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Lived experiences of parents of adolescents with behavioral and emotional disorders following a suicide attempt: A qualitative study in hospitals affiliated with Shiraz University of Medical Sciences

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Abstract

Adolescence is a critical developmental period during which behavioral and emotional disorders can significantly increase vulnerability to self-harm and suicide attempts. In these circumstances, parents are often the first to observe warning signs, playing a pivotal role in help-seeking and recovery. Understanding their lived experiences is essential for informing family-centered prevention and intervention strategies. This study aimed to explore parents' lived experiences of the consequences of behavioral and emotional disorders among adolescents who attempted suicide.

A qualitative study with a descriptive phenomenological design was conducted. Participants were 48 parents of adolescents aged 12–18 years who had attempted suicide and were either hospitalized in centers affiliated with Shiraz University of Medical Sciences or received psychiatric emergency services. Data were collected through in-depth, semi-structured interviews (45–90 minutes) and analyzed using Colaizzi's method. Credibility and rigor were ensured through member checking and peer debriefing.

Prior to the suicide attempt, many parents had noticed changes such as social withdrawal, irritability, declining academic performance, and increased family conflict; however, these behaviors were often interpreted as normative adolescent fluctuations. The suicide attempt was characterized as an overwhelming emotional crisis marked by shock, fear, guilt, and elevated family tension. Higher levels of mental health literacy and stronger perceived social support were associated with lower parental distress, whereas structural and cultural barriers to accessing mental health care intensified their struggles.

Enhancing parental mental health literacy, strengthening family communication, and reducing systemic barriers to mental health services may play a vital role in preventing recurrence and supporting families through the aftermath of a suicide attempt.

Keywords: Adolescent suicide attempt, Behavioral and emotional disorders, Parents, Lived experience, Qualitative study, Phenomenology, Iran

Introduction

Behavioral and emotional disorders during adolescence constitute a major public health concern with substantial implications for social functioning, emotional regulation, and long-term psychological well-being. Adolescence represents a critical developmental period marked by profound biological maturation, cognitive restructuring, identity formation, and heightened emotional reactivity. Within this vulnerable window, the onset or exacerbation of emotional and behavioral disturbances may significantly increase susceptibility to academic underachievement, interpersonal dysfunction, and engagement in high-risk behaviors, including suicide attempts (1,2), Accumulating empirical evidence consistently identifies depression, anxiety disorders, impulsivity, emotion dysregulation, and conduct-related problems as key predictors of suicidal ideation and suicide attempts among adolescents (3–5), Globally, suicide remains one of the leading causes of mortality in this age group, underscoring the urgency of preventive and therapeutic interventions (6), Contemporary research conceptualizes suicide attempts not as isolated incidents, but as the outcome of complex, multifactorial interactions involving individual vulnerabilities, maladaptive cognitive-emotional processes, family dynamics, and broader social determinants (6),Adolescents experiencing persistent emotional and behavioral difficulties appear particularly vulnerable to self-injurious and suicidal behaviors when confronted with environmental stressors, familial discord, or interpersonal adversity (7,8), Within this framework, the family environment assumes a pivotal and often ambivalent role. Functional family systems characterized by cohesion, emotional warmth, and adaptive communication may serve as protective buffers against psychological distress. In contrast, chronic conflict, ineffective communication patterns, emotional neglect, or exposure to violence may intensify vulnerability and heighten the risk of suicidal behavior (12,13), Importantly, parents' interpretations of their child's emotional and behavioral difficulties, their affective responses to emerging crises, and their engagement in help-seeking and treatment decision-making processes substantially shape the trajectory of care, adherence to therapeutic interventions, and recovery outcomes (9–11), Confronting a child's suicide attempt frequently constitutes a profound psychological crisis for parents, evoking intense feelings of shock, guilt, shame, anxiety, and helplessness (14,15), These lived experiences may influence parental coping strategies, patterns of interaction with healthcare professionals, and sustained participation in therapeutic processes. Understanding these subjective experiences is therefore essential for strengthening family-centered approaches to suicide prevention and post-attempt care. In Iran, emotional and behavioral disorders among adolescents are relatively prevalent, and emerging evidence suggests significant associations between family-related stressors, socioeconomic pressures, and suicidal behaviors (16,17). In large metropolitan areas such as Shiraz characterized by cultural heterogeneity, economic challenges, and variability in access to specialized mental health services—the familial and sociocultural context of adolescent suicide attempts warrants particular attention (18–20). Sociocultural norms, stigma surrounding mental illness, and differences in mental health literacy may further shape how parents interpret symptoms, respond to crises, and engage with available support systems, despite the well-documented epidemiology of adolescent suicide, comparatively limited attention has been directed toward the subjective and lived experiences of parents navigating the aftermath of a suicide attempt within specific sociocultural contexts. Quantitative studies have clarified prevalence patterns and risk factors; however, they often fail to capture the nuanced meanings, emotional complexities, and contextual interpretations that influence parental responses and caregiving trajectories. A qualitative exploration grounded in parents' lived experiences can provide in-depth insight into how emotional and behavioral

disorders are perceived, interpreted, and managed within families facing suicidal crises. Such knowledge is essential for informing culturally sensitive, family-centered interventions, strengthening support systems, and optimizing child and adolescent mental health services. Furthermore, elucidating parental experiences may assist clinicians, policymakers, and service providers in developing more contextually responsive prevention and treatment strategies.

Methods

Study Design

This qualitative study was conducted using a descriptive phenomenological approach to explore the lived experiences of parents of adolescents who had attempted suicide. Descriptive phenomenology was chosen because of its methodological strength in uncovering the essence and meaning of human experiences as perceived by individuals themselves. Given the emotionally complex and context-bound nature of parental reactions to adolescent suicide attempts, this approach enabled an in-depth exploration of familial, emotional, and situational dimensions of the phenomenon.

Setting and Participants

The study was conducted in hospitals affiliated with Shiraz University of Medical Sciences in Shiraz, Iran. Participants included 48 parents of adolescents who had attempted suicide and were either hospitalized or had received psychiatric emergency services in Shiraz, A purposive sampling strategy with maximum variation was applied to capture diverse parental experiences. Variation was sought in terms of parent gender, socioeconomic status, educational level, and family structure to ensure a comprehensive representation of perspectives.

Inclusion criteria

Participants were eligible to participate if they were parents or legal guardians of adolescents aged 12–18 years whose child had a documented suicide attempt during the first three months of the study period. Participants were also required to have sufficient psychological stability to participate in an in-depth interview and be willing to voluntarily share their personal experiences.

Exclusion criterion

Participants were excluded if they withdrew their consent or expressed unwillingness to continue participation at any stage of the research process.

Data Collection

Data were collected through in-depth semi-structured interviews conducted in a quiet and private space within the hospital setting. Each interview lasted between 45 and 90 minutes.

Prior to each interview, participants received a full explanation of the study objectives and procedures, and verbal informed consent was obtained. With participants' permission, interviews were audio-recorded and subsequently transcribed verbatim. Field notes were taken to document contextual details and nonverbal expressions.

The interview guide consisted of open-ended questions designed to elicit rich descriptions of parental experiences. The interviews explored parents' perceptions of their adolescents' emotional and behavioral difficulties, their emotional responses and interpretations following the suicide attempt, family challenges before and after the event, experiences with healthcare services, and the support they perceived to have received as well as their unmet needs. Probing and follow-up questions were used to deepen the discussion and clarify emerging meanings.

Data collection and analysis occurred concurrently. Interviews continued until data saturation was reached, defined as the point at which no new themes or conceptual insights emerged from subsequent interviews.

Data Analysis

Data were analyzed using Colaizzi's seven-step phenomenological method. The analysis began with repeatedly reading all

interview transcripts to obtain an overall understanding of the data. Significant statements related to the phenomenon were then identified, and meanings were formulated from these statements. The formulated meanings were organized into clusters of themes, which were subsequently integrated to develop a comprehensive description of the phenomenon. The fundamental structure of the experience was then identified, and the findings were validated through member checking with selected participants. This systematic process ensured methodological rigor while maintaining fidelity to participants' narratives.

Trustworthiness

Rigor was ensured based on the criteria proposed by Lincoln and Guba, including credibility, dependability, confirmability, and transferability. Credibility was strengthened through prolonged engagement with participants, member checking, and peer debriefing. Dependability was supported by maintaining a detailed audit trail documenting methodological decisions and analytic processes. Confirmability was enhanced through reflexive journaling and independent review of coding by research team members. Transferability was facilitated by providing a rich and contextualized description of the research setting in Shiraz and participant characteristics.

Ethical considerations

Verbal informed consent was obtained after providing a comprehensive explanation of the study purpose, procedures, confidentiality safeguards, and participants' rights. Parents were assured that all information would remain confidential and anonymized. Participation was entirely voluntary, and participants were informed that they could withdraw at any time without any consequences for their child's medical or psychological care. This research was ethically approved by the Ethics Committee of IR.SUMS.REC.1395.5950.

Results

Analysis of parents' narratives revealed a set of interconnected themes that illustrate how emotional changes in adolescents, parental interpretations, family dynamics, and systemic barriers collectively shape the pathway leading to, and following, a suicide attempt. These themes do not represent isolated categories; rather, they form a continuous and mutually reinforcing process experienced by parents in Shiraz.

Theme 1: Early emotional and behavioral disruptions as overlooked warning signs

Parents consistently reported noticing emotional and behavioral shifts in their adolescents well before the suicide attempt. These shifts included social withdrawal, irritability, academic decline, increased family conflict, and disengagement from previously meaningful activities.

Although these signs were later recognized as indicators of distress, many parents initially understood them as typical manifestations of adolescence. Limited mental health literacy and uncertainty about appropriate responses contributed to delays in seeking help. This early misinterpretation set the stage for escalating distress, linking directly to the emotional crisis that unfolded later.

Theme 2: Emotional turmoil and parental vulnerability after the attempt

The suicide attempt triggered an intense emotional upheaval, described uniformly across participants. Feelings of fear, shock, helplessness, and profound anxiety dominated the immediate aftermath. Many parents reported that the event destabilized their sense of parental competence and challenged their understanding of their adolescent's inner world.

Self-blame and guilt emerged as persistent emotions, often tied to parents' earlier misinterpretation of warning signs (Theme 1). This connection created a cyclical pattern: the more parents reflected on missed cues, the

stronger their sense of responsibility and emotional vulnerability became.

Theme 3: Family dynamics under strain

Existing family tensions and communication challenges influenced both the development and aftermath of the suicide attempt. Parents described strained interactions, emotional distance, and recurrent misunderstandings that had existed prior to the attempt. While not directly blamed as causal factors, these relational difficulties often amplified adolescents' distress.

After the attempt, families experienced divergent trajectories. Some became more cohesive and attentive, driven by fear of recurrence, whereas others faced increased tension and emotional fragmentation. These patterns demonstrated how family dynamics interacted with both emotional warning signs (Theme 1) and the post-attempt emotional crisis (Theme 2) to shape the recovery process.

Theme 4: Barriers to the mental health services and unmet parental support needs

Many parents encountered significant challenges when attempting to access mental health services. Complex referral pathways, insufficient guidance, and delays in receiving specialized care intensified parental distress during a highly vulnerable period. These systemic obstacles not only delayed intervention but also deepened parents' sense of helplessness.

Parallel to these barriers was a strong, recurrent need for psychoeducation and emotional support. Parents expressed that earlier knowledge about warning signs, effective communication, and navigating mental health services could have changed the trajectory of their child's experience. This theme conceptually ties back to all preceding themes: the overlooked warning signs (Theme 1), emotional turmoil (Theme 2), and strained family dynamics (Theme 3).

Integrative interpretation

Taken together, the findings depict adolescent suicide attempts not as isolated events but as the culmination of multiple interacting factors: early but misinterpreted warning signs, intensified emotional responses among parents, preexisting relational tensions, and systemic barriers within the mental health care system. The themes form a coherent process illustrating how vulnerabilities across individual, familial, and structural levels converge.

Strengthening parental awareness, improving family communication, and enhancing accessibility to mental health services emerge as crucial components for prevention and post-attempt support.

Descriptive statistics of the parent sample

A total of 48 parents participated in the study. The mean age and standard deviation of the participants were 42.6 ± 7.8 years. Of these, 29 (60.4%) were mothers and 19 (39.6%) were fathers. The mean age and standard deviation of mothers were 41.8 ± 7.2 years, while the mean age and standard deviation of fathers were 43.9 ± 8.3 years (Table 1).

Table 1. Demographic distribution of parents in the study

Variables		Number	Percentage (%)	Mean ± Standard Deviation (Age, year)
Total Participants		48	100	42.6 ± 7.8
Mothers		29	60.4	41.8 ± 7.2
Fathers		19	39.6	43.9 ± 8.3
Marital Status	Married	39	81.2	-
	Divorced/Separated	9	18.8	

The analysis of the correlation matrix revealed meaningful patterns of associations among the variables, mental health literacy showed a positive relationship with perceived social support and a significant negative relationship with parental stress and concerns about adolescents' risk-taking behaviors, highlighting the importance of parents' knowledge of mental health concepts in reducing their psychological burden. Perceived social support also functioned as a protective factor; the more support parents experienced, the lower their levels of stress and worry. In contrast, parental stress displayed a positive and relatively strong association with concerns about adolescents' high-risk behaviors, indicating that increased stress may heighten parents' sensitivity to risk-seeking tendencies in their teenagers, additionally, parents' age and educational level demonstrated significant correlations with some psychosocial variables, potentially reflecting differences in experience, available resources, and cognitive capacities among parents (Table 2). Altogether, these findings underscore the role of individual and social factors in shaping parents' experiences when dealing with adolescents' risk-taking behaviors (Figure 1).

Table 2. Correlation matrix of the study variables (n = 48)

Row	Variables	1	2	3	4	5	6
1	Parents' Age	1					
2	Education Level	0.21	1				
3	Mental Health Literacy	-0.18	0.44**	1			
4	Perceived Social Support	-0.12	0.29*	0.46**	1		
5	Parental Stress	0.29*	-0.31*	-0.51**	-0.38*	1	
6	Concerns about Adolescents' Risk-Taking Behaviors	0.33*	-0.27	-0.48**	-0.41**	0.54**	1
* Correlation is significant at the 0.05 level. ** Correlation is significant at the 0.01 level.							

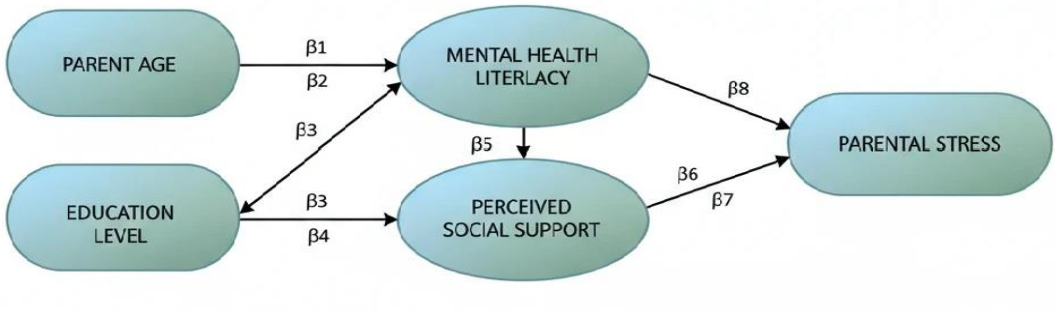

Figure 1. Proposed model of parents' lived experiences of the consequences of behavioral and emotional disorders in adolescents with suicide attempts

As shown in Table 3, the proposed model demonstrated an acceptable fit to the data. The chi-square statistic was 185.75 with 70 degrees of freedom, which despite its sensitivity to sample size is typically interpreted alongside other indices. The RMSEA value was 0.075, falling below the 0.08 threshold and indicating an acceptable fit, Similarly, the SRMR value of 0.062 was lower than 0.08, reflecting a good level of fit. The comparative fit indices also supported

the model's adequacy, with a CFI of 0.938 and a TLI of 0.921, both exceeding the recommended cutoff of 0.90. Overall, these indicators collectively confirm that the proposed model exhibits an acceptable and satisfactory fit to the data.

Table 3. Model fit indices for the proposed model

Row	Index	Value
1	χ^2 (Chi-Square)	185.75
2	df	70
3	RMSEA	0.075
4	SRMR	0.062
5	CFI	0.938
6	TLI	0.921

Discussion and Conclusion

This study aimed to examine the stress experienced by parents of adolescents who attempted suicide, employing an integrated conceptual model to elucidate the multifaceted psychosocial dimensions shaping their experiences. The findings indicate that parental stress is a multidimensional phenomenon influenced by a combination of individual, familial, and structural factors. In accordance with the proposed conceptual model, parental mental health literacy and perceived social support act as protective variables (22, 25), whereas feelings of guilt, self-blame, worry about adolescents' high-risk behaviors, and perceived barriers to mental health services were positively associated with higher levels of parental stress (24, 26, 27). These results correspond with prior evidence emphasizing the contribution of psychosocial determinants to the development and intensification of parental stress. Specifically, previous studies have confirmed the protective role of mental health literacy and social support in reducing parents' psychological burden (23, 25). Greater parental awareness of mental health issues can facilitate more effective understanding of their child's situation and reduce emotional distress. Conversely, the high prevalence of guilt and self-blame found in this study is consistent with previous literature identifying these reactions as common emotional consequences among parents confronting adolescent self-harm behaviors (29, 30). Additionally, difficulty in obtaining specialized mental health care—combined with experiences of social stigma and systemic complexity—emerged as a major contributor to increased parental stress. This finding aligns with studies highlighting how structural barriers and negative attitudes toward mental illness impede help-seeking (24, 27, 28). Parental worry regarding adolescents' risky behaviors constituted another salient factor associated with stress; this concern may perpetuate a cycle of anxiety and overprotective monitoring. Contextual factors such as parental age and educational level also influenced stress intensity, underscoring how sociodemographic contexts shape parental coping responses to crises, although the findings generally concur with prior research, several cultural distinctions were observed. The intensity of guilt and self-blame among parents appeared higher than what has been reported in other contexts, likely reflecting cultural expectations that assign strong moral responsibility to parents for their children's wellbeing (29, 30). Furthermore, unlike many previous studies focusing on direct social stigma, the present study emphasized structural and procedural stigma—such as bureaucratic obstacles and complex pathways to care—as vital contributors to parental stress (24, 27). Interestingly, social support exerted a

weaker-than-expected buffering effect regarding parental concerns about adolescents' high-risk behaviors. This may stem from the acute and crisis-driven nature of suicide attempts, where parental anxiety persists even in the presence of supportive networks. The significance of this study lies in its integration of quantitative and qualitative insights to construct a comprehensive model of parental stress among families of suicidal adolescents. In this model, stress results from a dynamic interplay of individual, interpersonal, and structural determinants. A major innovation is the emphasis on structural and procedural stigma in the help-seeking trajectory, a dimension that has received little attention in previous research (24, 27, 28). Moreover, identifying culturally specific patterns of shame and self-blame provides valuable implications for the development of culturally sensitive psychological interventions. Despite its scientific merit, the study has certain limitations. These include the small qualitative sample, the cross-sectional nature of the data that precludes causal inference, and reliance on self-reported measures susceptible to recall and social desirability biases. Furthermore, the cultural specificity of the study context may affect generalizability. Nevertheless, the mixed-methods approach allowed for a nuanced understanding of parental experiences, enriching the literature by focusing on a highly vulnerable group. Recognition of emerging concepts such as structural stigma contributes a novel perspective that may guide future support program development. From a practical and scientific standpoint, future research should adopt longitudinal designs (e.g., retrospective cohort studies) to explore causal pathways, involve larger and more diverse samples, undertake cross-cultural comparative investigations, and assess the effectiveness of interventions derived from this model. Including adolescents' and mental health professionals' perspectives may also be instrumental in designing more effective family centered support programs (21, 22, 31).

Ethical Approval and consent to participate

This study was approved by the ethics committee of Shiraz University of Medical Sciences (IR.SUMS.REC.1395.5950). Informed consent was obtained from all individual participants included in the study.

Availability of data and materials

The corresponding author can provide the data upon request.

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Competing interests

The authors declare that there is no competing interest.

Author contributions

Z.R and A.S. conceptualized and designed the study. H.S. was responsible for data acquisition and formal analysis. S.F. and H.A. contributed to the data interpretation and manuscript writing. S.F., H.A. and H.S. reviewed and edited the manuscript, providing critical intellectual feedback. A.S. oversaw the project and validated the research findings. All authors read and approved the final manuscript.

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The Ethics Committee approved this study at Shiraz University of Medical Sciences (IR.SUMS.REC.1395.5950). This paper was edited using large language models (LLMs), including Bard and ChatGPT. However, the accuracy of all information was independently verified by the authors.

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