



Understanding suicide clusters through exploring self-harm: Semi-structured interviews with individuals presenting with near-fatal self-harm during a suicide cluster

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ABSTRACT

There was a highly publicised cluster of at least ten suicides in South Wales, United Kingdom, in 2007–2008. We carried out a qualitative descriptive study using cross-case thematic analysis to investigate the experiences and narratives of eight individuals who lived in the area where the cluster occurred and who survived an episode of near-fatal self-harm at the time of the cluster. Interviews were conducted from 01.01.2015 to 31.12.2015. All interviewees denied that the other deaths in the area had affected their own suicidal behaviour. However, in other sections of the interviews they spoke about the cluster contributing to difficulties they were experiencing at the time, including damage to social relationships, feelings of loss and being out of control. When asked about support, the interviewees emphasized the importance of counselling, which they would have found helpful but in most cases did not receive, even in the case of close contacts of individuals who had died. The findings suggest that effective prevention messaging must be subtle, since those affected may not be explicitly aware of or acknowledge the imitative aspects of their behaviour. This could be related to stigma attached to suicidal behaviour in a cluster context. Lessons for prevention include changing the message from asking if people 'have been affected by' the suicide deaths to emphasising the preventability of suicide, and directly reaching out to individuals rather than relying on people to come forward.

1. Introduction

Suicide is one of the leading causes of death in young people in high-income countries (Patton et al., 2009). It is estimated that approximately 1–2% of suicides in young people occur in clusters (Gould et al., 1990). Clustering of suicides has been described repeatedly in the research literature and suspected clusters are often the focus of media attention (John et al., 2016). Two main types of cluster are reported in the literature - mass clusters, where suicide rates increase in the wider population in a time period, and point clusters, which involve a concentration of deaths by suicide in time and space within a specific locality (Joiner and Thomas, 1999).

There are several proposed mechanisms underlying the initiation and maintenance of suicide clusters (Haw et al., 2013; Hawton et al.,

2020). These are not mutually exclusive, and it is likely that several different mechanisms will be implicated in any one cluster. In their recent review Hawton et al. (2020) summarise four potential mechanisms as follows:

- (1) *Social transmission*. This is the idea that exposure to the suicide of a significant other can increase vulnerability to further suicide (Baller and Richardson, 2009; Mueller and Abrutyn, 2016). Haw et al. (2013) refer to this as contagion, using the metaphor of infectious disease; and the more specific social psychological processes of imitation and suggestion, including via media reporting (Phillips, 1974); projective identification; pathological identification; learning; priming; and complicated bereavement.

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- (2) *Descriptive norms*. This is the idea that the more prevalent suicidal behaviour is perceived to be, the more normalised it becomes. Suicide becomes seen as a less extreme and more usual response to distress, moving it closer to the potential ‘repertoire of action’ (Fincham et al., 2011) of a very vulnerable individual. A process of normalisation has also been noted in relation to social media influences on self-harm (Daine et al., 2013; Marchant et al., 2017).
- (3) *Assortative relating*. This theory proposes that the clustering of suicide is explained primarily by a group of individuals sharing certain risk factors and therefore associating with each other (Joiner and Thomas, 1999).
- (4) *Social integration and relating*. This refers to the effect of close-knit social networks in disseminating news and beliefs about suicides in a locality. This involves a combination of structural and cultural factors (Mueller and Abrutyn, 2016). The local diffusion of ideas and attitudes overlaps with the idea above of descriptive norms, where a local ‘cultural script’ becomes a ‘taken-for-granted social fact’ and common life pressures in a social group (e.g. adolescents) become seen as understandable reasons for suicidal acts, enhancing the ability of people in that group to ‘imagine suicide as something someone like them could do to escape’ (Abrutyn et al., 2019: 2).

Of these broad categories of theorising about mechanisms, arguably descriptive norms and social integration help to elaborate and explain social transmission, whereas assortative relating is a competing theory, not so easily compatible with the others.

The sociology of suicide has grappled with the interaction of collective culture and individual behaviour ever since Durkheim’s classic study (Durkheim, 2002 [1897]). Some important contributions (e.g., Douglas (1967)) have sought to emphasise the social meanings of suicidal acts to individuals, in contrast to the structural determination of Durkheim. There have been attempts to bring together macro and micro levels. Fincham et al. (2011) argue for more breadth in theory and method, with appreciation of the richness of individual cases as well as generalisation at the variable level. Good qualitative social research on suicide can encompass both micro- and macro-level influences, through the detailed study of relatively small samples of individual cases but with consideration of how individual behaviour takes place within a social and cultural context.

Informants in qualitative studies of suicide are often family members of individuals who have died (Groh et al., 2018; Owens et al., 2008). These are valuable informants; however, gaining the perspectives of people who self-harm and survive during a suicide cluster offers the advantage of a first-hand account of factors contributing to their suicidal behaviour. Such an approach has been used for studying influences on an individual’s choice of suicide method (Biddle et al., 2010; Rosen, 1975), and has been advocated, but not previously used, for the study of suicide clusters (Haw et al., 2013).

The current study focussed on a previously identified suicide cluster occurring in South Wales, United Kingdom. A significant cluster in this area was identified involving 10–15 deaths, predominantly in young people, from 27.12.2007 to 19.02.2008 (Jones et al., 2013). This cluster was highly publicised in both the local and national press, with a high volume of sensational reporting throughout the cluster (John et al., 2016). While news reporting may have played a role in the initiation of this cluster (Marchant et al., 2020) there were likely to be multiple factors underlying its initiation and maintenance.

We aimed to explore participant narratives and experiences, by conducting semi-structured interviews with individuals who presented to a local emergency department with near-fatal self-harm during this apparent cluster. There are, to our knowledge, no previous studies based on first-hand accounts from people who had a near-fatal self-harm incident during a suicide cluster, making this a novel exploration of such accounts.

2. Method

2.1. Participant recruitment and consent

Participants were identified from those who presented to the district hospital emergency department local to the area of the apparent suicide cluster with an episode of ‘near-fatal’ self-harm during the previously identified cluster (27.12.2007–17.03.2008; Jones et al., 2013). Eligible participants were identified by hand searching clinical records and using routinely collected data. The criteria used to define ‘near-fatal’ for the current study included: people who made suicide attempts who were likely to have died had they not received emergency medical intervention, including: those admitted to intensive care units; those who unequivocally employed a method with high case fatality and sustained an injury; and those who attempted hanging, where whole or part of the body weight was used to apply pressure to a ligature around the neck and sustained an injury (Biddle et al., 2010). Participants were excluded if their episode of self-harm did not meet the criteria for near fatal described above, if they were aged under 18 years at the time of contact for the study or did not have the capacity for consent.

2.2. Participant safeguarding

Steps were taken to minimise potential distress by participants when contacted regarding the study. Potential participants were initially contacted on behalf of the research team by a clinical emergency department consultant who determined whether it would be appropriate to contact individuals identified from emergency department records. The consultant assessed whether they had the capacity to participate in a semi-structured interview and, where it was deemed appropriate and people consented, forwarded them the study information together with details of how to contact the study team should they want to take part in the research. No contact was made with participants by the study team directly. This approach has been used previously (Biddle et al., 2010). Upon recruitment, and with their consent, a letter was sent to their GP, informing them of the nature of the study and the participation of their patient.

Interview participants have reported beneficial effects of taking part, including the cathartic value of talking about their experiences (Biddle et al., 2013). Procedures were put in place to assess emotional well-being and ensure support was in place if needed. Participants were asked to complete a simple visual analogue scale (VAS) measuring current emotional state at the start and end of the interview. This was depicted as a thermometer with scores ranging from zero (poor emotional state, illustrated with a sad face) to ten (best possible emotional state, illustrated with a smiling face; neutral face at mid-point; see Biddle et al., 2010). A protocol was devised to respond to any situation where a participant became distressed, or disclosed information that raised concern about potential or future risk including provision of sign-posting leaflets. If a participant appeared distressed the interviews were paused or stopped, and appropriate advice and emotional support given.

Interviewers (LC, ST) were experienced in clinical settings, providing emotional support and sign posting, as well as experienced in referring individuals on to appropriate treatment or support services. An experienced clinician was available by telephone if required.

3. Data collection

This is a qualitative descriptive study using cross-case thematic analysis. Qualitative interviews were conducted according to a semi-structured schedule, to explore the social and psychological causes of self-harm during an apparent cluster, and how individuals understood their own behaviour. Interviews began by the interviewer getting to know the participants and developing rapport. It was important given the topics to be discussed that participants felt at ease during the

interview and that a positive relationship was formed between interviewers and participants. The interviews went on to follow a semi-structured format. Questions were asked relating to participants' social circumstances, family history, childhood development, bullying, drug and alcohol use, limitations in daily living, life events, size and character of primary support group, the role of the media, links to other cases, identification with other cluster cases and their own thoughts about cluster initiation and propagation. Questions were also asked related to the support received by health services/voluntary agencies and anything that may have prevented their self-harm. Interviews were partially shaped by the discussions themselves with questions related to participants' experiences asked where appropriate.

The interview took between one and two hours to complete, and took place at the participants' home, the University or a healthcare setting, according to the participant's preference. All interviews were digitally recorded with the participants' consent and were transcribed verbatim from the audio recordings (LC, AJ). Completed transcripts were reviewed to ensure that complete anonymity was retained. Recording of the interview was not agreed with Participant 06, so detailed field notes were taken and written up for analysis.

3.1. Data analysis

Transcripts were examined via cross-case thematic analysis (Deterding and Waters, 2021). The analytic approach was largely inductive. This allows for exploration of how individuals choose courses of action and how they interpret, assess, and make sense of the world around them. Interview data were sorted thematically, using a code-and-retrieve system (Coffey and Atkinson, 1996). A coding frame was developed through a process of reading and re-reading interviews, inductive generation of codes and repeated discussions (LC, JS, AJ). All interviews were coded by one member of the study team (AM) and cross-checked by a senior member of the team (AJ). Themes were organised using Nvivo 12 software. The number of interviews referring to each theme was calculated. Individuals were given a participant number to replace their name and any names present in recordings were replaced with a random initial.

Ethical approval

Ethical approval for this study was obtained from the South West Wales Local Research Ethics Committee, reference 15/WA/0366.

4. Results

During the apparent suicide cluster (27/12/2007–17/03/2008), 88 individuals attended the emergency department with a recorded self-harm event. Sixty-two individuals were excluded following initial screening - i.e., the episode was not near-fatal (Fig. 1) - leaving 26 individuals who met the criteria for near-fatal self-harm eligible for inclusion in the study. Fourteen individuals could not be contacted and one refused contact. Eleven individuals contacted the study team three of whom declined to take part. In total eight individuals were interviewed for the study. There were six males and two females, aged 23–49 at the time of interview (median age 21.5 at time of cluster); and all had presented to the local emergency department during the cluster period with an episode of near fatal self-harm. All cases were living in the area local to the cluster at the time the self-harm took place and three of the eight were friends/close contacts of people who had taken their own lives during the cluster period. Interviews were conducted between June and December 2015.

A summary of participants is included in Table 1. Six participants reported that this was not the only incident of self-harm they had experienced, with five having had at least one self-harm episode prior to the index event and three having self-harmed subsequently. Five participants stated that they had intended to end their lives, two stated that they did not intend to end their lives and one was unsure.

4.1. Qualitative interviews and thematic analysis

Qualitative analysis of the interviews revealed 41 subthemes organised into three overarching thematic areas: individual narratives encompassing events and feelings leading up to the self-harm event and feelings afterwards; influence of the cluster; and support and prevention. Supplementary Table 1 includes a summary of all key interview themes.

Space only allows for a very brief overview here of the first overarching theme. Interviewees spoke about specific events leading up to self-harm, including bullying, relationship breakdown, sexual abuse or assault and substance misuse. They spoke about feelings of distress prior to self-harm which may underpin the motivation for near-fatal self-harm. Feelings included boredom, inadequacy (in terms of their roles as parent, partner, employee etc.), worthlessness, low mood or feeling depressed. Three participants described feelings of isolation and loneliness, referring to both geographical and social isolation.

Participants described a range and often a mix of feelings immediately following self-harm. The described feeling cold/empty, or like a failure, as well as having a low or depressed mood. Other feelings included regret, relief, and shame. While participants reported a range

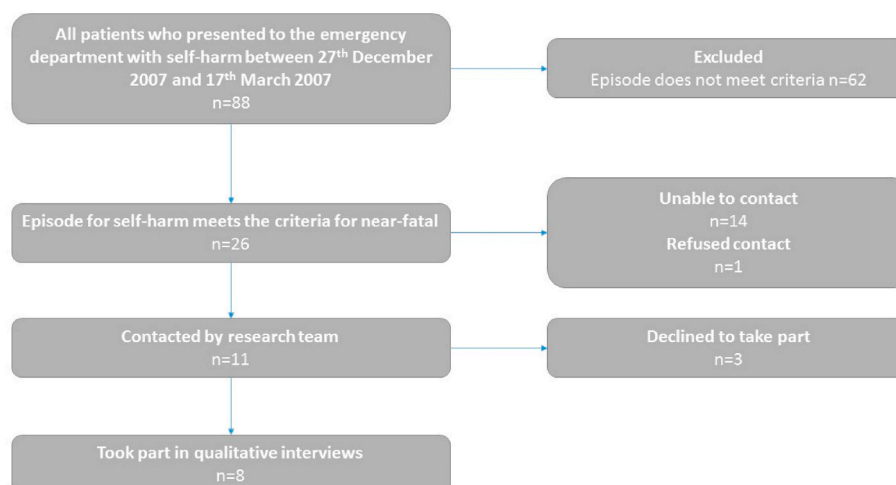


Fig. 1. Participant recruitment flow diagram.

Table 1
Summary of participants, episode of near-fatal self-harm.

ID	Gender, age	Summary of incident	Statement of intent	Other self-harm
P01	Male, 49	Self-poisoning following period of stress including accommodation move and relationship strain	Stated intended to end own life	Previous period of self-harm One subsequent self-poisoning
P02	Male, 49	Self-poisoning following a series of events, including brother having a serious accident, his own stroke, change to job role and relationship breakdown	Stated intended to end own life	Previous episodes of self-harm
P03	Male, 23	Self-poisoning, self-cutting and attempted hanging following six months of repeated self-harm. Participant lost several friends during cluster and describes period of grief and numbness.	Stated intended to end own life	Repeated self-harm in preceding six months One subsequent episode of self-harm
P04	Female, 32	Self-poisoning. Alcohol abuse and relationship breakdown in time before as well as historical abuse.	Stated did not intend to end life	Previous episodes of self-harm
P05	Male, 37	Self-poisoning. Brain injury, relationship breakdown and potential for loss of contact with children were sources of significant stress	Unsure of intent	None
P06	Male, 23	Self-injury and self-poisoning. Talked about being bullied and loss of three friends during cluster. Described emotional and physical numbness	Stated intended to end own life	None
P07	Female, 24	Self-injury. Sexual assault in the days prior. Lost two friends during cluster	Stated did not intend to end life	Was self-harming for five years prior to index self-harm Continued self-harm for one month afterwards
P08	Male, 27	Self-poisoning. Relationship breakdown and associated issues with access to child in time immediately beforehand. Father in hospital at time	Stated intended to end own life	None

of negative emotions, two participants talked about gaining perspective on the events and triggers leading to their self-harm following their experience.

4.2. The influence of the cluster

Due to the discourse, both in the press and the community, of a 'copycat' phenomenon, participants were asked directly whether the cluster had influenced their own self-harm. There was tension between interviewees' denial that the cluster had influenced their self-harm behaviour and decisions at the time, and accounts in other parts of the interviews of how the cluster had affected their lives. Importance was placed on individual biography and circumstances. All eight participants, when asked directly if they thought the cluster influenced their

behaviour, clearly stated that it had not. For example:

'I was very aware of it, but not my behaviour had nothing to do with that because I'd been like it years before.' (P04)

'No not at all. This was my situation and I looked at my situation and thought there was no way out. There wasn't anything to do with anyone else doing anything like that. It was me literally saying to myself, there's no way out of this'. (P08)

Q: So they didn't influence your behaviour in any way?

A: No, in no way at all.

Q: And you didn't know any of the cases--

A: No.

Q: They were not particularly people that'd you ever, you know, heard of, or met or anything--

A: No.

Q: Like that?

A: Absolutely not.' (P01)

Q: Was the fact that others had died by suicide in the area where you lived anything to do with you trying to harm yourself?

A: 'No'. (P06)

This was the case for participants with close relationships with those who died. For example, P07 described losing a friend from the same residential care setting but stated that this was not related to their own self-harm:

Q: Okay. And was the fact that others had died by suicide in your-- in the area that you lived have anything to do with you trying to harm yourself at that time?

A: No, I don't think it did. I think it made-- it made me think more about suicide rather than just self-harm, but I don't think it impacted my actions cause I'd been self-harming for a long time before that--' (P07)

Supplementary Table 2 includes all responses relating to the influence of the cluster. Some participants stated that they had their own issues that were nothing to do with what had happened to others. For example, P03 lost their best friend during the cluster. When asked if the events at the time influenced their own self-harm they responded:

'Pure coincidence I would say ... I was never a person to be influenced by any other person's personal choices basically. If I was going to do it for myself, nobody else' (P03)

Four participants stated that they knew people who had died as part of the cluster, with three participants talking about friends who had taken their own lives. All stated that these friends had their own circumstances that were not linked to the others. In contrast, another three participants talked about links between individuals who had taken their own lives or the feeling that suicide was being seen as a trend or a cool thing to do. Two of these interviewees did not know these individuals personally but had heard about them via the news, friends, or social media.

While all participants stated that the cluster and publicity did not influence their decisions, one stated that it did have an 'impact' in terms of friends being upset and the events being sad. Six participants also described specific ways the cluster had affected their lives, with most describing multiple ways in which the events at the time had an influence on them. This included events such as break down of social groups, and strong emotional reactions to long-term impacts such as difficulty with relationships. Those who lost friends described a profound impact

in terms of grief, sadness and struggling to cope with the loss. Of those who had lost friends, one participant described witnessing or being present at more than one of the deaths for example,

‘He ended up—, well we all thought that he’d passed out on another boy’s sofa, well, one of the other people started drawing on his face and then I noticed he wasn’t breathing so we tried shaking him and he wasn’t waking up and he was cold as ice and he was blue, I was like, “Right, you’d better phone an ambulance now,” phoned an ambulance, he was dead before he’d reached the hospital’ (P03)

Four participants described the impact on the social group or the community. Participants described how friendship groups fractured as result of the deaths.

‘Q: And what impact did those deaths have on you and your social group at the time?’

A: We actually split apart. Everybody went their own ways. A couple of us would still be close and still talking. The rest would be off on their own. So, it went from being, like, a group of about 50 all the way down to about a group of two or three of us.’ (P03)

Other emotional reactions included sadness and fear. Participants reported thinking more about suicide than self-harm, potentially reflecting suicide becoming a more imaginable option (e.g., [Abrutyn et al., 2019](#)). Others identified with individuals who had died by suicide, thinking about their circumstance and what the individuals may have been going through.

‘Well, it was everywhere wasn’t it - on the news, on the front page of newspapers. I did wonder if they were feeling the same as how I was feeling, wondering what the circumstances were and what had made them get to that point. Erm, knowing that something as little, now I can say it, you know something as little as finishing with an ex-partner and you know maybe not seeing my child for a little while is ... is something as little as that what caused them to kill themselves and kind of thinking like wow that’s kind of stupid and what help did they have and what help didn’t they have and were they in the same position as me where they didn’t want to talk to anyone, to a stranger, to their family. You know all sorts of different things’ (P08)

One participant described the cluster as being both frightening and sad. They gave a powerful account of long-term impacts including having concerns for their own son at the time of the interview

‘Just apart from anything else it frightened you, and sad, just really sad that these young people would think that was the only way out, yeah, that was it really sad and its—, I think about it now as well, you know, and like my oldest son he sleeps in the attic and he’s only nine, and I worry that, you know, if I shouted at him that he’s going to do something stupid, you know, and I have to go up and check then to make sure he’s okay’ (P04).

Cultural meanings, context and attitudes related to the deaths were evident in some statements. Two participants described a perceived lack of control over their own actions. Participant 03 described a desensitization to death ‘*I felt used to death then; it had become a major part of my life*’ and ‘*it felt like my friends were dropping like flies and I could have been next whether I did it myself or something else happened*’. Participant 04 said something quite similar:

‘A: That friends of friends that, you know, that my sister knew someone, you know, other people knew someone, you know, so everyone knew about it, it frightened me cause I was always frightened that I’d be one of them.

Q: Okay, tell me more about that

A: Just I didn’t trust myself, not to do stuff, you know, I’d get very anxious about it, and think what if one day, you know, I would. I remember ringing my parents once and saying, “you better come and get me or I’m going to kill myself,” and not trusting myself not to do anything, it felt totally out of control’ (P04)

Three participants described negative impacts of the press coverage. Anger was expressed about incorrect information being published with the coverage described as ‘sickening’.

‘It completely sickened me because half of the facts that they thought they had in the newspaper was completely wrong.’ (P03)

One participant recalls a friend of his chasing a reporter and that people were angry at the media attention. Another described the media reporting of a friend who had taken their own life as upsetting due to inaccuracies and speculation

‘A: Yeah, a little bit because—, well it seemed like the press were trying to find a link between all of them and I think obviously some of them were linked but [M] had nothing to do with any of the others. So that was upsetting for people reading it because it was like they were just saying how they were killing—, killing themselves because their friend had done it or their family had done it and that wasn’t the case, for [M] it wasn’t anyway cause I knew him, I spoke to him that day’ (P07)

Five participants talked about news of the cluster spreading on the internet and social media. This was mentioned primarily as a way of sharing information with the internet described as being ‘full of it [news of the suicides]’ and a preference described for looking for news and information online, rather than the internet being perceived as a negative influence.

Two participants described long-term negative impacts of the cluster. One participant stated that he still cannot have relationships because of what happened and that all his friends have ‘*something wrong with them*’ due to this. Another described the trauma of losing her friend and the impact on her life.

‘When my friends killed themselves then, yeah, it was—, it was horrible. I lost my son because of my friend killing himself. So—, cause I couldn’t deal with it, I couldn’t cope with it in my head, I went completely.’ (P07)

4.3. Prevention and support

Participants were asked what might have prevented their episode of self-harm during the cluster. They tended to focus on counselling and emotional support. This was perceived to be important but not always received or experienced positively. Several participants talked about the support available to them in hospital or from services following self-harm, although this was generally said to be absent or inadequate. For this section, we have focused on factors that may have had an impact prior to self-harm rather than evaluating support given by healthcare services following self-harm.

4.4. Support prior to self-harm event

Support related to the cluster prior to the self-harm episode was perceived to be largely absent. This was the case even in those reporting very close relationships with individuals who had died. Settings and organisations that could have provided support to individuals were reported not to have done so. For example, one participant talked about not receiving any emotional support around the time of the cluster despite being in a residential care setting with one of the individuals who had died.

‘Q: Okay. And what did you think of the support that was available at the time or that you received?’

A: Nothing

Q: There wasn’t any support as far as you were concerned?’

A: Nothing at all, no’ (P07)

Another talked about having been present for the death of a friend. While this would have been a highly distressing event, it appears that no support was offered. This participant stated:

‘Q: And what do you think of the support that was available at the time or that you received?’

A: I didn’t really receive anything but, on the other side of the coin, I didn’t seek out any.

Q: Did you discuss these problems that you were having or how you were feeling with anyone?’

A: No.’ (P03)

One participant talked about having good support available at the time, four described the support available as poor or absent, two discussed both good and poor support, and one stated that he was offered counselling but refused. Of those who talked about receiving good support, this appeared to be related to other stressors and issues in their lives rather than directly related to the cluster. One participant described being signposted to a local charity group that he found to be enormously helpful. However, he was signposted by someone he knew and not by health services. Another described having repeatedly good support from the hospital when recovering from an alcohol problem at the time, and seeking help from other organisations, one of which she found to be very helpful in her recovery. Another described having counselling following the episode of self-harm that helped him to deal with some of the issues he had been having, particularly related to physical health issues in the months preceding self-harm.

‘Q: And did that incident [episode of self-harm at time of cluster] help you alleviate your problems in any way?’

A: Erm, yeah. I mean, I still think for a while, I was sort of, I don’t know, still drinking a little bit and that sort of didn’t help the problems but in the end when I did go and see–, you know, the counselling and everything, that was a massive thing to say look, you’ve got to change your lifestyle,

Six participants talked about either not receiving any support at the time or the support available being poor, highlighting the need for any support or interventions to be appropriate for the individual. Three described counselling experiences that they did not consider helpful to them. One of these was as an inpatient, one as the client of a private counsellor and another as a one-off session as part of his job.

One participant talked about an absence of mental health support in hospital:

‘Q: Can you remember when you left hospital how were you feeling?’

A: Terrible. No one spoke to me like they cared.

Q: No one?’

A: No it was sort yourself out and go home.

Q: How long were you in for?’

A: A night and a day erm I probably could have gone out of hospital that day and walked in front of a bus. You know that kind of thing I was probably still bleak at that point.’ (P08)

Better support from health or voluntary agencies was suggested by

participants when asked what could have prevented self-harm at the time (n = 4). Earlier contact with a supportive voluntary agency was suggested as something that may have helped one participant through those difficult times. There was also discussion around the improvement of services over time with this participant talking about the support he receives currently through the community mental health team and psychiatrist that were not in place at the time. One participant talked about the support available for a brain injury needing to take a more holistic approach to help his family understand how the injury had affected him, and how this may have helped his recovery and relationships.

Having someone to talk to, both from services and, from family/friends, emerged as a common factor that may have helped. Two participants talked about counselling as a possibility for preventing self-harm. More pro-active support or outreach was suggested with one stating that the option to phone a helpline was not enough:

‘So, you know I said earlier, the talking, physically ring someone and saying I’m having these thoughts what do I do? I wasn’t going to do that. If someone had come to me and said- you know do you want to talk to me? Do you want help? Do you want counselling? I may have taken it you know because it’s been put in front of me you know?’ (P08)

Two participants stated that having someone to talk to may have prevented self-harm. Three stated that the support of family and friends may have helped.

‘Maybe another family member or if my neighbour had come down an hour earlier and had a cup of tea. Maybe I could have mentioned something to him and he could have said give your mum a ring and she could have come round and have a cup of tea and a chat.’ (P08)

Four participants stated that different circumstances, such as their relationship not breaking down, would have prevented the self-harm occurring.

5. Discussion

The individuals interviewed provide unique insights into the experiences of people who self-harm during a suicide cluster, including accounts from three individuals who were close contacts of people who had died. Analysis of these interviews builds on previous research focused on the potential role of print media in the initiation and maintenance of this suicide cluster (John et al., 2016; Marchant et al., 2020) to examine the influences on individuals from their own perspectives. All participants, when asked directly, stated that the suicidal behaviour of others did not influence their own self-harm. Similarly, participants who were close to people who had taken their own lives during the cluster stated that these individuals had their own circumstances and were not linked to the others. Anger was expressed with press coverage that attributed deaths to imitative behaviour. In contrast to statements that the cluster had not directly influenced their self-harm, interviewees spoke about the impact the cluster had on their lives including long-term impacts on relationships and concerns for their own children.

6. Summary of results

6.1. Emphasis on individual biography

Due to the high-profile reporting and discussion around ‘copycat’ suicidal behaviour, interviewees were asked directly whether they felt their behaviour may have been influenced by others. All interviewees responded that the cluster had not influenced them. This emphasis on the actions of individuals, unaffected by the behaviour of others, is in keeping with previous research finding a dichotomy between perceived genuine distress shown by self-harming in secret and strong negative

judgements around more public ‘attention-seeking’ self-harm in people both with and without a history of self-harm (Scourfield et al., 2011; Chandler, 2018; Crouch and Wright, 2004). This stigma and the desire not to be seen as ‘attention seeking’ has previously been shown to motivate individuals to hide their distress (Crouch and Wright, 2004).

Interviewees insisted on their own agency and the over-riding importance of individual biography. Undoubtedly each individual had their own unique circumstances that contributed to increased risk, some long preceding the onset of the cluster or media attention (e.g., substance abuse, a history of self-harm, or abuse). However, either a Durkheimian understanding or an emphasis on cultural sociology (e.g., Abrutyn et al., 2019) would see these suicidal acts as also determined by the collective context. In early 2008 there was the especially powerful context of high-profile media reporting in the area of what was assumed to be a suicide cluster, with emotive terms such as ‘craze’ and ‘cult’ used in newspapers (Luce, 2016). It is not possible therefore to detach the interviewees’ individual acts from this community context.

6.2. Stigma and help-seeking

Suicide and suicidal behaviour can be stigmatised, and this may particularly be the case of suicides within a cluster. There is research to suggest that exposure to suicide, through clusters or high suicide rates, may be associated with stigmatizing attitudes towards suicidal behaviour. For example, individuals with relationships closest to those who died during a suicide cluster are more likely to endorse stigmatizing beliefs about suicide (Abbott and Zakriski, 2014). Fear of stigmatizing responses may limit disclosure or restrict the pool of people that suicide survivors can seek support from. These individuals may also be less likely to believe that suicide is preventable (Abbott and Zakriski, 2014). Individuals living in areas with high suicide rates show more self-stigma and self-shame, which is in turn associated with reduced likelihood of help-seeking, compared to individuals living in areas where suicide rates are low (Reynders et al., 2014). Qualitative research suggests that stigma may contribute to silence and misunderstanding around self-harm which in turn reinforce stigma, representing a complex belief system acting as a barrier to help-seeking and recovery (Binnix et al., 2018). Normalisation of distress may mean that individuals perceive themselves as not in enough need to warrant help (Biddle et al., 2007). While it is likely that more people will present with self-harm during a cluster, the stigma around imitative behaviour might decrease the likelihood of seeking help before a crisis point is reached.

6.3. Long and short-term impacts of deaths

Interviewees did describe stressors related to the cluster such as the impact on social groups and grief, which have been found to increase the risk of suicide (Jordan, 2017; Song et al., 2015). The impact of a death by suicide extends beyond individuals close to the deceased to other young people in the school and the community (Cox et al., 2012). In addition to having elevated risk of subsequent suicide (Ho et al., 2000), adolescents experiencing the impact of another individual’s suicide may experience a range of social difficulties (Irmeli Saarinen et al., 2002), psychological symptoms (Melhem et al., 2004) and adverse impact on development (Forward and Garlie, 2003). This is supported by statements given here indicating long-term impacts on relationships after losing friends to suicide. Although mere exposure to a peer’s suicidal act increases the likelihood of suicidal behaviours (Ho et al., 2000), the closeness of the relationship is an important aspect to consider (Mauk et al., 1994). Statements in the interviews reported here show the level of trauma of those who had close relationships with individuals who took their own lives. The negative reactions to news coverage of the suicides supports previous work on the content of reporting and potential distress to the community and those bereaved (Marchant et al., 2020).

6.4. Possible mechanisms of cluster influence

This study is largely exploratory. However, these accounts give a unique perspective in relation to mechanisms of suicide diffusion. There is a tension between the interviewees’ denial of cluster influence when asked directly and other interview data where they spoke of suicides in the area as significant stressors. It may well be that the social and psychological processes of suggestion and diffusion of suicidality are subtle, with people affected not necessarily being consciously aware of any imitative aspect of their behaviour.

There was some evidence of normalisation (Hawton et al., 2020). Some interview exchanges implied a lack of agency, with two interviewees saying they felt out of control or feared they could ‘be next’. One of these said he had become ‘used to death’. A third interviewee said she thought about suicide more at the time of the cluster. There was evidence of social integration effects, with the rapid spreading of news via social media.

Abrutyn et al. (2019) found evidence that a series of sudden suicide deaths may have triggered the formation of new locally generalized meanings for suicide that became available, taken for granted social facts. This was hypothesised to facilitate young people’s ability to imagine suicide as something someone like them could do to escape. Statements from our participants may provide some support for this suggestion, with some describing a desensitization to death and perceived loss of control over their own suicidal behaviour. Abrutyn et al. (2019) suggest that cultural meanings are what make attitudes and behaviours spread from one person to another and cluster in some times and places. Cultural meanings were disseminated in the South Wales cluster via intense news coverage and discussion via social media.

Three interviewees spoke of social and geographical isolation. This could be seen as contrasting with social integration, or alternatively it could be a feature of it if people are more aware of isolation when living in a community with generally high levels of integration. Overall, however, it is not possible to draw clear conclusions from the interview data about cluster mechanisms as there is not strong enough evidence to support any specific interpretation.

6.5. Prevention and support

The absence of sufficient support was commonly discussed. The study participants would have presented with self-harm before the National Suicide Prevention Strategy for Wales was developed. Some reported not receiving adequate mental health support in hospital, which is in keeping with other evidence (Cooper et al., 2013; Quinlivan et al., 2021). The importance of pro-active support was highlighted with participants stating that they may not have initiated contact with a support agency but, may have taken help placed in front of them. Several participants here reported subsequent self-harm episodes and lasting negative impacts from their experiences during the cluster. The interview data underscore the importance of appropriate support being in place, particularly during a suspected suicide cluster, to reduce the likelihood of repeat self-harm and subsequent deaths.

7. Strengths and limitations

Interviews with individuals who experienced near-fatal self-harm at the time of a cluster represent a valuable resource for informing approaches to suicide prevention during a cluster (e.g., Department of Health and Social Care, 2019). Such individuals can provide unique insights into the events leading up to suicide. Interviews are often conducted with informants such as family and friends of individuals who have taken their own lives. Whilst providing valuable insight, there are several methodological issues with interviewing such informants (Hawton et al., 1998).

Individuals experiencing near-fatal self-harm are a difficult group to access for research and may be highly vulnerable (Biddle et al., 2010).

Recruitment was a multi-step process dependent on gatekeeping from health professionals, hence the final sample was small. Individuals who experience near-fatal self-harm may differ from those who die by suicide during a cluster. In addition, there may be important differences between those who choose to take part in research and those who do not. However, the insights provided here cannot be obtained from any other source. Interviews were conducted several years after the event (June–December 2015). While participants generally provided much detail about their experiences, the unique contribution of these accounts must be balanced against individuals reconstruction of their biographies with the passage of time. The potential for errors in recall is an important limitation of findings. Future research could take steps to address this, for example conducting interviews in a shorter time-period following the self-harm event. This should be done with appropriate safeguarding taking the potential vulnerability of participants into account, particularly in the context of a cluster.

As noted above, it is not possible to reach any strong conclusions from the study about specific mechanisms or combinations of these. It has been previously hypothesised that multiple mechanisms operate together, and that the main mechanism is different for different settings and populations (Haw et al., 2013). Gaining the perspectives of individuals themselves provides valuable additional insight not possible through informant interviews (Biddle et al., 2010). It is important to interpret these results in the context of what is achievable using qualitative interviews. Interviews can gain deep insights into an issue (Edwards and Holland, 2020). Qualitative interviews offer opportunities to determine how participants make sense of the interactions and public cultures they are a part of. This is particularly relevant when a person's behaviour may be influenced by others (Rinaldo and Guhin, 2019). While qualitative studies such as ours provide unique insights into potential processes contributing to clusters, they cannot definitively identify the actual mechanisms involved.

8. Implications

The findings of this study will be of relevance in furthering our knowledge of how to prevent and manage clusters of suicides. Experiences of individuals who have been affected by a cluster represent an important resource for informing appropriate interventions. Few studies have formally documented response strategies to a suicide cluster in young people (Cox et al., 2012). However, several strategies have been found to show promise, including developing a community response plan, providing counselling to affected peers, responsible reporting by the media and the promotion of health recovery in the community to prevent further suicides (Cox et al., 2012). The low-frequency nature of suicide clusters means that long-term systematic evaluation of response strategies is problematic.

Participants' denial that the cluster had affected their decision to self-harm, alongside testimony about social difficulties caused by cluster deaths, should inform prevention strategies. Suicide cluster management often includes asking people to come forward if the cluster is affecting them. It may be more relevant to highlight that the reasons for suicide are complex, that suicide is preventable and to signpost to services for anyone feeling distressed for any reason, rather than specifically relating the intervention to the cluster. Relying on people to come forward for support may also not be adequate and efforts to check in with people face to face are needed. Suicide prevention messages such as 'have you been affected by this?' may not be an effective way to engage individuals. The role of stigma in deterring help-seeking should also be considered, as should possibility of people not wanting to ask for help in case they are seen to be imitating or attention seeking. Interventions should focus on education and reduction of stigma to facilitate help-seeking. Six out of eight participants stated that support at the time was poor or absent, including three individuals who had lost close friends. This included individuals who were in school with people who had died by suicide and one individual who was living in residential care

with an individual who took his own life. The importance of support and post-vention being offered in such settings cannot be understated, particularly in the case of young people in contact with social care who may already be vulnerable. Several participants also described inadequate mental health support in hospital, in keeping with research finding negative experiences and limited follow-up (Quinlivan et al., 2021), emphasising the need for pro-active follow-up for individuals presenting to hospital with self-harm. Any contact with health or social care settings can be an important point of intervention and support, and the fact that this was lacking meant that important opportunities to offer help and support might have been missed.

Participants were aged from 23 to 49 years and with varied circumstances including residential care settings, living with parents or with partners and children. It is important to ensure that suicide prevention and cluster management strategies are inclusive, and that support is available to anyone who may need it, as well as targeted interventions for groups who may be particularly vulnerable, as recommended by Public Health England (Department of Health and Social Care, 2019). This guidance states that there should be focus on promoting wellbeing and help-seeking, considering the wider and longer-term needs of the local community, alongside targeted support for those bereaved by suicide who may themselves be more vulnerable. The cluster that formed the basis of our analysis was one of the first news stories where social media became connected with self-harm and suicide. Since then, use of social media has become almost ubiquitous, especially in young people. We are reminded that social media and the internet are channels to disseminate accurate and appropriate information, as well as 'fake news' and rumours that may heighten community tension. Agencies mounting the community response including schools and prevention agencies need to be aware of the way information might spread online and how to respond to this.

9. Conclusions

This study adds to existing evidence about the factors that may influence an individual to harm himself or herself during a suicide cluster. There was tension between participants' disavowal of direct cluster influence and other interview evidence of cluster-related stressors, normalisation, and social integration effects. Self-harm in the context of a cluster may be associated with a particular stigma, or individuals may normalize their own distress and delay help-seeking, particularly if they are aware that services are under strain. This has important implications for prevention and intervention as people may be less likely to seek help until a crisis point is reached. The role of social media in the spread of information also needs to be managed. Proactive interventions and carefully worded messages signposting individuals to help would represent an important step forward. Reaching out directly to individuals close to someone who has died is also important, particularly in settings such as social care and schools. The importance of support in hospital following self-harm was also emphasized.

Credit author statement

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Appendix A. Supplementary data

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