Original Paper

Developing a Digital Intervention to Support Parents of Young People Who Self-Harm: A Person-Based Approach Informed by Systematic Review and Qualitative Research

Faith Martin[1*], PhD, DClinPsy; Sarah-Lou Glover[2*]; Suzanne van Even[3*], MSc; Andy Turner[4], PhD

[1]University of Bath, Bath, England, United Kingdom
[2]Parental Minds, Honiton, Devon, United Kingdom
[3]University of Surrey, Guildford, England, United Kingdom
[4]Coventry University, Coventry, England, United Kingdom
[*]these authors contributed equally

Corresponding Author:
Faith Martin, PhD, DClinPsy
University of Bath
10West, Claverton Down
Bath, England, BA2 7AY
United Kingdom
Phone: 44 01225388388
Email: psmfm@bath.ac.uk

Abstract

Background: Self-harm among children and young people (CYP) is a major public health concern and is associated with increased risk of suicide and ongoing mental health difficulties. Parents frequently play a central role in supporting a young person who self-harms; yet, many report experiencing intense emotional distress, uncertainty, and isolation. Despite this, few interventions have been developed specifically to support parents' own well-being. Existing interventions typically involve parents as part of treatments targeting the young person rather than addressing parents' emotional needs directly.

Objective: This study aimed to develop a digital intervention designed to support the well-being of parents of CYP who self-harm using a Person-Based Approach.

Methods: Intervention development followed the stages of the Person-Based Approach. Evidence gathering included using an existing systematic review of parents' experiences and development-stage findings from a systematic review of interventions containing components aimed at improving parental well-being in the context of youth self-harm. Qualitative data were collected through interviews, focus groups, and co-design workshops with parents, young people, clinicians, and third-sector professionals to understand user needs and preferences. These findings informed the development of guiding principles and a theory of change. Intervention content was then developed iteratively with input from a parent advisory group. A small alpha test was conducted to identify actionable problems with content, presentation, navigation, emotional burden, and engagement to inform further optimization only.

Results: The systematic review identified few interventions that explicitly targeted parental well-being, with substantial variation in content, delivery, and evaluation. Qualitative findings highlighted parents' needs for support in managing emotional distress, understanding self-harm, responding to their child, and reducing isolation. These insights informed the development of a modular digital intervention including psychoeducation, strategies for managing parental distress, communication guidance, and reflective activities to support well-being. Formative alpha testing generated follow-up feedback from 7 of 12 enrolled parents; 5 provided no follow-up, leaving sustained engagement uncertain. Feedback from completers identified priorities for optimization, particularly around goal-setting content, crisis information, and login burden. Five of the 12 enrolled participants did not provide follow-up data, and reasons for noncompletion were unknown.

Conclusions: This study describes the development of a digital intervention to support the well-being of parents of CYP who self-harm. Grounded in systematic review evidence, qualitative research, and formative user testing, the intervention addresses an important gap in available support for families affected by youth self-harm. Actionable priorities for further development were identified, with further work needed to establish feasibility and effectiveness.

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(JMIR Form Res 2026;10:e77434) doi: 10.2196/77434

KEYWORDS

self-harm; adolescents; parents; caregiver support; digital intervention; Person-Based Approach; mental health; parent support

Introduction

Self-harm among children and young people (CYP) remains a significant public health concern in the United Kingdom and internationally. Recent data indicate a rising trend in self-harm incidents among adolescents. For example, in England, hospital admissions for self-harm among those aged 15- to 19 years increased by approximately 37% between 2012 and 2021 [1]. Nearly one-third of those aged 17- to 24 years reported having self-harmed at least once [2]. Self-harm in CYP is associated with heightened risks of suicide, persistent mental health difficulties, and significant burden on health care systems and families [3,4].

Parents and carers (hereafter "parents") often find themselves at the forefront of managing and responding to a child's self-harm. Young people may be supported by diverse caregiving arrangements, including biological, adoptive and stepparents, grandparents, kinship or foster carers, guardians, and other adults with primary caring responsibilities [5]. Throughout this paper, we use "parents" as shorthand only, without intending to imply a particular family structure or legal relationship to the young person.

Parents may experience shock, sadness, shame, guilt, self-blame, fear, anger, and helplessness [6,7]. Many parents describe feeling overwhelmingly alone and isolated, unable to talk openly to others due to the stigma surrounding self-harm and the fear of judgment [6,8]. This is often coupled with a perceived lack of information and formal support for coping with the situation [9]. Parents may also experience their own needs as invisible or secondary to those of their child [10]. These reactions can persist over time, impairing parents' own mental health and family functioning [10,11]. The UK clinical guidelines recommend support for families of people who self-harm; however, there is currently no evidence-based intervention to specifically recommend [12]. In many settings, including the United Kingdom, Child and Adolescent Mental Health Services (CAMHS) are under considerable pressure [2]. Waiting times for initial assessment can be long and can lead to discharge without intervention, meaning many parents are managing their child's self-harm without professional input.

Few interventions address parents' well-being as a primary concern. Parents may be involved in interventions for self-harming youth, such as Dialectical Behavior Therapy for Adolescents or family-based cognitive behavioral therapies [13,14], but typically as part of treatment directly at the CYP. Parent involvement may focus on parenting skills, communication or supporting treatment, and it is not always clear to what extent parents' own psychological needs and distress are directly addressed. Therapeutic formats such as dialectical behavior therapy often require access to high-intensity, specialist services, which is limited. Interventions to specifically support the parent with the impact of their child's self-harm are less common [11]. There remains uncertainty about what dedicated parent-well-being support should contain, which potentially modifiable processes it should address, and how such support should be delivered. This is a significant empirical and conceptual gap.

To respond to this gap, this study aimed to develop a novel intervention specifically to support parents of CYP who self-harm. We used a Person-Based Approach (PBA) to intervention design [15], combining existing evidence with iterative engagement with intended users to develop an in-depth understanding of their psychosocial context and translate this into intervention design. We report the formative development of Parents Support With Adolescent Self-Harm (PASH) up to formative alpha user testing.

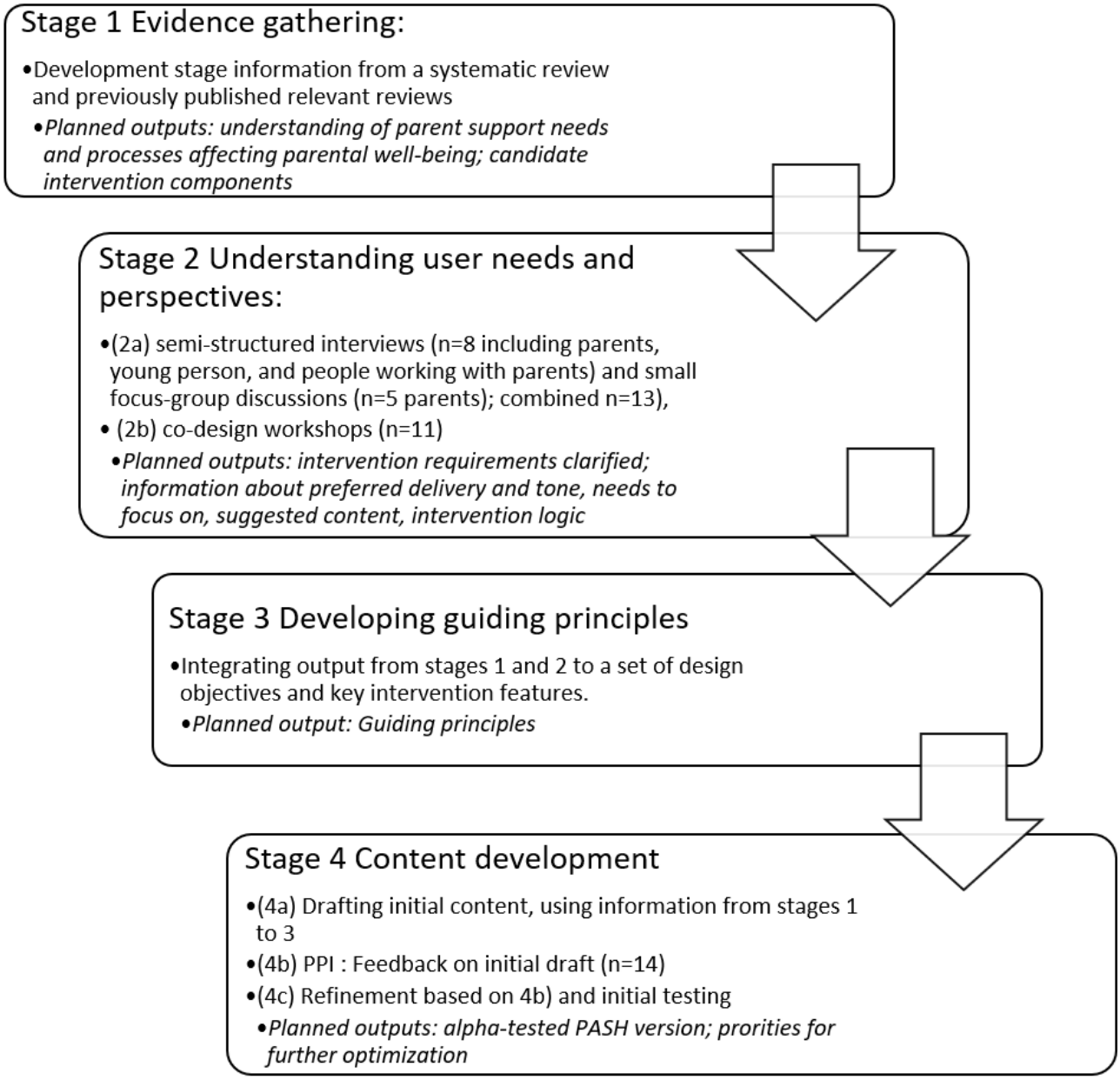
Methods

Study Design

PBA uses sequential intervention planning, design, development, and refinement [15]. Our 4-stage process (Figure 1) comprised evidence gathering, qualitative work to understand user needs and inform an initial theory of change, development of guiding principles, and content development with iterative feedback and formative alpha testing. The process of intervention development was informed by the GUIDED checklist [16], with application to our study shown in Multimedia Appendix 1.

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Figure 1. Person-Based Approach stages used to develop PASH, including participant numbers at each stage. PASH: Parents Support With Adolescent Self-Harm; PPI: Patient and Public Involvement.



Ethical Considerations

The study received a favorable ethical opinion via the Coventry University Ethical Approval Process (P109780). For each stage of the study, where participants were involved, informed consent was gained, with the provision of detailed information sheets, opportunities to ask questions, and signed consent forms. All data were deidentified prior to analysis to maintain participant privacy. Participants were provided with small vouchers.

Patient and Public Involvement

A "Patient and Public Involvement" (PPI) group was convened as a panel of parents who provided input throughout the study, with flexible involvement of different parents to maximize engagement and facilitate participation at their convenience. The panel was composed of 14 parents in total, all were parents of CYP who had self-harmed or continue to do so, 2 were fathers, and all recruited via charity ("Parental Minds") providing support for parents of children with mental health difficulties (led by SLG, PPI lead). They provided input during all stages, with email contact and discussions led by PPI lead throughout. Owing to the small scope of our project, and the need for PPI members to participate flexibly, the majority of this contact was informal. The PPI lead reviewed data collection tools (interview or discussion schedules) for stage 2. The PPI lead shared the draft theory of change, guiding principles, and early versions of the 12-module structure with members of the PPI group, collating and returning feedback via email or verbally. This feedback contributed to the overall focus of the intervention, emphasized the need for some practical strategies on parenting and communication specifically directed at improving parent well-being, and highlighted the importance of practical self-care strategies (particularly in the guiding principles). All took part in the review of materials (stage 4b).

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Although digital delivery was anticipated based on brief PPI conducted during the funding application, we remained open to other delivery formats.

Evidence Gathering Including Novel Systematic Review (Stage 1)

Our published literature explored parents' experiences and needs, which provided an overview of needs, a logic model of the problem (Figure 2), and an initial conceptualization of important pathways of distress (Figure 3) [11]. This summarizes how parents' cognitive appraisals (eg, self-blame and perceived failure), emotional responses (eg, anxiety and grief), and coping behaviors (eg, hypervigilance and avoidance) interact to maintain distress over time. This model informed the structure and focus of intervention components and guided the construction of a logic model outlining hypothesized mechanisms of change.

Figure 2. Logic model of factors associated with parental health outcomes following self-harm by a child or a young person (reproduced from Martin et al [11], which is published under Creative Commons Attribution 4.0 International License [CCBY reference citation [66]).

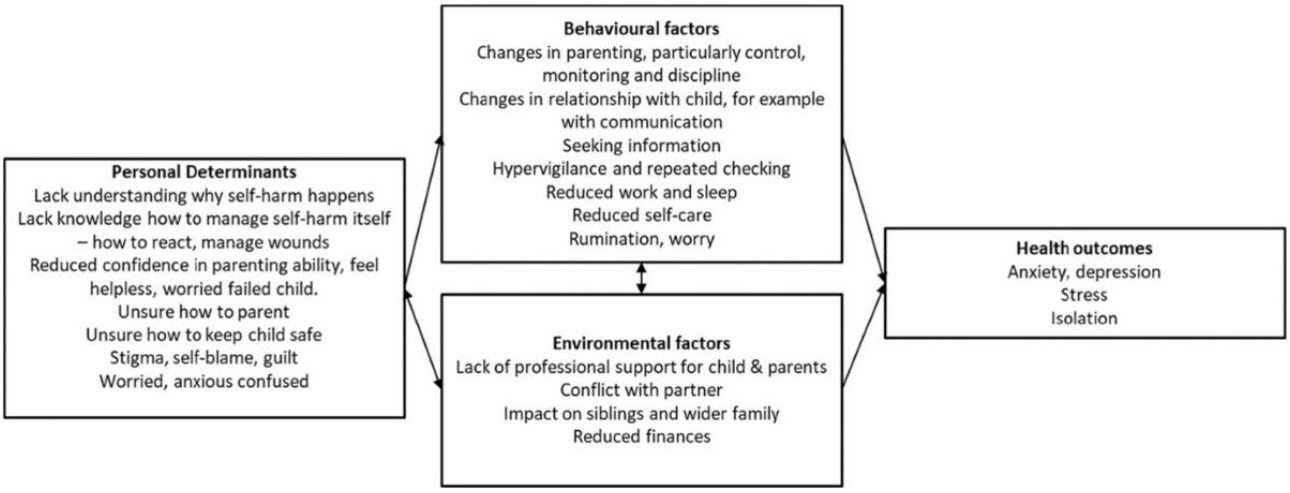
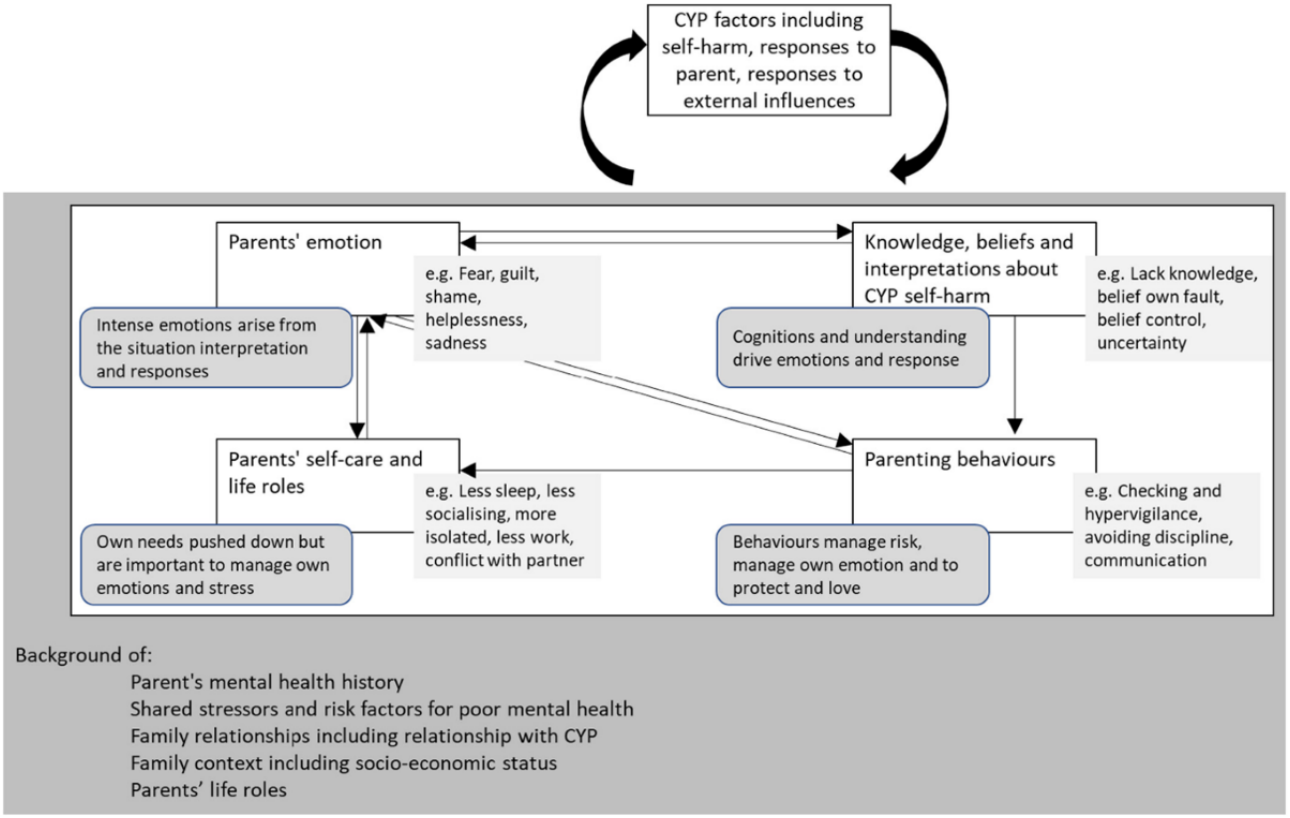


Figure 3. Conceptual model of relationships between parents' understanding of self-harm, emotional responses, self-care, and parenting behaviors (reproduced from Martin et al [11], which is published under Creative Commons Attribution 4.0 International License [CCBY reference citation [66]). CYP: children and young people.



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Systematic Review Evidence Used in Development

Alongside intervention development, we conducted a PROSPERO-registered systematic review of interventions for parents or carers of CYP who self-harm (CRD42020221126) to identify candidate intervention ingredients. Here, findings as we were developing the review are included, as such only reports published by June 2023 were considered. The full review has subsequently been updated and is reported separately in a manuscript currently under review elsewhere. In keeping with the intervention-development focus of this paper, we report here only the development-stage findings needed to show how this evidence informed PASH.

Understanding User Needs and Perspectives (Stage 2)

Semistructured Interviews and Small Focus Group Discussions (Stage 2a)

We conducted semistructured interviews or small group discussions (based on participants' preference and availability) with parents, health professionals, and young people. The topic guide focused on parents' experiences, perceived support needs, communication challenges, and suggestions for helpful intervention content. Following informed consent, sessions were audio-recorded and transcribed. Convenience sampling was used, with the aim to recruit 6 to 8 parents, 2 young people, and 2 clinicians, a smaller sample, however, sufficient to provide to supplement knowledge from literature reviews [18]. This stage focused on specific intervention design needs and ideas. Consistent with the formative intervention-development purpose, we did not seek thematic saturation or apply a formal information–power stopping criterion. Recruitment targets were set pragmatically to obtain perspectives from the principal stakeholder groups relevant to intervention development.

Co-Design Workshops (Stage 2b)

Overview

Two co-design workshops were conducted by videoconference. Following consent and discussion of confidentiality and emotional safety, participants completed journey-mapping exercises [19,20], using hypothetical parent scenarios to explore emotional, relational, and practical challenges. They identified unmet informational, emotional, and support-seeking needs; indicated preferred delivery modes; and cogenerated intervention features and content. Prompts addressed information needs, emotional support, peer connection, anonymity, tone, and accessibility. FM facilitated the workshops using participatory design principles, with participants leading priority-setting and design suggestions [21,22].

We primarily sought to recruit parents, as our intended users. Although predominately a convenience sample, we sought to recruit those identifying as any gender, and across a range of backgrounds and previous contact with services, to seek variation in our sample [21]. We had planned to also include a young person with previous lived experience and clinician at each workshop, not known to other participants, to provide their viewpoint within the discussion, with an underpinning spirit of partnership and co-design. We aimed for 6 participants in each workshop, as recommended by the literature to promote active involvement but allow everyone to be heard [22].

Recruitment

For all stage 2 activities (interviews, group discussions, and co-design workshops), participants were recruited via third-sector support organizations, supporting parents and young people, and their contacts with clinicians. For the interviews, small group discussions, and co-design workshops, the eligibility criteria and recruitment pathways were the same. Participants were eligible to take part if they were parents of a young person aged 5 to 25 years who either had a history of or current self-harm, however, were not currently in crisis. Young people aged 18 to 25 years with a previous history of self-harm were also eligible, alongside clinicians with a clinical role in supporting young people and their families with self-harm. All potential participants received an information sheet which set out the details of the data collection methods. They were given the opportunity to ask questions and completed a consent form. Study information materials highlighted the purpose of the study relating to developing materials and mention that people might find it distressing to talk about their experiences, providing signposting information for further support. The data collection was carried out by a qualified clinical psychologist, who provided signposting for support following data collection session as required.

Analysis of User Needs Data

Data were collected through journey mapping, think-aloud activities, and open-ended discussions. Audio recordings were transcribed and all notes and participant comments collated. The different stage 2 data sources were intended to provide complementary information for intervention development rather than to constitute a single homogeneous qualitative dataset. Interviews and longer-form discussions allowed in-depth exploration of experiences, meanings, and support needs, whereas shorter Padlet and chat contributions captured more concise reactions, priorities, and design suggestions. Data were analyzed according to the nature of the data themselves. Inductive content analysis [23] was used where the comments were shorter, and thematic analysis [24] was used for full interview or focus group discussion data. We examined areas of convergence, complementarity, and difference across sources to identify recurring user needs and actionable implications for intervention content, delivery, and design. This type of integration is consistent with the PBA, in which different forms of qualitative enquiry are used iteratively to develop an understanding of users' psychosocial context and translate this into guiding principles and intervention features [15,25].

Coding was done manually (by FM), using an iterative process to return to previously coded data to reexamine for new codes, and refinement into themes occurred via discussion with other authors. The analysis was led by a clinical psychologist (FM) without lived experience of supporting a child who self-harms but with professional experience of working with families managing this situation. The wider analytic team included a parent with lived experience of the topic and another psychologist with extensive experience in self-management approaches. We recognized that the psychologists' backgrounds

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might incline us to interpret parents' accounts through a behavior-change or intervention-focused lens. Team discussion took place to recognize this and ensure that analysis remained grounded in the data. A detailed logic model was created using the qualitative data to inform each element [26].

Development of Guiding Principles (Stage 3)

Guiding principles serve as a bridge between the intervention logic and practical design decisions such as intervention tone, delivery mode, and key design objectives important to effective implementation [15]. Themes identified through interviews, focus groups, and co-design workshops were reviewed in conjunction with the research literature. These were translated by the research team (with input from SLG) into provisional design objectives and key intervention features.

Content Development (Stage 4)

Drafting Content (Stage 4a)

Using results from stages 1 to 3, an initial outline of the intervention was drafted (by FM), with ongoing discussion with coauthors, and also drawing on relevant psychological theory and evidence-based intervention approaches (see Results section). Content was structured around the core behavioral and emotional challenges identified by participants (eg, guilt, fear of judgement, and communication uncertainty), with each section designed to be modular, brief, and practically useful, based on the guiding principles.

Existing resources and evidence-based techniques were integrated into the digital, web-based resource. Psychoeducational content about self-harm and its functions was informed by the UK-based *Coping with Self-Harm: A Guide for Parents and Carers* information leaflet [27], which consolidates clinical insights and empirical data from parents and young people. Cognitive-behavioral principles and techniques, including cognitive restructuring, strategies for managing worry and self-critical thinking, and behavioral activation, were included [28]. In response to qualitative findings that parents often experience intense guilt, shame, and self-blame, the intervention also incorporated self-compassion and acceptance-based approaches [29,30]. Sessions focusing on communication and relational repair between parents and their child were informed by literature on family connectedness, the importance of good parent-child communication, and the presence of emotional support from parents as protective for adolescent self-harm [31,32]. Communication strategies also reflected guidance available in various digital materials from UK mental health charities such as YoungMinds and Mind. To support behavior change and promote engagement, the intervention included structured goal-setting and reflection tools, common in self-management interventions [33]. These were adapted to the context of parental well-being and designed to facilitate self-monitoring, self-efficacy, and autonomy in applying new strategies.

Eliciting Feedback on Draft Content (Stage 4b)

A text version of the original prototype, with descriptions of the videos and interactive activities, was shared with the PPI panel for comments. Feedback was provided via email and/or in-group discussions led and collated by our PPI lead. These were analyzed using qualitative content analysis [23]. Sampling was opportunistic, based on who was interested and available to comment, reflecting that within PBA, even a small number of respondents can provide very useful information for design and refinements [15].

Initial Intervention Testing (Stage 4c)

Overview

An initial formative alpha user test was conducted. Its purpose was to identify actionable problems with content, presentation, emotional burden, navigation, engagement, and the proposed assessment procedures, and to inform further refinement. This use of small-sample iterative testing is consistent with PBA development, where detailed user reactions are used to optimize an intervention before formal feasibility evaluation [15]. Small samples of prototype users are typical, for example, 5 to 7 or 10 to 12 are seen in other studies using this approach [34,35]. We aimed to recruit 10 to 12 parents to test the intervention and provide feedback, as sufficient to identify key usability and design issues [15]. Participants were recruited via 2 established parent support groups, where the group leads shared details about the study via email and at a group meeting.

No formal feasibility, progression, or stop-go criteria were prespecified because this was an intervention-development activity rather than a feasibility study. Candidate parent-reported measures included the Warwick-Edinburgh Mental Well-being Scale, Patient Health Questionnaire-9, Generalized Anxiety Disorder-7, Kansas Parental Satisfaction Scale, and Parent-Adolescent Communication Scale [36-40]; these were included to examine the practicality of the proposed assessment battery and not to estimate intervention effectiveness. No young-person or family-level outcomes were collected. The alpha test was designed to identify actionable development issues only, rather than providing a benchmarked usability evaluation; therefore, standardized usability instruments were not included at this stage.

Safety and Scope of the Parent-Facing Intervention

PASH was developed as self-guided informational and well-being support for parents and carers, not as treatment for the young person or as a crisis service. There was no content aimed at CYP well-being, with no resources for CYP. The participant information sheet and consent materials for the alpha test clearly highlighted that the resource was intended to support parents' well-being and information needs. At all stages of the information and consent process we provided information about sources for more support. Intervention content was developed and reviewed with clinical psychologist input. The intervention onboarding process includes the information about the scope of the resource in relation to risk management and safety:

> *Sometimes unexpected events happen, life can become tough and you may find yourself in a crisis. We are not able to manage emergencies or provide crisis support and want to ensure that you know where to find the right help if that happens. If you, or someone you know, needs urgent help, contact one of the*

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emergency support agencies listed in "In a Crisis" page available in each session.

A clearly visible "In crisis" box was available on every intervention page, directing users to established urgent support including 999, NHS 111, Samaritans, and other relevant services. There were also pages listing "Additional support." The intervention was self-guided; it did not involve real-time clinical risk monitoring or participant-specific clinical oversight. Formal prospective adverse-event ascertainment was not undertaken at this intervention-development stage; this should be included in subsequent feasibility evaluation. Participants were recruited through parent support groups, meaning they had additional support available to them.

Results

Evidence and Systematic Review of Interventions (Stage 1)

Overview

A previous systematic review of 32 studies examining parents' experiences and needs following self-harm by a child or young person informed intervention development [11]. Quantitative evidence was limited and heterogeneous but broadly indicated poorer mental health and elevated psychological distress among parents. Qualitative findings described intense fear, guilt, shame, and helplessness, often linked to parents' interpretations of self-harm and perceived personal responsibility. Uncertainty and limited understanding could reinforce self-blame and distress, while parents also described rumination, hypervigilance, reduced sleep, diminished social support, and reduced engagement in self-care. These findings suggested that parent support should extend beyond information provision and identified self-blame, rumination, uncertainty, and reduced self-care as candidate processes for intervention development.

The intervention-focused systematic review identified 8 reports representing 7 intervention models published by June 2023 that were eligible for the review and were used to inform intervention design [41-48]. The interventions were predominantly structured, face-to-face, and clinician-delivered, most commonly within specialist outpatient settings or through CAMHS. None was self-guided or digitally delivered, and several were embedded within treatment principally directed toward the young person or family rather than designed primarily to support parents' own well-being. The therapist-led peer-support group "SPACE" was the intervention most clearly focused on parents' well-being in its own right [47].

The interventions were predominately clinically orientated, often dialectical behavior therapy based or informed [41,42,44,45,48], with some use of family-focused cognitive behavioral therapy [43] and a more supportive therapist facilitated peer-group approach [47]. Parent-facing content included psychoeducation, emotion regulation and coping, self-care, communication, problem-solving, boundaries, crisis management, and social support. It was not always clear whether components primarily targeted parents' well-being or their capacity to support the young person. Detailed characteristics of interventions used to inform PASH are provided in Multimedia Appendix 2 [41-48].

Quantitative evidence from the considered interventions was mixed and did not establish the effectiveness of any particular intervention or component for parental well-being. For example, some uncontrolled evaluations reported improvements in depression and caregiver strain [41], perceived stress [42], caregiver burden, grief, and stress [44,45] while a waitlist controlled evaluation [46] found no significant between-group differences in depression, caregiver burden, empowerment, or grief. Evidence was therefore used to identify candidate intervention ingredients rather than components with established efficacy.

From the intervention literature, a recurring set of parent-support functions was evident: helping parents understand self-harm; supporting their own emotion regulation and coping; addressing stress, guilt, or self-blame; legitimizing self-care; increasing confidence in communication, boundaries, and responses to crises; and providing validation and connection with others. Qualitative and formative findings informed intervention design: parents valued practical coping and emotion regulation skills, greater confidence in responding to their child, acknowledgment and validation of their own distress, opportunities for peer connection, and dedicated space or "permission" to attend to their own needs [41,44]. Feedback also suggested a preference for greater interactivity over didactic delivery [44] and for flexible timing around other demands [41]. These findings informed the intervention-design implications summarized in Textbox 1.

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Textbox 1. Implications for intervention design from systematic reviews.

Key issue identified in reviews

- Many parents experience high levels of depression, anxiety, stress, and grief. Some interventions appeared to ameliorate this.
- Parents report feeling overwhelmed, isolated, and blamed. Intervention content to specifically address these experiences was limited.
- Parents lack clear guidance on how to respond to self-harm. Some interventions included information.
- Parental burden and role strain are common and sustained. Interventions do not all address this issue.
- Grief and loss related to unmet expectations and ongoing worry emerge as key themes. Interventions vary in degree to which they address this.
- Peer support is valued. Many interventions do not use peer support.
- Parents value feeling permission to self-care. Many interventions offer parental support only as part of a wider young-person focused package.
- Engagement is shaped by emotional readiness and logistical constraints.

Implication for intervention design

- Include evidence-based emotional regulation and self-compassion strategies.
- Begin with validation and psychoeducation; use normalizing language and relatable parent voices.
- Offer simple, scenario-based tools (scripts, checklists, and brief videos) for common challenges.
- Normalize parent experiences, address issues of fatigue and competing responsibilities, and validate emotional load and encourage sustainable self-care practices.
- Provide short reflective content on ambiguous loss, emotional acceptance, and letting go.
- Embed authentic peer voices (quotes and videos); explore safe ways to offer peer interaction or community support.
- Provide dedicated content focused on parents' well-being in their own right.
- Structure content modularly; ensure asynchronous, flexible access and mobile-first delivery.

Implications for Intervention Design

Findings from these reviews of the literature had clear implications for intervention design, summarized in Textbox 1, which informed subsequent development stages.

User Needs and Perspectives (Stage 2)

Overview

Data from the interviews, focus groups (stage 2a, total n=13), and workshops (stage 2b, total n=11) are presented together. Interviews involved 2 health care providers (1 male and 1 female, both White British), 2 young people (1 male and 1 female, both White British), a charity worker (female, British Asian), and 3 parents (1 father and 2 mothers, all White British). Small focus-group discussions involved a further 5 parents (4 White British mothers and 1 British Asian father). The 2 workshops were attended by 11 people in total (5 and 6, respectively), including 1 young person (female, White British), 2 fathers (both British Asian, 1 also a health professional), and mothers identifying as White British, including another health professional.

Stage 2 findings were integrated for intervention development after source-appropriate analyses had been completed. Short-form Padlet/chat contributions were analyzed using content analysis, while interviews, small-group discussions, and longer workshop discussions were analyzed thematically. These generated complementary findings, which are reported separately and subsequently synthesized into intervention-design implications.

There was some overlap in participation across development activities. Two mothers participated in all participant-facing stages, including stage 2a user-needs research, a co-design workshop, prototype review, and alpha testing. A further 2 mothers contributed to a co-design workshop and prototype review. Other contributors participated in 1 or more activities, but no further systematic overlap was recorded.

Content Analysis

Content analysis was conducted (by FM) on short-form data from Padlet posts and chat contributions during co-design workshops. Six major content categories were identified through inductive coding.

Emotional Impact on Parents

Parents described guilt, fear, helplessness, sadness, and anger, alongside feeling overwhelmed and isolated. Some blamed themselves, while others described feeling that friends and family did not fully understand their experience. A strong sense of isolation emerged.

Family Dynamics

Parents often referred to the complexity of their family arrangements and how these dynamics intersected with their experiences of supporting a child who self-harms. Some discussed the added challenges of coparenting, stepparenting, or managing multiple siblings. There was evidence of tension in family relationships, especially when family members held differing views on how to respond, with strain in marital or partner relationships and feelings of being undermined or unsupported at home.

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Interactions With Health Services

This category included reflections on accessing health care services including general practitioners, accident and emergency departments, CAMHS, or inpatient units. Some parents described helpful professional support, while others reported delays, unclear advice, difficulty navigating services, or feeling dismissed, excluded, or blamed. These experiences could increase anxiety and disempowerment. Some experienced confusion about where to go next or how to navigate complex pathways. Parents sometimes described feeling unheard, or having their concerns dismissed or minimized. Some parents described feeling blamed by professionals, undermining trust in services.

Gaps and Needs for Support

This captured statements where parents asked directly for help, highlighted gaps in provision, or described what they wished had been available. Some needed emotional support, such as someone to talk to without judgment. Others wanted more information about self-harm or about what to expect from services. There were calls for better signposting and easier access to reliable resources.

Several comments highlighted that support for parents often seemed like “an afterthought” or was missing entirely. Barriers to access what support was available included being unable to attend support sessions as parents needed to be at home or with their child to monitor safety, or were managing their child’s appointments or work. Unpredictable changes in child’s well-being meant that rigid appointment schedules were stressful. Shame and stigma were also mentioned as making it hard to access support.

Strategy Sharing

A number of parents shared coping strategies, including tips on how to start a conversation with their child, how to check for injuries, or what kind of language to avoid. Others asked for advice on managing boundaries or knowing when to involve professionals. The tone was often pragmatic, however at times parents were asking for reassurance, understandably.

Importance of Peers and Not Feeling Alone

Many parents expressed gratitude for hearing from others in similar situations, with the comfort of recognition and shared stories clear. Parents described a reduction in shame when they realized they were not alone. Even brief posts that echoed someone else’s feelings were described as useful. There was a strong desire for nonjudgmental spaces where parents could exchange experiences and feel understood without stigma.

Thematic Analysis

Thematic analysis of the free discussion during interviews, focus groups, and workshop revealed the following themes.

Parents’ Emotional Experiences and Guilt

As seen in the shorter forms of data collection, here many parents described the experience of discovering their child's self-harm as emotionally overwhelming. Feelings of guilt, helplessness, and confusion were common, particularly when parents were advised not to intervene in ways that felt instinctive, for example, one parent stated, “You feel like you’ve failed—and you don’t even know what you did wrong.” Parents described working to hide visible panic or distress in order to protect their child’s emotional safety, while simultaneously feeling that they were falling apart: “It took me nearly 18 months to not look shocked when I saw it. But the look on your face, that’s real. That’s your child.”

The young people spoke about the importance of better information and support for their parents. One talked about how parents need to better understand how feelings leading to self-harm build up, recognize it has happened as soon as possible, have ideas for how to support at that moment, and know how to say, “like at dinner of something...saying, hey, are you feeling ok?” They both agreed that parents needed more support with their own feelings too: “support them through their stuff, with professional help.”

Uncertainty About How to Respond and Parent

Several spoke of a sense of lost authority or disorientation in their role as caregiver. One parent reflected, “It takes away your power as a parent. You’re watching someone you love hurt themselves and you’re told not to say stop. It breaks you.” Parents described significant uncertainty about how to respond, both emotionally and practically. This included uncertainty about how to handle disclosures, how to speak to their child, whether to monitor them more closely, and how to react if or when self-harm recurred. They described “I just needed someone to give me a plan” and “you don’t know what to say, you’re scared to say anything.” Some parents sought practical advice on how to create safety without escalating conflict or shame. There was a strong demand for simple, scenario-based tools such as scripts, checklists, or video examples, all delivered in a nonpatronizing and supportive tone. Parents emphasized that practical guidance needed to be available on demand rather than only during formal sessions. The need for support outside usual service hours, including during the night, was also raised; parents described being awake listening for their child moving around.

Need to Make Sense of Self-Harm

Parents described an urgent need to understand what was happening and why. For most, self-harm had been an unfamiliar and frightening behavior before it occurred in their own family: “The first thing I knew was a phone call from the school”; “She didn’t talk about it. It was private. And I didn’t know what to do with that.” Professionals and the young person themselves emphasized the value of psychoeducation for parents. The charity worker observed that “once parents understand it as a coping mechanism, they stop blaming themselves.” In discussion, participants agreed that early, clear, and nonstigmatizing information would be a core benefit of any digital support tool. One parent said, “something that is online that has information provided to you and sort of self-care...you can walk through when you need to.” Having well organized, trustworthy information was key. For example, one parent said, “you spend hours or you can spend hours, trawling the internet, can't you? I mean, where do you even start?”

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Managing Health Services

Experiences with professional services were highly variable, but many parents described being excluded from decision-making or support. One parent said, “We got no support. I got no advice, I got no support.” Some were denied access due to not meeting thresholds, while others were left to manage risk alone at home. This contributed to a sense of being ignored, and sometimes blamed, by the very systems meant to help. The health professional in the study noted: “Parents are often completely out of the loop...If I were one of those parents, I’d be very scared.” Practice guidance and realistic expectations, alongside empowerment to advocate for their child and themselves, were indicated as important needs. The challenge of finding support for themselves was clear: “[Mental health charity] signpost you, who then signposted you to [another charity] and then?...you just go round in a massive circle.”

Value of Peers

Parents expressed how powerful it was to feel heard, especially by other parents or professionals who took time to listen without judgment. Many described the loneliness of not being able to talk to friends or family, either because of stigma or fear of being misunderstood: “You can’t talk about this in the playground. People think you’re a bad parent or that your kid is broken.” Experiences of concern for parents themselves were rare. One parent reflected that after several years of their interactions with CAMHS, they were asked how they were: “It was the first time someone asked how I was. Not what I was doing, but how I was.” Peer groups, charities, and informal support networks were highly valued, particularly when they provided space for honesty without fear of blame. Warmth, authenticity, and inclusion of lived experience were indicated as important features of useful support. Others spoke about the importance of anonymity: “Maybe you can be able to ask questions anonymously, as well as be able to access information and things.”

Implications for Intervention Design

Despite differences in depth and mode of data collection, there was substantial convergence across the stage 2 sources in the needs and design priorities identified. Findings were therefore integrated at this stage to derive the intervention requirements. A web-based format was selected in response to stage 2 findings. Parents described needing support that could be accessed privately, flexibly, and at their own pace, including outside usual service hours and around unpredictable caregiving demands. Professionals and young people also supported digital delivery as a means of providing consistent information and support. These findings informed an asynchronous, modular design accessible through desktop and mobile devices. Stage 2 findings provided further implications for intervention design, set out in Textbox 2.

Textbox 2. Implications for intervention design from stage 2 results.

Key issue identified user need data

- Emotional overwhelm (guilt, fear, and isolation).
- Uncertainty about how to respond to self-harm.
- Feeling excluded or disempowered by services.
- Lack of understanding of self-harm.
- Need for peer support and shared experience.
- Logistical and emotional barriers to engagement.

Implication for intervention design

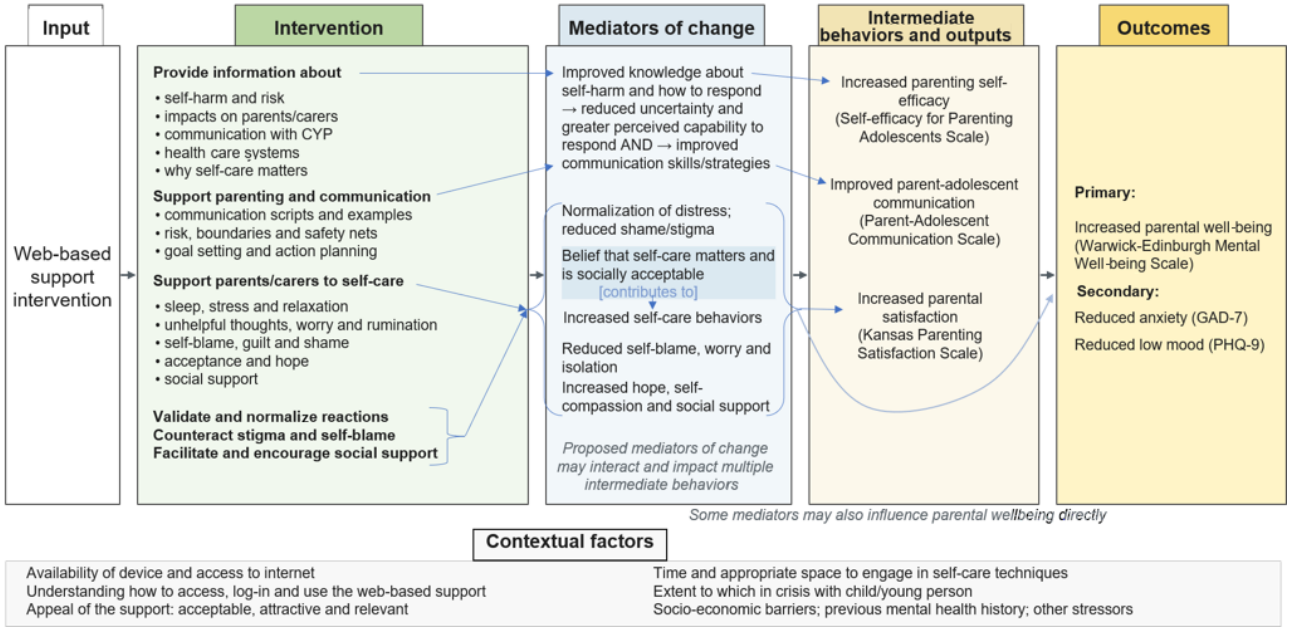
- Material to validate parent emotions, psychoeducation and normalization of parents’ distress, and emotion regulation techniques.
- Practical guidance tailored to common dilemmas and normalization of uncertainty.
- Content to support parents to feel empowered in supporting and parenting their child. Material re: navigating health systems.
- Accessible psychoeducation reframing self-harm as a coping strategy; stigma-reducing, nonblaming language.
- Embedded parent stories and quotes, optional peer support features, and warm, authentic tone prioritizing lived experience.
- Available when needed, modular, digital—accessible on desktop and mobile devices; asynchronous design; content grouped around needs, not linear progression.

Development of Initial Logic Model of the Intervention

Findings from stages 1 and 2 (systematic review and qualitative data) were used to create an initial logic model or theory of change shown in Figure 4. The intervention is hypothesized to support parental well-being by increasing understanding and perceived capability; normalizing distress and reducing shame and stigma; reducing self-blame, worry, and isolation; increasing hope, self-compassion, and social support; and increasing the perceived legitimacy and enactment of self-care. Improvements in parenting self-efficacy, parenting satisfaction, and parent-adolescent communication are hypothesized to provide an additional route to parental well-being by reducing uncertainty, helplessness, and relational strain. These processes are expected to interact, and some mediators may influence parental well-being directly rather than solely through the intermediate behaviors and outputs.

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Figure 4. Logic map or theory of change for our novel intervention to support parents of children who self-harm. Blue arrows detail proposed most direct, hypothesized impacts of intervention components. CYP: children and young people; GAD-7: Generalized Anxiety Disorder-7; PHQ-9: Patient Health Questionnaire-9.



Guiding Principles (Stage 3)

The guiding principles are set out in Table 1. These were used to support drafting of content. The importance of addressing specific psychological processes is clear throughout the design objectives, covering issues such as self-blame. These inform selection of theoretically informed techniques, described in stage 4a.

Table 1. Guiding principles for our intervention to support parents of children who self-harm.

Design objective	Key intervention features
Reduce self-blame and promote self-compassion among parents and carers	• Language that normalizes distress and communicates that difficult feelings are common • Real-life examples from other parents • Reflective exercises to challenge self-critical thinking • Dedicated session on guilt, shame, and kindness
Support emotional regulation and a sense of calm during distress and crisis	• Brief, actionable, regulation tools (eg, breathing techniques and grounding strategies) • Psychoeducation on the stress response • Integration of emotion regulation prompts across modules
Build parenting confidence in responding to self-harm and supporting well-being	• Scenario-based communication tips and scripts • Practical tools for managing safety and boundaries • Encouragement of self-efficacy through goal setting and reinforcement of competence
Validate parents' needs and reinforce the legitimacy of self-care	• Reframing self-care as a necessary foundation for caregiving • Dedicated modules on rest, sleep, and relaxation • Consistent tone that affirms the importance of the parent's well-being
Maximize accessibility, autonomy, and emotional safety in user experience	• Flexible, modular session structure that allows personalized pacing, delivered online, and available on-demand • Option to revisit or skip sessions • Trauma-informed and emotionally sensitive tone • Designed to reduce friction in access and engagement

Content Development (Stage 4)

Intervention Design and Content (Stage 4a)

The resulting intervention, given the working title "PASH," was a web-based, self-guided resource developed to support the emotional well-being of parents and carers of young people who self-harm. The intervention consists of 12 thematically structured modules, each focused on a specific aspect of parenting or coping in the context of adolescent self-harm (Table 2). Topics include understanding self-harm, managing emotional distress, improving communication, setting boundaries, and navigating guilt, shame, and self-care. Within this, we address 3 core sets of needs: information needs (predominately modules 1-2), skills and strategies (predominately modules 3 to 5), and

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self-care (predominately modules 6 to 12). The development was shaped by the guiding principles established in stage 3 and grounded in evidence from the systematic review and qualitative work completed in stages 1 and 2. The intervention was designed to be flexible, emotionally safe, and responsive to parents' lived experiences, while addressing the psychological and practical challenges identified across the development process.

Table 2. Modular content of PASH[a] intervention to support parents of children who self-harm.

Module	Content
1	Why is this happening
2	How other parents feel and what resources are out there
3	Managing risk
4	Communication
5	Parenting now
6	Difficult emotions, why self-care matters, and self-care goals (increasing belief re: need and acceptability of self-care)
7	Sleep, stress, and relaxation
8	Unhelpful thoughts
9	Self-compassion
10	Managing anxiety
11	Kicking guilt and self-blame
12	Acceptance and hope

[a]PASH: Parents Support With Adolescent Self-Harm.

The content was informed by multiple therapy approaches and theories, drawing on cognitive-behavioral, acceptance-based, compassion-focused, systemic, and positive psychology approaches. These approaches were selected to target candidate cognitive, emotional, behavioral, and relational processes identified in stages 1 to 3, including self-blame, rumination, hypervigilance, emotional dysregulation, and reduced self-care [11]. The "NSSI Family Distress Cascade Theory" was particularly influential, highlighting how a young person's self-harm can trigger cycles of parental guilt, anxiety, and controlling responses that increase family tension and inadvertently maintain risk [49]. This model directly informed the inclusion of strategies to address self-blame, regulate intense emotions, and support more adaptive relational patterns. A recent scoping review further underscored the high levels of stress among parents of young people with self-injurious thoughts and behaviors, and the need for interventions that address both cognitive and emotional responses [50].

The resulting intervention consists of 12 brief modules that parents can access in any order according to their needs and emotional readiness. Modules combine concise psychoeducation, reflective exercises, case examples, and practical tools, presented in a nonjudgmental, validating tone. A visible crisis support link is available across the platform, and modules are intentionally short to reflect parents' limited time and emotional capacity during periods of acute distress. A description of the intervention, based on the domains of an intervention description checklist (Template for Intervention Description and Replication), is provided in Table 3.

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Table 3. TIDieR[a]-based description of the alpha-tested version of PASH[b] digital intervention to support parents of children who self-harm.

TIDieR item	PASH description
Brief name	PASH (Parents Support With Adolescent Self-Harm).
Why	To support the emotional well-being of parents and carers of young people who self-harm. Parenting or communication content addresses uncertainty and perceived capability where these contribute to parental distress.
What: materials	Twelve web modules using written material, short videos or audio, parent quotations or examples, reflective exercises, quizzes, symptom tracking, gratitude/journaling activities, goal setting, bookmarking, practical guidance, and optional peer support.
What: procedures	Users select modules according to need. Modules combine a brief introduction, psychoeducation, practical strategies or tools, and reflective prompts. Crisis information and urgent-support signposting are available on every page.
Who provided	Self-guided; no clinician or therapist delivers the intervention. Content was developed by the research team with clinical psychology and digital self-management expertise and iteratively reviewed with parent or carer PPI[c] contributors.
How	Asynchronous web access through a smartphone, tablet, or computer. No scheduled sessions are required.
Where	Designed primarily for use at home or another community setting with suitable privacy and internet access.
When and how much	Twelve brief modules, generally approximately 15 to 25 minutes each. Users may access modules in any order, pause, revisit, or skip content; no prescribed total dose or completion schedule.
Tailoring	User-led tailoring through module choice, pacing, revisiting, and bookmarking. No therapist-led individual tailoring.
Modifications before alpha	Following PPI review, revisions were made to tone and some information about managing emotions during crisis. Resource constraints meant that not all suggested additions were implemented before alpha testing.
Modifications after alpha	Revisions to goal-setting and crisis information sections were recommended in alpha feedback using softer wording, clearer examples, greater optionality, and more supportive framing. Login burden remains a separate technical optimization issue.
How well: planned	No therapist-delivery fidelity assessment was applicable. The alpha stage used usage data, ratings, candidate measures, and open feedback to identify intervention problems. No formal adherence, feasibility, progression, or stop-go threshold was prespecified.
How well: actual	Twelve parents enrolled; 7 viewed at least 50% of available content and returned all follow-up measures. Five did not return follow-up and did not respond to subsequent contact; reasons are unknown.

[a]TIDieR: Template for Intervention Description and Replication.

[b]PASH: Parents Support With Adolescent Self-Harm.

[c]PPI: Patient and Public Involvement.

The modules relate to 3 broad content domains. First, parents' information needs are met through clear explanations of the functions of self-harm, common misconceptions, and typical parental emotional reactions. This material draws on cognitive-behavioral and systemic perspectives emphasizing the role of appraisals and family dynamics in shaping emotional responses [28,51]. Psychoeducation on rumination, catastrophic thinking, and self-blame aligns with established evidence linking these processes to stress and low mood, as seen in many parents and caregivers [52]. Lived-experience narratives were included to reduce shame and normalize feelings of fear, guilt, and confusion [11].

Second, practical parenting and coping skills are provided, reflecting behavioral, cognitive-behavioral, and systemic approaches. Parents are supported in responding to disclosures, assessing risk, communicating in validating ways, maintaining routines and boundaries, and coregulating emotions with their child. These elements reflect evidence that supportive communication, problem-solving, and adaptive parental response styles are associated with improved parental mental health and family functioning [31,53]. Strengthening parenting self-efficacy was a key aim, given its potential role in reducing parental distress [54]. Practical content reflected tools and approaches parents had found useful, including first aid guidance and links to Parental Minds videos, knowing when to seek urgent support (including 111 or 999), recognizing potential triggers, and keeping the child safe. Coregulation included planning shared, enjoyable activities [55]. Communication guidance covered crisis and everyday situations, encouraging active listening, curiosity, and nonjudgment. Parenting content also addressed discipline, monitoring, maintaining a sense of fun, and establishing clear boundaries and safety nets.

Third, modules address parents' own emotional well-being, targeting processes such as anxiety, rumination, guilt, shame, and exhaustion. Cognitive-behavioral strategies support identification and reframing of unhelpful thoughts and catastrophic appraisals [56], while acceptance-based approaches encourage grounding, willingness, and psychological flexibility

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in response to ongoing stressors [57]. Compassion-focused strategies were included to address the high levels of shame and self-criticism reported by parents of children with mental health difficulties [30,58]. Goal setting, noticing moments of resilience, sleep and stress management, and reengagement with restorative activities are based in positive psychology and self-management approaches [59,60]. Self-care materials began with the need for acceptance, recognizing that the situation was happening and that it was okay to find it difficult. Self-compassion was emphasized, along with recognizing and managing difficult emotions. The section encouraged strategies for managing unhelpful thoughts, rumination, worry, and anxiety, particularly where hypervigilance had been an issue. Stress management was addressed through distress tolerance techniques. Content also addresses sleep hygiene, basic needs for rest and nutrition, relaxation, and realistic self-care goals. Materials balance hope that self-harm can reduce or stop with acceptance of its current presence.

Together, these design decisions support the theory of change developed in stage 3. By reducing self-critical thinking, rumination, and emotional reactivity; strengthening coping skills, psychological flexibility, and self-compassion; and supporting effective communication and parenting strategies, the intervention aims to enhance parental well-being and increase parents' capacity to respond calmly and effectively to their child's self-harm across both acute and ongoing contexts.

The intervention is delivered asynchronously through a web browser (available on desktop or mobile devices) via the Powered by H4C digital platform, which provides multimedia, interactive content, reflection tools, quizzes, bookmarking functions, exercises such as goal setting and gratitude practices, and an optional peer support forum. No therapist input is required, and participants engage with the content independently at their own pace. The tone is intentionally validating, nonjudgmental. The design incorporates trauma-informed framing, modular structure, and a soft visual style to promote accessibility and engagement. Most sessions are designed to be completed within around 15 to 25 minutes; however, there was no set time limit.

Feedback on Draft Content (Stage 4b)

A group of 14 parents, from the PPI panel, provided review of the content, including 2 fathers and 12 mothers, all identifying as White British, all with children who had started self-harming between 1 and 8 years previously. Overall, the content was perceived as useful, highly relevant, reassuring, and compassionate. There was strong consensus that the resource should be widely disseminated to parents, particularly through schools, CAMHS, general practitioner surgeries, and online networks. Indeed, some expressed frustration that they had not come across such material earlier in their journey. Participants consistently noted that the materials struck the right balance between providing clear guidance and showing emotional understanding:

> *It's really easy to read and easy to dip in and out of when needed.*
>
> *I feel reassured that someone knows how I'm feeling supporting my young person.*
>
> *Though I'm sad to have to make use of this, I found it comforting that I'm not the only one.*

The tone of the materials was described as "nonpatronizing," "sympathetic," and "human." Several participants commented that the course gave them a sense of hope. They valued the emphasis on parental reassurance and noted that the material made them feel less alone.

In relation to specific content, feedback highlighted the importance of representing the range of ways CYP self-harm: some participants suggested a brief outline of the range of methods, including more extreme methods, as this reflected their lived realities, while others suggested careful wording to avoid triggering readers, perhaps by using more technical language; however, overall, there was agreement that frankness was appropriate when handled sensitively. However, parents raised concerns about conflicting guidance on restricting access to harmful items. While some had been advised by professionals to lock everything away, others felt that this could erode trust or was practically impossible. They suggested content be adapted to reflect the complexities of this issue. Many also valued the inclusion of messages about self-compassion, validation of emotions, and the idea that parents cannot always be perfect. The "Sushi Train" metaphor (a common acceptance commitment therapy–based metaphor that invites people to consider that just because a thought is going round in our heads we do not have to take it and give it attention) was particularly well received for communicating emotional processes visually. Parents described it as engaging, easy to understand, and useful for discussion with young people.

The navigation and "look" of the resource was typically neutrally or positively received. One parent noted that photographs of real people helped with relatability. The organization of information was seen as clear and easy to navigate. Bullet points, diagrams, and chapter progression were viewed as helpful. Some felt that a printed copy of information could usefully support the digital resource. Several parents indicated that they would be interested in completing the resource as part of a structured course and felt that more time for reflection and discussion would be helpful, while others were keen on a self-study, unstructured approach.

Specific issues requiring improvement were raised. Several participants felt that some of the most emotionally resonant sections, such as self-care and messages about not blaming oneself, should appear earlier or be more prominent. They described these sections as "spot on" but suggested that they could have more impact if users were directed to these as a place to start. Participants also suggested a stronger emphasis on tools and techniques that parents could share with their young people to regulate distress, but others were grateful for the focus on parents directly. While some alternatives to self-harm were referenced, some parents recommended including more specific strategies (eg, using ice water and sensory boxes), ideally in a bullet point format for easy access during crisis. In addition, suggestions were made to expand content on communication styles (eg, "how to talk to schools when your child doesn't want

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you to"), managing sibling relationships, and navigating unhelpful peer influences or social media exposure.

Initial Intervention Testing (Stage 4c)

Following changes to the intervention's content, based on the feedback (limited by resources to focusing on revisions of tone, small changes in adding information about managing emotions during crisis), a small-scale alpha test of the intervention was carried out with 12 parents recruited through a parent peer support group. Of these, 7 participants completed the intervention (defined as viewing at least 50% of the content) and all associated measures. All participants were mothers, with 1 describing themselves as "Mixed Ethnicity" and the others White British. The remaining 5 did not provide any reasons for noncompletion. Measure scores were not analyzed directly, owing to the aims and sample size of this formative intervention development study. However, responses to the Patient Health Questionnaire-9 item relating to risk of harm to self were inspected for safety monitoring. All participants rated this item as "never"; therefore, no further action was taken. No participants reported significant distress or requested additional support from the research team.

Participants gave mean session ratings between 6 and 7 out of 10, with individual scores ranging from 4 to 10 (1=extremely poor, 5=neutral, and 10=excellent). Participants reported recalling content relating to goal setting, reminders to "slow down," and messages such as "not my fault" and "it will get better," which were described as reassuring and memorable. All participants who completed the intervention reported that they would recommend it to others.

Feedback highlighted areas for improvement. In particular, the goal-setting content was perceived as potentially overwhelming in its original format. Some participants felt that it came across as abstract or emotionally loaded, particularly when they were already feeling depleted. It was suggested that the activity should be simplified, reframed more gently, and made optional, with clearer examples and greater emphasis on flexibility. Similarly, the crisis information, including guidance on safety planning and recognizing risk, was seen as important but emotionally intense. Participants noted that this section might benefit from clearer signposting, simpler language, and supportive framing to help avoid panic or feelings of being solely responsible for their child's safety. As a result, revisions are planned to both sections to soften the tone, provide more concrete examples, and give users more control over when and how to engage with this content. Six of the 7 participants also reported that the need to log in to an account was off-putting, highlighting a barrier to access to be further explored.

Discussion

Principal Findings

This study describes the formative development of PASH through a structured PBA involving parents and carers, young people, clinicians, and third-sector professionals. Evidence synthesis identified limited existing support developed specifically for parents' own well-being following youth self-harm, while the qualitative and co-design work identified recurring needs for support with understanding self-harm and how to respond, managing emotional distress and persistent worry, addressing guilt and self-blame, attending to parents' own needs, and reducing isolation. These findings informed the development of a 12-module, self-guided digital intervention combining psychoeducation and sense-making, practical guidance for responding to self-harm, and direct psychological support for parental well-being. Formative alpha testing identified further priorities for optimization, particularly around goal-setting content, the repeated presentation of crisis information, and login burden.

Interpretation and Comparison With Existing Literature

Parents' needs identified here are consistent with existing literature, relating to emotional distress such as fear and guilt, and uncertainty for how to respond [8,9]. Substantial "secondary stress" has been observed among parents of young people who self-injure [10]. Parents' understanding and interpretation of self-harm, emotional reactions, self-care, and parenting responses may influence one another rather than forming independent domains [11]. This provides an important rationale for PASH combining direct psychological support with information and practical guidance rather than treating parent well-being as simply a problem of anxiety or low mood.

Existing interventions have previously included mindfulness and emotion-regulation skills, validation, coping and self-care, psychoeducation, communication and problem-solving, and support around responding to crises [41,44,47]. However, these components were frequently embedded within programs principally designed to improve adolescent or family outcomes, with an unclear link to parents' well-being. Here, practical parenting and communication content is included where uncertainty about what to do, perceived loss of competence, or difficult interactions may themselves contribute to parental distress. This is consistent with relational accounts such as the NSSI Family Distress Cascade Theory, which conceptualizes reciprocal relationships between youth self-injury, parental emotional responses, and family interaction [49].

The theory of change specifies interacting candidate mediators through which PASH may influence parental well-being. The proposed link between increased understanding, reduced uncertainty, and well-being is consistent with meta-analytic evidence that caregiver uncertainty is associated with poorer psychological functioning and illness-related distress across pediatric populations [61]. Parenting self-efficacy is positioned as an intermediate behavior and output because systematic review evidence links it with parental mental health and parent-child relationships [62]. In the specific context of adolescent self-harm, parental stress responses characterized by rumination and emotional or physiological arousal have been associated with poorer mental health and functioning, whereas more adaptive coping has been associated with better outcomes [63]. This literature supports the inclusion of psychoeducational, cognitive-behavioral, acceptance-based, and emotion-regulation strategies within PASH.

Self-blame, guilt, shame, and isolation were prominent in both previous literature and the present qualitative work [11],

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supporting intervention content that promotes normalization, self-compassion, and social connection. Wider meta-analytic evidence also indicates that self-compassion and worry or rumination are modifiable through psychological intervention [64,65]. Parenting and communication content is similarly included because uncertainty about how to respond and stressful interactions with the young person may themselves contribute to parental distress. The NSSI Family Distress Cascade Theory provides a theoretical basis for reciprocal relationships between caregiver distress, caregiver responses, and family interactions [49]. Our intervention logic hypothesizes that greater perceived capability, parenting self-efficacy, and less difficult or uncertain communication may support parents' well-being by reducing worry, helplessness, and relational strain.

Parental well-being is the primary intended outcome. Parenting confidence, parenting satisfaction, and parent-adolescent communication are positioned as intermediate parent and relational outcomes where they may contribute to parental distress or change alongside well-being, rather than as alternative primary outcomes. No young-person or family-level outcomes were evaluated in this study, and the model does not assume that changes in parenting or communication necessarily result in changes in youth outcomes.

The proposed mediators and intermediate behaviors and outputs should nevertheless be regarded as testable hypotheses rather than established causal pathways. The processes shown in the theory of change (Figure 4) are expected to overlap and influence one another, rather than operate independently. Some proposed mediators, such as reductions in worry, self-blame, or isolation, may influence parental well-being relatively directly, while other effects may also operate through changes in parenting confidence, communication, or satisfaction. The strength of existing evidence varies across these proposed relationships. Subsequent evaluation should therefore assess changes in parental well-being alongside measures corresponding to the proposed mediators and intermediate behaviors and outputs.

The development and refinement of these intervention components are consistent with the PBA, which emphasizes understanding users' psychosocial context and using iterative qualitative feedback to optimize intervention content before formal evaluation [15]. Small formative samples have similarly been used in other PBA digital intervention-development programs [34,35]. Accordingly, the present alpha findings should be interpreted as identifying actionable development issues rather than estimating feasibility. The 5 participants lost to follow-up leave important uncertainty about sustained engagement, while the reported burden of logging in demonstrates that aspects of digital delivery may themselves impede engagement. These findings identify priorities for further optimization and subsequent formal feasibility evaluation.

Limitations

The qualitative and co-design samples were relatively small and predominantly recruited through convenience routes. Neither saturation nor a formal information-power criterion was used to determine sample size, and some contributors participated at more than 1 stage of development. Repeated involvement supported iterative development but may also have narrowed the range of perspectives represented.

Diversity was limited. Fathers contributed to the qualitative or co-design work and PPI panel, but all 7 alpha participants providing follow-up were mothers. The study included limited representation of diverse caregiving arrangements, such as kinship, foster, stepparent, or other nonparental caring roles, and the relevance or adaptation needs of PASH for these groups require further exploration. Participants were predominantly White British, with some British Asian and Mixed Ethnicity representation, and socioeconomic disadvantage, language needs, and digital exclusion were not systematically sampled. The intervention may therefore insufficiently reflect the needs of fathers, racially and ethnically minoritized communities, different family and caregiving arrangements, families experiencing socioeconomic adversity, and parents with restricted digital access or literacy. Although digital delivery was intended to improve flexibility of access, it may also create engagement and equity barriers, including limited digital access or literacy, privacy constraints, language needs, and differing confidence with online resources; these factors were not systematically sampled or evaluated in this study. While PPI input was included throughout, the recording of this was limited, owing partly to the very embedded nature of working with our PPI lead to develop the written materials. Further development of our intervention should follow reporting guidelines for this [66].

Finally, the alpha stage involved only 12 enrolled parents, with follow-up data from 7. Reasons for noncompletion among the remaining 5 are unknown. Viewing at least 50% of available material was used as a pragmatic descriptor of intervention exposure and not as a validated therapeutic dose, adherence criterion, or feasibility threshold. The alpha study was not designed or powered to estimate intervention effects, and questionnaire changes cannot be interpreted as evidence of effectiveness. Formal prospective adverse-event ascertainment was not undertaken at this development stage, and the post–alpha modifications have not yet themselves been user-tested. The proposed mechanisms of change also remain to be empirically tested.

Implications and Future Directions

The immediate next step should be further optimization, followed by a prospectively designed feasibility study, rather than an effectiveness trial. Optimization should implement and test the planned revisions to goal-setting and crisis-information content, explore ways to reduce login friction, and involve a broader range of parents and carers, particularly fathers, racially and ethnically diverse communities, families experiencing socioeconomic disadvantage, and people with differing levels of digital access and literacy.

A subsequent feasibility study should define its objectives and progression criteria prospectively, consistent with guidance for complex intervention evaluation [26]. Key uncertainties include recruitment, intervention initiation, patterns of module use, study retention, outcome data completion, burden, safety and adverse event procedures, and the feasibility of collecting proposed mechanism measures. PASH is modular intervention.

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As such, meaningful use and research retention should be considered separately rather than combined into a single "completion" metric. Any future feasibility study should use prespecified reminder and follow-up procedures, offer flexible routes and timings for follow-up completion, systematically record reasons for withdrawal or noncompletion where participants are willing to provide them, and distinguish intervention disengagement from loss to research follow-up.

Parental well-being should remain the primary intended outcome. Warwick-Edinburgh Mental Well-being Scale is proposed as the candidate primary measure of well-being [40], with anxiety and low mood as secondary parent outcomes and parenting confidence, satisfaction, and parent-reported communication as intermediate outcomes. Measures corresponding to uncertainty, self-blame or self-compassion, rumination and worry, self-care, and social connection would allow the proposed pathways to begin to be examined. Formal mediation analysis should be reserved for a later adequately powered evaluation.

If feasibility is established, a subsequent randomized evaluation should test whether PASH improves parental well-being. Effects on youth self-harm, youth mental health, or family functioning should not be assumed from improvement in parents and should be treated as distinct downstream questions. At service level, PASH may eventually offer one means of operationalizing recommendations that families and carers affected by self-harm receive appropriate information and support [12].

Conclusions

PASH is a self-guided digital intervention developed specifically to support the well-being of parents and carers of young people who self-harm. A PBA translated evidence and user needs into a 12-module intervention. Formative testing identified actionable refinements but does not establish feasibility or effectiveness. Further optimization and a prospectively designed feasibility study are required before evaluation of intervention effects and mechanisms.

Acknowledgments

The authors thank the parents, young people, clinicians, and third-sector professionals who contributed their time and experiences to the intervention development process. The authors are particularly grateful to the parents who participated in the Patient and Public Involvement panel and provided feedback throughout the development of the intervention. Their insights were essential in shaping the content and design of the resource.

Data Availability

The datasets generated and analyzed during this study are not publicly available due to the sensitive nature of the topic and the potential risk of participant identification, but anonymized data may be available from the corresponding author on reasonable request and subject to appropriate ethical approvals.

Funding

This study was funded in part by a small grant provided by the Emerging Minds Network and the UK Research and Innovation grant (ES/S004726/2).

Generative AI Use

GenAI (Open AI: ChatGPT, September 10, 2026) was used as part of the checking process, during authors' revisions, to help ensure that all comments had been addressed. This use was as an additional check, providing no final text.

Conflicts of Interest

None declared.

Multimedia Appendix 1

GUIDED checklist.
[DOCX File , 30 KB-Multimedia Appendix 1]

Multimedia Appendix 2

Summary of methods and findings from literature search for interventions with at least 1 component to support parents' well-being in relation to child self-harm.
[DOCX File , 37 KB-Multimedia Appendix 2]

References

1. Hospital admissions as a result of self-harm in children and young people. Nuffield Trust. 2024. URL: https://www.nuffieldtrust.org.uk/resource/hospital-admissions-as-a-result-of-self-harm-in-children-and-young-people [accessed 2026-10-18]

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2. Mental Health Statistics UK | Young People. YoungMinds. 2024. URL: https://www.youngminds.org.uk/about-us/media-centre/mental-health-statistics/ [accessed 2026-10-18]
3. Hawton K, Saunders KE, O'Connor RC. Self-harm and suicide in adolescents. Lancet. 2012;379(9834):2373-2382. [Medline: 22726518]
4. Mars B, Heron J, Crane C, Hawton K, Kidger J, Lewis G, et al. Differences in risk factors for self-harm with and without suicidal intent: findings from the ALSPAC cohort. J Affect Disord. 2014;168:407-414. [FREE Full text] [doi: 10.1016/j.jad.2014.07.009] [Medline: 25108277]
5. Boughey H, Poole J, Mezes B. Parents' and caregivers' understanding of self-harm in young people: a systematic review. Adolescent Res Rev. 2026. [FREE Full text] [doi: 10.1007/s40894-026-00289-3]
6. Curtis S, Thorn P, McRoberts A, Hetrick S, Rice S, Robinson J. Caring for young people who self-harm: a review of perspectives from families and young people. Int J Environ Res Public Health. 2018;15(5):950. [FREE Full text] [doi: 10.3390/ijerph15050950] [Medline: 29747476]
7. Raphael H, Clarke G, Kumar S. Exploring parents' responses to their child's deliberate self-harm. Health Educ. 2006;106(1):9-20. [doi: 10.1108/09654280610637166]
8. Ferrey AE, Hughes ND, Simkin S, Locock L, Stewart A, Kapur N, et al. The impact of self-harm by young people on parents and families: a qualitative study. BMJ Open. 2016;6(1):e009631. [FREE Full text] [doi: 10.1136/bmjopen-2015-009631] [Medline: 26739734]
9. Mughal F, Troya MI, Dikomitis L, Tierney S, Corp N, Evans N, et al. The experiences and needs of supporting individuals of young people who self-harm: a systematic review and thematic synthesis. EClinicalMedicine. 2022;48:101437. [FREE Full text] [doi: 10.1016/j.eclinm.2022.101437] [Medline: 35783485]
10. Whitlock J, Lloyd-Richardson E, Fisseha F, Bates T. Parental secondary stress: the often hidden consequences of nonsuicidal self-injury in youth. J Clin Psychol. 2018;74(1):178-196. [doi: 10.1002/jclp.22488] [Medline: 28493555]
11. Martin F, Ferrey A, Hobbs L, Lascelles K, van Even S, Oliver T. Understanding the impact of children's and young people's self-harm on parental well-being: a systematic literature review of qualitative and quantitative findings. Child Adolesc Ment Health. 2024;29(4):371-384. [doi: 10.1111/camh.12692] [Medline: 38362819]
12. Self-harm: assessment, management and preventing recurrence [NG225]. National Institute for Health and Care Excellence. 2022. URL: https://www.nice.org.uk/guidance/ng225 [accessed 2026-10-18]
13. Glenn CR, Franklin JC, Nock MK. Evidence-based psychosocial treatments for self-injurious thoughts and behaviors in youth. J Clin Child Adolesc Psychol. 2015;44(1):1-29. [FREE Full text] [doi: 10.1080/15374416.2014.945211] [Medline: 25256034]
14. McCauley E, Berk MS, Asarnow JR, Adrian M, Cohen J, Korslund K, et al. Efficacy of dialectical behavior therapy for adolescents at high risk for suicide: a randomized clinical trial. JAMA Psychiatry. 2018;75(8):777-785. [FREE Full text] [doi: 10.1001/jamapsychiatry.2018.1109] [Medline: 29926087]
15. Yardley L, Ainsworth B, Arden-Close E, Muller I. The person-based approach to enhancing the acceptability and feasibility of interventions. Pilot Feasibility Stud. 2015;1(1):37. [FREE Full text] [doi: 10.1186/s40814-015-0033-z] [Medline: 27965815]
16. Duncan E, O'Cathain A, Rousseau N, Croot L, Sworn K, Turner KM, et al. Guidance for reporting intervention development studies in health research (GUIDED): an evidence-based consensus study. BMJ Open. 2020;10(4):e033516. [FREE Full text] [doi: 10.1136/bmjopen-2019-033516] [Medline: 32273313]
17. Attribution 4.0 International (CC BY 4.0). Creative Commons. URL: https://creativecommons.org/licenses/by/4.0/ [accessed 2026-10-17]
18. Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies: guided by information power. Qual Health Res. 2016;26(13):1753-1760. [doi: 10.1177/1049732315617444] [Medline: 26613970]
19. Donetto S, Tsianakas V, Robert G. Using Experience-Based Co-Design (EBCD) to Improve the Quality of Healthcare: Mapping Where We Are Now and Establishing Future Directions. London. King's College London; 2014.
20. Stickdorn M, Hormess ME, Lawrence A, Schneider J. This Is Service Design Doing: Applying Service Design Thinking in the Real World. Sebastopol, CA. O'Reilly Media; 2018.
21. Greenhalgh T, Jackson C, Shaw S, Janamian T. Achieving research impact through co-creation in community-based health services: literature review and case study. Milbank Q. 2016;94(2):392-429. [FREE Full text] [doi: 10.1111/1468-0009.12197] [Medline: 27265562]
22. Boyd H, McKernon S, Mullin B, Old A. Improving healthcare through the use of co-design. N Z Med J. 2012;125(1357):76-87. [Medline: 22854362]
23. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res. 2005;15(9):1277-1288. [doi: 10.1177/1049732305276687]
24. Braun V, Clarke V. Thematic Analysis: A Practical guide. London, UK. Sage Publications; 2021:A.
25. Muller I, Santer M, Morrison L, Morton K, Roberts A, Rice C, et al. Combining qualitative research with PPI: reflections on using the person-based approach for developing behavioural interventions. Res Involv Engagem. 2019;5(1):34. [FREE Full text] [doi: 10.1186/s40900-019-0169-8] [Medline: 31807316]

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26. Skivington K, Matthews L, Simpson SA, Craig P, Baird J, Blazeby JM, et al. A new framework for developing and evaluating complex interventions: update of medical research council guidance. BMJ. 2021;374:n2061. [FREE Full text] [doi: 10.1136/bmj.n2061] [Medline: 34593508]
27. Hawton K, Saunders K, O'Connor R. Coping With Self-Harm: A Guide for Parents and Carers. Oxford, United Kingdom. University of Oxford, Centre for Suicide Research; 2015:A.
28. Beck JS. Cognitive Behavior Therapy: Basics and Beyond. New York. Guilford Press; 2011.
29. NEFF KD. Self-compassion: an alternative conceptualization of a healthy attitude toward oneself. Self Identity. 2003;2(2):85-101. [doi: 10.1080/15298860309032]
30. Gilbert P, Procter S. Compassionate mind training for people with high shame and self‐criticism: overview and pilot study of a group therapy approach. Clin Psychology and Psychoth. 2006;13(6):353-379. [doi: 10.1002/cpp.507]
31. Resnick MD, Bearman PS, Blum RW, Bauman KE, Jones J, Harris KM, et al. Protecting adolescents from harm. JAMA. 1997;278(10):823. [doi: 10.1001/jama.1997.03550100049038]
32. Chu JP, Goldblum P, Floyd R, Bongar B. The cultural theory and model of suicide. Appl Prev Psychol. 2010;14(1-4):25-40. [doi: 10.1016/j.appsy.2011.11.001]
33. Turner A, Martin F. Spreading HOPE: the development of a hope-based self-management intervention. In: Promoting Self-Management of Chronic Health Conditions: Theories and Practice. Oxford. Oxford University Press; 2017:58-79.
34. Bradbury K, Morton K, Band R, van Woezik A, Grist R, McManus RJ, et al. Using the person-based approach to optimise a digital intervention for the management of hypertension. PLoS One. 2018;13(5):e0196868. [FREE Full text] [doi: 10.1371/journal.pone.0196868] [Medline: 29723262]
35. Llahana S, Mulligan K, Hirani SP, Wilson S, Baldeweg SE, Grossman A, et al. Using the behaviour change wheel and person-based approach to develop a digital self-management intervention for patients with adrenal insufficiency: the study protocol. Front Endocrinol (Lausanne). 2023;14:1207715. [FREE Full text] [doi: 10.3389/fendo.2023.1207715] [Medline: 37455898]
36. Kroenke K, Spitzer RL, Williams JBW. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613. [FREE Full text] [doi: 10.1046/j.1525-1497.2001.016009606.x] [Medline: 11556941]
37. Spitzer RL, Kroenke K, Williams JBW, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166(10):1092-1097. [doi: 10.1001/archinte.166.10.1092] [Medline: 16717171]
38. Barnes HL, Olson DH. Parent-adolescent communication and the circumplex model. Child Dev. 1985;56(2):438. [doi: 10.2307/1129732]
39. James DE, Schumm W. Development of a parent satisfaction scale. Psychol Rep. 1985;56(3):735-738.
40. Tennant R, Hiller L, Fishwick R, Platt S, Joseph S, Weich S, et al. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. Health Qual Life Outcomes. Nov 27, 2007;5(5):63. [FREE Full text] [doi: 10.1186/1477-7525-5-63] [Medline: 18042300]
41. Berk MS, Rathus J, Kessler M, Clarke S, Chick C, Shen H, et al. Pilot test of a DBT-based parenting intervention for parents of youth with recent self-harm. Cogn Behav Pract. 2022;29(2):348-366. [doi: 10.1016/j.cbpra.2020.10.001]
42. Cloutier P, Gray C, Sheridan N, Silverman A, Cappelli M, Zemek R, et al. Building Resilience and Attachment in Vulnerable Adolescents (BRAVA): a brief group intervention for adolescents with mild-to-moderate suicidal ideation and their caregivers. Child Adolesc Ment Health. Nov 2022;27(4):343-351. [doi: 10.1111/camh.12506] [Medline: 34498386]
43. Esposito-Smythers C, Wolff JC, Liu RT, Hunt JI, Adams L, Kim K, et al. Family-focused cognitive behavioral treatment for depressed adolescents in suicidal crisis with co-occurring risk factors: a randomized trial. J Child Psychol Psychiatry. 2019;60(10):1133-1141. [FREE Full text] [doi: 10.1111/jcpp.13095] [Medline: 31328281]
44. Flynn D, Gillespie C, Joyce M, Spillane A. An evaluation of the skills group component of DBT—a for parent/guardians: a mixed methods study. Ir J Psychol Med. 2023;40(2):143-151. [doi: 10.1017/ipm.2019.62] [Medline: 31973788]
45. Gillespie C, Joyce M, Flynn D, Corcoran P. Dialectical behaviour therapy for adolescents: a comparison of 16-week and 24-week programmes delivered in a public community setting. Child Adolesc Ment Health. 2019;24(3):266-273. [doi: 10.1111/camh.12325] [Medline: 32677209]
46. Payne L. The role of family intervention in improving individual and family functioning in DBT for adolescents. Eisenhower Pkwy. ProQuest Information & Learning; 2018.
47. Power L, Morgan S, Byrne S, Boylan C, Carthy A, Crowley S, et al. A pilot study evaluating a support programme for parents of young people with suicidal behaviour. Child Adolesc Psychiatry Ment Health. 2009;3(1):20. [FREE Full text] [doi: 10.1186/1753-2000-3-20] [Medline: 19604392]
48. Wijana MB, Enebrink P, Liljedahl SI, Ghaderi A. Preliminary evaluation of an intensive integrated individual and family therapy model for self-harming adolescents. BMC Psychiatry. 2018;18(1):371. [FREE Full text] [doi: 10.1186/s12888-018-1947-9] [Medline: 30477463]
49. Waals L, Baetens I, Rober P, Lewis S, Van Parys H, Goethals ER, et al. The NSSI family distress cascade theory. Child Adolesc Psychiatry Ment Health. 2018;12(1):52. [FREE Full text] [doi: 10.1186/s13034-018-0259-7] [Medline: 30568727]
50. Simon OCB, Daches S, Gvion Y. Parents' stress and distress in the face of their children's self-injurious thoughts and behaviors: a scoping review. Eur Child Adolesc Psychiatry. Mar 2026;35(3):691-706. [doi: 10.1007/s00787-025-02886-4] [Medline: 41196303]

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51. Dummett N. Cognitive–behavioural therapy with children, young people and families: from individual to systemic therapy. Adv Psychiatr Treat. 2010;16(1):23-36. [doi: 10.1192/apt.bp.107.004259]
52. McLaughlin KA, Nolen-Hoeksema S. Rumination as a transdiagnostic factor in depression and anxiety. Behav Res Ther. 2011;49(3):186-193. [FREE Full text] [doi: 10.1016/j.brat.2010.12.006] [Medline: 21238951]
53. Townsend E, Wadman R, Sayal K. Family connectedness and adolescent self-injury: a narrative review. Child and Adolescent Mental Health. 2021;26(2):108-115.
54. Wu M, Zhou W, Hu S, Peng F, Yang F, Zhang L. Parenting self-efficacy and parenting stress mediates the effects of the association of perceived social support and readiness for discharge among parents of children with primary nephrotic syndrome. J Pediatr Nurs. 2024;75:e93-e101. [doi: 10.1016/j.pedn.2023.12.035] [Medline: 38199933]
55. Paley B, Hajal NJ. Conceptualizing emotion regulation and coregulation as family-level phenomena. Clin Child Fam Psychol Rev. 2022;25(1):19-43. [doi: 10.1007/s10567-022-00378-4]
56. Watkins ER, Mullan E, Wingrove J, Rimes K, Steiner H, Bathurst N, et al. Rumination-focused cognitive-behavioural therapy for residual depression: phase II randomised controlled trial. Br J Psychiatr. 2011;199(4):317-322. [doi: 10.1192/bjp.bp.110.090282] [Medline: 21778171]
57. A-Tjak JG, Davis ML, Morina N, Powers MB, Smits JA, Emmelkamp PM. A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. Psychother Psychosom. 2015;84(1):30-36. [doi: 10.1159/000365764] [Medline: 25547522]
58. Neff KD, Faso DJ. Self-compassion and well-being in parents of children with autism. Mindfulness. 2014;6(4):938-947. [doi: 10.1007/s12671-014-0359-2]
59. Bolier L, Haverman M, Westerhof GJ, Riper H, Smit F, Bohlmeijer E. Positive psychology interventions: a meta-analysis of randomized controlled studies. BMC Public Health. 2013;13(1):119. [FREE Full text] [doi: 10.1186/1471-2458-13-119] [Medline: 23390882]
60. Schulman-Green D, Jaser S, Martin F, Alonzo A, Grey M, McCorkle R, et al. Processes of self-management in chronic illness. J Nurs Scholarsh. 2012;44(2):136-144. [FREE Full text] [doi: 10.1111/j.1547-5069.2012.01444.x] [Medline: 22551013]
61. Szulczewski L, Mullins LL, Bidwell SL, Eddington AR, Pai ALH. Meta-analysis: caregiver and youth uncertainty in pediatric chronic illness. J Pediatr Psychol. 2017;42(4):395-421. [FREE Full text] [doi: 10.1093/jpepsy/jsw097] [Medline: 28177514]
62. Albanese AM, Russo GR, Geller PA. The role of parental self-efficacy in parent and child well-being: a systematic review of associated outcomes. Child Care Health Dev. 2019;45(3):333-363. [doi: 10.1111/cch.12661] [Medline: 30870584]
63. Townsend ML, Miller CE, Matthews EL, Grenyer BFS. Parental response style to adolescent self-harm: psychological, social and functional impacts. Int J Environ Res Public Health. 2021;18(24):13407. [FREE Full text] [doi: 10.3390/ijerph182413407] [Medline: 34949017]
64. Ferrari M, Hunt C, Harrysunker A, Abbott MJ, Beath AP, Einstein DA. Self-compassion interventions and psychosocial outcomes: a meta-analysis of RCTs. Mindfulness. 2019;10(8):1455-1473. [doi: 10.1007/s12671-019-01134-6]
65. McCarrick D, Prestwich A, Prudenzi A, O'Connor DB. Health effects of psychological interventions for worry and rumination: a meta-analysis. Health Psychol. 2021;40(9):617-630. [FREE Full text] [doi: 10.1037/hea0000985] [Medline: 34410760]
66. Staniszewska S, Brett J, Simera I, Seers K, Mockford C, Goodlad S, et al. GRIPP2 reporting checklists: tools to improve reporting of patient and public involvement in research. BMJ. 2017;358:3453. [FREE Full text] [doi: 10.1136/bmj.j3453] [Medline: 28768629]

Abbreviations

CAMHS: Child and Adolescent Mental Health Services
CYP: children and young people
PASH: Parents Support With Adolescent Self-Harm
PBA: Person-Based Approach
PPI: Patient and Public Involvement

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Edited by J Sarvestan; submitted 10.Mar.2026; peer-reviewed by M Kaess; comments to author 24.Jul.2026; revised version received 06.Oct.2026; accepted 06.Oct.2026; published 26.Nov.2026

Please cite as:
Martin F, Glover S-L, van Even S, Turner A
Developing a Digital Intervention to Support Parents of Young People Who Self-Harm: A Person-Based Approach Informed by Systematic Review and Qualitative Research
JMIR Form Res 2026;10:e77434
URL: https://formative.jmir.org/2026/1/e77434
doi: 10.2196/77434
PMID:

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