My heart is weak, not physically, but emotionally. I feel like I have failed as a parent for not being able to keep my child safe. Even though my intellect knows that I have done everything that I possibly could to care for her.”

Along with guilt, parents also experience shame [5, 12-13, 18-19, 24, 27, 29], supported by the fear of negative judgments from others due to a lack of understanding about self-harm [12-13, 16-17, 19, 21-23, 27-29]. The stigma and shame they perceive often lead them to withdraw socially [4-5, 7-8, 10, 12, 16, 18-21, 25, 28-29]. Another parent shared [28]:

“I would tell her to hide those scars when we go out; people look at us strangely and point. We rarely go out anymore.”

Consequently, parents may develop a distrust in their parenting skills, questioning their competence and effectiveness as caregivers [4-8, 10, 12, 16-17, 22-23, 25, 27]. This lack of confidence leads to uncertainty about how to best support their child, further undermining their sense of parental efficacy.

2.3. Safety Concerns and Changes in Parenting Styles

Many parents report a constant state of fear [4-5, 7-8, 12-13, 16-18, 20, 23, 27-29] and anxiety, concerning their young person’s safety, often driven by the fear of recurrence or evolving into suicide. This can manifest itself physically [4-5, 7, 12-13, 16-18, 22, 29]. As one parent shared [23]:

“I just felt, well, we’re getting through all these possibilities, we’re getting to the very last one really which was that she was going to end up, self, you know, trying to kill herself and even succeeding and so, I was just really, really frightened.”

Consequently, parents often become excessively cautious [4-5, 7-8, 11-13, 17, 20, 22-23], concerned with provoking further self-harm and what might trigger such behavior. This approach leads to a reluctance to set boundaries and a perceived change in power dynamics, with the child gaining control [4, 7, 9, 11, 13, 22, 24, 26]. Furthermore, many parents also develop a stance of constant vigilance to alleviate their fears [4-5, 7-9, 11-12, 17-20, 26, 29]. However, when parents realize that they cannot control or prevent their young person’s self-harm, they face intense feelings of hopelessness and powerlessness [5-6, 8-9, 16-24, 27-29].

Other parents adopted supportive strategies [4, 11, 13, 17, 20-21, 26, 28] including emotional support, calm and patient communication, and collaboratively developing

coping strategies. Some parents reported feeling closer to their children due to their enhanced support [4, 20, 28]. One mother reflected [4]:

“I think I showed my daughter how understanding and supportive and loving I can be. I saw it as the ultimate test in strength and unconditional love of a mother. I feel it has brought us closer and she knows she can come to me and talk about anything after this experience.”

Theme 3: Family Dynamics Impact

This theme explores how self-harm affects family dynamics, disrupting personal and professional lives, as well as relationships with partners, other children, and extended family members. It contains four subthemes: **(3.1.)** balancing caregiving with life; **(3.2.)** impact on partner relations; **(3.3.)** impact on siblings; and **(3.4.)** impact on extended family relations (GRADE-CERQual confidence level: high).

3.1. Balancing Caregiving with Life

Parents face difficulties in balancing caregiving responsibilities with their lives. Parents often need to adjust to be more available for their children, leading them to neglect their personal needs, such as reducing time spent with friends or engaging in leisure activities [5, 7, 10-11, 13, 18, 20, 29]. As one parent noted [7]:

“So I try to be absent as little as possible, I phone her a lot, before I did a lot of sport, I do less because we can’t leave her alone, yes of course we make ourselves available.”

This reduction often extends to their professional lives, with parents reducing work hours, relocating, or even leaving their jobs to provide the necessary support [5, 7, 10, 12-13, 18-20, 22, 27, 29]. The challenge of maintaining a full-time job further contributes to financial strain [5, 12, 19, 27].

3.2. Impact on Partner Relations

Studies show that managing a child’s self-harm issues often strains partner relationships, with stress and differing opinions on how to handle the situation leading to increased conflict and tension [5, 7, 10-12, 16, 22, 29]. One parent noted [11]:

“[her daughter’s father] blamed me because he’s saying that... I condoned her behavior.”

3.3. Impact on Siblings

Parents often become so consumed by their child's self-harm that they inadvertently neglect their other children [8, 11-12, 17-20, 29]. This phenomenon is captured in observations such as [17]:

"You get all consumed over that one sibling and just leave the others to just get by."

Consequently, siblings may feel it's unfair and experience exclusion, anger, frustration, and anxiety due to the self-harm exposition and the attention their sibling receives [5, 12, 18-19, 29], as illustrated by a parent [5]:

"One child has had trouble sleeping so I asked her to write down what she was worried about and give it a rank out of 10. She gave her brother's situation a 10/10."

Few studies reported differences between younger and older siblings. For instance, younger siblings might experience heightened anxiety [5, 12, 18] and stigma related to their sibling's self-harm, which can be pronounced at school [12]; while older siblings, may feel a stronger sense of responsibility and be more protective [12, 18].

3.4. Impact on Extended Family Relations

Studies revealed mixed experiences among extended family members. Self-harm can strain extended family relationships, sometimes exacerbating pre-existing tensions [5, 7, 12, 16]. For instance, one parent described the negative impact [7]:

"I didn't get along very well with my in-laws, mainly with my mother-in-law. Following Laure's first suicide attempt, we no longer see each other, we don't speak to each other anymore."

Conversely, some families find that dealing with the crisis together strengthened their bonds [5, 21, 28, 29]. Another parent described the positive impact [28]:

"My mother-in-law, who used to be quite firm with me, surprised me this time. In order to support her granddaughter's medical treatment, she handed over her bankbook. I found it quite touching."

Theme 4: Seeking and Accessing Support

This theme explores the challenges families encounter in obtaining effective support for self-harm and their expressed needs. It encompasses four subthemes: **(4.1.)** information and practical support; **(4.2.)** prompt and easy access to specialized care; **(4.3.)** healthcare professionals' approach; and **(4.4.)** emotional and psychological support to families (GRADE-CERQual confidence level: high).

4.1. Information and Practical Support

Many parents initially overlook self-harm behaviors in their children due to denial, minimization, or misunderstanding of the severity, leading to delayed help-seeking and subsequent regret [4, 6, 13-14, 16, 20-21, 26]. Parents report a need for information about self-harm, including its reasons and implications, to facilitate earlier support [4, 6-7, 10-13, 17, 19-21, 23, 25-26]. A parent shared [21]:

"If I had brought my child to the doctor when she began to hurt herself, it would not have been as serious as it is now. I advise that parents ought to seek medical help as soon as possible when they find something wrong with their children."

Additionally, the uncertainty about where to seek help and who to contact for support often leads to difficulties in navigating the health system, highlighting the need for clear guidance on navigating and accessing appropriate resources [6, 10, 25]. One parent stated [6]:

"There needs to be someone in place that for the family and to help them find these resources and to help them find the right professionals... Do not leave it to the family who have no idea or the expertise required to source the correct services/treatments."

A lack of practical support in managing self-harm risks was also pronounced, with confusion on how to effectively aid their child's recovery and prevent future behaviors [4, 6, 8-11, 14, 17, 19, 21]. Parents need guidance on communication strategies, coping mechanisms, and overall support techniques for managing self-harm.

Furthermore, parents emphasized the importance of active school involvement, noting that schools play a crucial role in monitoring and supporting young people with self-harm behaviors [7, 20-21, 24].

4.2. Prompt and Easy Access to Specialized Care

Obtaining specialized care for young people often presents challenges for parents, including long waiting times [4, 6, 11, 14, 25, 28], high thresholds for care [10, 15], difficulties in obtaining referrals [4, 6, 10, 13-14], and costs of treatments [6, 12-13, 28]. As one parent advised [12]:

"Make [a] fuss. Ask for help. Don't consider waiting for referral for 6 months is okay."

The difficulties in finding a professional who specializes in self-harm further complicate access [4, 13-14, 16, 22], as noted by another parent [4]:

“Trying to find the right person and, you know, trying to find someone who specializes in this area. It’s not there’s not much out there.”

Moreover, the lack of follow-up after discharge from specialized care can leave families feeling unsupported [4, 6, 22]. One parent stated [22]:

“The lack of any follow-up appointment left us feeling insecure and uncertain about our ability to cope or prevent future incidents.”

Current resources are often perceived as ineffective and insufficient [4, 6-7, 14-15, 22, 25, 28] by many parents, emphasizing the need for systemic improvements in accessibility and quality of care.

4.3. Healthcare Professionals’ Approach

Parents often report negative interactions with healthcare professionals, such as feeling judged or dismissed [4, 6-7, 9, 17, 22-25, 28-29], which has exacerbated their distress. They stress the need for a nonjudgmental, empathetic, and compassionate approach [4, 6-10, 12, 15, 19, 22, 25]. As one parent articulated [15]:

“I think it’s an individual approach and, in our daughter’s case, it’s an empathetic approach, understanding, caring, loving, kind of approach... So there has to be a caring, empathetic approach.”

Moreover, many parents report feeling excluded and underappreciated by professionals [4, 6, 7, 10, 16, 22, 23]. Parents voiced the need for consistent communication from professionals [7, 9-10, 14-15, 19, 23, 25], as well as active involvement in their child’s treatment [6, 9-10, 23, 25]. Another parent shared [6]:

“We need to feel included in the treatment, education and support. We need to feel confident that when we leave the safety of your support that we have the knowledge and ability to provide our children with the right support so that we don’t make things worse.”

Nonetheless, the involvement raises questions about the barriers imposed by confidentiality requirements, leading to frustration among some parents [22, 25].

4.4. Emotional and Psychological Support for Families

Many parents recognized the importance of self-care in coping with their children's self-harm. Parents expressed their need for emotional support from loved ones to increase understanding and reduce isolation [7, 9-10, 12, 16-17, 19], as well as support networks of parents with lived experiences to provide mutual understanding, encouragement, and practical advice [6-9, 10-12, 16-17, 19, 21, 25, 29].

Additionally, the need for professional support was expressed by parents to maintain their well-being and better support their child [4, 6-7, 10, 16-17, 20, 28-29], as well as for the entire family [6]. One parent stated [29]:

| *“If you aren't taking care of your own therapeutic needs, you cannot begin to parent a kid properly.”*

CHAPTER 4: DISCUSSION

This systematic review synthesized findings from 29 articles to elucidate the experiences and needs of families affected by youth self-harm. Although often framed as an individual issue, self-harm profoundly disrupts family mental well-being and dynamics. This review aligns with previous studies, corroborating the dual role of families as both supporters and those in need of support, highlighting the complexity and importance of addressing their needs (Asare-Doku et al., 2017; Osafo et al., 2011).

The quantitative data reveals that self-harm affects both parents and siblings, causing substantial emotional distress, altering relationships, and generating concerns about future recurrence. This data underscored the need for psychoeducation and psychological support to help families manage self-harm effectively.

The qualitative data allowed a more in-depth analysis. The intense negative emotions and recurring grief, coupled with feelings of failure and guilt, may contribute to long-term psychological distress, which is often exacerbated by social stigma and shame. This emotional toll can impact parents' mental health (Whitlock et al., 2018), potentially leading to mood disorders.

The fear of recurrence leads parents to hypervigilance and weakening their ability to set boundaries, disrupting family dynamics. This echoes the “*double trauma*” described by Bus et al. (2014), where upon discovering self-harm, parents fear further incidents and feel manipulated by their child. The unpredictability of self-harm deepens this sense of helplessness. However, research shows that increased hypervigilance and control can worsen family dynamics, elevating the risk of further self-harm (Waals et al., 2018).

In the review, some parents adopted supportive strategies that reportedly strengthened their relationships with their children; however, this was not the case for everyone. The effectiveness of these strategies may differ due to individual variations in parental approaches, the severity of the child's self-harm, the existing family dynamics, and the level of external support available.

The impact on family dynamics is noticeable, as observed in previous research (Byrne et al., 2008). Balancing caregiving with personal and professional life demands strains partner relationships and the neglect of other siblings' well-being and needs. The impact on extended family is mixed, with some relationships strained and others strengthened.

Families face significant barriers to timely, specialized care, including long wait times, high intervention thresholds, and referral difficulties, as well as inadequate follow-up. Negative interactions with healthcare professionals further exacerbate these challenges, underscoring the need for a compassionate, nonjudgmental approach and family involvement.

These issues, noted in literature from two decades ago (e.g., Coggan et al., 1997; Potter et al., 2005; Storey et al., 2005), persist today, indicating that improvements have been insufficient. A recent systematic review by Cox et al. (2024) highlights that while barriers and facilitators often relate to lower system levels (e.g., individual professionals and social networks), there is a need to address higher levels (e.g., policy and organizational management). This suggests that effective change requires not only attention to lower system levels but also a focus on policy initiatives and their impacts on help-seeking behaviors.

Schools should also play a more active role in support, and families need enhanced emotional and psychological support, including peer support networks for parents with lived experiences.

The integration of quantitative and qualitative findings from this review reveals the profound emotional, psychological, relational, and dynamic impact of self-harm on families, underscoring the urgent need for comprehensive support systems. These findings are particularly significant because families are key supporters of young people who self-harm, and their well-being is essential to the success of the young person's recovery (Byrne et al., 2008).

Limitations and Strengths

Some limitations affected the generalizability of the findings. Firstly, the small number of quantitative studies included suggests that current research may not consistently capture the same construct or that a standardized method for assessing the experiences and needs of families of young people who self-harm is lacking. Variations in how constructs are measured further limit the ability to compare findings and draw clear conclusions.

Additionally, small sample sizes and a predominance of female caregivers in several studies restrict generalizability to male caregivers and other family members. Some studies also inadequately analyzed data, potentially overlooking key findings.

Lastly, while the thematic synthesis provided valuable insights, a deeper analysis could have further enriched the results. These limitations highlight the need for more robust research methods in future studies.

Despite these limitations, the review remains comprehensive. A key strength of this review is its integration of both quantitative and qualitative studies, providing a comprehensive overview of the current state of research. The quantitative data provide a broad overview, while the qualitative data offer in-depth, nuanced insights into personal experiences. Furthermore, although the review timeframe spans from 1980 to 2024, it includes recent studies, with 15 out of 29 articles published between 2020 and 2024, ensuring that the findings are current and relevant.

Future Research

Future research should prioritize larger sample sizes and balanced gender representation to improve generalizability. Efforts to increase fathers' participation have often been unsuccessful, highlighting the need to emphasize to fathers the value of their insights. More creative and engaging strategies are needed to encourage participation. Additionally, it is crucial to explore the experiences of siblings and other family members more extensively, rather than focusing predominantly on parents' perspectives.

Furthermore, there is a lack of quantitative questionnaires designed to assess the experiences and needs of families affected by young people's self-harm. Developing these tools is essential for understanding the impact on families and facilitating consistent measurements across studies, thereby improving the comparability of findings.

Long-term quantitative and qualitative studies are needed to understand how experiences and needs evolve over time, as current research often focuses on retrospective analyses and single-time assessments of families' experiences. Moreover, research should also evaluate the effectiveness of specific interventions and support programs to determine which best meet the diverse needs of these families.

Clinical Implications

Implications for Healthcare Practice

Healthcare professionals should adopt a compassionate and empathetic approach, provide supportive communication, and actively involve families in their child's care, within the bounds of confidentiality.

Implications for Healthcare Systems

Addressing issues such as long waiting times, difficulties in obtaining referrals and providing follow-up can help ensure that families receive timely and effective support, ultimately improving patient outcomes.

Implications for Interdisciplinary Collaboration

Strengthening collaboration among healthcare providers, schools, and community organizations is essential for creating a comprehensive support network, thereby improving overall care for affected individuals.

Implications for Support Resources

Psychoeducation programs and informational resources should offer guidance on recognizing early signs of self-harm, managing stress, emotional regulation, and effective communication. They should also offer advice on self-care for parents and detailed instructions on navigating the healthcare system, including where to seek help and whom to contact. Support networks for parents with lived experiences are crucial for providing peer support and understanding.

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ANNEX A

PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Title
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	i
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	10
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	11
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	13-14
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	14
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Appendix A
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	15
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	15
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	15
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	15
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	15-16
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	N/A
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data	N/A

Section and Topic	Item #	Checklist item	Location where item is reported
		conversions.	
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	15
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	16
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	17
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	18
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	18, Appendix B
Study characteristics	17	Cite each included study and present its characteristics.	20-27
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	20-27
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	N/A
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	19, 20-27
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Appendix E

Section and Topic	Item #	Checklist item	Location where item is reported
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	39-40
	23b	Discuss any limitations of the evidence included in the review.	40
	23c	Discuss any limitations of the review processes used.	41
	23d	Discuss implications of the results for practice, policy, and future research.	41-42
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	13
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	13
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	N/A
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	N/A

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;372:n71. doi: 10.1136/bmj.n71

APPENDIX A

Database Search Strategy

DATABASES SEARCHES

Database	Search Syntax
PsycINFO (via EBSCOhost)	TI (Self Injurious Behavior OR Intentional Self Injur* OR Intentional Self Harm OR Self Destructive Behavior OR Deliberate Self Harm OR Self Injur* OR Self Harm OR Non suicidal Self Injur* OR Suicide Attempt* OR Parasuicide OR Self mutilation OR suicide survivor OR suicid* behavior) AND AB (famil* OR career OR caregiver* OR informal caregiver* OR parent* OR mother OR father OR sibling* OR grandparent*) AND AB (experiences OR impact OR perspectives OR needs OR difficulties OR views) AND TX (youth* or adolescent* or teenager* or child* or young adult* or young people* or young person* or young individual or emerging adult* or son* or daughter* or grandchild* or sibling*)
MEDLINE full text (via EBSCOhost)	TI (Self Injurious Behavior OR Intentional Self Injur* OR Intentional Self Harm OR Self Destructive Behavior OR Deliberate Self Harm OR Self Injur* OR Self Harm OR Non suicidal Self Injur* OR Suicide Attempt* OR Parasuicide OR Self mutilation OR suicide survivor OR suicid* behavior) AND AB (famil* OR career OR caregiver* OR informal caregiver* OR parent* OR mother OR father OR sibling* OR grandparent*) AND AB (experiences OR impact OR perspectives OR needs OR difficulties OR views) AND TX (youth* or adolescent* or teenager* or child* or young adult* or young people* or young person* or young individual or emerging adult* or son* or daughter* or grandchild* or sibling*)
Scopus	TITLE ("Self-Injurious Behavior" OR "Intentional Self-Injur*" OR "Intentional Self-Harm" OR "Self-Destructive Behavior" OR "Deliberate Self-Harm" OR self-injur* OR self-harm OR "Non-suicidal Self-Injur*" OR "Suicide Attempt*" OR parasuicide OR self-mutilation OR "suicide survivor" OR "suicid* behavior") AND TITLE-ABS-KEY (family OR families OR career OR caregiver OR caregivers OR "informal caregiver" OR "informal caregivers" OR parent OR parents OR mother OR father OR sibling OR siblings OR grandparent OR grandparents) AND TITLE-ABS-KEY (experiences OR impact OR perspectives OR needs OR difficulties OR views) AND ALL (youth* OR adolescent* OR teenager* OR child* OR "young adult*" OR "young people*" OR "young person*" OR "young individual" OR "emerging adult*" OR son* OR daughter* OR grandchild* OR sibling*)
Web of Science	TI=(Self-Injurious Behavior OR Intentional Self-Injur* OR Intentional Self-Harm OR Self-Destructive Behavior OR Deliberate Self-Harm OR self-injur* OR self-harm OR Non-suicidal Self-Injur* OR Suicide Attempt* OR parasuicide OR self-mutilation OR suicide survivor OR suicid* behavior) AND AB=(family OR families OR career OR caregiver OR caregivers OR informal caregiver OR informal caregivers OR parent OR parents OR mother OR father OR sibling OR siblings OR grandparent OR grandparents) AND AB=(experiences OR impact OR perspectives OR needs OR difficulties OR views) AND ALL=(youth* OR adolescent* OR teenager* OR child* OR "young adult*" OR "young people*" OR young person* OR young individual OR emerging adult* OR son* OR daughter* OR grandchild* OR sibling*)

Table 5. Databases search syntax (Appendix A)

APPENDIX B

Corpus Analysis

Appendix B aims to document the process of identifying studies through databases to complete the PRISMA 2020 flow diagram for the current systematic review. The appendix is divided into four phases: (1) identification in databases; (2) screening of titles and abstracts; (3) selection through full texts; and (4) fast-forward tracking through the selected articles.

Phase 1 – Identification in Databases

Results obtained from the search conducted on July 3, 2024, in the following databases:

- **PsycINFO: 915** articles, with no duplicates, resulting in **915** articles.
- **MEDLINE Full Text: 945** articles, with **571** duplicates, resulting in **374** articles.
- **Web of Science: 966** articles, with **656** duplicates, resulting in **310** articles.
- **Scopus: 1077** articles, **789** with duplicates, **288** resulting in articles.

Total: 1887 articles

The detailed results are summarized in Table X below:

Databases	Results	Duplicates	Total number of articles after exclusion of duplicates
PsycINFO	915	0	915
MEDLINE Full Text	945	571	374
Web of Science	966	656	310
Scopus	1077	789	288
Total	3903	2016	1887

Table 6. Identification via databases (Appendix B)

PsycINFO | 03.07.2024

Search Equation: TI (Self Injurious Behavior OR Intentional Self Injur* OR Intentional Self Harm OR Self Destructive Behavior OR Deliberate Self Harm OR Self Injur* OR Self Harm OR Non suicidal Self Injur* OR Suicide Attempt* OR Parasuicide OR Self mutilation OR suicide survivor OR suicid* behavior) AND AB (famil* OR career OR caregiver* OR informal caregiver* OR parent* OR mother OR father OR sibling* OR grandparent*) AND AB (experiences OR impact OR perspectives OR needs OR difficulties OR views) AND TX (youth* or adolescent* or teenager* or child* or young adult* or young people* or young person* or young individual or emerging adult* or son* or daughter* or grandchild* or sibling*)

Available Results: 1107 articles

Refinement of Results:

- **Publication Year:** 1980-2024 | 1098 articles
- **Source Types:** Academic Journals | 936 articles
- **Language:** English, Portuguese, Spanish, and French | 915 articles

Medline full-text | 03.07.2024

Search Equation: TI (Self Injurious Behavior OR Intentional Self Injur* OR Intentional Self Harm OR Self Destructive Behavior OR Deliberate Self Harm OR Self Injur* OR Self Harm OR Non suicidal Self Injur* OR Suicide Attempt* OR Parasuicide OR Self mutilation OR suicide survivor OR suicid* behavior) AND AB (famil* OR career OR caregiver* OR informal caregiver* OR parent* OR mother OR father OR sibling* OR grandparent*) AND AB (experiences OR impact OR perspectives OR needs OR difficulties OR views) AND TX (youth* or adolescent* or teenager* or child* or young adult* or young people* or young person* or young individual or emerging adult* or son* or daughter* or grandchild* or sibling*)

Available Results: 981

Refinement of Results:

- **Publication Year:** 1980-2024 | 977 articles
- **Source Types:** Academic Journals | 977 articles
- **Language:** English, Portuguese, Spanish, and French | 945 articles

Web of Science | 03.07.2024

Search Equation: TI=(Self-Injurious Behavior OR Intentional Self-Injur* OR Intentional Self-Harm OR Self-Destructive Behavior OR Deliberate Self-Harm OR self-injur* OR self-harm OR Non-suicidal Self-Injur* OR Suicide Attempt* OR parasuicide OR self-mutilation OR suicide survivor OR suicid* behavior) AND AB=(family OR families OR career OR caregiver OR caregivers OR informal caregiver OR informal caregivers OR parent OR parents OR mother OR father OR sibling OR siblings OR grandparent OR grandparents) AND AB=(experiences OR impact OR perspectives OR needs OR difficulties OR views) AND ALL=(youth* OR adolescent* OR teenager* OR child* OR "young adult*" OR "young people*" OR young person* OR young individual OR emerging adult* OR son* OR daughter* OR grandchild* OR sibling*)

Available Results: 1085

Refinement of Results:

- **Publication Year:** 1980-2024 | 1082 articles
- **Document Type:** Article | 997 articles
- **Language:** English, Portuguese, Spanish, and French | 966 articles

Scopus | 03.07.2024

Search Equation: TITLE ("Self-Injurious Behavior" OR "Intentional Self-Injur*" OR "Intentional Self-Harm" OR "Self-Destructive Behavior" OR "Deliberate Self-Harm" OR self-injur* OR self-harm OR "Non-suicidal Self-Injur*" OR "Suicide Attempt*" OR parasuicide OR self-mutilation OR "suicide survivor" OR "suicid* behavior") AND TITLE-ABS-KEY (family OR families OR career OR caregiver OR caregivers OR "informal caregiver" OR "informal caregivers" OR parent OR parents OR mother OR father OR sibling OR siblings OR grandparent OR grandparents) AND TITLE-ABS-KEY (experiences OR impact OR perspectives OR needs OR difficulties OR views) AND ALL (youth* OR adolescent* OR teenager* OR child* OR "young adult*" OR "young people*" OR "young person*" OR "young individual" OR "emerging adult*" OR son* OR daughter* OR grandchild* OR sibling*)

Available Results: 1315

Refinement of Results:

- **Publication Year:** 1980-2024 | 1300 articles
- **Document Type:** Article | 1140 articles
- **Language:** English, Portuguese, Spanish, and French | 1077 articles

Phase 2 – Screening of Titles and Abstracts

After reviewing the titles and abstracts of the 1887 articles, only 62 articles met the inclusion criteria, resulting in the exclusion of 1825 articles.

References (ID & Title)

- [1] ~~The experiences of attempt survivor families and how they cope after a suicide attempt in Ghana: A qualitative study~~
- [2] ~~The effects of nonsuicidal self-injury on parenting behaviors: A longitudinal analyses of the perspective of the parent~~
- [3] Qualitative study of parents' experience after their teen's suicide attempt
- [4] ~~Experiences of parents whose sons or daughters have (had) attempted suicide~~
- [5] ~~Deliberate self-harm in children and adolescents: A qualitative study exploring the needs of parents and carers~~
- [6] ~~Consumer and family experiences in the emergency department following a suicide attempt~~
- [7] ~~Qualitative investigation of relatives' and service users' experience of mental healthcare for suicidal behaviour in bipolar disorder~~
- [8] Parental self-efficacy to support teens during a suicidal crisis and future adolescent emergency department visits and suicide attempts
- [9] ~~The role of non-suicidal self-injury and binge-eating/purging behaviours in the caregiving experience among mothers and fathers of adolescents with eating disorders~~
- [10] Some guidance and somewhere safe': Caregiver and clinician perspectives on service provision for families of young people experiencing serious suicide ideation and attempt
- [11] ~~The spectrum of care within a university context: the differing roles of carers in supporting students who self-harm~~
- [12] ~~As a parent, there is no rulebook!': A new resource for parents and carers of young people who self-harm~~
- [13] The impact of self-harm by young people on parents and families: A qualitative study
- [14] ~~Tensions in perspectives on suicide prevention between men who have attempted suicide and their support networks: Secondary analysis of qualitative data~~
- [15] ~~Parents' information needs in relation to adolescent self-harm: Perspectives of parents and professionals~~
- [16] Parents' attitudes toward and experience of non-suicidal self-injury in adolescents: A qualitative study
- [17] Parents' and medical staff's experience of adolescents with suicide-related behaviors admitted to a general hospital in China: Qualitative study
- [18] Staff responses to self-harm by children and young people in mental health inpatient settings: Experiences and views of children and young people, parents and staff
- [19] ~~Concerns most important to parents after their child's suicide attempt: A pilot study and collaboration with a rural mental health facility~~
- [20] ~~Making sense of an unknown terrain: How parents understand self-harm in young people~~

- [21] ~~Relatives' experiences of brief admission in borderline personality disorder and self-harming behaviour~~
- [22] ~~Life is precious: Views of adolescents and their mothers on methods to reduce suicidal behavior in Latinas~~
- [23] ~~Causal explanations, concern and optimism regarding self-injurious behaviour displayed by individuals with Cornelia de Lange syndrome: The parents' perspective~~
- [24] ~~Perspectives on self-harm and suicidal ideation in Nigeria: A mixed-methods study of patients, family caregivers, clinicians, and the public~~
- [25] ~~Re-constructing parental identity after parents face their offspring's suicidal behaviour: An interview study~~
- [26] ~~The relationship between nonsuicidal self-injury and family functioning: Adolescent and parent perspectives~~
- [27] ~~School response to self-injury: Concerns of mental health staff and parents~~
- [28] ~~Parents' experiences of nonsuicidal self-injury among adolescents and young adults~~
- [29] ~~Parents' experience and psychoeducation needs when supporting a young person who self-harms~~
- [30] ~~Receiving a gift and feeling robbed: A phenomenological study on parents' experiences of brief admissions for teenagers who self-harm at risk for suicide~~
- [31] ~~Brief admission by self-referral for individuals with self-harm and suicidal ideation: A qualitative study based on focus groups exploring relatives' experiences~~
- [32] ~~Adolescent, parent, and provider perspectives on school-related influences of mental health in adolescents with suicide-related thoughts and behaviors~~
- [33] ~~Information needs of people after a suicide attempt: A thematic analysis~~
- [34] ~~The psychosocial needs of parents of adolescents who attempt suicide~~
- [35] ~~Parents' perspectives on adolescent self-harm: Qualitative study~~
- [36] ~~Perspectives of parents of adolescents with repeated non-suicidal self-injury on sharing their caretaking experiences with peers: A qualitative study~~
- [37] ~~Adolescents at risk of self-harm in Ghana: A qualitative interview study exploring the views and experiences of key adult informants~~
- [38] ~~Experiences and needs of parents whose child has attempted suicide~~
- [39] ~~Exploring parents' responses to their child's deliberate self-harm~~
- [40] ~~A qualitative analysis of family caregiver experiences accessing treatment for self-injurious behavior in individuals with intellectual and developmental disabilities~~
- [41] ~~Mothers' experiences of mental health services following their children's self-harm~~
- [42] ~~Experiences of an online treatment for adolescents with nonsuicidal self-injury and their caregivers: Qualitative study~~
- [43] ~~Adolescents-parents relationships around deliberate self-harm behaviours: A qualitative exploration~~
- [44] ~~How do people experience a family member's high risk self-harm? An interpretative phenomenological analysis~~
- [45] ~~I couldn't say the words': Communicative bodies and spaces in parents' encounters with nonsuicidal self-injury~~
- [46] ~~Navigating an unfamiliar world: How parents of young people who self-harm experience support and treatment~~
- [47] ~~A narrative inquiry into caregivers' experiences and management after a relative's suicide attempt in a rural community in Northeast Thailand~~

- [48] ~~Family care of Taiwanese patients who had attempted suicide: A grounded theory study~~
- [49] ~~What parents tell us: Perspectives of Chilean parents whose children were hospitalized for suicide ideation or a suicide attempt~~
- [50] Parental response style to adolescent self-harm: Psychological, social and functional impacts
- [51] Adolescent self-harm: Parents' experiences of supporting their child and help-seeking
- [52] Experiences and needs of parents of adolescents with self-harm behaviors during hospitalization
- [53] ~~Warning signs for suicide attempts in psychiatric inpatients: Patient and informant perspectives~~
- [54] Sibling relationships of female adolescents with nonsuicidal self-injury disorder in comparison to a clinical and a nonclinical control group
- [55] ~~Fatherhood's subjective experience in the face of adolescent children' depressive symptomatology and suicide attempt~~
- [56] ~~Caregiver experiences of adolescent school reentry after adolescent hospitalization due to suicidal thoughts and behaviors: Recommendations to improve reentry practices~~
- [57] Caregiving information needs of family caregivers of adolescent patients with suicide attempts: A qualitative study in China
- [58] Parents' lived experience of adolescents' repeated non-suicidal self-injury in China: A qualitative study
- [59] A qualitative internet-based study of parental experiences of adolescents suffering from affective disorders with non-suicidal self-injury during the COVID-19 pandemic
- [60] ~~The human approach to supportive interventions: The lived experience of people who care for others who suicide attempt.~~
- [61] Parental secondary stress: The often hidden consequences of nonsuicidal self injury in youth
- [62] ~~Psychological well-being and associated factors among parents of adolescents with non-suicidal self injury: A cross-sectional study~~

Phase 3 – Selection through Full-texts

After assessing the full text of the 62 articles, only 24 met the inclusion criteria, and 38 were removed due to the following exclusion criteria.

Reasons for exclusion	Article (ID)	Total excluded
Not youth specific	1, 7, 14, 21, 24, 31, 33, 44, 45, 47, 48, 53, 60	13
Youth age not disclosed	5, 12, 19, 20, 34, 37	6
Youth outside the 10-24 age range exceeds 50%	4, 15	2
Not family's experiences or needs	2, 32, 49	3
Self-harm due to intellectual disabilities or other behaviors (e.g. eating disorder, substance abuse)	9, 23, 40	3
No outcome of interest	22, 26, 42, 56, 61, 62	6
Not available	6, 11, 27, 38, 55	5

Table 7. Exclusion analysis of full-text articles (Appendix B)

Articles included in this systematic literature review: 3, 8, 10, 13, 16, 17, 18, 25, 28, 29, 30, 35, 36, 39, 41, 43, 46, 50, 51, 52, 54, 57, 58, 59

***Note:** The article ID numbers referenced here pertain exclusively to Appendix B.

Phase 4 – Fast-forward Tracking

After selecting the 24 articles, an additional 5 studies were included through forward tracking of references from these selected studies, resulting in a final sample of **29** articles.

References of the additional studies

- Daly, P. (2005). Mothers living with suicidal adolescents: A phenomenological study of their experience. *Journal of Psychosocial Nursing and Mental Health Services*, 43(3), 22-28.
- Ferrey, A. E., Hughes, N. D., Simkin, S., Locock, L., Stewart, A., Kapur, N., Gunnell, D., & Hawton, K. (2016). Changes in parenting strategies after a young person's self-harm: A qualitative study. *Child and Adolescent Psychiatry and Mental Health*, 10(1). <https://doi.org/10.1186/s13034-016-0110-y>
- Greene-Palmer, F. N., Wagner, B. M., Neely, L. L., Cox, W., D., Kochanski, K. M., Perera, K. U., & Ghahramanlou-Holloway, M. (2015). How parental reactions change in response to adolescent suicide attempt. *Archives of Suicide Research*, 19(4), 414-421. <https://doi.org/10.1080/13811118.2015.1094367>
- McDonald, G., O'Brien, L., & Jackson, D. (2007). Guilt and shame: Experiences of parents of self-harming adolescents. *Journal of Child Health Care*, 11(4), 298-310. <https://doi.org/10.1177/1367493507082759>
- Weissinger, G. M., Evans, L., Van Fossen, C., Winston-Lindeboom, P., Ruan-Iu, L., & Rivers, A. S. (2023). Parent experiences during and after adolescent suicide crisis: A qualitative study. *International Journal of Mental Health Nursing*, 32(3), 917-928. <https://doi.org/10.1111/inm.13137>

APPENDIX C

MMAT Tool: Quality Assessment of the Included Studies

Table 8. MMAT Tool: Quality assessment of the included studies (Appendix C)

Author, Year	1.1	1.2	1.3	1.4	1.5	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5	%		
	Qualitative					Quantitative randomized controlled trials					Quantitative non-randomized					Quantitative descriptive					Mixed methods							
Boussat et al. (2022)	1	1	1	1	1																					5/5	100%	
Czyz et al. (2018)																	1	1	1	0	1						4/5	80%
Daly (2005)	1	?	1	1	1																					4/5	80%	
de Miranda Trinco et al. (2017)	1	1	1	1	1																					5/5	100%	
Dempsey et al. (2019)	1	?	1	1	1																					4/5	80%	
Ferrey et al. (2016)	1	1	1	1	1																					5/5	100%	
Ferrey et al. (2016)	1	1	1	1	1																					5/5	100%	
Fu et al. (2020)	1	1	?	1	1																					4/5	80%	
Fu et al. (2021)	1	1	?	1	1																					4/5	80%	
Greene Palmer et al. (2015)																	1	1	1	0	0					3/5	60%	
Griffiths et al. (2023)	?	?	1	1	1																					3/5	60%	
Juel et al. (2023)	1	1	1	1	1																					5/5	100%	
Kelada et al. (2016)																						0	1	0	?	1	2/5	40%
Krysinska et al. (2020)	?	1	1	1	1																					4/5	80%	
Lantto et al. (2023)	1	1	1	1	1																					5/5	100%	
Mcdonald et al. (2007)	1	?	1	1	1																					4/5	80%	

Legend: "1" – Yes, the item of the instrument meets the criterion; "0" – No, the item does not meet the criterion; "?" – Can't tell, uncertain if the item meets the criterion.

Table 8. Continued

Author, Year	1.1	1.2	1.3	1.4	1.5	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5		%	
	Qualitative					Quantitative randomized controlled trials					Quantitative non-randomized					Quantitative descriptive					Mixed methods							
Oldershadow et al. (2008)	1	1	1	1	1																						5/5	100%
Qin et al. (2023)	1	1	1	1	1																						5/5	100%
Raphael et al. (2006)	1	?	1	1	1																						4/5	80%
Rose et al. (2011)	1	?	1	1	1																						4/5	80%
Spiers et al. (2020)	1	1	1	1	1																						5/5	100%
Stewart et al. (2018)	?	1	1	1	1																						4/5	80%
Townsend et al. (2021)																						1	1	1	1	1	5/5	100%
Townsend et al. (2023)																						?	1	1	1	1	4/5	80%
Tschan et al. (2019)											1	1	1	0	1												4/5	80%
Wang et al. (2022)	1	?	1	1	?																						3/5	60%
Wang et al. (2024)	1	?	1	1	?																						3/5	60%
Wang et al. (2024)	1	1	1	1	1																						5/5	100%
Weissinger et al. (2023)	1	?	1	1	?																						3/5	60%

Legend: "1" – Yes, the item of the instrument meets the criterion; "0" – No, the item does not meet the criterion; "?" – Can't tell, uncertain if the item meets the criterion.

APPENDIX D

Thematic Synthesis Process

Table 9. Descriptive themes (Appendix D)

Descriptive themes (n = number of data extracts)	Description	Descriptive themes extracts
Emotional distress (n = 67)	Parents experience a profound state of shock, distress, anger, and sadness due to their child's self-harming behavior.	<i>“Participants emphasized that supporting a young person who engages in self-harm is overwhelming, upsetting, and can easily trigger intense emotional reactions.”</i> (Qin et al., 2023)
Cautious and monitoring parenting (n = 62)	Parents often adopt a cautious approach, marked by increased leniency and avoidance of conflict, coupled with hypervigilance in monitoring their child's behavior	<i>“Somehow, since Laure is not well, and what's more, she is a teenager, we let her do everything, we are deprived of our role as parents, we no longer refuse her anything, for fear that it upsets her and she takes action.”</i> (Mother; Bouszat et al., 2022)
Practical support understanding and managing self-harm risk (n = 61)	Parents seek clear, actionable guidance to understand and manage the risk of suicide in their children.	<i>“Parents expressed a need for information and resources to help them better understand and support their child.”</i> (Krysinska et al., 2020)
Stigma and sense of isolation (n = 61)	Parents worry about social stigma arising from negative judgments, lack of understanding, and discriminatory comments related to their child's self-harm or mental health issues.	<i>“Frequently mentioned by mothers were perceptions of stigma around the ‘kinds’ of families who access services and the sense of shame that arose when they found themselves there.”</i> (Rose et al., 2011)
Perceived parental failure and distrust in parenting competence (n = 60)	Parents commonly perceive themselves as having failed in their role and doubt their parenting skills.	<i>“Many participants struggled with a feeling that they had ‘really failed’ as parents.”</i> (Krysinska et al., 2020)
Feelings of guilt, shame and embarrassment (n = 51)	Parents often experience profound guilt and shame, feeling responsible for their child's self-harm.	<i>“The parent experiences internal and external blame, guilt, and shame for not doing or being enough.”</i> (Lanto et al., 2023)
Healthcare professionals’ approach (n = 49)	Parents desire non-judgmental, empathetic understanding and compassionate communication from healthcare professionals.	<i>“I think it's an individual approach and, in our daughter's case, it's an empathetic approach, understanding, caring, loving, kind of approach. On the ward, yes, you're in a medical setting, you're on a medical ward, but you're perhaps acting as parent and families as well as medical professionals. So there has to be a caring, empathetic approach.”</i> (Parent 4; Griffiths et al., 2023)
Peer support with similar experiences (n = 47)	Parents seek peer support to connect with others who share similar experiences, providing mutual understanding, encouragement, and practical advice.	<i>“Some participants emphasized the importance of emotional communication, noting that sharing their caretaking experiences with peers could provide them with hope and emotional support.”</i> (Qin et al., 2023)
Safety concerns (n = 42)	Parents described a persistent fear about whether their child will self-harm or escalate their behavior in the future.	<i>“Because the fear, it's always the fear, is she going to go in her room? Is she going to do it? Have I upset her that much that she's going to keep doing it sort of thing?”</i> (Parent 7; Krysinska et al., 2020)
Helplessness and hopelessness (n = 41)	Parents often experience profound helplessness and hopelessness, in preventing their child's self-harm.	<i>“This prompted strong feelings of powerlessness and helplessness because parents regarded themselves as single-handedly responsible for keeping their offspring safe.”</i> (Juel et al., 2023)

Table 9. Continued

Descriptive themes (n = number of data extracts)	Description	Descriptive theme extracts
Anticipatory grief and mourning (n = 33)	Parents experience grief and loss as they mourn the loss of the child they once knew and their idealized parental identity, often developing depressive symptoms.	<i>“To some mothers, the entire child was gone; to others, a part of the child was lost. ... An additional loss was of a part of who they were and valued the most—a good mother and a good person.”</i> (Daly, 2005)
Siblings’ neglect (n = 31)	Parents may neglect their other children due to the intense attention required by a child who self-harms. Siblings often feel angry, neglected, or emotionally strained due to the focus on the self-harming child. This can lead to conflicts, withdrawal.	<i>“There was nothing in place for my other children. They were stuck in the middle; so was the whole family. You can’t give them [the other children] what they deserve because you are too wrapped up.”</i> (Mother; Daly, 2005)
Ignoring and delayed help-seeking (n = 29)	Parents often downplay or ignore their child’s self-harm, delaying professional intervention due to denial, minimization, or misunderstanding of the severity.	<i>“When parents initially learned that their children had NSSI behaviors, many of them were reluctant to admit that their children were ill and refused to take them to a psychiatrist.”</i> (Qin et al., 2023)
Prompt and easy access to care (n = 29)	Parents often experience difficulties accessing resources, obtaining appointments, long waiting times, and lack of follow-up.	<i>“There seems to be a great distance between physical help and psychological help. I felt very alone and continue to feel alone in my attempts to receive assistance for my daughter’s needs. Follow-up seems to never happen.”</i> (Elizabeth; Townsend et al., 2023)
Desire for involvement (n = 27)	Parents want to be actively involved in their child’s treatment and support, but often feel excluded, disregarded, or underappreciated by healthcare professionals and the system.	<i>“Parents wanted to be actively involved in the treatment of their child; however, they often felt it was not possible or that their role in providing support was disregarded or underappreciated.”</i> (Townsend et al., 2023)
Psychological support (n = 23)	Parents seek emotional and professional assistance to manage their well-being and cope with their child’s self-harm.	<i>“Participants sought help from mental health professionals and services, and advised other parents to “tell them [professionals] as much as you can”</i> (Parent 6; Kryszynska et al., 2020)
Supportive strategies (n = 22)	Parents adopt strategies like calm communication, emotional support, and cooperative problem-solving to manage their child’s self-harm.	<i>“Unsurprisingly, most parents also tried to increase supportive parenting strategies.”</i> (Ferrey et al., 2016)
Work strains (n = 22)	Parents face work-related strain, often reducing their hours or even resigning to meet the demands of caring for a child with self-harm.	<i>“Mothers reported strategies such as reducing their work hours or even leaving paid employment to take on a more active role in caring for their self-harming child.”</i> (McDonald et al., 2007)
Impact on extended family dynamics (n = 21)	Self-harm can cause strain, conflict, or withdrawal among extended family members, but can also lead to increased support and closer relationships.	<i>“Participants reported a significant change in the interactions among immediate family members when an adolescent was engaging in self-harm.”</i> (Townsend et al., 2021)
Partners strain (n = 20)	Parents experience marital strain due to disagreements over how to manage their child’s self-harm, heightened stress, and divergent coping mechanisms.	<i>“A third factor was the relationship with the co-parent where diverging opinions could be challenging, for instance, if the parents did not agree on what would help their offspring.”</i> (Juel et al., 2023)

Table 9. Continued

Descriptive themes (n = number of data extracts)	Description	Descriptive theme extracts
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Self-harm professionals and treatments (n = 18)	specialized Parents experienced difficulties due to limited availability of specialized professionals and treatments for self-harm. They often consider the interventions useless and ineffective.	<i>“The parents recounted the difficulties of finding a professional who specialized in NSSI treatment. They also reported that therapy was often ineffective and wanted professionals to be better trained in NSSI.” (Kelada et al., 2016)</i>
Balancing Caregiving and Personal Life (n = 17)	Parents face challenges managing caregiving responsibilities and personal lives, often leading to significant adjustments and sacrifices.	<i>“This makes for an everyday life jagged by interruptions the parent suddenly needs to leave work, drop the employment interview, cancel family activities and any personal plans – essentially drop everything to speed to their teenager’s rescue.” (Lantto et al., 2023)</i>
Financial Strains (n = 17)	Parents experience financial strain due to high medical costs, loss of income from reduced work hours or job loss, and additional expenses for their child's care and support.	<i>“On the one hand, they face a great financial burden. In addition to the expenses of medication, hospitalization, psychological counseling, etc., in order to make their children happy and stop hurting themselves, parents address their children’s various desire for shopping, traveling, etc.” (Fu et al., 2020)</i>
Traumatic Experience (n = 16)	Parents experience profound trauma from learning about their child's self-harm.	<i>“The experiences were deeply traumatic; their understanding of the world and their family’s safety was shaken.” (Weissinger et al., 2023)</i>
Active School Role (n = 12)	Parents highlight the importance of timely and supportive school involvement in managing their child’s self-harm.	<i>“Some participants explained that school had a great influence on children and that teachers’ attitudes were crucial. Parents should maintain close contact with teachers and seek their support.” (Qin et al., 2023)</i>
Support Navigating the System (n = 5)	Parents often expressed doubts about where and whom to reach out to for help, which influenced their help-seeking pathways.	<i>“Two parents noted they did not know where to go to ask for help. The uncertainty of what to do influenced the help-seeking pathways of some parents.” (Townsend et al., 2023)</i>

APPENDIX E

GRADE-CERQual Tool: Assessment of the qualitative evidence

Table 10. GRADE-CERQual: Assessment of the qualitative evidence (Appendix E)

Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual Assessment of Confidence in the Evidence	Explanation of CERQual Assessment
<i>Emotional and Psychological Burden</i>	23 studies: 4-7, 9-12, 15-29	Moderate concerns: A total of 11 studies were of high quality, 7 studies were of medium-high quality, 1 study was of medium quality, and 4 studies were of medium-low quality.	No or very minor concerns: Data consistent across studies	No or very minor concerns: High data quantity and richness	No or very minor concerns	<u>Highly confident:</u> It is highly likely that the review findings accurately represent the phenomenon of interest.	Although there were moderate concerns regarding the methodology of some medium-quality studies, we have high confidence that the coherence, adequacy, and relevance of the data accurately represent the phenomenon of interest.
<i>Biographical Disruption and Parenting Shifts</i>	24 studies: 4-13, 16-29	Moderate concerns: A total of 11 studies were of high quality, 9 studies were of medium-high quality, and 4 studies were of medium-low quality.	No or very minor concerns: Data consistent across studies	No or very minor concerns: High data quantity and richness	No or very minor concerns	<u>Highly confident:</u> It is highly likely that the review findings accurately represent the phenomenon of interest.	Although there were moderate concerns regarding the methodology of some medium-quality studies, we have high confidence that the coherence, adequacy, and relevance of the data accurately represent the phenomenon of interest.
<i>Impact on Family Dynamics</i>	17 studies: 5, 7-8, 10-13, 16-22, 27-29	Moderate concerns: A total of 9 studies were of high quality, 6 studies were of medium-high quality, and 2 studies were of medium-low quality.	No or very minor concerns: Data consistent across studies	No or very minor concerns: High data quantity and richness	No or very minor concerns	<u>Highly confident:</u> It is highly likely that the review findings accurately represent the phenomenon of interest.	Although there were moderate concerns regarding the methodology of some medium-quality studies, we have high confidence that the coherence, adequacy, and relevance of the data accurately represent the phenomenon of interest.
<i>Seeking and Accessing Support</i>	25 studies: 4-17, 19-26, 28-29	Moderate concerns: A total of 10 studies were of high quality, 10 studies were of medium-high quality, 1 study was of medium quality, and 4 studies were of medium-low quality.	No or very minor concerns: Data consistent across studies	No or very minor concerns: High data quantity and richness	No or very minor concerns	<u>Highly confident:</u> It is highly likely that the review findings accurately represent the phenomenon of interest.	Although there were moderate concerns regarding the methodology of some medium-quality studies, we have high confidence that the coherence, adequacy, and relevance of the data accurately represent the phenomenon of interest.

Note: The study IDs refer to those assigned in Table 3 of the results section.