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Non-Suicidal Self-Injury and Motivational Interviewing: Enhancing Readiness for Change

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The authors advance motivational interviewing and the transtheoretical model of change as a conceptual framework for counseling clients who engage in nonsuicidal self-injurious behaviors. The major principles of motivational interviewing are applied in a case study of a client who self-injures. Recommendations are made for mental health counseling practice.

Non-suicidal self-injury (NSSI), or self-injury (SI), is often defined as "a volitional act to harm one's own body without intention to cause death" (Yaryura-Tobtas, Neziroglula, & Kaplan, 1995, p. 33). Although the relationship between suicide and SI is complex, the behavior is by definition discrete from suicide; it is an act intended to injure the body *without* causing death (Simeon & Favazza, 2001; Yaryura-Tobias, Neziroglu, & Kaplan). Examples of SI are self-cutting, self-burning, and deliberate self-hitting—behaviors generally considered intermittent, discrete acts of self-directed self-harm (Simeon & Favazza).

It is estimated that 1%–4% of the general population and 21%–66% of clinical samples engage in SI (Darche, 1990; DiClemente, Ponton, & Hartley, 1991); there is evidence that prevalence rates are equally distributed among men and women in community samples (Briere & Gil, 1998). An average of 13% of high school students report having engaged in SI at least once (Ross & Heath, 2002), and one recent study of college students found the lifetime prevalence rate of college students having at least one SI incident was 17% (Whitlock, Eckenrode, & Silverman, 2006), suggesting that a significant number of adolescents and young adults self-injure.

SI has attracted considerable attention in recent years, not only in clinical environments but also in a number of recent television episodes, movies, and

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popular music (see Rayner, Allen, & Johnson, 2005). The depiction of SI in aspects of popular culture and the press, and the significant prevalence of SI, highlight the need for further comprehension of the topic.

SI is a complex behavior. People who self-injure have both a variety of mental health diagnoses and a variety of developmental and personal contexts that can contribute to the behavior (Klonsky & Muehlenkamp, 2007). Thus, SI serves a myriad of functions for different people at different times (Kress, 2003). The multifarious nature of the behavior makes it difficult for many mental health counselors to determine the best interventions to use (Muehlenkamp, 2006). The possible health risks secondary to SI also contribute to many counselors feeling beleaguered at the prospect of working with this population (Deiter & Pearlman, 1998). Many people who self-injure do not have concerns about the behavior and do not wish to stop. This lack of interest in ceasing the behavior can frustrate mental health providers and may explain their reporting that SI is one of the most frustrating client behaviors they encounter (Deiter & Pearlman).

Mental health counselors may wonder how best to facilitate a client's desire to change while avoiding potential power struggles and attempts to control the client (e.g., forcing clients to stop injuring, demanding they stop injuring; White, McCormick, & Kelly, 2003). In general, attempts to control clients typically increase resistance to change (Miller & Sanchez, 2004) and are often considered unethical for counselors (Kress, Costin, & Drouhard, 2006; White et al.). Some counselors may want the cessation of the SI to be the primary treatment goal, yet clients may not be ready to change. Often clients have ambivalence about disengaging from SI, and counselors may want to facilitate the client's desire to discontinue the behavior.

In order to best help clients who self-injure, it is imperative that mental health counselors have a clear framework with which to conceptualize their work with this population, draw up effective treatment plans, and implement interventions. In counseling people who self-injure, a treatment approach that recognizes client ambivalence toward change may be helpful.

Motivational interviewing (MI) is one model that may be helpful in counseling people who self-injure. This is a "directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence" (Rollnick & Miller, 1995, p. 326). In many ways, MI's basic tenets are consistent with a professional counseling philosophy (e.g., the focus on change as a normal human growth and development process and the understanding that people have the capacity to move forward, to change, to adapt, and to attain optimal mental health or wellness [Fitzsimons & Fuller, 2002; Myers, Sweeney, & Witmer, 2001]).

MI and the transtheoretical model (TTM; Prochaska & Norcross, 2001) can be applied to this population in individual, group, or family counseling. The

model can also be used in conjunction with many other theoretical models and interventions and in a variety of settings. For example, school counselors typically serve a supportive role with their students and do not implement a treatment plan. Yet because they are often among the first people to become aware of a student's SI (Kress et al., 2006), they can use basic MI techniques to help enhance readiness to make changes as the student begins—ideally—to receive community-based counseling services (Kress et al.). Even if student and family do not follow up on accessing community-based services, the school counselor can continue to use basic MI principles to help facilitate the student's change process.

This article briefly reviews the functions and correlates of SI; presents MI and TTM as a possible treatment/intervention model that may be helpful when working with people who self-injure; and then provides a case example and practice recommendations.

SELF-INJURY: FUNCTIONS, CORRELATES, AND TREATMENT

In this section, we do not provide an exhaustive review of SI. For more detailed information, we suggest the following resources: for information about diagnosis and assessment, see Kress (2003) and Walsh (2007); for information about evidence-based practices, see Muehlenkamp (2006) and Klonsky and Muehlenkamp (2007); and for the meanings or behavioral functions of SI, see Nock and Prinstein (2005).

In the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Press, 2000), SI is typically conceptualized as being related to an Axis I or Axis II disorder (Kress, 2003). In research on relationships between SI and several DSM-IV-TR (2000) Axis I disorders, for instance, SI has been associated with eating disorders (Favazza & Conterio, 1989), childhood sexual abuse and subsequent posttraumatic stress disorder (PTSD; Favazza & Conterio, 1989; Parker, Malhi, Mitchell, Kotze, Wilhelm, & Parker, 2005), anxiety and depressive symptoms (Ross & Heath, 2002), borderline personality disorder (BPD; Bohus et al., 2004), and depressive and PTSD symptoms (Nock & Prinstein, 2005).

It is estimated that 70%–80% of clients meeting the criteria for BPD engage in some form of self-injury (Bohus et al., 2000). Diagnostic criteria for BPD identify the presence of SI in criterion five for the diagnosis, stating "frantic efforts to avoid abandonment may include impulsive actions such as self-injury or suicidal behaviors" (DSM-IV-TR, 2000, p. 706).

The relation between SI and suicide attempts can be especially complicated when counseling people with BPD. While it is important not to overreact to self-injurious behaviors, it is even more important not to underreact. Some counselors, perceiving clients diagnosed with BPD who self-injure as being

manipulative, may not take potential suicide attempts seriously. For some counselors, this negative reaction to clients may be rooted in personal frustrations secondary to a perceived inability to be helpful (Nafisi & Stanley, 2007; White et al., 2003).

Suicide and SI have a complicated relationship. SI should only be viewed as suicidal if the client indicates an intent to die (Simeon & Favazza, 2001). However, one can have suicidal ideation and self-injure without being considered suicidal (Simeon & Favazza). In fact, while self-injuring, 28%–41% of people reported suicidal ideation (Gardner & Gardner, 1975; Pattison & Kahan, 1983). Welch (2001) reviewed 20 studies that examined parasuicide (attempted but uncompleted suicide) and stated that it is difficult to study this area because parasuicide and SI without intent to die are often blurred together. In summary, there is a link between suicide and self-injuring behavior, but the nature and extent of this link is still under investigation. Related to the discussion of counselor perceptions of clients who self-injure as "manipulative," counselors must be cognizant that completed suicide occurs in approximately 8%–10% of individuals with BPD (DSM-IV-TR, 2000). Great care should be exercised in determining the true intention of a self-injurious act (e.g., attempted suicide or acts of SI as a self-preservation strategy). Mental health counselors should be aware of how their personal frustrations with clients might impact how they work with them.

There is a link between psychological trauma and SI; some people who self-injure demonstrate a significant history of trauma. Herman (1992) suggested that the DSM criteria for PTSD do not sufficiently address those individuals who have experienced chronic, long-term traumatic events (e.g., domestic violence, repeated childhood abuse). Herman proposed "complex trauma" as a diagnosis that was more accurate for such individuals. Symptoms of complex trauma include chronic suicidal preoccupation, SI, isolation from others, and persistent distrust. Individuals who self-injure as a result of chronic, long-term trauma may do so in an effort to regulate affective states or to avoid intrusive symptoms (e.g., flashbacks, recollections of the trauma; Herman, 1996). Mental health counselors who work with clients who self-injure should consider a thorough psychosocial assessment to determine whether any previous psychological trauma exists, and the role it might play in causing and sustaining the SI. Herman (1992) cautioned that clients with complex trauma symptoms may be misdiagnosed as having BPD.

There are a variety of reasons people self-injure, and the behavior appears to serve a variety of functions that typically evolve with time and experiences; often, SI serves several functions at once. Nock and Prinstein (2004) proposed that SI serves as a form of autonomic reinforcement (emotion regulation) or a means of obtaining social reinforcement (e.g., gaining support from others). Other research has found that people may self-injure to diminish dissociation,

depersonalization, and derealization and to relieve feelings of emptiness and numbness; others report that they gain a sense of control over their lives and their emotions secondary to injuring (Dallam, 1997; Simeon & Favazza, 2001).

Biological theories have also been proposed to explain why people self-injure. It has been suggested that some people have genetic predispositions or chemical imbalances and vulnerabilities, or that they experience neurochemical changes that reinforce and support the SI (Dallam, 1997; Pies & Popli, 1995; Simeon et al., 1992). Research on the biological functions of self-injury suggests that decreased serotonergic function is associated with increased impulsivity, aggression, suicidality, and SI (Kraemer, Schmidt, & Ebert, 1997; Spoont, 1992).

According to Deiter, Nicholls, and Pearlman (2000), childhood sexual abuse and family violence are two strong predictors of self-injury. Since individuals subjected to such abuse or violence often experience constant emotional dysregulation, they may not acquire the skills to standardize intense emotional experiences and may resort to SI in an attempt to regulate strong emotions.

Furthermore, individuals who lack impulse control may also be more likely to self-injure (Fong, 2003). Fong stated that SI shares two qualities with impulse control disorders (e.g., gambling, stealing): an inability to resist impulses or urges to engage in a particular act or behavior, and an increase in autonomic nervous system activity before the act, with a release of pleasure or satisfaction after it.

The literature offers little guidance on effective treatment of SI; empirical research and evidence-supported treatment guidelines are limited (Klonsky & Muehlenkamp, 2007; Muehlenkamp, 2006). However, problem-solving therapy and dialectical behavior therapy have the most support for decreasing SI (Muehlenkamp, 2006). Therapeutic approaches that emphasize problem-solving, emotion regulation, and functional assessment and analysis of the behavior are cited as important treatment elements (Klonsky & Muehlenkamp, 2007), as are cognitive restructuring and a strong therapeutic relationship (Muehlenkamp, 2006).

Although recent research (Laye-Gindhu & Schonert-Reichl, 2005) indicates that SI occurs mostly in private, it is an often-stigmatized behavior that helpers sometimes conceptualize as manipulative or "attention-seeking" (Rayner et al., 2005). This conceptualization may contribute to some negative counselor attitudes toward this population and could cause countertransference reactions and unethical practices when mental health counselors work with people who self-injure (White et al., 2003). SI is closely tied to feelings of worthlessness, so that recognition of the problem must be followed by compassionate counseling designed to help individuals who self-injure to become aware of their emotional states and, when they are ready, help them to replace the SI with more effective coping skills (White et al., 2002; Zila & Kiselica, 2001). To this end,

attempts to control clients' behavior by giving them ultimatums or otherwise forcing them to stop engaging in SI are ineffective at best and destructive and harmful at worst (White et al., 2003). The use of MI (also referred to as motivational enhancement techniques; Miller & Rollnick, 2002) may be an effective way to facilitate clients' motivation to change while respecting their sense of personal agency and control. The MI model is commonly used to treat substance abuse disorders—a clinical issue that, like SI, typically involves ambivalence about making behavioral changes. In the following section, MI and the TTM model of change will be discussed in relation to counseling people who self-injure.

MOTIVATIONAL INTERVIEWING AND THE TRANSTHEORETICAL MODEL

Some researchers, conceptualizing SI from an addictions model, believe that there is an addictive quality to SI that sustains the behavior (Nixon, Cloutier, & Aggarwal, 2002). Yates (2004) suggested that SI acts typically precipitate tension release and mood evaluation, so that over time they may take on an addiction-like quality. Other research suggests that most individuals who self-injure struggle to resist the impulse (Brain, Haines, & Williams, 1998). These findings support the notion that SI might have addiction-like dynamics; therefore, treatments that have demonstrated effectiveness with addictions, like MI, might also show promise in addressing SI.

In recent years MI has surged in popularity. Originally developed to treat substance abuse issues, it has increasingly proven effective in changing other behaviors (Dunn, Deroo, & Rivara, 2001). In one review of the substance abuse literature, 73% of the studies in which MI was applied resulted in statistically significant effects, demonstrating its impact in facilitating client behavioral change (Dunn et al., 2001). Specifically, MI has demonstrated effectiveness in facilitating smoking cessation (Butler, Rollinick, Cohen, Russel, Bachmann, & Stott, 1999; Colby et al., 1998); decreasing HIV risk-related behaviors (Carey, Maisto, Kalichman, Forsyth, Wright, & Johnson,1997); increasing condom use (Belcher et al., 1998); reducing unprotected sex among high-risk women (Carey et al.); and improving compliance with diet/exercise programs (Harland, White, Drinkwater, Chinn, Farr, & Howel, 1999; Rollnick, 1996). Recent research (Tantillo, Nappa Bitter, & Adams, 2001; Treasure & Ward, 1997; Wilson & Schlam, 2004) has also identified the use of MI in the treatment of eating disorders. Killick and Allen (1997) suggested that MI can be adapted for use with eating disorders in order to help the counselor assess the client's current relationship with the eating difficulty and tailor interventions accordingly. The successful application of MI to various clinical issues suggests that it might also be effective in helping those who self-injure.

Extratherapeutic change factors, such as clients' personal motivation to

change, their belief they can effect change, and their commitment to change, are among the most important considerations in the client change process (Hubble, Duncan, & Miller, 1999). Through the use of MI, mental health counselors can help enhance these extratherapeutic change factors.

The role that counselors play in facilitating a client's hope that change can and will occur has also been found to be exceptionally important to the client change process (Hubble et al., 1999). Thus mental health counselors can contribute to the counseling relationship by having an expectancy of change that facilitates client hope (Hubble et al.). Motivational interviewing may be helpful in developing and enhancing these important client attitudes.

Motivational Interviewing

The foundation of MI has three main elements: (a) collaboration, (b) evocation, and (c) autonomy (Miller & Rollnick, 2002). The concept of *collaboration* promotes the value of an egalitarian therapeutic relationship that honors the experiences and perspectives of the client. *Evocation* refers to building the client's inherent resources and intrinsic motivation for change. The final concept, *autonomy,* refers to the value of the client's right and capacity for self-direction and informed consent within the treatment process. In addition to these foundational principles, MI facilitates a process by which counselors invite client change by following four basic principles: (a) counselor expression of empathy; (b) developing the client's discrepancies; (c) rolling with the client's resistance; and (e) supporting the client's self-efficacy (Miller & Rollnick). The MI concepts of collaboration, evocation, and autonomy promote the development of a positive working alliance in order to empower the client for change.

Expressing empathy refers to the building of a strong client and counselor relationship; this is the foundation of MI and is facilitated by the counselor's empathy. *Developing discrepancy* encourages the counselor to uncover and amplify discrepancies between the client's current behavior and his or her values or goals. In other words, how is the behavior getting in the way of the person reaching life goals? *Rolling with resistance* suggests that the counselor reframe resistance to encourage momentum toward change. Rolling with resistance is in many ways paradoxical; it will often bring the client back to a more open-minded perspective on behavior change. The final principle, *supporting self-efficacy,* describes MI as a collaborative process that considers a client's motivation and resources for change (Miller & Rollnick, 2002). By enhancing client self-efficacy, counselors build clients' hope that they can change their behavior. Even if clients perceive the need to make changes, they may not embrace change if they believe they cannot successfully complete the process; that is why building client self-efficacy is important.

MI proceeds in two phases (Miller & Rollnick, 2002). In the first, there is an

emphasis on "change talk" as a technique that builds the client's intrinsic motivation for change. The acronym OARS is used to represent stage one; it consists of *open questions*, *affirming*, *reflecting*, and *summarizing*. The purpose of phase one is to explore ambivalence and clarify reasons (and thus facilitate motivation) for change. In phase 2 of the MI process, the client's commitment to change is strengthened. The counselor encourages readiness for change and helps the client identify potential obstacles to success.

One of the goals of MI is to alter how the client sees, feels, and responds to problematic behaviors, with the counselor amplifying any discrepancy between the client's present behavior and goals that he or she verbalizes as important (Britt, Blampied, & Hudson, 2004). MI creates a supportive, nonjudgmental, directive environment to facilitate exploration of one's motivations, readiness for, and confidence about change, as well as any ambivalence to change (Miller & Rollnick, 2002).

Transtheoretical Model

MI is not based on theory; the foundation of the model is its developers' perceived successful clinical experiences (Miller & Rollnick, 2002). However, conceptually MI and TTM (which is often referred to as the stages of change model; Prochaska & Norcross, 2001) are related and are often discussed in conjunction with each other (e.g., Gintner & Choate, 2003).

Clients typically experience fluctuations in their motivation to make behavior changes. Typically, a part of a person wants to make changes, yet another part does not; the motivation may ebb and flow depending on a variety of internal and external factors. The TTM or stages of change model as conceptualized by Prochaska and DiClemente (1982) consists of six stages, each encompassing the many possible dimensions of change. These six stages as further elaborated by Prochaska, DiClemente, and Norcross (1992) and Prochaska and Prochaska (2004) are described in terms of the major behaviors and attitudinal beliefs the client exhibits at each stage. In what follows, the six stages—precontemplation, contemplation, preparation, action, maintenance, and termination—will be discussed in further detail, with specific attention to their application to MI.

During the *precontemplation* stage the client does not make any discernable effort to change the behavior and is not considering changing it in the immediate future. An individual in this stage may have little or no awareness that a problem behavior exists and may be resistant to attempts from family and friends to encourage behavior change.

At the *contemplation* stage, the client recognizes the problem behavior but has not made a serious commitment to eliminating or replacing it. The client might recognize the negative impact that the behavior has but feel unwilling or unable to stop engaging in it.

During the *preparation* stage the client has a desire to make changes but might experience difficulty in determining what specific changes need to be made. Individuals at this stage typically have a plan of action, such as consulting a mental health professional, and will generally take action within one month (Prochaska & Prochaska, 2004).

Action refers to the stage in which the client makes progress toward engaging in some sort of behavioral change: The client not only recognizes the need to alter the behavior but also makes some discernable progress toward achieving this goal.

At the *maintenance stage,* the person has made significant treatment gains and is actively pursuing behavioral change. In this stage, clients have successfully met goals and are encouraged to continually monitor and adhere to the new behavioral practices and actively avoid relapsing to old behaviors.

The final stage, *termination,* is the point at which individuals have zero temptation and 100 percent self-efficacy. Although this stage is considered an ideal goal, it is possible that many people will go no further than the maintenance stage (Prochaska & Prochaska, 2004).

In applying the TTM, counselors must identify the particular stage where a client is upon entering counseling, and then adapt the treatment to the client's motivation, interest, and readiness to change (Freeman & Dolan, 2001). Moreover, matching change processes to stages requires that the therapeutic relationship be matched to the client's stage of change, and the relationship must progress as the client moves through each stage (Prochaska & Norcross, 2001). Matching interviewing style and interventions to the client's stage is a continuing dynamic process.

MI is a useful model for people in the early stages of change (e.g., precontemplation and contemplation) who are still working on problem recognition and developing their motivation to change. For these people, the cons of making changes outweigh the pros. The use of MI with them can help illuminate pros of behavior change, may cast a shadow on the cons, and could ultimately help resolve client ambivalence about behavior change.

Although no research has applied or investigated the stages of change model in terms of people who self-injure, it is often recognized that many people who present for counseling do not want to stop the behavior, or they have ambivalence about doing so (White et al., 2002). The ambivalence about ceasing the behavior may be even higher in populations of people who are mandated to counseling (e.g., criminal justice populations, adolescents whose parents require them to attend counseling or who are in hospital or residential settings). It is likely that many people who self-injure and receive counseling could benefit from enhanced motivation to change.

At the later stages of the TTM clients recognize a need to change, and they want to do so. At this point in the counseling process, a counselor's role is to

provide clients with the skills they need to be successful in initiating and sustaining the changes they are ready to make. As clients demonstrate increased interest in making changes, they may become more compliant with treatment models that require their active participation. In order to follow through on the work required by active counseling approaches such as DBT and various cognitive behavioral counseling approaches, clients must have a genuine desire to cease the self-injurious behavior. If the client's motivation should ebb, the use of MI techniques may again help enhance motivation, facilitating a move to more advanced stages.

APPLYING MI AND TTM: COUNSELING CLIENTS WHO SELF-INJURE

Assessment

During the initial session with a client who self-injures, the mental health counselor should obtain a thorough biopsychosocial history and detailed mental status exam, information about the frequency and duration of the SI, information about past suicide attempts, cultural or religious factors, or comorbid DSM-IV-TR diagnoses, and the history and level of medical attention required for wound care (White, 2003; White et al., 2002). After conducting this assessment, using the TTM the counselor should identify the client's current readiness to change or motivation to cease the SI. Prochaska and Prochaska (2004) present a template for identifying the client's stage of change as follows:

(a) Stage 1 – Precontemplation: no intention to change within the next 6 months.
(b) Stage 2 – Contemplation: considering change within the next 6 months.
(c) Stage 3 – Preparation: intending to change in the next month.
(d) Stage 4 – Action: has made a change but has not sustained it for 6 months.
(e) Stage 5 – Maintenance: change has been sustained for more than 6 months.
(f) Stage 6 – Termination: change has been maintained for more than 5 years.

Interventions

Incorporating MI and the TTM, the mental health counselor would, in the first session, ask the client to reflect on how his or her problem interferes with daily functioning (Treasure & Ward, 1997). Counselors using MI ask open questions about the client's values and goals and identify ways in which these values might be discrepant with the client's current behavior. They can use these discussions as a way of responding to discrepant client behavior with reflections that convey a sense of understanding and can subsequently avoid arguments when encountering resistance, which may ultimately convey hope that change is possible (Moyers & Rollnick, 2002). The counselor might begin

by questioning the lifestyle of the client, which might include looking for costs and benefits of the SI. For example, research has suggested that SI is a way of expressing emotional pain and anger (Warm, Murray, & Fox, 2003). It would appear that this emotional regulation might produce positive effects for the client, in that the SI removes unpleasant or painful emotions. However, in addition to identifying this positive gain, it would be important to also identify potential costs of the SI, which might include social stigmatization or guilt over not being able to control behaviors.

When applying MI, mental health counselors avoid confrontation and instead aim to support the client to generate reasons, plans, and motivations for change (Wahab, 2005). Resistance is not confronted head-on but is skillfully deflected to encourage continued open exploration (Miller, 1996). Central to MI's client-centered spirit and techniques is the consistent emphasis on client autonomy and self-determination (Wahab). Client resistance is a signal to change therapeutic strategy; argumentation or persuasion by the counselor is considered counterproductive (Britt et al., 2004).

As mentioned, from a treatment planning perspective it is important to match interventions to the client's stage of change (Prochaska & Prochaska, 2004). The concept of readiness to change provides the ability to tailor interventions to suit the client's degree of readiness for change. Application of this model in counseling people who self-injure should ensure greater parity between the agendas of counselor and client, and therefore minimize resistance and improve the effectiveness of intervention (Britt et al., 2004).

The following case example demonstrates the use of MI with a client who presented for treatment of anxiety-related symptoms. Although the client, Emory, was engaging in SI when she presented for counseling services, she indicated that she wanted to work on her "stress" and did not identify cessation of SI as a goal for treatment.

CASE EXAMPLE

Emory, a college senior, presented for counseling services at a small liberal arts college's counseling center. She reported that she was "stressed" and experiencing a variety of anxiety-related symptoms. As a student in the college's music conservatory, she said she experienced a great deal of pressure to excel. Emory described practicing her instrument upward of 12 hours a day. No matter how hard she practiced, and despite her 4.0 GPA and many accolades and awards, she perceived that her instructors believed she had not practiced enough. In response to the counselor's inquiry as to what she wanted to get out of counseling, she stated that she wanted to become "less stressed."

Toward the end of the first session, Emory casually mentioned that for the past three months she had been self-injuring by making delicate cuts on her

forearms. She reported that the cutting behaviors helped her to feel calm and to "manage her stress." When the counselor asked her if she wanted to address the cutting behaviors in counseling, she reported that the behavior was one of the only things that made her "feel better" and decreased her stress, and she did not want to stop engaging in the behavior. Emory also mentioned that her parents had strongly encouraged her to come to counseling because her older sister had seen her injuries and "told on her" to them. In processing these events with the client, it become evident that she was very close to her sister and her parents; she cared deeply what her parents thought, and how they felt about her. She also mentioned off-hand that she wasn't sure she wanted to come for more than the one counseling session.

Expressing Empathy

Emory clearly felt a great deal of pressure, stress, and anxiety; these issues were her presenting concern. Despite the fact that she was an outstanding student and gifted artist, her perceptions of her situation were that she was near "failure" and had "no room to make a mistake." The mental health counselor empathized with the pressures she was managing, and did all she could to fully understand Emory's unique experiences. A focus on the SI at the expense of building empathy for Emory's concerns could have detracted from the counseling process. At the same time, the counselor empathized with Emory's concerns that her family was worried about her SI.

Developing Discrepancy

Emory cared deeply about her family's perception of her and was worried enough about their concern about her SI to come to counseling voluntarily. This concern about her family's perceptions opened an opportunity to maximize the discrepancy between how things were going for Emory and how she wished them to be different. Additionally, Emory had mentioned concerns that other students or her professors would see the cuts on her arms. She stated that she believed these people thought she was "so together" and that seeing these cuts would make them think she was "crazy." This information also provided an opportunity to examine discrepancies between her present and her desired behaviors.

Rolling with Resistance

Emory continued to elect to focus the sessions on managing her stress and anxiety and rarely discussed the SI. Often in the counseling process the counselor might have encouraged Emory to stop self-injuring or suggested that injury cessation become a counseling goal. At times, it almost seemed as though Emory was waiting for the counselor to challenge the behavior. Rolling with her "resistance," paradoxically, facilitated her change process.

Although Emory could have benefited from weekly sessions, at first she only wanted to attend counseling every other week; as time progressed she decided to come weekly. The counselor's comfort with Emory's pacing of sessions is also an example of rolling with resistance and demonstrates how resistance can be turned around.

Supporting Self-Efficacy

Although Emory stated that she did not want to address her self-injurious behaviors, developing her skills in other areas increased her global sense of self-efficacy. For example, in counseling she learned several new anxiety management tools that she applied, in her own time and on her own terms, as an alternative to self-injuring. Because of her expressed desire to work on decreasing her "stress," she was vested in learning these techniques.

Additionally, Emory felt anxiety about her impending graduation and uncertainty about a career. The mental health counselor addressed career issues and processed various career plans, and this helped enhance Emory's sense of control over her future. These counseling experiences increased her belief that she could make changes related to the self-injurious behavior.

Transtheoretical Model

At the close of the first counseling session, Emory was assessed as being at the *precontemplation* stage of change with regard to the SI. During the initial session, she stated that she had no intention of abstaining from self-injuring. By assessing Emory's stage of change and implementing MI principles appropriate to this stage, the counselor was able to help her effect changes in her life. Although Emory had not set cessation of self-injury as a goal, as she developed her skills and increased her sense of efficacy, she was able to eventually stop injuring all together. Additionally, as she became more actively involved in the counseling process and entered the *action* stage, the counselor was able to implement various CBT strategies. More specifically, Emory learned how to manage her anxiety by increasing her awareness of her thoughts, in other words her self-observation and mindfulness; she began to use imagery and relaxation to manage her anxiety, she acquired the ability to refute her negative self-talk and cognitive distortions and start a new internal dialogue when wanting to self-injure, and she learned more effective coping skills, which included more effective problem solving (Meichenbaum, 1977). By the end of the counseling process, Emory was in the *maintenance stage:* she was no longer engaging in SI, and she did not express a desire to self-injure. She was able to cease self-injuring with little to no direct processing of the behavior.

SUMMARY AND RECOMMENDATIONS

Many people who present for counseling are not entirely ready to stop self-injuring, and due to a variety of factors, such as wavering readiness and motivations, most clients who take action to modify behaviors (e.g., SI) do not successfully maintain gains on their first attempts (Prochaska et al., 1992). Approaching clients with an element of curiosity and a recognition that they may not be ready to or want to stop injuring might prove helpful in facilitating open conversations related to SI. The recognition that some clients may not be ready to stop injuring and a subsequent assessment of their readiness to stop injuring may be more effective, and more ethical, than developing treatment plans and applying interventions that have as an underlying premise the assumptions that the client wants and is ready to stop the behavior (White et al., 2002). To prematurely assume a client is ready to stop self-injuring may result in the client's hasty termination of counseling services or resistance to the proposed treatment plan (e.g., not following through on between-session assignments) and may thus hinder effective treatment.

The value of fully comprehending a client's personal reality related to his or her SI experiences cannot be overstated (Johnston, 1997; Ross & McKay, 1979). Johnston argued that the underlying philosophy of a medically based psychiatric approach tends to remove power and control from the person who self-injures, denies his or her feelings, and ignores the meanings behind his or her actions; all of these factors may parallel the experiences that led to the original need to self-injure and ultimately prove helpful to clients. In research that examined the personal attributes of those who self-injure, Favazza and Conterio (1989) found that 75% of those who self-injure identified themselves as being a burden to others. These findings point to the value of a counseling approach that is empowering and provides an opportunity for clients to feel committed, engaged, rather than feeling as though they have burdened yet another person by not following through or being successful in managing the SI.

One advantage of the model proposed in this article is the ease with which it can be used with other theoretical models (Prochaska & DiClemente, 1992; Prochaska & Prochaska, 2004). This model might provide some direction for mental health counselors in that it suggests that clients at earlier stages of the TTM model might benefit from MI, and clients at later stages of the TTM model might benefit from evidence-based approaches, which typically require client commitment and active involvement.

The use of MI as an adjunct to evidence-based practice has been supported in the professional literature. For example, Slagle and Gray (2007) suggested that MI may be used at several treatment junctures, and in conjunction with exposure-based practices, in the treatment of anxiety disorders. In a study of individuals receiving CBT for anxiety, Westra and Dozois (2006) found that

individuals receiving MI as a pretreatment demonstrated greater CBT homework compliance than those who did receive MI pretreatment.

Despite MI's ostensible value as an adjunct to evidence-based practices (Slagle & Gray, 2007; Westra & Dozois, 2006), it is important to recognize that there is no research on the use of MI in counseling clients who self-injure. Thus, it is recommended that MI be used only as an adjunct to evidence-based practices.

Additionally, mental health counselors should monitor their personal reactions to disclosures of SI and make decisions based on client-reported experiences and intentions rather than transference reactions, such as fear or a desire to control the person's SI (White et al., 2003). Counselors who believe that SI is intentionally manipulative or "attention-seeking" may inadvertently reinforce these notions. By utilizing MI, counselors might be better equipped to provide effective, nonjudgmental treatment that respectfully facilitates clients' motivation to make changes.

Although MI may represent a useful approach to treating clients who self-injure, there are some potential limitations of this approach. For example, clients engaging in unsafe self-injuring practices (e.g., sharing implements used for injuring, injuring while intoxicated) may require more directive counseling to ensure their personal safety. Also, clients with limited cognitive skills may not be particularly well-suited for MI. Clients who are suicidal will require a more active, directive approach than MI can provide. Finally, clients with severe mental disorder symptoms may benefit more from a more structured, active, and directive treatment program that includes elements of motivational enhancement (e.g., DBT).

Overall, MI represents a potentially effective approach to helping clients who self-injure. The supportive and empathic foundation of MI presents a strong base for the therapeutic alliance. Furthermore, MI allows client and counselor to move beyond an exclusive focus on the SI, which the client may be reluctant to cease, and instead focus on areas that the client may be willing to change.

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