



Distress Tolerance Kit Contents

Responding to Superficial Cutting as a Residential Counselor:

- Reviews a sequence for responding to superficial cutting.
- Notably, outlines 7 different focus areas that can potentially be integrated into processing with a client soon after an incident of superficial cutting. Processing can shift the counseling intervention only being reactive to being proactive toward impacting the next potential incident.

Common Reasons for Superficial Cutting:

- Outlines the 15 most common psychological reasons clients give for superficial cutting.

Physiological Resets:

- Outlines the research-supported techniques for physiologically interrupting a client's state-of-mind and the one technique (cold-water face wash) that I found to be the most practical and natural to use with kids.
- Presents the need to then anchor the changed state-of-mind by using a breathing exercise.

4-7-8 Breathing:

- Presents a specific ancient breathing exercise that I've found to be structured in a way that is most powerful for kids.
- References that there are a series of audio-recordings, available in the Resources section of the www.BearClanllc.com website that guide listeners through different variations of the 4-7-8 technique. Designed for direct use with clients.

How to Tell Your Stress Level:

- Presents a simple, but structured, way to help kids determine their level of emotional, cognitive, physiological, and behavioral distress. Improvements in clients' skills at monitoring their own level of stress are key to creating and implementing a plan for handling distress in a mature fashion.

How High Is Your Stress Level:

- For use directly with clients; presents a 5-scale thermometer structure for reporting on your overall level of distress. This tool is an example of a SUDs Scale (Subjective Units of Distress). SUDs Scales helps clients improve their skill at self-monitoring their own level of distress and provide the basis for formalizing a structured Distress Level Action Plan.

Distress Level Action Plan:

- This document is a sample of a plan that builds off of a SUDs scale report and associates specific coping actions with different levels of distress.



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Coping Activities Chart:

- This chart lists a variety of activities that can help kids better tolerate feelings of distress before those feelings become overwhelming. This chart is designed to potentially be used directly with clients in designing an individualized Distress Level Action Plan.

Negative Coping Actions Chart:

- This chart lists negative coping actions, like superficial cutting, that different people use in ultimately damaging ways to manage their overwhelming feelings. It can be used directly with clients to help them understand how some of their problem-behaviors are actually driven by overwhelming feelings of distress.

Responding to Suicidal Ideation:

- This document presents an outline for responding to suicidal ideation, which can, but doesn't have to, include any self-injurious actions.
- It includes material on assessing the degree of suicidal ideation. That's bonus material for most Residential Counselors but a good review for Clinicians tasked with assessing whether a self-injurious behavior should be treated as an example of non-suicidal self-injury or as a suicidal gesture. Understanding this approach can help Counselors process incidents, give more useful information to Clinicians, and determine the appropriate immediate programmatic response.

Safety Contracts:

- This document presents an outline and example of how to create a Safety Contract with a client. Safety Contracts can be purely verbal or can be more formal written documents. In either case, this technique has an excellent track record for reducing the risk of repeat self-injurious incidents during the same shift.

Safety Watch:

- The details of a Safety Watch are going to be different for different types of residential programs and should be customized to individual clients. This document gives a sample from which programs can develop their own program form and/or other standardized structures for keeping kids safe after a self-injurious incident, significant suicidal ideation, or suicidal gestures not requiring hospitalization.



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.



Common Reasons For Superficial Cutting

It can be very helpful for a counselor to know the most common reasons actual clients have given for superficial cutting. These reasons can be thought of as fitting into one of three broad categories. The first category relates to clients attempting to manage and cope with their own overwhelming experience of emotional distress. Superficial cutting turns that emotional pain into physical injury. That experience releases endorphins and other neuro-chemicals that change the client's state of mind.

Reacting to / Managing Emotional Distress:

- Turning emotional pain into physical pain. Physical injury causes changes in brain chemistry. The physical pain triggers the release of endorphins and other brain chemicals that change the client's state-of-mind. Even when there's little physical pain, observing your own injury can do the same thing..
- Attempting to influence others. The superficial cutting is a way to communicate to other people that help is needed. The cutting is a dramatic non-verbal way to communicate the extreme extent of their emotional distress, and to then receive nurturing attention.
- Punish self or others. The self-injury is a way to receive deserved punishment or to punish someone else, such as parents or anyone else who will predictably become upset when they learn about the incident.
- Manage feelings of disassociation. Overwhelming feelings of numbness, unreality, or undefined anxiety are ended by the brain chemistry changes triggered by physical injury.
- Ending suicidal ideation. Some clients have found that when they become stuck in a cognitive loop of suicidal ideation that self-injury snaps them out of it.

The two other broad categories for superficial cutting are more likely to be addressed in individual or group therapy, rather than by a counselor processing a recent incident.

Nevertheless, it can be helpful for a counselor to be aware of these other common reasons.

Superficial Cutting as a Positive Experience:

- Comfort or enjoyment. Some clients reportedly find the chemical changes triggered by superficial cutting to feel comforting or even enjoyable.
- Sensation seeking. Some clients seek the feelings of excitement that can accompany superficial cutting.
- Experimenting. Especially for first-time cutters, some clients have heard about the behavior and are curious to experience it for themselves.
- Protecting self or others. Some clients develop a delusional belief that the cutting somehow protects them from other harm or somehow protects their loved ones. It is



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possible that such a belief be based on actual traumatic experience as well; for example, abuse that stopped once the bleeding started.

- Personal Mastery: Some clients report a feeling of being especially in control of themselves when engaging in superficial cutting.

Superficial Cutting as a Source of Personal Identity:

- Defining character – some clients express believing that it shows how tough and how strong they are. It makes them feel powerful.
- Responding to sexuality – a small percentage of clients identified superficial cutting as relating to a sexual feeling, associating the self-injury with past sexual experiences.
- Validation – some clients expressed feeling that the cutting proves the legitimacy and power of their feelings.
- Belonging to a subculture – some clients felt a sense of belonging to a group that engages in self-harm rituals.
- Having a personal language – some clients experience a cutting episode as bringing up good past feelings or memories. The cutting has a personal meaning to them.

Explaining the How the Brain Reacts to Non-Suicidal Self-Injury:

- People can, temporarily, use physical pain or injury to get rid of emotional pain. Physical pain or injury causes the body and the brain to produce chemicals that dull the physical pain, are automatically triggered by injury, and are also highly distracting. The person stops paying so much attention to their emotional pain. Some of these brain chemicals have an addictive quality causing an effect that feels like a huge relief or even feels good to the person.
- For a little while, those changes in the person's state-of-mind make them feel much better emotionally. However, those chemical brain changes wear off and the emotional pain returns, plus the person now also feels bad about how they chose to handle their distress.
- Even though the brain changes are temporary, the self-injurious behavior works quickly and dramatically, So it can easily become a habitual way of coping with overwhelmingly strong feelings of distress or with an overwhelming numbing of feelings. It becomes a very powerful trap that can go on for years.
- Using physiological resets, like face-washing and breathing exercises, combined with using coping activities, will not work as quickly or as dramatically. But these things will greatly help a person to tolerate overwhelming feelings. Over time, practicing regulating and tolerating negative feelings will help those feelings to become less intense or even go away. Most people will become proud of having learned how to handle their strong feelings in a positive fashion.



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Physiological Resets

Superficial Cutting becomes an enduring way to cope with certain states-of-mind because it triggers physiological actions that literally change the chemistry and functioning of the person's brain. There are non-injurious stimuli that will also change brain functioning.

Physiological Resets should be thought of as a two-part neurobiological loop. The first part is the "Interrupt" which can last from a matter of seconds to perhaps a couple minutes. The second part is the "Anchor" which takes about two to five minutes to reset the nervous system in a more enduring fashion.

The Interrupt, what I think of as the "snap-out-of-it" intervention, is an action that delivers a jolt to the brain's anterior cingulate cortex and to the frontolimbic system, instantly distracting parts of the brain and creating a window in which a different state-of-mind can be established.

The most practical and effective Interrupt that I've extensively used is to have the client wash their face, especially around the eyes and upper checks, in cold water; followed by massaging dry their face at whatever level of gentleness or vigor feels most effective to them.

I've frequently used cold-water face washing as a transitional tool at the end of processing an incident, just before having the client rejoin the group or rejoin regular programming. I've also used cold-water face washing as a preventative action when clients self-identify that they are starting to think about self-harm. A big advantage of this technique is that it feels, to the client and to their peers, like a relatively normal thing to do. It also requires minimal preparation and is an available action in most situations.

According to research literature there are other physiological resets that will interrupt a hyperactive amygdala. I've experimented with most of these; however, they tend to feel gimmicky and I suspect a lot of their change power comes from novelty. At least in my experience, they seem to stop working as well after the first time and I suspect that a lot of their initial power came from the high-level of engagement the client felt with the staff person facilitating the intervention. I also have a philosophical issue with the mixed-message that a way to manage emotional pain is to interrupt it with physical discomfort – even if that physical pain is non-injurious.

Nevertheless, the research literature identifies the following Interrupt techniques:

- Submerge your face in ice water for 15 to 30 seconds.
- Place an ice-pack over your eyes and upper checks for one to three minutes.
- Hold a cold ice cube and focus on the burning sensation.
- Press a cold object against your wrist for a minute or two.
- Snap a thick rubber-band against your wrist.
- Suck on a super-sour candy, lemon juice, or hot sauce.
- Deep muscle massage.



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- Wall pushes, squeezing a stress ball or therapy putty, or other muscle clenching exercises.
- Controlled auditory overload with white noise or high-frequency beats.

The Anchor builds off of the Interrupt to produce a longer lasting physiological change. My preferred anchor exercise is 4-7-8 breathing. Please note that to be truly effective, breathing exercises work best when they are practiced when the client is relatively calm. That practice lays the physiological groundwork for the intervention to work when the client is upset.

There are a huge number of breathing exercises that all can work. Breathing is part of the autonomic nervous system – physiological actions that happen without a person having to consciously think about it. However, breathing also responds to conscious control. Thus, it serves as a powerful way that people can purposefully take charge of and leverage their autonomic brain functions (including things like heart-rate, blood-pressure, muscle tension, and skin conductivity).

I particularly like the 4-7-8 breathing technique because it combines several factors that work together to make it more powerful.

- Counting while breathing engages the analytical parts of your brain and distracts from negative thinking.
- Deep inhales send air to the bottom of your lungs (known as diaphragmatic breathing where your belly sticks out a little). Holding your breath then gives your lungs time to extract more oxygen from the breath. Increased oxygen has a calming effect on the brain.
- Slow breaths in, holding your breath, and then slow controlled breaths out require controlling the large muscles in your chest. This muscle control adds to an overall feeling of being in control and being safe.
- Breathing in through your nose, but exhaling through your mouth has a calming, in-control effect.
- Keeping your tongue in the yogic position (gently resting the tip against the roof of your mouth) creates a conditioned anchor point. After much practice, simply putting your tongue in that position will trigger a relaxation response.
- The exercise can be done with eyes open or shut, sitting or laying down; whatever position works best for a client, as long as their stomach has room to expand as part of diaphragmatic breathing.

One breathe cycle consists of breathing in through your nose for a slow count of 4, in as relaxed a way as possible holding your breath for a count of 7, and in a slowed and controlled fashion exhaling through your mouth for a count of 8 (frequently accompanied by a whooshing sound). All of this is done while sitting or lying down in a relaxed position, with the tongue in the yogic position. With practice the count gets slower. Typically, a set of 4-7-8 breathing includes either 4 or 8 breathe cycles.



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4-7-8 Breathing

There's lots of effective breathing exercises you can practice. In my work, I've used the *Beginner's Guide to Healthy Breathing* by Ken Cohen and *Breathing: The Master Key to Self-Healing* by Andrew Weil, M.D. It's from Dr. Weil's recording that I found my favorite, which is the 4-7-8 Breathing sequence.

As a counselor and as a therapist I've frequently taught this technique to clients while counting for them. I've also used a recording of myself counting out the sequence so that I can do the exercise with them – creating a co-regulating experience.

With some of my clients I've used a lot of Native American themes to add appeal to the therapeutic work. Here's a brief story I created for some of my clients:

Bear and King Snake are very different animals.
However, they have a lot in common – for instance, they both hibernate!

When Bear needed additional help learning how to be a calmer, more thoughtful, and more centered creature, he went to King Snake. King Snake taught Bear a powerful breathing technique.

With your tongue pressed gently against the roof of your mouth, behind your front teeth,
breath in through your nose for a count of 4;
hold your breath for a count of 7; and
in an even fashion breath out through your mouth for a count of 8.

King Snake Breathing for Centering your Inner Spirit
(repeat 8 times)
(use in the morning and during all time outs)

“In”...2...3...4
“Hold”...2...3...4...5...6...7
“Out”...2...3...4...5...6...7...8

When you become more skilled, you count slower. You can download different versions of this exercise on the Resources page of my website (www.BearClanllc.com).

Some people feel a little light-headed after doing this type of breathing, which fades with repeated practice. If you're prone to dizziness, until you get used to this exercise, please be careful when you first stand up. Also, if you're just starting with this exercise, remember to do the exhale slowly and smoothly. There may be an impulse to explosively exhale. Instead, practice relaxed control of your chest muscles and use the entire 8-count to exhale. Practice when calm for maximum positive effect when upset.



How to tell your stress level:

Are you experiencing some or a lot of the following symptoms?

Emotional Signs:

- ☒ Becoming more irritable.
- ☒ Low frustration tolerance.
- ☒ Sudden waves of intense shame, guilt, or hollow emptiness.
- ☒ Feeling suddenly disconnected, detached, or “spacing out”.

Cognitive Signs:

- ☒ Racing thoughts.
- ☒ Can't keep thoughts on track.
- ☒ Can't focus on what other people are saying.
- ☒ All-or-Nothing thinking (“Everything is ruined!”, “I can't handle this!”)
- ☒ Hyper-vigilance (becoming acutely aware of every noise, movement, or perceived insult).

Physical Signs:

- ☒ Sudden tightness or heavy feelings in your chest.
- ☒ Rapid, shallow breathing.
- ☒ Spike in heart rate.
- ☒ Upset or odd stomach feeling.
- ☒ Clenching your jaw, grinding your teeth.
- ☒ Making fists.
- ☒ Tunnel vision.
- ☒ Sudden changes in body temperature (intensely hot or getting cold chills).

Behavioral Signs:

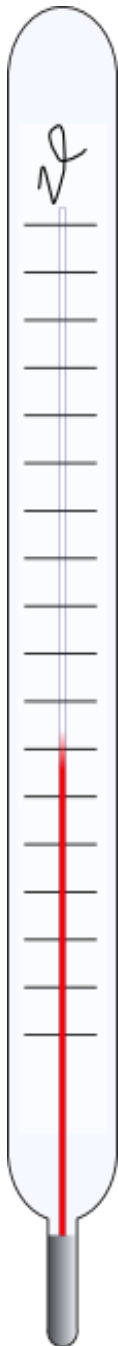
- ☒ Pacing, fidgeting, restlessness, inability to sit still.
- ☒ Withdrawing from conversations, abruptly leaving others, isolating.
- ☒ Loud voice, speaking faster than usual, or becoming completely silent.
- ☒ Snapping at people over minor things.



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How high is your stress level:



5

Maximum Stress:

No ability to self-control feelings, thoughts, and behaviors. Can't access planning, values, beliefs, etc.

4

Critical Stress:

On the edge of overwhelmed. Trouble thinking, trouble controlling behavior.

3

High Stress:

Feelings and behaviors are difficult to control but still able to think before acting or speaking.

2

Medium Stress:

All physical and mental functions are relaxed but are ready for peak performance.

1

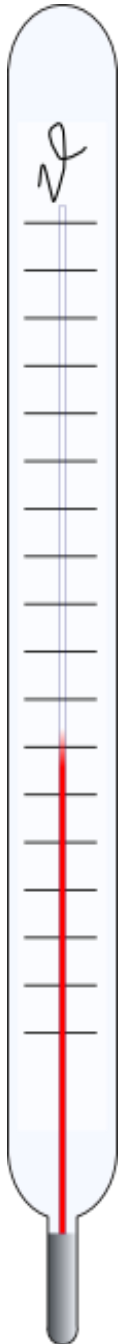
Low Stress:

All physical and mental functions are so totally relaxed that you're meditating, relaxing, or asleep.



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Distress Tolerance Action Plan

5

Maximum Stress:

GET HELP! All human beings sometimes need other people to help recover from feeling overwhelmed. Work with staff on implementing a custom Distress Tolerance Action Plan.

4

Critical Stress:

ASK FOR A CHECK-IN. Face Wash. 4-7-8 Breathing. Commit to staying around other people. Stay engaged in program activities. Schedule a next check-in.

3

High Stress:

DO NOT WAIT. Cold face wash. 4 to 8 cycles of 4-7-8 Breathing. Share with a staff person that you are having to actively manage feelings of distress.

2

Medium Stress:

Daily journaling, daily breathing exercise practice, focus on helping others if starting to get too self-absorbed.

1

Low Stress:

Get enough sleep, good nutrition, exercise, socializing, fully participating in all program activities.

This is just a sample. An individualized Distress Tolerance Plan might include scheduled check-in times, keeping a written record of stress scores, individualized / preferred positive coping activities, a reward / recognition system for not using negative coping actions, or other ways to make it engaging and personalized. Modifying it over time to be most effective is encouraged. Actively become engaged in finding what will work!



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Coping Activities

Diversions – any hobby or activity that engages your attention.

- ✦ Writing, drawing, painting, crafts
- ✦ Listening to music, playing an instrument, singing, dancing, acting
- ✦ Gardening
- ✦ Taking a walk, or going for a drive
- ✦ Watching television or a movie
- ✦ Guided Imagery Meditations
- ✦ Playing a game
- ✦ Shopping
- ✦ Reading
- ✦ Taking a break or vacation

Tension Releasers

- ✦ Going on a walk
- ✦ Exercising
- ✦ Breathing Exercises
- ✦ Playing sports
- ✦ Systematic Muscle Relaxation
- ✦ Playing a musical instrument
- ✦ Taking a hot shower or bath
- ✦ Eating a little chocolate
- ✦ Crying
- ✦ Laughing
- ✦ Singing

Organizing Tasks – any activity that involves ordering things.

- ✦ Cleaning
- ✦ Organizing your environment
- ✦ Putting things away
- ✦ Sudoku, Crossword puzzles, Jigsaw puzzles
- ✦ Update your calendar
- ✦ Outline the steps in a project

Cognitive Coping Skills

- ✦ Making lists (Pro-Con, Goals, Ideas)
- ✦ Brainstorming solutions
- ✦ Managing your expectations
- ✦ Considering an inspirational quote
- ✦ Being flexible
- ✦ Consciously changing your attitude
- ✦ Rewarding yourself for successes
- ✦ Analyzing a situation
- ✦ Reframing a problem to be an opportunity

Social or Interpersonal Coping Strategies

- ✦ Talking to someone you trust
- ✦ Writing a note to someone you care about
- ✦ Spending time with friends or family
- ✦ Serving someone in need
- ✦ Caring for or play with a pet
- ✦ Role-playing challenging situations with others
- ✦ Encouraging others

Physical Maintenance Strategies

- ✦ Getting enough sleep
- ✦ Eating healthy foods
- ✦ Getting into a good routine
- ✦ Limiting caffeine and other substances
- ✦ Taking medication as prescribed
- ✦ Deep / slow breathing

Limit Setting

- ✦ Dropping some activities if you're over-extended
- ✦ Setting boundaries and saying "no"
- ✦ Prioritizing important tasks
- ✦ Scheduling time for yourself
- ✦ Being assertive to the demands of others

Spiritually Fulfilling Activities

- ✦ Praying
- ✦ Meditating
- ✦ Enjoying nature
- ✦ Getting involved in a worthy cause
- ✦ Experiencing appreciation or gratitude



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Negative Coping Actions

Diversions

- ✦ Procrastination – putting off important tasks
- ✦ Misusing drugs or alcohol as self-medicating
- ✦ Wasting time on unimportant tasks

Tension Releasers

- ✦ Tantrums
- ✦ Throwing things at people
- ✦ Hitting people
- ✦ Yelling at others
- ✦ Destroying property
- ✦ Speeding or driving recklessly

Social or Interpersonal Strategies

- ✦ Blaming others
- ✦ Isolating or withdrawing
- ✦ Mean or hostile joking
- ✦ Putting down others behind their back
- ✦ Criticizing others to their face
- ✦ Manipulating others
- ✦ Refusing help from others
- ✦ Lying to other people
- ✦ Sabotaging other people's plans
- ✦ Being late to appointments
- ✦ Provoking violence from others
- ✦ Enabling others to take advantage of you

Physical

- ✦ Suicidal Gestures
- ✦ Self-harm
- ✦ Excessive exercise
- ✦ Developing illnesses
- ✦ Abusing drugs or alcohol

Over-Indulging

- ✦ Spending too much
- ✦ Gambling
- ✦ Eating too much
- ✦ Continually crying

Cognitive Strategies

- ✦ Denying any problem
- ✦ Stubbornness or inflexibility
- ✦ All or nothing, black or white, thinking
- ✦ Blaming yourself and others
- ✦ Catastrophizing
- ✦ Unproductive Repetitive Thoughts
- ✦ Hiding or Burying Your Feelings
- ✦ Withdrawing or Isolating
- ✦ Name-Calling

Self-Diminishing

- ✦ Making excessive fun of yourself
- ✦ Self-sabotaging behaviors
- ✦ Blaming yourself
- ✦ Thoughts and behaviors that suggest that you deserve to feel bad or overwhelmed



Responding to Suicidal Ideation

Suicidal Ideation:	Thinking about committing suicide. Passive suicidal ideation is when you wish were dead or that you could die, but you don't actually have any plan. Active suicidal ideation, on the other hand, is not only thinking about it but having the intent to commit suicide, including planning how to do it.
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Overview of Responding to Suicidal Ideation:

Clients identifying that they're struggling with suicidal thoughts is one of the more intimidating and challenging situations for a residential counselor. In general, the empathic listening technique can be very useful for discussing suicidal ideation with the client.

By way of review Empathic Listening involves:

- Mirror or match the client's general body language, speech, intensity; lead to slower and lower.
- Intense Listening.
- Asking clarifying questions in a non-judgmental fashion.
- Focusing on emotions.
- Avoid slipping into problem-solving.
- Avoid the "empathizing equals agreeing with" trap if client is being negative about others.
- Plug the client back into program structures.

The intent of Empathic Listening is for the client to experience a feeling of being understood and supported by staff. It is not a problem-solving technique. Rather than attempting to fix *why* the client is having suicidal thoughts, instead focus on helping them see those thoughts as a symptom. How often does this happen? How strong are these thoughts? How intrusive are they? When are they happening? What triggers having these sorts of thoughts?

The Columbia Protocol suggests a series of questions to determine the extent, if any, to which the client has a plan or has taken any actions toward suicide.

1. Have you wished you were dead or wished you could go to sleep and not wake up?
2. Have you been thinking about killing yourself?
3. Have you been thinking about how you might do this?
4. Have you had these thoughts and had some intention of acting on them?
5. Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?
6. Have you done anything, started to do anything, or prepared to do anything to end your life (such as collecting pills, giving valuables away, writing a suicide note, etc.)?

Ask the client if they have any contraband items to turn in to staff.



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Suicidal Gesture:	A non-verbal behavior expressing suicidal intent.
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A common way to assess suicidal gestures or suicide plans is to evaluate both the risk factors inherent in the attempt and the rescue factors.

Risk / Rescue Assessment for suicidal gestures:

A. Method of attempt:

1. No or questionable seriousness: nonlethal, recovery certain.
2. Mildly serious: Death is unlikely, but possible as a secondary complication.
3. Moderately serious: Possibility of death.
4. Highly serious: Death is likely.
5. Extremely serious: Death is the usual outcome; survival chance is minimal to none.

B. Rescuability:

1. High: Most easily rescued.
2. High / Moderate: More chance of rescue.
3. Moderate: Chance of rescue 50:50.
4. Low / Moderate: Less chance of rescue.
5. Low: Chance of rescue is minimal to none.

C. Physical Consequences:

1. No or nonspecific symptoms.
2. Mild symptoms.
3. Moderate symptoms.
4. Severe symptoms.
5. Extremely severe symptoms, organ failures.

E. Medical intervention need:

1. Medical intervention not required or observation only.
2. First aid.
3. Emergency care.
4. In-patient care, specialized units.
5. Intensive-care, life support.

F. Global impression of lethality:

1. Subliminal: Death impossible or highly improbable.
2. Low: Death improbable.
3. Moderate: Death probable.
4. High: Death highly probable.
5. Extremely high: Death extremely probable to almost certain.



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The following chart presents a slightly different way to look at risk factors:

Talking About:	Behaviors	Mood
<ul style="list-style-type: none">• Killing themselves;• Feeling hopeless;• Having no reason to live;• Being a burden to others;• Feeling trapped;• Unbearable pain.	<ul style="list-style-type: none">• Increased use of alcohol or drugs;• Looking for a way to end their lives, such as searching online for methods;• Withdrawing from activities;• Isolating from family and friends;• Sleeping too much or too little;• Visiting or calling people to say goodbye;• Giving away prized possessions;• Idolizing celebrities who have committed suicide;• Aggression;• Fatigue.	<ul style="list-style-type: none">• Depression;• Anxiety;• Loss of interest;• Irritability;• Humiliation/Shame;• Agitation/Anger;• Relief/Sudden Improvement.

Rescue factors frequently involve the person letting other people know about their suicidal ideation or gesture, or making comments or gestures in a location where their distress is going to be noticed by responsible adults.

Suicidal gestures can be related to self-injurious behaviors (such as superficial cutting or head-banging). However, self-injurious behaviors typically are not directly correlated with suicidality; are most often seen as examples of non-suicidal self-injury, serving a different psychological purpose. Nevertheless, self-injurious behaviors should be reported to program leadership, a clinician, or whatever protocols your program uses, as soon as possible.

Qualities to look for in accessing risk factors include:

- **Excessive sadness or moodiness:** Long-lasting sadness, mood swings, and unexpected rage.
- **Hopelessness:** Feeling a deep sense of hopelessness about the future, with little expectation that circumstances can improve.
- **Sleep problems.**
- **Sudden calmness:** Suddenly becoming calm after a period of depression or moodiness can be a sign that the person has made a decision to end his or her life.
- **Withdrawal:** Choosing to be alone and avoiding friends or social activities also are possible symptoms of depression, a leading factor in suicide. This includes the loss of interest or pleasure in activities the person previously enjoyed.
- **Changes in personality and/or appearance:** A person who is considering suicide might exhibit a change in attitude or behavior, such as speaking or moving with unusual speed or



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slowness. In addition, the person might suddenly become less concerned about his or her personal appearance.

- **Dangerous or self-harmful behavior:** Potentially dangerous behavior, such as reckless driving, engaging in unsafe sex, and increased use of drugs and/or alcohol might indicate that the person no longer values his or her life.
- **Recent trauma or life crisis:** A major life crises might trigger a suicide attempt. Crises include the death of a loved one or pet, divorce or break-up of a relationship, diagnosis of a major illness, loss of a job, or serious financial problems.
- **Making preparations:** Often, people considering suicide will begin to put their personal business in order. This might include visiting friends and family members, giving away personal possessions, making a will, and cleaning up their room or home. Some people will write a note before committing suicide. Some will buy a firearm or other means like poison.
- **Threatening suicide:** 50% to 75% of those considering suicide will give someone – a friend or relative – a warning sign. However, not everyone who is considering suicide will say so, and not everyone who threatens suicide will follow through with it. Every threat of suicide must be taken seriously.

After processing suicidal ideation:

Communication and Initial Documentation (will be different in different programs):

1. Contact Health Services if there is any medical follow up indicated.
2. Verbally communicate about the incident of suicidal ideation to your shift colleagues and to staff covering the next shift.
3. Contact the On-Call Clinician.
4. Document the incident on an Incident Report Form. Your processing of the suicidal ideation may not be captured fully by the Incident Report so if indicated send a separate email to the resident's clinician and/or case manager with additional information.
5. Complete other documentation used by your program such as a Daily Shift Log.

Structural Interventions:

In general, residents should be returned to the regular program structures. However, similar to after any emotionally intense incident, it may make sense to add some additional structures.

Possibilities include, but are not limited to:

- ☒ Scheduled Check-In's for the remainder of the shift
- ☒ Increasing structure of various activities – for example, by only giving one-step directions.
- ☒ Staff Shadowing – requiring the resident to remain in arms reach of staff.
- ☒ Re-entry Plan – requiring a meeting to facilitate the resident being reintegrated with the group.
- ☒ Relationship Repair activities and/or Restitution
- ☒ Safety Watch (see Safety Watch form).
- ☒ Safety Contract (see below).



Safety Contracts

Safety Contracts are used in response to a client expressing suicidal ideation. While ultimately symbolic, they have an excellent track record for putting some positive closure on processing suicidal ideation or gestures.

Essentially the client signs a personalized individually crafted agreement promising to use only safe behaviors. There may be various limits built in, perhaps some scheduled check-ins, and typically an agreement to let a staff person know if suicidal ideation re-emerges. A combination of the following steps can serve as a guideline to create a safety contract:

- ◆ Identify personal warning signs. (I will use this crisis plan when...).
 - List any thoughts, behaviors, emotions, images, physical sensations, etc. that you typically experience while in crisis.
- ◆ Self-management Strategies. (Things I can do on my own...).
 - Develop coping strategies that can be done in response to warning signs.
 - Often times, these include relaxation or distraction techniques.
- ◆ Healthy Structures which serve as distraction. (My schedule for the remainder of the shift will look like...).
 - If self-management strategies do not reduce emotional distress, use a social setting as distraction.
- ◆ Social Support. (If self-management and healthy structures don't work, I will let a staff person know by...).
- ◆ Follow up. (I will speak with <therapist> at <time>.).
 - If self-management and/or social supports do not reduce emotional distress, I will let staff know by...).
- ◆ Environmental Safety. (I will turn in my shoes, etc., to increase safety...).
- ◆ Identify Reason to Not act on any Suicidal Ideation. (I agree to not harm myself because doing so would...).

Sample:

Angus has been struggling with some scary thoughts, thinking/wishing that he had never been born. Angus has identified that being around staff and peers can be helpful. When alone, reading a book and writing in a journal is helpful. Calling home to speak with his family can also be helpful.

For the rest of the night, Angus agrees to stay with the group and to fully participate in bedtime routines, including getting his laundry started. He's going to call home between 9:00 and 9:15pm. Staff will do at least a brief check-in once an hour. Angus will rate how he's doing on a scale from 1 (doing great) to 5 (totally overwhelmed). At any time tonight, if Angus is at a 4 or above, he agrees to let a staff person know the he needs a check-in.

Angus agrees to not hurt himself in reaction to how he is feeling. He wants to feel better and to be able to go home during the upcoming vacation week.

Name

Staff Name

Date



Safety Watch (page 1)

1. On-call staff will be contacted by direct care staff when a resident is placed on a Safety Watch. Applicable behaviors include, but are not necessarily limited to: significant threat of self-harm, harming others, or running away, suicidal ideation or behaviors, extreme risk-taking, self-injurious behaviors, atypical aggressive behaviors or verbalizations. **Document incident on a Critical Incident Report**
2. Any staff person can make the initial decision to place a student on a Safety Watch; however, the individual or On-Call Clinician will review and approve that decision and the specific restrictions included as part of the Safety Watch.
3. If the incident occurs during evenings and/or weekend hours, the Clinician will decide whether a formal clinical assessment can wait until the following weekday.
4. When a student is removed from Safety Watch the Clinician will ensure that the client and all appropriate staff are informed that any restrictions have been lifted. The signed form is returned to the main file to be attached to the original Critical Incident Report that documented the resident's actions/behaviors.

Student's Name: _____ Start Date/Time: _____

Staff on Duty: _____

Name of On-Call Clinician contacted: _____

Name of Clinical Supervisor contacted: _____

Name of Family worker messaged: _____

(Family worker or case manager will contact outside collaterals as indicated)

Name of Health Services staff notified: _____ PRN: Yes / No

Name of Individual Clinician messaged: _____

Brief Description of Behavior (Incident Report will contain more detail):

Filled out by Clinician - Clinical Assessment:

Signature: _____

Date/Time: _____



Safety Watch (page 2)

Student Name: _____

Start Date / Time: _____

Check all that apply:

- ☐ One-to-one staff monitoring outside of bedroom, bathroom, and while using the shower.
- ☐ Scheduled check-ins: _____
- ☐ Safety Contract Made: _____ verbal _____ written
- ☐ No off-campus trips unless approved by Clinician, Family Worker, and the parent if indicated.
- ☐ Documentation of supervision every _____ min. when awake; _____ min. when asleep.
- ☐ Must sit next to a staff person for all activities.
- ☐ No more than 5 feet away from staff and in visual sight at all times (Staff Shadowing).
- ☐ Must stay within close proximity and visual sight of staff and within 5 feet during transitions.
- ☐ Must have two staff with them in order to be outside of a building.
- ☐ Must hold staff's hand during transitions.
- ☐ Door open during room time.
- ☐ Awake Overnight Staff will sit outside bedroom door for overnight shift.
- ☐ Directed activities (individualized schedule for the remainder of the shift)
- ☐ Bedroom modifications at staff discretion:
 - ☐ Room stripped of specific items related to behavior (shoes, belts, sharp objects, cords, etc.)
 - ☐ Room stripped of everything except bed, bureau and clothing.
 - ☐ Room stripped of furniture except for mattress.
- ☐ Not allowed in the kitchen.
- ☐ Use of plastic utensils at staff discretion.
- ☐ Other restrictions: _____

Filled out by Clinician - Written determination for ending a Safety Watch:

Signature: _____

Date/Time: _____