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Review Article

Factors influencing family support and family burden in caring for family members with a history of violent behavior: A systematic review

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Abstract

Background: Family caregivers play a central role in caring for relatives with severe mental illness, particularly those with a history of violent behavior. In this context, caregivers are required to provide continuous supervision, emotional support, and practical assistance, while also managing fear, stigma, and prolonged caregiving demands. These conditions may influence both family support and family burden through a complex interaction of clinical, psychosocial, and structural factors.
Objective: This study aimed to systematically identify, analyze, and synthesize the factors influencing family support and family burden in caring for family members with a history of violent behavior.
Methods: This study employed a systematic review design. A comprehensive literature search was conducted in PubMed, Scopus, ProQuest, SAGE Journals, and ClinicalKey for Nursing for studies published between 2015 and 2025. Quantitative, qualitative, and mixed-method studies were included if they examined determinants of family support or caregiver burden among family caregivers of individuals with severe mental illness involving aggression or a history of violent behavior. Study selection, data extraction, and methodological quality appraisal were conducted independently by two reviewers using standardized procedures and the Joanna Briggs Institute critical appraisal tools.
Results: Ten studies met the inclusion criteria. The review identified three major domains influencing family support and family burden: clinical factors, psychosocial factors, and structural factors. Patient aggression, symptom severity, relapse, and poor social functioning consistently increased caregiver burden. Psychosocial factors, particularly affiliated stigma, emotional distress, gendered caregiving roles, and family relationship patterns, further intensified burden and reduced caregiving resilience. Structural barriers, including limited access to mental health services, weak care coordination, insufficient caregiver involvement in decision-making, and economic hardship, also weakened family support capacity. Intervention evidence suggested that family psychoeducation and structured support may reduce caregiver burden, although their effectiveness varied across contexts.
Conclusion: Family support and family burden in the care of relatives with a history of violent behavior are shaped by interrelated clinical, psychosocial, and structural determinants. Family-centered and context-sensitive mental health interventions are needed to reduce caregiver burden and strengthen sustainable family support.

Background

Severe mental disorders remain a major health problem that creates broad clinical, psychological, and social consequences for affected individuals and their families, especially when patients have a history of violent behavior or behavior that may endanger others (Bete et al., 2024; Miliauskas et al., 2022). Family members often assume the main caregiving role by providing supervision, daily assistance, emotional presence, and decision-making support during treatment at home and during contact with health services (Issac et al., 2022; Villena Jimena et al., 2026). This role becomes more complex when families care for individuals with schizophrenia, psychotic disorders, or other severe mental health conditions accompanied by aggression, stigma, and unstable behavior (Karambelas et al., 2022; Rapiya et al., 2025). Such conditions position the family not only as a source of support but also as a group that is highly vulnerable to emotional strain, fatigue, and prolonged caregiving burden (Andrade et al., 2021; Kaggwa et al., 2023). In this context, family support and family burden are important concepts because both can influence continuity of care, patient stability, and overall family well-being (Qiu et al., 2023; Yasuma et al., 2024).

Family support represents an essential social resource that can strengthen treatment adherence, adaptation, and caregiving success across many health conditions, including chronic illness and mental health problems (Aprita, 2024; Hafiza Usnaini et al., 2025). Previous studies have shown that support from family members can improve caregiving engagement, enhance coping responses, and create a more therapeutic home environment for vulnerable individuals (KK et al., 2024; Oktarida, 2025). In psychiatric care, family support can help reduce relapse, improve treatment participation, and maintain patient functioning through consistent supervision and emotional involvement (Yasuma et al., 2024; Ibrahim et al., 2026). However, the capacity of the family to provide support is not always stable because it can be affected by stress, limited resources, stigma, and the long duration of caregiving demands (Kaggwa et al., 2023; Xiong et al., 2023). Therefore, family support should be understood as a dynamic process that is shaped by multiple internal and external factors within the caregiving context (Kurniawan et al., 2025; Yun & Ji, 2025).

Alongside the supportive role of the family, caregiving burden has emerged as a major issue in families caring for relatives with severe mental disorders (Andrade et al., 2021; Kalayci et al., 2023). Family burden includes physical exhaustion, psychological distress, social disruption, economic pressure, and restrictions in daily life that arise from continuous caregiving responsibilities (Peng et al., 2019a; Zhou et al., 2016). The burden tends to become heavier when caregivers face unpredictable symptoms, potentially harmful behavior, social rejection, and persistent fear related to the patient's condition (Qiu et al., 2023; Phoeun et al., 2023). Comparative and qualitative studies have also shown that caregivers of people with schizophrenia and bipolar disorder frequently report high levels of stress, hopelessness, and reduced quality of life during long-term care (Di Sarno & Louzã, 2023; Vijayan et al., 2025). These findings indicate that family burden is not a marginal issue, but a central dimension that directly affects caregiving capacity and the sustainability of mental health care in the community (Karambelas et al., 2022; Rapiya et al., 2025).

The interaction between family support and family burden becomes even more important in cases involving a history of violent behavior because violence increases fear, uncertainty, and the complexity of supervision within the home (Hildebrand et al., 2019; Scott et al., 2020). Families who care for relatives with violent tendencies may experience ambivalence because they are expected to provide affection and protection while also protecting themselves and other family members from possible harm (Phoeun et al., 2023; Villena Jimena et al., 2026). In many settings, stigma attached to mental illness and violent behavior can further isolate the family and reduce the availability of social support from the surrounding community (Kaggwa et al., 2023; Sedieghifar et al., 2026). At the same time, personal dignity, psychosocial adaptation, and emotional resilience remain important elements in caregiving relationships and may shape how families respond to challenging behaviors (Amiri et al., 2025; Hildebrand et al., 2019). These conditions suggest that the determinants of family support and family burden in this population require deeper synthesis because they involve clinical, relational, social, and cultural dimensions simultaneously (Issac et al., 2022; Monari et al., 2024).

Several studies have examined caregiver burden, social support, stigma, and caregiving experiences in schizophrenia, bipolar disorder, substance use disorders, and other severe mental health conditions, but the available evidence remains fragmented across populations and settings (Karambelas et al., 2022; Monari et al., 2024). Some studies emphasize illness severity, patient disability, and harmful behavior as major predictors of burden, whereas other studies highlight stigma, social support, and coping strategies as more influential factors (Peng et al., 2019a; Qiu et al., 2023). Other evidence also shows that psychoeducation, nursing support, and mental health promotion interventions can reduce family burden and strengthen caregiving capacity, although their effects may vary depending on family context and service access (Yasuma et al., 2024; Santonja-Ayuso & Carmona-Simarro, 2026). Despite these developments, no clear synthesis has specifically focused on factors influencing both family support and family burden among families caring for relatives with a history of violent behavior (Issac et al., 2022; Kalayci et al., 2023). This gap indicates the need for a systematic review that can integrate available findings and clarify the main determinants that shape family responses in this high-risk caregiving situation (Karambelas et al., 2022; Rapiya et al., 2025).

A systematic review is important because it can provide a more comprehensive understanding of the factors that strengthen family support and the factors that intensify family burden in the care of relatives with a history of violent behavior (Issac et al., 2022; Karambelas et al., 2022). A clearer synthesis can help nurses, mental health professionals, and policy makers design interventions that are more responsive to family needs and better aligned with community-based mental health care (Ibrahim et al., 2026; Santonja-Ayuso & Carmona-Simarro, 2026). This review can also support the development of family-centered strategies that reduce stigma, improve coping, and promote safer and more sustainable caregiving practices at home (Yasuma et al., 2024; Sedieghifar et al., 2026). In addition, the findings may contribute to the strengthening of nursing roles in psychoeducation, caregiver support, and preventive mental health services for families facing severe behavioral challenges (Sullivan-Bolyai et al., 2023; Purwanty et al., 2024).

Therefore, this study aims to systematically identify, analyze, and synthesize the factors influencing family support and family burden in caring for family members with a history of violent behavior.

Methods

Study Design

This study employed a systematic review design to comprehensively identify, evaluate, and synthesize evidence on the factors influencing family support and family burden in caring for family members with a history of violent behavior. The review was developed and reported in accordance with the PRISMA 2020 guideline, which is part of the EQUATOR Network reporting standards for systematic reviews and meta-analyses. PRISMA 2020 was selected because it provides a transparent and structured framework for documenting the identification, screening, eligibility assessment, and inclusion of studies, thereby improving the reproducibility and methodological rigor of the review.

Before the literature search was conducted, the review protocol was conceptually developed to define the review focus, eligibility criteria, search strategy, screening procedures, quality appraisal, data extraction process, and synthesis approach. This design was considered appropriate because the topic involves a complex caregiving context that includes clinical, psychosocial, and structural determinants, which are best understood through a structured synthesis of existing evidence rather than through a single empirical study. The study also adopted a broad evidence perspective by allowing the inclusion of quantitative, qualitative, and mixed-method studies, as this approach enabled a more comprehensive understanding of family caregiving experiences and determinants across different methodological traditions.

Research Question

The review was guided by a focused research question: What factors influence family support and family burden in caring for family members with severe mental illness who have aggression components or a history of violent behavior? This question was formulated to capture the multidimensional nature of caregiving in psychiatric settings, where family members often function as the main source of supervision, emotional support, and daily care. The question was intentionally framed to explore both supportive and burdensome aspects of caregiving because family support and family burden are interrelated but conceptually distinct phenomena.

Family support refers to the emotional, instrumental, informational, and relational resources provided by family members during care, whereas family burden refers to the physical, psychological, social, and financial strain experienced by caregivers as a consequence of prolonged caregiving demands. The review question also sought to identify whether these outcomes were influenced primarily by clinical factors such as aggression and symptom severity, psychosocial factors such as stigma and social support, or structural factors such as health service access and economic conditions. By formulating the review question in this way, the study aimed to generate findings that are relevant not only for psychiatric nursing practice but also for family-centered mental health interventions and policy planning.

Inclusion and Exclusion Criteria

The eligibility criteria were developed to ensure that the included studies were directly relevant to the review objective and methodologically appropriate for synthesis. Studies were included if they met the following criteria: first, they involved family caregivers, such as parents, spouses, siblings, or other immediate family members, who were caring for individuals with severe mental illness, including schizophrenia and psychotic disorders, particularly where aggression or a history of violent behavior formed part of the clinical context. Second, eligible studies had to examine determinants, associated factors, predictors, correlates, or explanatory variables related to family support or caregiver burden. Third, studies using quantitative, qualitative, or mixed-method designs were considered eligible because the review aimed to capture both measurable determinants and lived caregiving experiences. Fourth, studies had to be published in English or Indonesian between January 2015 and December 2025, a time range selected to ensure that the review reflected contemporary mental health care contexts, recent family caregiving evidence, and current psychiatric nursing perspectives.

Studies were excluded if they were narrative reviews, editorials, opinion pieces, theoretical papers, conference abstracts without full data, or single case reports, because such publications do not provide sufficient empirical evidence for systematic synthesis. Publications were also excluded if they did not explicitly involve family caregivers, did not address support or burden outcomes, or did not report data relevant to determinants within the context of severe mental illness and aggressive or violent behavior. In addition, grey literature, including dissertations, conference reports, and papers from local non-indexed journals, was excluded from the final analysis in order to maintain a consistent level of academic quality, indexing traceability, and methodological comparability across included studies. These criteria were established to optimize the validity, relevance, and interpretive strength of the final synthesis.

Search Strategy

A systematic literature search was conducted across five electronic databases: PubMed, Scopus, ProQuest, SAGE Journals, and ClinicalKey for Nursing. These databases were selected because together they provide broad coverage of psychiatric, nursing, psychological, and interdisciplinary health sciences literature, which is essential for a topic that lies at the intersection of family caregiving, severe mental illness, and behavioral risk. The search strategy used a combination of free-text terms and controlled vocabulary, including Medical Subject Headings (MeSH) where applicable. The main search concepts included terms such as "Caregivers," "Family," "Caregiver Burden," "Violence," "Aggression," "Severe Mental Illness," and "Psychotic Disorders," which were combined using Boolean operators AND and OR to maximize retrieval sensitivity while preserving conceptual relevance. The search covered publications from 2015 to 2025 and yielded a total of 21,631 records, comprising records from PubMed, Scopus, ProQuest, SAGE Journals, and ClinicalKey for Nursing.

All identified references were exported into Mendeley Desktop for data management, duplicate detection, and organization of the screening process. In addition to database searching, handsearching was conducted to identify potentially relevant studies that may not have been adequately indexed in major databases. This manual searching targeted local journals, topic-relevant journals, and conference-related materials associated with family caregiving, psychiatric nursing, or severe mental illness. The purpose of combining electronic database searching with manual searching was to strengthen retrieval comprehensiveness and reduce the risk of missing relevant evidence during the identification stage. This dual strategy enhanced the breadth of the review while preserving methodological discipline through predefined search concepts and database boundaries.

Study Selection Process

The study selection process followed the staged logic recommended by PRISMA 2020 and was conducted in a systematic and transparent manner. The initial search identified 21,631 records across the five databases. Before title and abstract screening, 16,606 records were removed because they did not meet the preliminary eligibility boundaries, such as publication year limitations, document type restrictions, broad irrelevance to the review topic, or duplication across databases. After this initial filtering process, 5,025 articles remained for title and abstract screening. During the screening stage, 4,945 articles were excluded because they did not focus on family caregivers, did not examine family support or caregiver burden, or did not relate to severe mental illness with aggression or a history of violent behavior. This step substantially refined the evidence pool to those most likely to answer the review question.

Following title and abstract screening, 80 articles were considered potentially eligible for full-text retrieval. However, 68 articles could not be accessed or were unavailable in complete full-text form, which reduced the number of studies available for eligibility assessment. As a result, 12 full-text reports were assessed in detail for methodological and substantive eligibility. Of these, 2 reports were excluded because they were judged to have a high risk of bias or insufficient methodological quality for reliable inclusion. Ultimately, 10 studies met all eligibility criteria and were included in the final synthesis, with 8 study reports analyzed in depth according to the available documentation. To minimize selection bias, the screening and eligibility assessment process was conducted independently by two reviewers, and disagreements were resolved through discussion and consensus. When differences in judgment could not be immediately resolved, a senior reviewer was designated to make the final decision. This multi-reviewer process strengthened reliability and consistency throughout the selection stage (See Figure 1).

Quality Appraisal

The methodological quality of the included studies was assessed using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist, with the specific checklist selected according to each study design. The JBI appraisal tool was chosen because the review included a range of methodological designs, and JBI provides flexible but rigorous criteria for appraising cross-sectional, qualitative, and mixed-method evidence. The appraisal process focused on methodological domains such as clarity of inclusion criteria, appropriateness of sampling procedures, validity and reliability of outcome measurement, adequacy of data analysis, transparency of reporting, and management of confounding or bias. Based on this assessment, five studies were categorized as having high methodological quality, while three studies were categorized as having moderate quality. The most common limitations identified across studies included the frequent use of cross-sectional designs, which limited causal interpretation, and the use of self-reported measures, which may have increased the possibility of response bias or information bias.

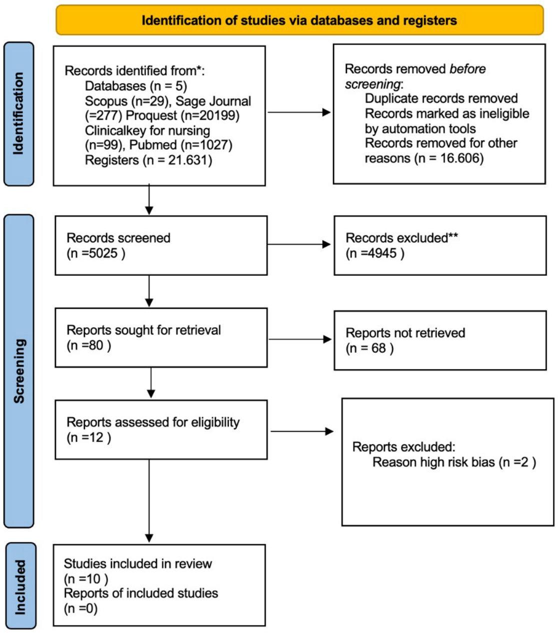

Figure 1. PRISMA flowchart of the article selection process in a systematic review

The quality appraisal was conducted independently by two reviewers working in parallel to reduce subjective bias in the assessment process. Any disagreement between reviewers was discussed until consensus was reached, and unresolved discrepancies were referred to a senior reviewer for adjudication. The results of the appraisal were not used as an automatic basis for excluding all methodologically limited studies, but they were incorporated into the interpretive phase of the review. In other words, studies with weaker methodological features were retained only when they still offered relevant evidence, but their findings were interpreted with caution during synthesis. This approach preserved the comprehensiveness of the review while maintaining critical attention to evidence strength and methodological trustworthiness.

Data Extraction and Synthesis

Data extraction was performed using a standardized form developed with reference to the Cochrane Handbook for Systematic Reviews of Interventions. The extraction form was designed to capture both descriptive and analytical information relevant to the review objective. Extracted data included study characteristics such as publication year, country, study design, sample size, caregiver type, and clinical characteristics of the patients. The reviewers also recorded the instruments used to measure family burden and family support, including tools such as the Zarit Burden Interview (ZBI), Burden Scale for Family Caregivers (BSFC-s), Affiliate Stigma Scale, and Family Burden Interview Schedule (FBIS), where reported. In addition, key explanatory variables were extracted and grouped into meaningful domains, including clinical variables such as aggression, relapse, symptom severity, or disability; psychosocial variables such as stigma, perceived social support, and distress; and structural variables such as health service access, economic status, and sociocultural context. The extraction process was conducted independently by two reviewers to reduce transcription errors and subjective interpretation during evidence coding.

Because the included studies were heterogeneous in terms of design, participant characteristics, contexts, and measurement instruments, a meta-analysis was not performed. Instead, the findings were synthesized using a narrative thematic synthesis approach. This approach was considered appropriate because it allowed the reviewers to integrate findings from multiple methodological designs and to identify patterns across conceptually related but statistically non-comparable studies. The synthesis grouped determinants into three overarching domains: clinical factors, psychosocial factors, and structural factors. Within these domains, the review examined consistencies, divergences, and interaction patterns among variables such as medication adherence, level of aggression, social support, social stigma, access to mental health services, and family burden. Particular attention was given to how these variables influenced family caregiving capacity, distress, and support provision. The planned synthesis outcomes included changes or variations in family burden, caregiver psychological distress, received social support, and the potential influence of interventions on patient aggression and relapse. Through this analytic strategy, the review aimed to identify dominant determinants and possible mediating or moderating mechanisms that shape caregiving experiences among families caring for relatives with a history of violent behavior.

Results

A total of 10 studies met the eligibility criteria and were included in the final narrative synthesis. The included studies represented diverse methodological approaches, comprising cross-sectional studies, a cluster randomized controlled trial, qualitative studies, a mixed-method study, and review-based evidence syntheses, conducted across a wide range of countries including Uganda, Brazil, Canada, Australia, South Africa, Japan, Spain, China, Cambodia, and Singapore. Across these studies, family caregivers of individuals with severe mental illness or related behavioral instability consistently reported a substantial caregiving burden, although the magnitude and expression of burden varied according to clinical presentation, family context, and health-system support. The included evidence also indicated that family support was not a static resource, but a context-dependent capacity shaped by the interaction between patient behavior, caregiver characteristics, stigma, and access to formal services. Table 1 summarizes the principal characteristics of the included studies and their main findings.

The synthesis identified three major domains of determinants influencing family burden and family support: clinical factors, psychosocial factors, and structural factors. Clinical factors emerged as the most consistently reported contributors to increased family burden. Across quantitative and qualitative studies, patient aggression, agitation, symptom severity, relapse, unstable behavior, and poor social functioning were repeatedly associated with higher burden scores and greater emotional distress among caregivers. Evidence from China and Brazil showed that verbal aggression, physical violence, and destructive behavior toward property significantly intensified caregiver strain, while international comparative evidence suggested that symptom severity may exert a stronger effect on burden than diagnostic category alone. These findings indicate that a history of violent or aggressive behavior is a highly relevant clinical marker for identifying families at elevated caregiving risk (See Table 1).

Table 1. Characteristics of included studies and summary of main findings

Study	Country	Participants and setting	Design and measures	Key factors examined	Main findings
Kaggwa et al. (2023)	Uganda	385 informal caregivers of people with severe mental illness in community psychiatric services	Cross-sectional; Zarit Burden Interview; Affiliate Stigma Scale; regression and mediation analysis	Affiliated stigma, caregiver involvement, duration of care, patient characteristics	Caregiver burden increased significantly among caregivers with high stigma. Affiliated stigma mediated the relationship between caregiver involvement and burden, indicating a strong psychosocial pathway.
Andrade et al. (2021)	Brazil	61 family caregivers of patients with mental disorders in psychosocial care centers	Cross-sectional; Family APGAR; Family Burden Interview Schedule	Physical aggression, agitation, emotional tension, caregiver–patient relationship, family structure	Aggressive and agitated patient behavior increased subjective burden. Family functioning was poorer in families with young children and female patients. Violent behavior was a significant predictor of burden.
Monari et al. (2022/2024 synthesis cited in source)	Canada	26 empirical studies on families of individuals with substance use disorders and aggressive or violent behavior	Integrative literature review; thematic synthesis	Aggression, stigma, family conflict, social support, support-system needs	Aggressive behavior increased psychological stress and family stigma. Limited social support intensified burden, highlighting the importance of structured family support systems.
Li et al. (2024)	Singapore	Family caregivers of children with a history of maltreatment in a tertiary hospital context	Observational study; family risk and behavioral assessment tools	Family risk, caregiving quality, caregiver support, family stress	Family risk and caregiver stress were associated with behavioral problems. Lower family support increased the risk of family dysfunction and caregiver stress.
Karambelas et al. (2022)	Australia	28 studies involving 6,166 informal caregivers across community and hospital mental health services	Systematic review; major tools included Zarit Burden Interview and depression/anxiety scales	Symptom severity, relapse, social dysfunction, caregiver psychological distress	Caregiver burden was greater in the presence of severe symptoms and repeated relapse. Symptom severity appeared more influential than diagnosis in predicting burden.
Rapiya et al. (2025)	South Africa	22 caregivers of people with severe mental	Qualitative study; in-depth	Social stigma, economic strain, social isolation,	Burden increased when caregivers experienced stigma and inadequate

Study	Country	Participants and setting	Design and measures	Key factors examined	Main findings
		illness in urban and rural communities	interviews; thematic analysis	unstable patient behavior	system support. Unstable patient behavior intensified emotional and social strain.
Yasuma et al. (2024)	Japan	83 caregivers of people with schizophrenia in community psychiatric services	Cluster randomized controlled trial; Zarit Burden Interview; 6-month follow-up	Caregiver coping, illness knowledge, social support, patient relapse	Brief family psychoeducation reduced burden. Burden remained higher among caregivers of patients with recurrent relapse and aggressive symptoms.
Villena Jimena et al. (2026)	Spain	27 caregivers of people with chronic psychosis in community and psychiatric service settings	Qualitative study; focus groups; thematic analysis	Medication supervision, management of aggressive behavior, formal support, system coordination	Caregiver burden increased during relapse and aggressive episodes. Lack of formal support and poor service coordination amplified caregiver pressure.
Peng et al. (2019)	China	300 patient–family caregiver dyads in rural community settings	Cross-sectional; ICD-10; BSFC-s; aggression and social functioning measures; multivariable regression	Aggression, symptom severity, social functioning, caregiver relationship, economic status	Burden increased significantly with verbal aggression, physical violence, and property-directed aggression. Greater symptom severity and poorer social functioning further increased burden. Burden also varied by kinship relationship.
Phoeun et al. (2023)	Cambodia	37 caregivers in focus groups and 115 caregivers in quantitative assessment in community and NGO psychiatric settings	Mixed-method; PHQ-9; GAD-7; DASS-21; thematic analysis	Financial burden, unstable behavior, stigma, social isolation, emotional distress, access barriers	Caregivers experienced high levels of depression, anxiety, and stress. Major contributing factors included uncontrolled patient behavior, stigma, economic strain, and inadequate social support. Female and unemployed caregivers were especially vulnerable.

Psychosocial determinants also played a major role in shaping caregiving experiences. Affiliated stigma, emotional distress, family relationship patterns, and gender-related vulnerability were repeatedly identified as factors that intensified burden and weakened caregiving resilience. Studies from Uganda and Cambodia showed that stigma not only co-occurred with burden, but also acted as a mechanism through which caregiving involvement translated into greater psychological strain. Female caregivers and those without employment were more likely to report depressive symptoms, anxiety, and severe burden, while biological relatives, particularly parents and children, appeared to experience more intense distress than spouses in some contexts. Collectively, these findings suggest that caregiver burden is strongly embedded in social identity, emotional labor, and family relational structure rather than being driven solely by patient symptoms.

Structural and service-related determinants were also prominent across the included evidence. Caregivers described limited access to mental health services, weak coordination between formal care providers and families, insufficient involvement in treatment decisions, and financial hardship as major barriers that undermined caregiving capacity and increased burden. Qualitative findings from South Africa and Spain highlighted that families often experienced caregiving as an unsupported responsibility, particularly when they lacked clear information, regular follow-up, or practical service integration. In this context, family support was influenced not only by willingness to care but also by the availability of external resources that enabled families to sustain that role. These findings reinforce the view that caregiver burden and family support should be interpreted within the broader ecology of mental health systems, social protection, and community-based care.

Intervention-related evidence was comparatively limited but informative. The cluster randomized controlled trial from Japan suggested that brief family psychoeducation may reduce caregiver burden, although the effect was not uniformly strong across outcomes and follow-up periods. Other evidence indicated that supportive programs, including structured support systems and peer-oriented approaches, may have potential value, but implementation was often constrained by caregiver workload, participation barriers, and contextual limitations. Thus, while interventions appear promising, the evidence suggests that their effectiveness depends heavily on contextual fit, caregiver readiness, and the extent to which they address both emotional and practical caregiving needs.

Discussion

This review showed that family burden and family support in caring for relatives with a history of violent behavior were shaped by a complex interaction of clinical, psychosocial, and structural factors. The findings indicated that patient aggression, symptom severity, and relapse consistently increased caregiver burden across different settings. The synthesis also demonstrated that stigma, gendered caregiving roles, and family relationship patterns intensified emotional strain and reduced caregiving resilience. In addition, the review found that weak mental health service systems, economic hardship, and limited formal support reduced the family's capacity to sustain supportive care. The evidence further suggested that family psychoeducation and structured support interventions may reduce burden, although their effects varied across contexts. Overall, the findings confirmed that caregiving in the context of violent behavior requires integrated responses that address both patient instability and family vulnerability.

The first important point arising from this review is that clinical instability remains a central driver of caregiver burden. Aggressive behavior, agitation, relapse, and poor social functioning increased fear, supervision demands, and emotional exhaustion within families, which explains why caregivers of individuals with severe mental illness often experience greater strain than caregivers in many other chronic conditions. Peng et al. showed that verbal aggression, physical violence, and property-directed aggression significantly increased caregiver burden, particularly across different kinship roles within rural Chinese families. Andrade et al. also found that agitation and physical aggression intensified subjective burden and disrupted family functioning in Brazilian psychosocial care settings. Karambelas et al. further demonstrated that symptom severity and relapse predicted burden more strongly than diagnostic category, which suggests that the lived intensity of the illness may matter more than the formal label of schizophrenia or bipolar disorder. These studies indicate that violent behavior should be understood not merely as a symptom cluster, but as a destabilizing force that amplifies caregiving demands and reduces the predictability of family life (Peng et al., 2019a; Andrade et al., 2021; Karambelas et al., 2022).

Building on this clinical interpretation, the present review also highlights the decisive role of psychosocial factors in shaping caregiving outcomes. Family burden increased not only because of patient behavior, but also because caregivers carried emotional responsibilities, social expectations, and internalized distress over long periods. Kaggwa et al. found that affiliated stigma fully mediated the relationship between caregiver involvement and burden, which means that the emotional meaning attached to caregiving can intensify suffering beyond the practical tasks of care. Phoeun et al. reported that female and unemployed caregivers experienced higher levels of depression, anxiety, and stress, which indicates that social vulnerability influences how burden is experienced and managed. Rapiya et al. described how stigma and social isolation deepened caregivers' emotional exhaustion, especially when families felt abandoned by both community and service systems. Taken together, these studies suggest that caregiver burden is embedded in social identity, role expectations, and emotional labor, so family support cannot be strengthened unless psychosocial distress is addressed directly (Kaggwa et al., 2023; Phoeun et al., 2023; Rapiya et al., 2025).

The review further suggests that family relationships themselves can function as both a protective resource and a source of strain. Family members often provide supervision, encouragement, treatment support, and crisis management, but this caregiving role can become overwhelming when the patient's behavior is unstable or threatening. Issac et al. emphasized that caregivers of individuals with schizophrenia face multidimensional needs and often rely on coping strategies that are shaped by relational closeness, perceived obligation, and available family resources. Villena Jimena et al. showed that caregivers of relatives with chronic psychosis experienced major pressure in managing medication, monitoring aggressive behavior, and coordinating care, particularly when they lacked support from formal services. Zhou et al. found that burden varied across family roles, which suggests that the meaning and weight of caregiving differ between parents, spouses, and children. These findings support the argument that family support should not be viewed as an unlimited informal resource, but as a relational capacity that can erode when caregiving is prolonged, emotionally charged, and insufficiently supported. Therefore, interventions should consider the kinship structure and emotional proximity of caregivers, because the same patient behavior may affect different family members in different ways (Issac et al., 2022; Villena Jimena et al., 2026; Zhou et al., 2016).

In addition to interpersonal dynamics, the review demonstrates that structural conditions strongly determine whether families can maintain supportive care. Families can only sustain caregiving when they have access to responsive mental health services, clear communication, social protection, and practical support that reduces the daily intensity of care. Rapiya et al. found that limited service access, weak care coordination, and financial pressure intensified the burden experienced by caregivers in South Africa. Villena Jimena et al. similarly reported that caregivers in Spain felt excluded from clinical decision-making and underinformed about treatment processes, which reduced their confidence and increased uncertainty. Monari et al. showed that in families dealing with substance-related behavioral instability, lack of structured support systems increased psychological stress and worsened stigma-related isolation. These observations indicate that family burden is not only a household problem, but also a system-level issue that reflects the adequacy of community mental health infrastructure. Accordingly, family support is likely to improve when service systems treat caregivers as active partners rather than passive companions in the care process (Rapiya et al., 2025; Villena Jimena et al., 2026; Monari et al., 2024).

Another important implication of this review concerns the role of nursing and family-centered interventions. The included evidence suggests that burden can be reduced when caregivers receive psychoeducation, practical information, and opportunities to strengthen coping skills in relation to symptom management and relapse prevention. Yasuma et al. demonstrated that brief family psychoeducation reduced caregiver burden among families of people with schizophrenia, even though the magnitude of change varied over time and across outcomes. Ibrahim et al. argued that nurse-led support models can strengthen family support and symptom management, particularly when services integrate continuity, communication, and family needs into care delivery. Santonja-Ayuso and Carmona-Simarro also showed that nurse-led mental health promotion and prevention interventions can contribute meaningfully to emotional support and caregiver preparedness. These findings align with the current review, which indicates that the burden associated with violent behavior cannot be reduced solely by treating the patient, but must also involve structured support for the family caregiver. For this reason, psychiatric nurses should be positioned more explicitly as facilitators of family resilience, psychoeducation, and coordinated community-based support

(Yasuma et al., 2024; Ibrahim et al., 2026; Santonja-Ayuso & Carmona-Simarro, 2026).

The present review also has important theoretical implications because it shows that family burden and family support should be conceptualized as interconnected processes rather than separate outcomes. Families who experience repeated aggression, stigma, and structural neglect may gradually lose their capacity to provide emotional and practical support, whereas families who receive adequate support may be more resilient in managing burden. Qiu et al. found that potentially harmful behavior, affiliate stigma, and social support mediated the relationship between patient disability and caregiver burden, which supports the idea that burden is shaped through interactional pathways rather than direct clinical effects alone. Xiong et al. showed that social support buffered the relationship between stress and psychological complications in bereaved parents, which suggests that supportive environments may modify distress trajectories in family caregiving contexts as well. Amiri et al. emphasized that dignity-related experiences in severe mental illness are influenced by personal and relational factors, which implies that family responses to violence-related behavior may also be shaped by how the patient is perceived within the caregiving relationship. This broader interpretation suggests that future research should move beyond simple risk-factor identification and instead examine mediating and moderating pathways linking violent behavior, family stress, support, stigma, and caregiving outcomes (Qiu et al., 2023; Xiong et al., 2023; Amiri et al., 2025).

Finally, the review must be interpreted in light of several limitations that also point toward future research priorities. The included studies showed substantial heterogeneity in design, setting, sample composition, and measurement tools, which limited direct comparison and prevented meta-analysis. Several studies used cross-sectional designs, so causal relationships between violent behavior, stigma, support, and burden could not be firmly established. Karambelas et al. noted that caregiver burden evidence often varies because of differences in measures and psychological outcomes, while Kalayci et al. showed that qualitative studies capture dimensions of burden that structured instruments may overlook. Kurniawan et al. also highlighted the importance of valid family support measurement, which indicates that methodological refinement remains essential for stronger future evidence. Therefore, future studies should use longitudinal or mixed-method designs, standardized and culturally validated instruments, and explicit measurement of violent behavior characteristics in order to clarify how family support and family burden evolve over time in mental health caregiving contexts (Karambelas et al., 2022; Kalayci et al., 2023; Kurniawan et al., 2025).

Conclusion and Recommendation

This systematic review concludes that family burden and family support in caring for family members with a history of violent behavior are influenced by an interrelated combination of clinical instability, psychosocial vulnerability, and structural limitations in mental health care. Aggressive behavior, relapse, and symptom severity increase caregiving demands, while stigma, emotional distress, and unequal family roles intensify the burden experienced by caregivers. At the same time, inadequate service access, limited information, and poor system coordination weaken the family's ability to provide sustained support. These findings indicate that families require not only emotional encouragement, but also practical, educational, and service-based interventions that are responsive to the realities of caregiving in high-risk psychiatric contexts. Mental health professionals, especially nurses, should strengthen family-centered care through psychoeducation, relapse management support, and structured caregiver assistance. Future research should prioritize longitudinal and culturally sensitive studies to develop stronger evidence for interventions that can simultaneously reduce caregiver burden and enhance family support.

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Declaration on the Use of AI

There are no AI tools used in the preparation of this manuscript.

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