



Responding to Superficial Cutting as a Residential Counselor

Immediate Safety Concerns:

A Residential Counselor's first concern is the safety of their clients and the safety of the residential unit or surroundings. This might mean convincing a client to turn in a sharp item intended for self-inflicted cutting. This could, although rarely, mean having to physically intervene to remove a sharp item from a client's possession. However, the vast majority of the time, a Residential Counselor will learn about an incident of superficial cutting directly from a client, within an hour or so of the actual self-injurious behavior.

1. Attend to any medical or first aid needs of your client. Typically, this involves cleaning and bandaging any cuts. Follow universal precautions to avoid the possible spread of blood-borne pathogens. It's generally recommended that medical interventions be done in a "clinical" no-nonsense fashion, taking care of the medical issues in a relatively mechanical fashion. Of course, it is possible that hospital emergency room intervention is required, and staff should know their program's procedures should that be indicated.
2. Acquire any sharps used for the cutting behavior. Ideally, the client will ally with staff and agree to turn in whatever was used to cut. However, clients will sometimes hide additional sharps, so it's worth asking if there are others and collecting those as well. It may be indicated to do a search of the client's personal belongings and parts of the residential unit to look for contraband.
3. Attend to any environmental safety issues. Specifically, there may be broken glass, plastic, or other items that need to be collected, and there may be clothing or other places where blood needs to be cleaned up. Again, your program should have policies and procedures in place on how to safely and appropriately address these concerns.

Processing the Self-Injurious Incident:

There are several different possible goals for a Residential Counselor when processing an incident of self-injurious behavior.

1. Help the client settle into the remainder of the shift. The specifics of this will depend on an individual client and on what is happening in the program at the time. Sometimes, it's at or after bedtime and the most appropriate goal is get the client settled into bed and to sleep. This might mean doing relatively little psychological processing and instead focusing on soothing. Other times, this might mean the client transitioning into an activity. It can be helpful to get the client to anticipate and think about how it will feel to rejoin the group.
2. Help the client find words to express their distress. Psychologically, the most common reason for superficial cutting is an attempt to change overwhelming feelings of distress. During such times, most clients have very limited access to the parts of their brain that



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have language. Regardless, using words to describe feelings is always relatively difficult. Helping clients to find the words, even after the incident, engages their higher cognitive functions in analyzing what they experienced. This makes it all less mysterious and can make it more likely that the client will be able to use words the next time they get into a similar level of emotional distress.

3. Help the client lessen the psychological traumatic impact of their own self-injurious actions. Even though the trauma is self-inflicted, it is still trauma. It's stored in memory based on the intensity of the emotions associated with the memory. Help your client over-write that emotional intensity by speaking calmly in describing the earlier overwhelming feelings. A frequent request I'll make of a client is "Can you talk about how you were feeling, without automatically re-experiencing those feelings?" I'm trying to teach the client the coping skill of depersonalization. Describe what happened, but kind of like it happened to someone else. I want my client to practice how to remain calm, even when talking about having been overwhelmingly upset.
4. Help the client develop a plan for the next time. In the programs in which I've been a director, a therapist, and/or a residential counselor, the development of a formal action plan is a team effort among a small group of staff. However, residential counselors can certainly create less formal, but potentially just as effective, short-term plans that can help for the remainder of the shift. The basic action plan has three elements: (1) Monitor your own level of distress. (2) Take pre-determined actions to cope with lower level of distress. (3) Ask for direct help with higher levels of distress. Scheduled check-ins are frequently a helpful part of these more informal verbal plans, especially for helping clients develop their self-monitoring abilities.
5. Help the client review an existing action plan. If the client already has a Distress Tolerance Action Plan, it can be very helpful to review it. Perhaps there are aspects of it that did not work well and can be modified.
6. Psycho-education about the psychological reasons and neuro-psychiatric mechanisms that make superficial cutting habitual and addictive. It can be exceptionally difficult for kids to put their overwhelming feelings into words. Often times, an early stage of processing is simply making the issues speakable. One way to do that is through psychoeducation in which the Counselor shares the most common reasons other people have given for superficial cutting and asking the client if any of those reasons are true for them. A skilled Counselor, with a non-judgmental approach, can draw out the client to be able to talk calmly about their own experience of becoming overwhelmed.

For different reasons, psychoeducation about the how the brain functions is also an excellent processing objective. Some of the delusional or illogical beliefs that clients can develop around their own experience of superficial cutting arise from the brain's insistence on trying to make sense of all experiences.

In other words, some clients will develop illogical, irrational, or uninformed beliefs around their cutting behavior. Perhaps it somehow makes them feel special or satisfies some innate desire for drama. In any case, those beliefs can actually encourage repetition of the self-injurious behavior.



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It can be helpful to give kids a scientific understanding that what they're doing is a mechanism of how the brain works and is not something dramatic or unique about them. Psycho-education about the brain can set the stage for empowering kids to take charge of their own brains by consciously regulating their own feelings, thoughts, internal physiology, and external behaviors.

7. Determine the level of supervision needed for the remainder of the shift. Residential Counselors don't, technically, need to assess suicidality. That's typically more the role for a clinician. However, Counselors probably do need to determine what additional supervision and restrictions make sense until a clinician can make a formal determination around suicidality. Safety Contracts and Safety Watches are common tools used to formalize and document efforts to keep a client from repeating any self-injurious behaviors.

Communicating with Teammates:

All the other staff on the residential shift need to be informed. Staff for the next shift need to know about any incidents, supervision plans, and restrictions. Clinical and Administrative staff need to be informed so that they can do a variety of follow-up actions. Some of this is done verbally, but there is typically an incident report to write, and depending on the specifics of your program, there might need to be a reference to the incident in a daily log note, a medical note, a formal safety contract, a formal safety watch, or other required documentation.