**Title: Practitioners' experiences of adolescent suicidal behaviour in peer groups**

**Accessible summary**

**What is known on the subject?**

- Group suicidal behaviour can be devastating for all concerned
- There is an absence of research on adolescent suicidal group behaviour
- The perspectives of practitioners' experiences of these groups are largely lacking from research literature

**What this paper adds to existing knowledge**

- Practitioners work regularly with suicidal behaviour in adolescent peer groups
- Practitioners identify peer relationships in groups as complex, including elements that are both suicide encouraging and preventing
- Practitioners identify a range of ways in which young people become involved in suicidal behaviour in groups, including indirectly through risk taking and care-seeking as well as directly suicidal or self-harming

**What are the implications for practice?**

- Assessments of young people should routinely include a focus on the qualities of peer relations, including those in the online/digital realm
- Assessments and interventions need to consider the complexity of group relationships and roles, and the multiplicity of factors that can contribute to suicidal behaviour in groups
- Interventions that sustain therapeutic connectedness are helpful for taking dynamic/fluctuating risks into account

**Abstract**

**Introduction**: Group suicidal behaviour by young people can have harmful effects; it may be increasing, influenced by online media and reported increasing self-harm rates; new knowledge and understanding to inform interventions is required.

**Aim:** To explore how practitioners experience group suicidal behaviour amongst adolescents, how they assess risks/ needs, and how these insights inform understanding about these groups.

**Method:** 10 practitioners, including Mental Health Nurses, were interviewed in one multidisciplinary CAMHS, in England. Data analysis was by Thematic Analysis (Braun & Clarke 2006).

**Results**: Participants described frequently working with suicidal groups. Roles in groups include suicide encouraging and preventing. Practitioners identify risky and protective connections between young people, online and offline. Clinical tensions include living with suicidal risks, emotional and positional challenges, and getting to grips with digital media.

**Discussion:** Peer-groups appear to have a larger role in adolescent suicide than recognised to date. Practitioners need to assess young people's roles in groups, their diverse motivations, and to understand constantly changing digital media.

**Implications for Practice:** Assessments of suicide risk for young people should routinely include focus on peer relations including the online/digital realm. Maintaining relationships with vulnerable young people facilitates managing fluctuating risks and understanding different group dynamics.

**Keywords:** adolescents, peer-groups, qualitative studies, thematic analysis, self-harm, suicide clusters

**Relevance Statement**: Mental health nurses are widely and routinely involved in assessing suicide risks, intervening to prevent suicide and offering therapeutic interventions to patients. In child and adolescent mental health services, nurses occupy key roles within multidisciplinary teams where the focus is on reducing suicide risks amongst young people, including undertaking outreach. As in this study, nurses carry a significant responsibility for these interventions, and thus can be deeply impacted emotionally by the work. The need for informed interventions in this area of group suicidal behaviour amongst young people is particularly important for nurses.

## Introduction

Group suicidal behaviour amongst young people has received worldwide attention following the spate of 26 suicides in South Wales between 2007 and 2009 (Jones *et al*. 2013) and South Australia (Austin *et al.* 2011), where 14 young people died; hitherto considered rare events, there are suggestions that these groups may be occurring more frequently. Of particular concern is whether online media may be contributing to a process of normalising suicidal behaviour (Daine *et al.* 2013), and whether reported increases in adolescent self-harm may also contribute to more frequent group suicidal behaviour. Group suicidal behaviour can have devastating consequences for young people, families and communities, yet very little is known about which young people become involved, or are susceptible, nor how suicidal behaviour spreads amongst groups; yet systematic reviews have concluded that we need to undertake in-depth interview based studies to learn more about mechanisms (Haw *et al*. 2013) and contexts (Niedzwiedz *et al*. 2014).

Nurses, together with practitioners of all disciplines, in primary, secondary and mental health services, and in social care and education, are used to making assessments of suicide risk as a core part of their work with vulnerable young people. It is important to know more about the clinical dilemmas they experience when confronted with group suicidal behaviour; whether and to what extent they recognise it as an issue; how they make assessments in these situations; how they understand the processes and dynamics in these groups, and how they intervene to reduce suicidal risks. Practitioners' perspectives are potentially valuable for understanding adolescent group suicidal behaviour, because they have a particular 'lens' for observing young people's experiences, through their routine assessments and interventions and the close relationships they develop with individual patients.

Group suicidal behaviour is usually studied as suicide clusters, where a group of suicides or suicide attempts occur closer together in time and/or space than would normally be expected (Center for Disease Control 1988). Research of suicide clusters usually focuses on retrospective identification, using statistical methods based on geo-spatial mapping techniques (Larkin & Beautrais 2012, Jones *et al.* 2013). These methods have the important merits of providing accurate data about increases in suicides in time and/or space, but they do not access the reasons for individual involvement in group suicidal behaviour.

Study of suicide clusters recognises that suicidal behaviour can occur whether or not people involved are directly in contact with each other (Haw et al 2013). The focus on group suicidal behaviour provides a different perspective in two respects. Firstly, it limits the field

of study to where there is direct contact between young people thus involved, whether online or offline. This highlights adolescent peer relationships, and the dynamics that can influence suicidal behaviour (Goldblatt et al. 2015). It is widely recognised that peer relationships are important in adolescence for developing a sense of identity and increasing separateness from parental figures (Briggs 2008). In the new contexts for young people, involving different concepts of friendship, especially through social media, the importance of peer groups that are mediated through both the real and online worlds have been identified as key areas for exploration (Whitlock, *et al.* 2006, Mitchell &Ybarra 2007). To date, however, research has not explored how professionals engage with adolescent peer groups where suicidal behaviour is taking place, both on and offline.

Secondly, in contrast to the retrospective methods used to identify suicide clusters, the focus taken in this study on group suicidal behaviour aims to approach the subject through exploring current suicidal and self-harming behaviour. One way to achieve this is to adopt the lens of practitioners as they make assessments of risks, including how seriously suicidal are the motivations in each case. This is particularly complex in the confused and contested area of definitions of suicide and self-harm, where there is a distinction, in one view, between suicidal motivation and non-suicidal self-injury, as now included in DSM-V. This has been seen as a false dichotomy (Kapur *et al.* 2013) since suicidal motivation can accompany apparently non-suicidal self-injury, self-poisoning is not always undertaken with suicidal motivation, and individuals can use more than one method in different episodes (Hawton et al 2012). The key risk factor for completed suicide is a previous episode of self-harm (Kendall *et al.* 2011; Hawton *et al.* 2015), so suicide risk assessments must pay particular attention to any act of self-harm, and recognise that self-harm and suicide can be

continuous behaviours on a spectrum, involving multiple or diverse motivations and outcomes. On the other hand, the reported rise in rates of adolescent self-harm – up to 28% young people have one episode (Brunner *et al.* 2014) – and the fact that most episodes of self-harm – 80% (Hawton *et al*. 2012) - do not reach clinical services mean that clinical assessments need to account both for the rise in self-harm, especially by self-cutting, as a factor in contemporary youth culture (Adler & Adler 2011) and the relatively rarity of suicide completion. However, the reality of suicide risks is shown by the continuing deaths of young people by suicide; most recent statistics show that 188 (133 male and 50 female) young people between 15 and 19 years died completed suicide in 2014 (Samaritans 2016)

Haw *et al.* (2013) discuss different theories for how suicidal behaviour spreads between individuals to form clusters; these include perhaps the most commonly assumed method of transmission, contagion, originally suggested by Durkheim (1897/2006). The notion of contagion implies that something is transmitted, just as in the case of infectious diseases, between people with or without a strong apparent sentient connection with each other. However, mechanisms of communication and influence remain unclear (Boyce, 2011). Other possibilities include imitation, complicated bereavement (Johansson *et al.* 2006), homophily (Joiner 1999), and assortative relating/susceptibility (Chotai 2005). Identification with the suicide victim, has been considered a mechanism of communication between those affected by a suicide (Sachs & Eth 1981) and in 'copycat' suicides (Austin *et al.* 2011).

Young people attending mental health services, both in-patient and out-patient settings are likely to be more exposed to others' suicidal behaviour and thoughts, given the high rates of people attending these settings who are suicidal (Children's Commissioner for England

2016). There are few studies of how contact with young people, who harm themselves or have suicidal thoughts within mental health services impacts on others, and none of these study these effects in outpatient settings (Haw et al 2013). With the exception of King *et al.* (1995), few studies of the influence of suicidal behaviour on others in inpatient settings focus solely on adolescents. In the King *et al.* (1995) study, there was no evidence that exposure to others who harmed themselves led to increased suicidal behaviour, although some (14-26%) recorded higher suicidal thoughts. In contrast, for adults, Taiminen *et al.* (1998) found that a majority of self-harm incidents were triggered by self-harm by other patients, including those who were hitherto self-harm 'naive' becoming involved in self-harm. Amongst qualitative studies exploring adolescent peer groups, Crouch and Wright (2004), studying peer relationships in an adolescent inpatient unit, identify competition between young people about self-harm and suicide as a pervasive factor, which led to these adolescents distinguishing between 'genuine' self-harm and 'self-harming for attention'. Moody (2009) studied peer relationships in a small sample of adolescents who self-harmed and attended an outpatient mental health service, finding that self-harm was motivated by becoming closer to peers, and at the same time creating more distance from adults.

**Aims**

The aim of this study is to explore the experiences of mental health practitioners working with young people who engage in suicidal behaviour in their peer groups. This involves exploring the clinical dilemmas practitioners face in this work, their understanding and thinking about how they perceive the characteristics of young people who are involved in these groups, the dynamics in these groups, and how suicidal ideas and behaviour are transmitted between individuals.

## Methods

In this study, funded by the Tavistock and Portman NHS Foundation Trust, we have explored the experiences of practitioners with adolescent suicidal groups. Our reporting adheres to the COREQ (Consolidated criteria for reporting qualitative research) guidelines (Tong et al. 2007). The sensitive nature of the topic area, and the associated risk of emotional distress, necessitated that consent be understood as an ongoing process and the researchers consider the emotional wellbeing of participants (Cutcliffe and Ramcharan, 2002). An application to the University of East London University Research Ethics Committee was made and approved (Ref: UREC_1415_50). Following this, application was made and granted for NHS R&D approval; national research guidelines were adhered to (DoH 2005). No conflicts of interest exist. All participants were given an information sheet describing the project and all gave written informed consent.

### Research team and reflexivity

The research team of this study comprised two university-based researchers (S.B. & T.S.) and a mental health nurse practitioner (J.B.). The team members have experience in undertaking qualitative research and in clinical practice settings, including adult, adolescent and child mental health and social care services. Researchers had diverse views about the topic, and bias was avoided through team reflections and research design; two members of the team interviewed together, and all contributed separately and then together to data analysis and writing this report.

### Participant recruitment and selection

Practitioners from one Child and Adolescent Mental Health Service (CAMHS) in England were recruited. One service with multiple participants was selected to gain different practitioner perspectives. Participants were identified in discussion with the service's lead clinician, to include practitioners working with suicidal young people with diverse professional backgrounds and in different roles in the service. Ten participants, who all agreed to participate; this was thought to be a sufficient number to represent this diversity and provide a rich source of data for analysis for this exploratory study, and fits with criteria for samples for this kind of qualitative research (Morse 2000). They consisted of 4 nurses, 2 psychiatrists, 2 psychologists, one social worker and one family therapist.

**Data collection**

Interviews were conducted by two researchers (S.B and J.B) and lasted 40-50 minutes. The interviews were audio-recorded, with written informed consent from all the participants, and transcribed verbatim. Accuracy of transcriptions were checked by JB and SB. Participants were given the opportunity to ask questions prior to the interviews and could end the interviews at any time. Participants were given a copy of the transcripts of their interviews to check for accuracy and further comments were invited. Feedback was also provided to the whole service through a presentation. We are using extracts from the interviews when reporting findings, hence to protect anonymity, participant names have been changed into codes (01, 02, etc.).

The interviews were semi-structured to ensure consistency of issues addressed across all participants, whilst also offering opportunities to develop individual narratives of their experiences. Interviews of this type were chosen because of their flexibility and ability to

capture the individual's personal views (Wilkinson *et al.* 2004). The interview schedule consisted of 7 questions with prompts, as shown in Table 1 below:

**Table 1: Interview schedule**

**Insert table 1 here**

**Method of analysis**

Interviews were analysed using thematic analysis (TA), as this is well suited to exploratory studies, and allows the identification, analysis and reporting of patterns (Braun & Clarke 2006), and to making interpretations of what occurs within the data (Boyatzis 1998). Our theoretical approach to TA recognises both the reality of the group suicidal behaviours we are exploring, and the subjective, constructed qualities of how participants describe their motivations and contexts. Data was analysed to an extent deductively by assessing responses to our interview and research questions, but predominantly inductively to investigate the naturally occurring themes in the data itself, including individuals' thoughts and feelings. This dual approach, which involves analysing latent as well as manifest content and themes is considered important in high quality qualitative work (Joffe 2012, Mason 2002). We followed Braun and Clarke's (2006) guidance for the stages of analysis. Initial codes were developed manually by all authors working independently, themes were developed from the codes to form thematic charts, and these were then refined, through working iteratively, returning to the codes and dataset. Thematic charts were then shared in team meetings, reviewed and refined to form two agreed overarching themes: (1) risky and protective connections and (2) managing risks, dilemmas and tensions.

**Results**

The ten participating practitioners in the multidisciplinary service undertook different roles including management, individual therapy and outreach work. Their experiences ranged from two years post qualification to 20 plus years, with 7 having worked in the service for 5 years or longer.

**Risky and protective connections**

All participants indicated they were familiar with young people involved in group suicidal behaviour. For some practitioners, it was a prominent feature of their work:

> "*Many. It feels like. Yes, it's part of our everyday job" (05*).

Amongst these, one participant questioned what was meant by a 'group', and described pairs of young people influencing each other; another described 'a large peer group around' an individual patient. They described current and recent cases.

Practitioners emphasised suicidal behaviour was generated through connections between young people in mental health services (in-patient and out-patient), schools and online. Mental health services were particularly prominent, forming a 'trellis' on which suicidal ideas 'crystallise and grow' (07):

> *"I would put sort of the in-patient unit as sort of on the top how intense things can develop. But I think our services [out-patient] contribute too in terms of giving a forum where similarly distressed young people… have a voice together… So these sort of areas provide a powerful connection" (02)*

A particular example, mentioned by two participants (O2, O5), was of two young people who met in the waiting room of the CAMHS service and went on to influence each-others' risk-taking behaviour, which included self-harm, and drug taking. The more experienced could induce younger or more naïve individuals, though this can be disturbing:

> *"And I've ….. had a case of a young girl who's from one of the [place name] schools who kind of rang me in a frantic state because her friend knew she self-harmed and wanted to experiment. Wanted to know what it was like. And actually kind of asked my young person to show her what she did and then this young girl did it" (08)*

Schools referred young people who may be influencing each other but more troubling for practitioners was the impact of online connections, partly because these were more 'unpredictable' (02), with increased possibilities for disinhibited disclosures of self-harm and suicidal thoughts, separate from everyday social contexts (09), and thus being vulnerable to making risky connections:

> *If they're people kind of looking around for those kind of conversations you will attract some people and maybe that's how these kind of connections and networks form (07)*

Though participants emphasised the importance of monitoring and managing connections between potentially vulnerable individuals, they were at pains to emphasise that *'peer groups are not all bad'* (02), recognising their developmental importance in adolescence. Practitioners discussed how connections also provided possibilities for protecting a suicidal peer, and helping them refrain from suicidal or self-harming behaviour:

*"they've sort of suggested an awareness of you know when the other person is self-harming or how long they've managed to resist self-harming for. That is…… they kind of sustain each other in maybe periods of abstinence from self-harm as well (06)*

Frequently participants detailed examples where peer connections contained uncertainty or ambiguity: the relationship might protect a vulnerable young person but also might increase the risk of becoming involved in suicidal behaviour. The strength of the suicidal dynamic in the group could defeat the intention to prevent suicidal behaviour. In other words, it could go either way: suicidal behaviour could be prevented, or others could be infected:

*"there's other young people who they spend time with and who know about their overdosing behaviour… but not that would partake in it…. friends who anyone of them would call to let them know when they've taken an overdose or that they need help or they're in trouble or … that they reach out to. But not that would join them in the behaviour … at the moment anyway" (04).*

Practitioners took different positions about whether in some groups the intention to save or care for a suicidal young person was genuinely protective, or not. Whilst some emphasised that the groups were a place to practice care, others assessed these young people as vulnerable, looking for the group to provide security and a sense of belonging. Examples included young people becoming overwhelmed with others' suicidal behaviour, feeling others' pain and distress, and then harming themselves; or becoming involved in brinkmanship, and thus getting involved in suicidal enactments with mixed or contradictory motives, both to attempt suicide and prevent the other from so doing:

*but … then she'll describe oh we're gonna jump and one has to pull the other back and … it just … it feels like she wants to kind of get the other person involved but … when the other person 'I'm gonna jump', she then feels the need to kind of pull her back but they've got this pact, they've gone up there with this pact together but they don't … they're kind of saving each other' (003)*

**Managing risks, dilemmas and challenges**

The ambiguous, often contradictory and uncertain kinds of connections in groups meant that practitioners experienced dilemmas and tensions about how to understand the meaning and risks in each situation they faced. Thus practitioners had to find ways of managing themselves in their work, including their emotional experiences while cognitively applying a framework for thinking and decision-making. Key subthemes were: living with risks, managing emotional and positional challenges, and getting to grips with the digital realm.

The risk of a young person dying by suicide was ever-present in the minds of the practitioners. Participants reflected on the seriousness of suicide attempts; for example: how close to the brink of jumping, the numbers of tablets taken. They took into account the risk of dying, too, through the physical effects of repeated overdoses, for example, through liver failure.

Frequently practitioners referred to risk-taking behaviour that could be accompanied by a frisson of excitement about their bonding in the group and the dangers they are facing,

*'they're kind of, they're kind of in a way they're kind of skylarking. It's partly done in a kind of spirit of just crazy, joint fun. And they do enjoy it. They cause us plenty of headaches and there's a really dark side to it' (07)*

Excitement could easily flip into danger when the group activity consisted of taking paracetamol tablets, not with overtly suicidal motives, but with the aim of getting a high and seeking fun. As one practitioner reported a young person saying:

*" well it's just taking paracetamols is a kind of buzz. It's kind of quite, it kind of makes you feel kind of lightheaded and it's nice" (07)*

Practitioners described being involved with suicide attempts in real time, sometimes alerted to the risks through a phone call or text from one of the young people involved, but without sufficient information to intervene effectively:

*'So kind of like a staggered overdose during the day and two people together. And then one girl making us aware of that. But not wanting to divulge her location (…) just trying to kind of work with that dynamic and trying to work with safety and trying to encourage them to support each other or to at least to call for help or to let somebody else know. And kind of leaving work at the end of the day thinking what's gonna happen? Is help gonna find them and catch up with them?' (*O4)

Practitioners repeatedly said that they felt the likelihood of suicide completion was reduced when young people maintained contact with them. They preferred to maintain contact with these young people, including by phone and text between meetings, especially in the outreach team, even if this raised anxieties and difficulties, rather than to experience lack of communication from more socially isolated young people, as these young people are thought to be more likely to complete suicide:

> *'…my own experience of suicides, because the other suicides I've experienced in my career … you don't see them coming that's my experience. They, they, you know … you don't get the texts, the phone calls'* (01)

As this practitioner added, *"If someone's gonna do it then they're not gonna advertise it."* (01) and those who repeatedly attempted suicide, though needing to be taken seriously '*would have done it by now [completed suicide] if they were going to'* (01).

Thus, practitioners felt they were occupying a zone of uncertainty in most cases, where something serious, or deadly, might happen, though equally, it might not. One practitioner talked about where one group were talking online about their self-harm:

> *it felt intensive although nothing actually happened in that group of young people who were blogging about their self-harm. It just felt always on a bit of a knife edge that it just needed for someone to say something, yeah, a little bit more than what they were already saying that could trigger these people individually and then as a group. (05)*

As in this example, the online realm provided distinct risks, and practitioners expressed different views about managing this new medium. Some participants, particularly the younger ones, expressed an almost understated competence in understanding young people's online connections and the almost seamless transitions they make from online to offline relating. These participants were comfortable discussing the different media and forums, whilst also recognizing that young people could make risky connections online. They were also comfortable in talking with young people about their online lives. Some of the more experienced, and also older, participants seemed more troubled by social media; it held a strangeness and signified something different, creating a gap between themselves and the young people.

> '*I'd no idea what all this Snapchat and Instagram and Tumblr was all about. And the dark net and you're like huh, huh?*' (08).

One participant (02) expressed acceptance that it was important to recognise that young people turn away from adults in order to develop identity and separateness, and that the digital realm provided an ideal opportunity to exercise this. Another (10) expressed how difficult it was to keep in mind the young person's online activities:

> *'it's hard to get a hold of it and then and keep it in mind from week to week or fortnight to fortnight, you know. Of what is important to them.' (10)*

One strategy the service had invested in was to seek training to understand social media, so that staff would feel more able to discuss with their patients.

> *'it created an awareness so we the clinicians were a bit more sort of knowledgeable (…) So at least people through okay this is something we can talk to them otherwise it sort of created a gap between clinicians and the young people' (02)*

Managing risks also involved taking account of the emotional impact of the work, the intensity of which could be draining and they 'can feel quite burnt out by it' (05). Practitioners were aware of being pulled and pushed to take up particular positions, for example between supporting and setting limits. They commented on the importance of treading a line between anxiety-led over reacting, and conveying that needs and risks were being taken seriously, particularly when the suicidal behaviour was assessed as including care-seeking motive. Most frequently, participants talked about the challenge of boundaries. This was powerfully expressed in considerations about confidentiality issues especially when young people talked to practitioners about others' suicidal intentions.

> *'They … bring them in a session by mentioning their name and you kind of go I can't talk about this (…) how do I preserve each person's confidentiality and all those kinds of ethical questions?'* (05)

Pressure from group dynamics impacted on practitioners' attempts to maintain boundaries, focus on individuals and not be pulled into group dynamics, where individual differences could be lost:

> *Because one would hear about the other person's patient and it became with that boundary this feeling of how to respond …. Who needs what? Let's not lump them together* (01)

There were different perspectives about how to manage these boundary issues. One view was that at times it could be helpful to explicitly talk with the young person about information received from another and managing these disclosures was a skill to put into practice; in contrast, breaking individual confidentiality boundaries was considered risky, if necessary sometimes. A risk was that the relationship with either or both young people could be compromised, and could lead to contact being lost (05) which they tried to avoid. Further, it was suggested that breaking boundaries could lead to splits between practitioners with the young person favouring the boundary-breaching practitioner against the one who maintained boundaries and limits (01).

Practitioners weighed up the advantages and disadvantages of introducing a group oriented treatment approach. The group model was felt to be natural since young people's interconnected lives included their peer relationships; they met each other in the service and talked about peers, but it was also felt that a group model could escalate risks. On the other hand, practitioners commented that peer-relations – including online – should be more highlighted in assessments.

**Discussion**

In this study, we aimed to explore the experiences of mental health practitioners working with young people who engage in suicidal behaviour in their peer-groups. Our focus was on how practitioners recognised and intervened with these young people, the sense they made of suicidal behaviour and its impact on them. We also explored the view of group suicidal behaviour provided by this practitioner 'lens'. Though evidence suggests that suicide clusters occur in institutional settings, including mental health services (Niedzweidz et al 2014), there is currently very little literature that addresses adolescent peer-group suicidal behaviour, and thus we appraise the potential for this approach in furthering understanding.

Our findings emphasised that practitioners approached suicidal risks in adolescent peer groups from two perspectives: firstly, that they form a common occurrence amongst vulnerable people accessing mental health services; nurses and other practitioners described this as a key aspect of their work. Secondly, the uncertainties of assessing risks combined with complex group dynamics to create clinical dilemmas. The fact that suicides did occur, albeit rarely relative to the frequency of attempts, and the traumatic impact of completions on young people, family and professionals, served to focus practitioners on preventing the possibility of suicide. In the absence of more precise ways for assessing suicide risks in groups, practitioners focused on identifying connections between young people, maintaining therapeutic relationships and making detailed and repeated assessments of risks in the contexts of young people's complex peer relationships and vulnerabilities. This appears to accord with the recommendations of the NICE guidance (2011) for working with self-harm, based on recognition that reliable predictive tools are not

available, of undertaking detailed psychosocial assessments, assessing needs and risks, and initiating and maintaining therapeutic relationships.

Thus practice occupies an uncertain field, in which the unpredictabilities of suicide risks combined with individuals' ambiguous intentions and patterns of peer group relationships. Groups were experienced as existing not solely to promote suicidal behaviour but, on the contrary, containing a complex mix of suicide encouraging and protecting roles and relationships. On the one hand, young people inducted others to self-harm and encouraged suicidal behaviour (Taiminen *et al.* 1998). On the other hand, young people also supported and protected each other; they supported abstinence from self-harm, tried to ensure that an episode did not get out of control, and maintained links with adults to help if necessary. Individuals changed roles in their groups, moving from abstinence to partaking and vice versa. Practitioners held different views about whether the peer groups genuinely supported individuals, to keep them safe, or whether these were perhaps false positions, derived from the needs of these vulnerable individuals to find a sense of belonging and acceptance. In this study, practitioners worked reflectively, individually and as a team, to make sense of these ambiguities and contradictions.

Practitioners prioritised maintaining therapeutic connections to assess and work with risky and protective connections between young people. They experienced young people's group-oriented ways of relating challenging to individual-centred therapeutic work, notably through pressure on maintaining professional boundaries. They differentiated young people's motives, which they categorised as suicidal, excitement through risk-taking and care-seeking. Particular emphasis was placed on the new factor of the digital realm, which

was seen as aiding the transmission of suicidal behaviour, through extending the range of possible connections (Mitchell & Ybarra, 2007). The sense of insecurity around online communication was heightened by some practitioners' self-identified knowledge deficit about the online world. Young people's use of the digital realm was seen to create an additional layer in young people's interconnected lives, as they move apparently seamlessly between online and offline worlds, increasing opportunities for risky connections, that could encourage suicide, and generating uncertainty and separateness from adults, including practitioners.

The unpredictabilities of assessing and working with suicide risks have been well-documented as a source of anxiety for practitioners from a range of professional backgrounds (Ting, *et al.* 2011), whilst other studies have focused on practitioners' attitudes to individuals who self-harm (Saunders et.al 2011). This is the first study to demonstrate how practitioners experience and respond to adolescent group suicidal behaviour. The complexity of working with peer-groups increases the intensity of the emotional experiences through several factors. Firstly, ever changing group dynamics, occurring through a variety of real-world encounters and in the online realm, generated considerable uncertainty, as to whether peer relationships were a source for concern or a protective factor (Moody, 2009; Daine, *et al.* 2013). Secondly, though practitioners held a view in general terms that suicidal behaviour and intention can transmit from one individual to another, in practice this was seen to occur in different ways in specific contexts. No single, overarching theory of the transmission of suicidal behaviour could be used to structure risk assessments and interventions, as multiple mechanisms appear to contribute within peer-group relationships. This is consistent with current knowledge of suicide clusters, that

multiple mechanisms are likely to operate together, and these may vary in different settings (Haw et al 2013, page 105). As there is a lack of clarity (Boyce 2011), and a need for further research (Haw et al 2013) more in-depth research is indicated to elucidate how different dynamics impact on the transmission of suicidal behaviour between individuals.

Practitioners noted and worked with ambiguities and contradictions, often under intense emotional pressure, and these clinical observations suggest a more nuanced picture of group suicidal behaviour than has been assumed in the literature to date (Haw et al 2013). The approach taken here appears to hold promise that, with further study, the importance of the group dimension of adolescent suicidal behaviour can be better understood in order to develop informed practice interventions.

**Limitations**

The limitations of this study include the small number of participants and the heterogeneities of a local study, which reduce transferability to other settings. This is an exploratory study and conclusions and implications for practice are made consistent with this. The research was conducted in a major city and contextual issues also need to be taken into account. The findings may also be restricted in time, to the particular conditions at the time in the service, which may be subject to service delivery changes as well as changes in youth culture.

**Implications for practice**

Including information about peer-group relationships, both off line and online, is important in assessing risks and needs of vulnerable young people accessing services. Practitioners

can expect that risks and roles in groups involved with suicidal behaviour will fluctuate over time, and maintaining therapeutic relationships facilitates assessing these changes and the balance between risk and protective factors in group dynamics. Thus practice is enhanced by the detailed understanding of different roles and dynamics in groups, and individual motivations, rather than by assuming a general mechanism for transmission of suicidal behaviour. Reflective teamwork is important in working with the intense emotional impacts, challenges to professional boundaries, understanding current social media, and working with the different viewpoints that reflect ambiguities, uncertainties and limited knowledge.

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