Motivational Interviewing (MI) and Brief Action Planning (BAP): Two Independent or Synergistic Approaches to Health Behavior Change

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P. Liamputtong (ed.), *Handbook of Concepts in Health, Health Behavior and Environmental Health*, https://doi.org/10.1007/978-981-97-0821-5_167-1

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Abstract

This chapter reviews two independent or synergistic client/patient-centered approaches for guiding individuals toward health behavior change: Motivational Interviewing (MI) and Brief Action Planning (BAP). Regarding MI, the chapter addresses the "Spirit of MI," four foundational skills ("OARS"), "Change Talk" ("DARN CAT"), and the "Four Tasks" of MI. The chapter describes how clinicians can employ MI skills over the arch and resolution of ambivalence to increase readiness for action planning before using the skill set of BAP as a roadmap into and through "Planning" (the 4th Task of MI). BAP can also function as an independent tool for health behavior change for individuals ready or nearly ready for change. BAP and MI have been integrated synergistically in an innovative conceptual framework described as "BAP-MI." To help readers understand these varying applications, the authors provide details of their clinical use of MI, BAP, and BAP-MI in areas of their clinical expertise and experience (smoking cessation and bariatrics).

Keywords

Brief Action Planning · BAP · Motivational Interviewing · MI · Health behavior change · BAP-MI · Client-centered care · Patient-centered care · Relationship-centered care · Ambivalence · Health psychology

1 Introduction

Motivational Interviewing (MI) has become widely accepted as a gold standard for client-centered/patient-centered approaches in healthcare. It aims to help individuals resolve ambivalence and strengthen motivation toward behavior change. Meta-analyses report statistically significant and positive effect sizes of the impact of MI across multiple areas of health outcomes, including blood pressure, body weight, cholesterol level, mortality, dental caries, HIV viral load, and others (Huang et al., 2023; Lundahl et al., 2013; Michalopoulou et al., 2022; Zhu et al., 2024). Brief Action Planning (BAP) was developed circa 2003 as an MI-consistent skill set to support patient self-management in chronic illness care (Cole et al., 2012) and facilitate health behavior change for those individuals who are ready or nearly ready for change (Cole et al., 2023; Gutnick et al., 2014). Uptake across diverse

settings as well as evidence has been increasing: a scoping review of the literature reported 143 peer-reviewed studies (Jadotte et al., 2023) and a systemic review and meta-analysis reported statistically significant and meaningful effect sizes (Jadotte et al., 2025). A recent editorial describes how BAP serves as a technique that can be used as either a part of MI or function as a stand-alone tool to support self-management for people ready or nearly ready for change (Cole & Jadotte, 2023).

This chapter describes use of Motivational Interviewing (MI) and Brief Action Planning (BAP) in healthcare, independently and synergistically. It illustrates these uses with clinical examples from fields of smoking cessation and bariatric medicine.

2 Motivational Interviewing

2.1 Defining Motivational Interviewing

MI has its roots in Rogerian, client-centered therapy and was born out of work with substance abuse populations as an intentional alternative to confrontational or coercive styles of treatment. Since its origin, MI has also been proven useful for many different populations in many different settings. Of relevance to this chapter, MI has proven useful in diverse healthcare settings for individuals with persistent unhealthy behaviors and ambivalence. The definition of MI has evolved over time, as well, for consistency with emerging evidence, to refine its use from expert clinical experience, and to meet the needs for its use across numerous helping professions. Currently, MI is defined as "a particular way of talking to people about change and growth to strengthen their own motivation and commitment" (Miller & Rollnick, 2023, p. 3). This definition underscores the broadly collaborative and empowering mission of MI. This background mindset (and "heartset") has been described as the underlying "Spirit of MI."

2.2 The Spirit of MI

In traditional approaches to healthcare, clinicians facilitate adherence to medical advice and lifestyle behavior change through giving advice, recommendations, and prescriptions. Based on their knowledge, experience, training, and judgment, clinicians quite rightly assume expert roles to advise and persuade patients towards health. Within more traditional models of healthcare, individuals have been expected to do their best to understand and follow the advice they have received.

Unfortunately, especially in complex situations of persistent unhealthy behaviors, as well as individuals' ambivalence about elements of the advice they have received, providing information advice or persuasion is often ineffective. Nonadherence to medical recommendations is typically 50% or greater across studies. Individuals with ambivalence about following a medical recommendation typically become even more hesitant (somewhat paradoxically) about following this advice, as a clinician may advocate for its importance more and more emphatically, even

"grounding" such advice on "medical evidence." Thus, clinicians need to understand the limits of education, advice, and persuasion.

In contrast to a traditional "medical model" of the "expert" clinician, MI recognizes the presence and complexity of ambivalence and seeks an alternative approach, as needed for many people, for education, advice, and behavior change to increase patient alignment or adherence to best medical practice. Through resisting the desire to jump into action and fix the client's problem for them (known in MI as the "Fix It Reflex"; see Box 1, below), MI focuses on building the person's own intrinsic motivation and strengthening commitment through guiding the person toward the resolution of ambivalence. MI techniques have their origins in Rogerian client-centered therapy, where the clinician opens the space to listen to and follow the client's lead. Based on this fundamentally Rogerian approach, MI techniques have been scientifically refined and streamlined into strategic tools that hold the client at the center. This purposeful support of a client's/patient's autonomy and expertise is known as the "Spirit of MI" (see Fig. 1, further below).

Within the Spirit of MI, providers expect and appreciate ambivalence. Unlike the traditional model, MI sees the client as a collaborative partner whose expertise should align with the expertise of the professional in a shared space of acceptance, empowerment, compassion, and partnership. Through a collaborative style of communication, the client's own reasons for change and personal strengths are elucidated. Ultimately,

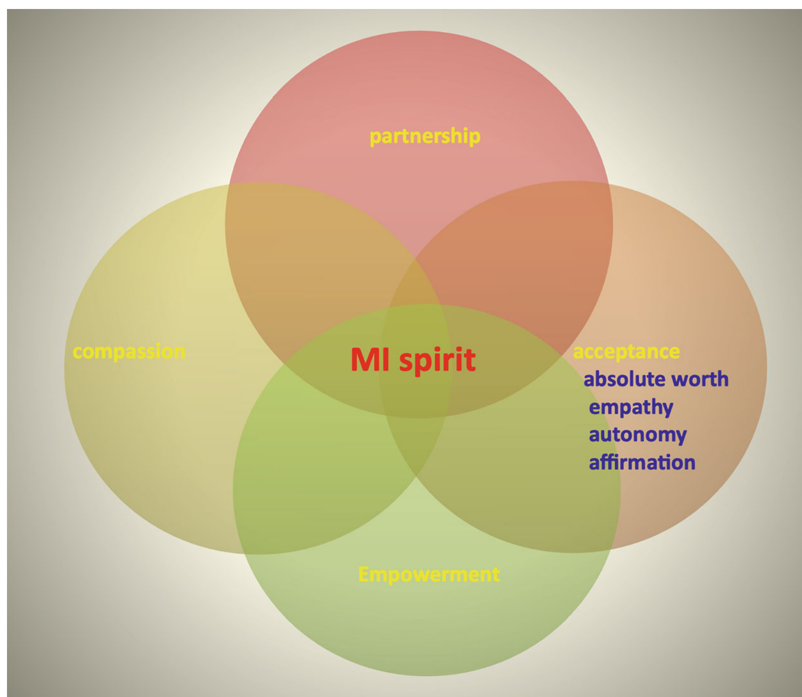


Fig. 1 Venn diagram of the spirit of MI

decisions are made based on client's preferences instead of based on the judgment of the provider alone. Although this terminology may suggest an "ethereal" and "fuzzy" flavor, MI Spirit has become rigorously defined, reliably measured, studied in observational as well as randomized controlled trials, and systematically associated with improved client outcomes (Copeland et al., 2015; Magill et al., 2023).

Box 1. Examples of the "Fix it Reflex"

1. This person ought to want to change.
2. Clients are either motivated or not, if not there is nothing we can do for them.
3. Now is the only (right) time to change.
4. A tough approach is always best.
5. I'm the expert, so the client should follow my advice.
6. If the person decides not to change then the consultation has failed.

(Miller & Rollnick, 2023)

2.3 Exercise to Understand the Spirit of MI

To help learners develop a sense of applying the Spirit of MI in clinical practice, the following exercise is often utilized. The exercise is known by different names but often referred to as "Personalizing the MI Spirit." The learner is invited to take a moment to think about a key figure in their life. This could be a family member, coach, community member, or spiritual figure who has helped them achieve or feel motivated at a one time or another. Thinking about the qualities that made this figure so meaningful and helpful, list these qualities out on paper or mentally note them. These characteristics are often close to or part of the "spirit." They are the same qualities that a clinician will often want to possess when working with clients from an MI standpoint. Qualities often evoked through this exercise include "believing in me when others didn't" (absolute worth), "encouraging me by reminding me of my strengths" (empowerment), "never giving up on me" (affirmation), and "loving me despite my flaws" (acceptance). (See Fig. 1, above.)

2.4 Key Components of MI Spirit: Compassion, Partnership, Acceptance, and Empowerment

There are four key components of MI Spirit. These are discussed below.

2.4.1 Compassion

In MI, the term "compassion" highlights the importance of serving the client's best interest. MI strategies should not be used for one's own purposes (e.g., sales) nor to

promote behaviors inconsistent with what the client desires. Compassion refers to a helper's desire to ameliorate another's suffering and better themselves and also to its role as an ethical compass. Conceptualizing compassion as an ethical compass begins by asking whether or not, as a clinician, one should guide another toward a particular life change. In some instances, this is very simple. For example, helping a client make behavior changes to prevent or improve any chronic illness is a relatively straightforward area where a clinician would want to support change by using guiding words and tactics. Conversely, there are other situations that may be much more complicated and less straightforward, in which helpers should remain more neutral and compassion would require avoidance of any strategic guiding strategies of MI. Consider situations in which a client feels ambivalence about leaving a nonabusive relationship or terminating a pregnancy. In these types of circumstances, despite the possible presence of personal, political, or religious opinions or biases, MI Spirit of compassion suggests ethical neutrality is primary and preferred.

2.4.2 Partnership

As alluded to earlier, MI Spirit seeks to marry the knowledge of the provider with the expertise of the client. Within this framework, it is understood that the client is an expert on their own preferences and life circumstances. Ideally, a clinician aims to support the client in leading them in a shared direction toward change behaviors. This balance is central to creating an atmosphere that is not coercive but conducive to change.

2.4.3 Acceptance

The quality of acceptance within the MI Spirit is comprised of four key concepts: autonomy support, accurate empathy, affirmation, and absolute worth. "Autonomy support" involves deferring the power of decision making and choices to the client through using phrasing such as "this is your choice" or "what you decide to do with this information is up to you." Similarly, with the process of "accurate empathy," the provider seeks to understand the client's perspective and maintain this understanding as things shift over time. "Affirmation," which will be talked about again in the Foundational Skills section, encompasses identifying strengths of the client (versus weaknesses). Finally, "absolute worth" underscores the importance of focusing on the worth of the client rather than the elements of the client that create burnout. For instance, a clinician can decide to focus on the client's making their appointment on time rather than focusing on changes they did not make in their diet or medication regime. As these four concepts suggest, acceptance is not a quality that is achieved and maintained, but a process that often has to be actively reestablished over time, especially in a challenging clinician-client relationship.

2.4.4 Empowerment

Empowerment encompasses another important fundamental component of MI Spirit. It involves the purposeful attempt to orient clients to their own resources, skills, or strengths, and in doing so help them to feel able and motivated to make changes toward better health. Empowerment is achieved by paying attention to what

is said by the client and recognizing even the smallest movement in the direction of change. Then the clinician responds to the movement by repeating back to the client what was heard. For example:

Client: *I have been trying to lose weight for many years and nothing really works.*
Provider: *You have tried a lot of things and haven't given up. In the meantime you have gained a lot of knowledge about what works for you and what doesn't.*

2.4.5 Change Talk

Clinical and research advances in MI now focus on psycholinguistic findings, principles, and applications. That is, clinicians use language to evoke and/or reward the clients' language that favors making changes in the direction of their health. In MI, this is defined as "Change Talk." Learning more about change talk is critical in helping clinicians to recognize it when they hear it, respond to it, and elicit more. Also the type of change talk a client is using can increase in strength over time and demonstrate to clinicians when the client's ambivalence is resolving. The type of change talk can help clinicians predict when the client might be ready for action.

The opposite of change talk is "sustain talk." This is any speech that favors the status quo. Studies have shown that a reliable predictor of a client's readiness for change is a reduction of sustain talk (Magill & Hallgren, 2019).

2.5 Preparatory Versus Mobilizing Change Talk: "DARN CAT"

MI uses the acronym "DARN CAT" to help describe, recognize, and understand change talk (Miller & Rollnick, 2023). "DARN" describes early, "preparatory" change talk articulated by a client. DARN stands for "desire," "ability," "reason," and "need." Preparatory change talk occurs when clients are starting to think about change, and will increase as ambivalence starts to resolve. Examples of what preliminary change talk might sound like are listed in the chart below. When first meeting with a client and wanting to elicit change talk providers can directly ask for this type of exchange. For example, a provider might say "Why would you want to take better care of your health?" Often, the answer to this type of question would include change talk.

The second part of the "DARN CAT" acronym focuses on "mobilizing" change talk. With this type of change talk, a client demonstrates that they are getting ready to make a change. This type of talk is stronger than the preliminary/preparatory change talk in that it emphasizes activation or commitment toward taking a particular step toward change or actually starting to make changes by taking small steps. Within this framework, the acronym "CAT" stands for "commitment," "activating," and "taking steps." (Examples of CAT can be seen in Table 1, below.) Significant CAT talk is a clue that a client may be ready for action planning.

Table 1 DARN CAT

Preparatory change talk	Mobilizing change talk
Desire: I want to stop coming to the hospital over and over I want to stop having problems with my blood pressure	**Commitment**: I will work with the nurse to better monitor my blood sugar I will start exercising
Ability: I can do this if I just start walking more regularly I can do this if I pay better attention to how much I eat	**Activation**: I am willing to consider keeping a food journal I am thinking about joining a gym
Reasons: My family needs me I want to see my grandkids grow up	**Taking Steps**: This week I called and set up an appointment with an endocrinologist I organized all my pills in a weekly pill-box on Sunday
Need: I need to do this so I can go home I need to do this for my health	

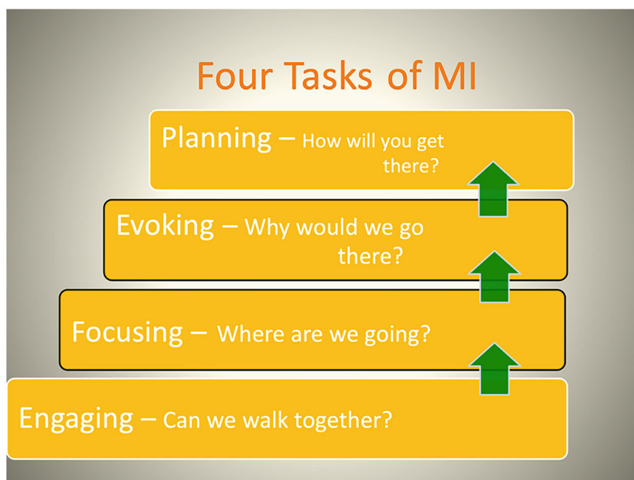


Fig. 2 The four tasks of MI

2.6 The Four Tasks of MI

MI is broken into four tasks for a provider to accomplish with the client (see Fig. 2, below). An analogy of going on a walk or a journey together with a client is often used to help illustrate movement through these tasks. Each task has a corresponding question that the clinician metaphorically asks the client, in order to gain a sense of what is the task in which the clinician-client relationship resides (Miller & Rollnick, 2023).

The first task of MI is “Engagement,” and it involves building rapport or connecting with the client to increase their willingness to work in a partnership. Engagement often happens quickly in a matter of moments after greeting a client.

However, as many clinicians know, not all clients engage quickly, and, for some, it is an ongoing task present at each appointment. The corresponding question intrinsic to this task is “Can we walk together?” Unless a clinician has engagement with a client, unless the client is willing to walk together with the clinician, they cannot move on to any other tasks. This task is not meant to take a lot of time but to bring awareness to the fact that if a client is not engaged, they will not be open to working with the provider on change.

Once engagement has been established, the next task comprises “focusing” on a target behavior or set of target behaviors. Sometime, the nature of the visit decides the focus. For example, in an oncology clinic, a diabetes education class, or a smoking cessation program, the target is already largely decided by the nature of the clinic. Other times, like in a primary care appointment, there may be many different directions to take. Regardless, the metaphoric question in this task is, “Where do you want to go?” The question is geared toward the client’s making the decision of what to target.

Once the provider and client have established rapport and have a focus, the next task is “Evocation.” This task is the most central to MI creativity, research, and innovation. In this task, the clinician is working to evoke “change talk” from the client around the agreed-upon target behavior. This is how the client’s motivations are solidified and encouraged. It is through this process that the client moves toward taking action. Ultimately, the task of MI is to motivate another person through conversation toward a target that they chose with reasons that come from the client. The ways that the provider can do this is using the foundational skills of MI, which will be covered in the next section. Evocation is fundamentally the core component of MI. The question for this task is, “Why do you want to go there?” The answer to that question is change talk.

Once ambivalence seems to be resolving—change talk has increased while the sustain talk is decreasing—it is time to move beyond the evoking task of MI. The fourth and final task of MI is “Planning.” Once a clinician and client enter into the task of planning, they are moving beyond the core MI task of evoking change talk and into planning for change. The focus now is more action-oriented, and more on action planning, but must be infused and sustained with MI Spirit as well. MI clinicians can partner with clients using skill sets, like BAP (Cole et al., 2023), to help guide the client through evidence-based steps for action planning. The question in this task is, “How do you want to get there?” Consistent with MI Spirit, this question emphasizes the autonomy and expertise of the client.

Finally, it is important to note that these four tasks are not linear. It is better to think of them as a spiral in that the clinician-client relationship may be traveling up and down through the tasks at any point in one session or over the course of several sessions. As noted before, often engagement needs to be reestablished from visit to visit. Focus on a target behavior can shift and change over time, and movement in and out of planning is normal as ambivalence may spike again from time to time, requiring a revisiting of evoking skills.

2.7 Foundational Skills of MI: OARS

In the Evoking task, where the clinician's goal is to try and evoke change talk, guiding a client toward a target behavior, certain skills are employed. These skills are known as "OARS," which stands for "open-ended questions," "affirmations," "reflections," and "summaries." Using OARS creates a frame work for a clinician/client conversation that shares power in an equal partnership, elicits values and motivation from the client, and strengthens motivation along with empowering the client. Below, each element of OARS will be explored a little more deeply.

2.8 Open Questioning

The *O* in OARS stands for open-ended questions (Miller & Rollnick, 2023), or, alternatively, "open questioning" can be used (Cole et al., 2025). As the term suggests, this is a style of questioning aimed at generating more information from the client and can be used strategically to evoke change talk. "Open questioning" is defined as a style of questioning that opens up conversations for exploration. Conversely, "closed questioning" tends to generate one-word answers, which closes conversations. Rather than interrogating or assessing a client for every item of information, by simply opening up a question a provider can spend less time and gather more information. For example, closed questioning—"Have you been taking your metformin?"—may lead to a simple "yes" or "no," with little information added. The more open (preferred) alternative would ask, "How has the new medication been going?" The latter is less judgmental and leaves space to learn about other aspects of medication management, possibly reducing the majority of follow-up questions needed. Certain types of grammatically closed questions may function in an open manner, such as "Can you tell me about the stresses in your life?" These are termed as GCQs, or "generative closed questions," which are a form of open questioning. In MI conversations focused on persistent unhealthy behaviors, ambivalence, and evoking change talk, questions (open or closed) are used sparingly and strategically. Affirmations and reflections are preferentially encouraged.

2.9 Affirmations

The *A* in OARS stands for affirmation. In MI, affirmations are a unique type of reflection. They are not the other well-known type of affirmation from the positive psychology domain Self-Affirmation Theory, where a person states positive things about themselves over and over—such as, "I am strong" (Steele, 1988). Instead, an affirmation is a deliberate attempt to highlight and reinforce a strength, enduring trait, or value that can serve the client in reaching their behavior change goal. These are "You" statements and not "I" statements. An affirmation is not "cheerleading" or telling someone that they did a "good job." Instead, an affirmation is a genuine statement about something heard, seen, or implied about the client. For example:

"You show great resilience in the face of many setbacks by never giving up." Or, "Your health is clearly important to you!" These types of statements are used to orient a client toward a strength and to empower them to keep going. See Box 2, below, for more examples of affirmations.

Box 2. Affirmation examples
Affirmations

Recognizing strengths: Once you make up your mind you really stick with it.
Recognizing effort: You have been working really hard to change your eating habits.
Appreciating values: Being honest is important to you.
Reinforce behaviors, successes or intentions: You have already started this process by looking at your options.

2.10 Reflections

Reflections are the most central skill to MI. In fact, three out of the four letters in OARS are types of Reflections (the only one that is not is the *O* for open-ended questioning). MI experts recommend emphasizing and encouraging use of reflections during effective MI conversations. A reflection is a statement that repeats or rephrases what the client just said (simple reflection) or takes a guess at the deeper meaning of what someone has said by adding an emphasis or hypothesis test (complex reflection). Even when the same exact words are used, MI points out that voice inflection or intonation can turn a question into a reflection or vice-versa. For example, consider the words "You went there." If one's voice goes up at the end of these three words, this conveys the phrase as a question: "You went there?" Suggesting elements of uncertainty or questioning. If the provider states, rather, "You went there," with voice inflection down, it comes across as a simple statement.

Complex reflections can be used strategically to invite more change talk into the conversation or verbally reward and encourage change talk. There are many types of complex reflection; a few of the most common are reviewed here: double-sided, amplified, reflecting a feeling value, and reframing.

The double-sided reflection is a way of recognizing a client's ambivalence up-front but ending on the change talk side. For instance, a client might state that taking their blood sugars regularly hurts, but if they track enough they can get an arm scanner and a provider can reply, "On the one hand, taking your blood sugar is painful, but on the other hand, if you complete your records for few short weeks you can get an arm scanner, which would make this much more sustainable for you." In a double-sided reflection the clinician always ends on the side of change, utilizing the recency effect (Berry, 2023; Braithewaite, 2023; Dixon, 2018), which invites the

client to pick up on the last thing that was said and talk more about it—in this case, the targets of change and tracking blood sugars.

An amplified reflection amplifies the likelihood of not changing. In doing so, it is a way of leveraging an element of ambivalence that recognizes that when one is pushed one way they are likely to push back in the other way. An example of this would be saying to a smoker, “There is no way you will ever consider quitting smoking”—hoping that this will tap into their ambivalence and create a pushback that might sound something like, “I wouldn’t say that I will never quit, I know it’s pretty bad for my health.” Furthermore, to the extent that the amplication itself is a bit exaggerated, a patient may be encouraged to voice change talk, with a simple correction back to the reality of their actual proclivities.

Reflecting a feeling or value is a powerful yet simple way to deliver a complex reflection. In doing so, a clinician has the opportunity to communicate empathy and accurate understanding toward the client. The reflection acts as a hypothesis that may or may not be correct. The client has the opportunity to correct the clinician; and once they confirm or correct empathy, shared understanding strengthens. An example of this could be a primary care client saying, “I just can’t seem to lose any weight; I have tried everything and nothing works.” The provider might say, “You’re very frustrated” (reflecting a feeling), or, “Despite all these setbacks, losing weight is important to you” (reflecting a value). In response, the client might agree or correct, bringing the relationship to deeper levels of shared empathic understanding.

2.11 Summary

Summary—*S*—is the final skill in OARS. A summary is a strategic collection of change talk statements used in a conversation. Summaries focus particularly on the motivating parts of a conversation and echo them back to the client. A summary can be used to pause a conversation and pivot to those parts at the end of a session or to get back on track during tangential moments of a conversation. Often, gathering up the change talk and presenting it to a client leaves a good opening to ask the client key questions such as, “Given all this, what do you want to do next?” or, “So, given all we have explored, what is important to you to do before we meet again?” These questions guide a client toward making a goal or decision but allows them the autonomy to pick what it will be or to decline.

2.12 Pulling It All Together: Supporting Change Talk and Resolving Ambivalence

Ultimately, the goal of OARS, along with other MI skills, is to help cultivate change talk in support of a client’s resolving ambivalence. There are a variety of MI methods that a clinician can utilize to elicit change talk. For instance, using skills of OARS, a clinician may ask strategic evocative questions, such as, “What do you think will happen if you don’t change anything?” Similarly, encouraging a client to “look

forward," a clinician may ask, "If you were to decide to stop drinking alcohol, how might your life be different?" In support of change talk, a clinician can utilize a scale of importance. For example, consider a client, "John," presenting due to increasing concern around his tobacco use within the context of several quit attempts. A clinician might say to John, "Even though it's been difficult, I am hearing several reasons why it is important to you to quit smoking. How important is it to you to quit smoking—on a scale of 0 to 10, with 0 equaling not important at all and 10 meaning it is the most important thing for you? What number best demonstrates how important it feels to you right now?" No matter what number John identifies, a clinician can use his answer to help cultivate change talk. This can be accomplished by the clinician's asking John to explain why he provided a given number verses a low number. A clinician may say to John, "Even though it feels difficult, you gave quitting smoking an importance of a 6. I wonder what puts you at a 6 versus a 3 or 4?" In general, this strategy pulls for change talk, asking a client to more clearly express why behavior change *is* important. Over time, the ruler exercise has been refined to include two types of rulers; importance ruler and confidence (see Figs. 3 and 4, below, for images of the ruler exercise).

3 Recognizing Readiness for Action

Mobilizing change talk will increase as clients become more ready for change. At the same time, sustain talk or talk defending the status quo will reduce in frequency. The literature has shown a reduction in sustain talk to be more predictive of readiness to change than an increase in change talk (Magill & Hallgren, 2019), although one could argue that they are two sides of the same coin. Within encounters with a client, other signs of readiness may also emerge, including envisioning of the future, resolution around what they have to do, fewer signs of ambivalence, and starting to take baby steps toward change. It is important to move forward with the pace of the client, encouraging action plans as signs of readiness emerge.

Within this discussion, it is also important to highlight the role of intrinsic motivation. In fact, a large body of research supports Self-Determination Theory (SDT). SDT suggests that it is the type of motivation (i.e., intrinsic or extrinsic) that is important with readiness for behavioral change, and not the amount of motivation (i.e., high or low). SDT further underscores the role of intrinsic motivation with sustained behavioral change (Flannery, 2017; Ng et al., 2012).

3.1 Staged-Matched Treatment

Different individuals, depending on varying backgrounds and types of illnesses involved, demonstrate wide-ranging variations in readiness for change. A clinician's approach to treatment is most effective when it is matched to the client's stage of change, or readiness for change.

Importance Ruler

Not at all important 0--1--2--3--4--5--6--7--8--9--10 Extremely important

- "On a scale of 0-10, how important is it to you to keep your sugar in a healthy range?"
- "Why is it a (x) and not (a lower number)?"
- Reflect
- (If number is less than 8), "What would it take to move it up in importance just one number?"
- Reflect
- Key question: "Where does this leave you?"

Fig. 3 Importance ruler, in the ruler exercise

Confidence Ruler

Not at all confident 0--1--2--3--4--5--6--7--8--9--10 Extremely confident

- "On a scale of 0-10, how confident are you that you can keep your sugars in a healthy range?"
- "Why is it a (x) and not (a lower number)?"
- Reflect
- (If number is less than 8), "What would it take to move it up in importance just one number?"
- Reflect
- Key question: "Where does this leave you?"

Fig. 4 Confidence ruler, in the ruler exercise

As suggested above, when treatment can meet a client where they are in terms of their readiness to change, it is a much more efficient way to move forward. Utilizing MI is best matched to clients who are exhibiting ambivalence to change. In avoiding the tendency to try and fix things for the client and push against ambivalence, MI allows the provider to work with the ambivalence and honor the client as the expert on the way forward. In most healthcare settings time is very limited, with providers often only having about 15 min to spend with clients. Not all clients will present with enough ambivalence to warrant full engagement of the foundational skills of MI; using tools that encourage change and test readiness and invite open dialogue may be more efficient in deciphering and matching the readiness of the client. Brief Action Planning (BAP) offers an efficient and MI-consistent way to probe for readiness for action planning.

4 Brief Action Planning: A Roadmap to the Task of Planning and More

Once it is determined that a client is ready to engage change, it is important to support the client in moving toward action. It can feel challenging to help a client create an autonomy-supportive action plan, particularly with limited time. Cole et al. (2023) developed BAP as an approach to facilitate efficient, patient-centered action planning that works well within time constraints. Scoping and systematic reviews (cited above) indicate that BAP is an emerging evidence-based approach (Jadotte et al., 2023, 2025). Akin to MI, the core competencies of BAP are designed to support the client's autonomy and promote patient-provider partnership. BAP comprised of eight core competencies. Five are considered "foundational," while the other three skills are considered "stepped care," useful for follow-up and for clinical situations with increased complexity. Further details around the basic sequence (known as the Five Foundational Skills) of BAP are outlined below in Fig. 5.

4.1 Exploring a Behavior Goal

Once a client expresses satisfactory change talk about a specific change behavior, BAP encourages creating a detailed behavioral action plan.

To start this process, a clinician can begin by asking Question One re: Whether he or she would like to do anything for his or her health in the next week or two. Knowing what a client wants to change, a clinician may also ask a more individualized version of Question One. For example, a clinician might note, "It sounds like you are expressing concerns about (exercise, eating, etc.)…. Would you like to make a specific plan about that?"

If the client expresses uncertainty around making a change or creating a plan, the clinician can offer a behavioral menu, suggesting two or three ideas for change. A clinician can base these suggestions on discussions with the client about areas he/she is considering changing, or can provide examples of changes other clients have

successfully engaged in. For instance, the provider may note, “You had mentioned that you might want to make changes around reducing your sugar intake or increasing exercise. I have also had clients successfully work on increasing their vegetable intake.” This approach is meant to suggest ideas without pressure. The behavioral menu is considered one of the three stepped-care skills that combine with the five foundational skills shared in Fig. 5, above. Ultimately, if the client expresses that he/she does not want to develop an action plan currently, it is important that the clinician respect this. In this circumstance, the clinician can ask permission to revisit

Fig. 5 BAP flow chart. (Revised 2024 © BAP Professional Network, all rights reserved, 2024)

the potential for change at a future visit. This gives the client autonomy while clinician leaves the door open for potential change in the future.

On the other end, if a client expresses readiness to create a plan, the focus becomes collaboratively creating a "SMART" plan. As the name suggests, this plan should be "specific," "measurable," "achievable," "relevant," and "time-based." In general, the more you can help the client create a specific plan, the increased likelihood of his/her successfully following through with the plan.

The dialogue below represents an example of SMART planning with a client.

Clinician: *Is there anything you would like to do for your health in the next week or two?*

Client: *I have been thinking about making changes to my eating. I really need to start losing weight and getting my AIC under control.*

Clinician: *That is a good idea. Would you like to make to make a plan to help you move forward with this?*

Client: *Yeah. What type of plan?*

Clinician: *Well, making a plan would involve identifying specifically what you would like to do, including when, where, how often, how long ...*

Client: *OK. I think I can start eating more vegetables again. I used to eat veggies at dinner.*

Clinician: *OK. That's great. When would you start doing this?*

Client: *Well, I need to go buy vegetables that I like. I can go to the store tomorrow after work and start eating a side of vegetables at dinner tomorrow night.*

Clinician: *Great! How often do you want to consume vegetables at your dinner meal?*

Client: *Humm... I want to say every night, but maybe I will start with four days per week.*

4.2 Elicit a Commitment Statement

After a detailed plan has been created, the next step is to assess the client's commitment and understanding by asking the client to repeat back his/her understanding of the SMART plan. Research supports how external expression of intent is a significant predictor of later completion (Cialdini, 2022). Moreover, the extent of the commitment expressed is associated with the probability of success. For example, the use of the words "I will" is correlated with an increased likelihood of completion (vs. words such as "I will try") (Miller & Rollnick, 2023). In addition, asking a client to write out the plan may further increase follow through (Cialdini, 2022). Thus, helping a client to express intent, using their own words, can be an important step toward enhancing their commitment to the plan.

As demonstrated below, eliciting a commitment statement can underscore a desire to work as a team and have clear communication.

Clinician: *Great! Now that you have a detailed plan, let's make sure we are on the same page. Would you mind reviewing with me your understanding of the plan?*

Client: *So from what we talked about, I'm going to walk one mile per week around my neighborhood on Monday, Wednesday, and Saturday. For my Saturday walk I'm going to see if my neighbor if available to walk with me.*

4.3 Assess Client's Confidence in Actualizing Health Goals

In supporting the client in creating realistic goals, it is important to also access the client's confidence in his/her ability to implement the outlined plan. A clinician can ask the client how confident he/she is in his/her ability to carry out the plan on a scale of 0 to 10. This is a similar format to the assessment of the importance or confidence of change described above (see Figs. 3 and 4, above), however different in the intent of the ruler. The MI ruler is used as a tool to evoke change talk; whereas, in BAP, the ruler is used to gauge and support an increase in confidence level. Importantly, a confidence of 7 or higher reflects higher self-efficacy and is correlated with increased likelihood of success. The aim of using the ruler is to identify confidence levels lower than 7. The ruler is considered the second stepped-care skill in BAP (see Fig. 6, below).

If a client rates his/her confidence lower than a 7, it is important to support the client in problem solving around how he/she could increase their confidence level. This can be done by constructing a more realistic/less ambitious plan, or increasing support in service of completing the initial plan. These types of adjustments are meant to help improve the client's level of confidence and overall self-efficacy. Within this framework, a client's belief in their ability to successfully complete the plan is critical.

4.4 Fostering Accountability

The last step in BAP anchors to a goal of increasing the client's sense of accountability. This might include coordinating a follow-up with the clinician to support the client in making progress toward his/her SMART action plan. It can sometimes also be helpful to have the client identify external accountability. This can involve establishing an "accountability partner" (friend, spouse, etc.) or self-monitoring at home. Below, in Fig. 6, see the five foundational skills of BAP, with the additional two stepped-care skills discussed.

4.5 Follow Up: The Last Stepped-Care Skill in BAP

Follow-up improves outcomes when using BAP and may be especially powerful if it occurs with the clinician who participated in developing the plan itself. BAP follow-up involves three core elements—nonjudgmental inquiry, empathy, and support if plan is not completed—and checking into the patient's ideas and desires about the next steps (see Fig. 7, below).

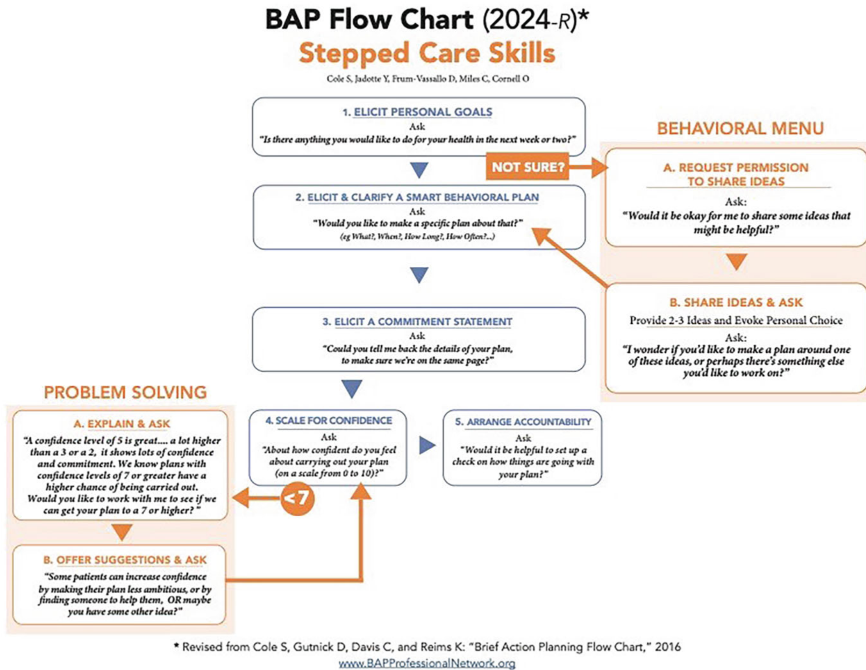


Fig. 6 BAP flow chart with stepped-care skills

5 Synergistic Use of BAP and MI: BAP-MI

As highlighted in the discussions above, each set of skills within MI and BAP is specifically geared toward resolving ambivalence or supporting a client toward action. Across many real-life clinical situations, MI and BAP can be combined in a method now described as "BAP-MI" (Cole et al., 2023). BAP-MI is a stepped-care integration of evidence-informed skills from BAP and MI to support client self-management and facilitate health behavior change. BAP-MI is particularly relevant for clients who are not ready to make action plans with BAP alone. For instance, for clients who experience persistent unhealthy behaviors and/or ambivalence about change, it is important to resolve ambivalence prior to supporting action behaviors. In the practice of MI or BAP-MI, the eight core competencies of BAP function as an evidence-based roadmap into and through planning.

5.1 The Bookend Metaphor for Understanding BAP-MI

BAP-MI has been described using a bookend metaphor (see Fig. 8, below).

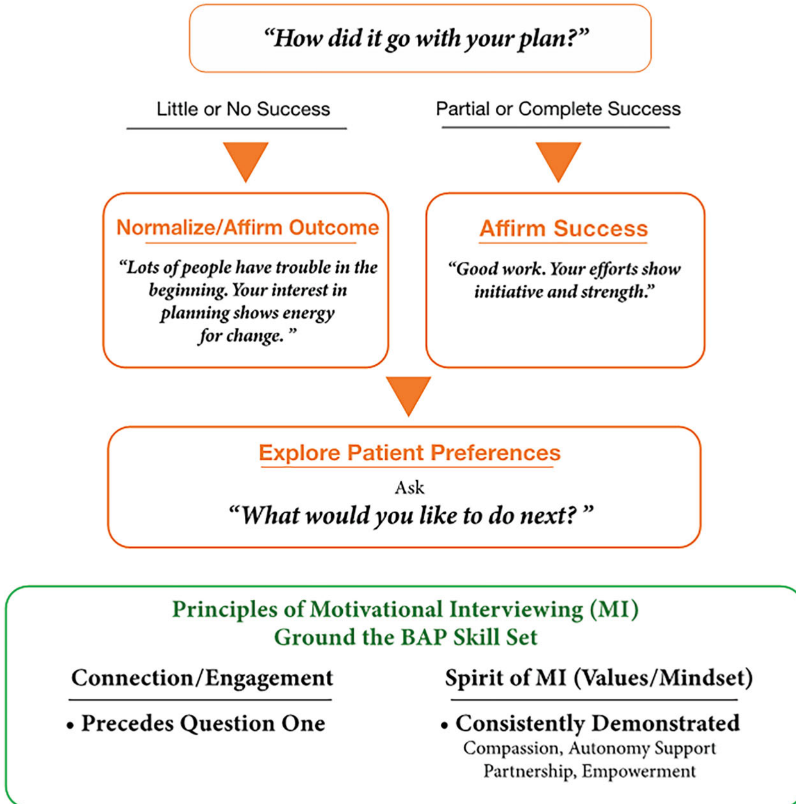


Fig. 7 BAP flow chart for third stepped-care skill of follow up

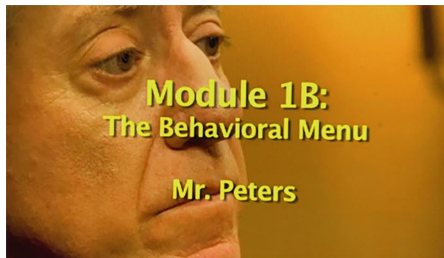
When bringing to mind the image of a set of books being supported by a bookend on either side, the bookends are BAP and the books in the middle are MI skills. At times a clinician may feel for various reasons that it is best to initiate planning. Perhaps they have limited time, believe the client may be ready for a variety of reasons, or just want to see what will happen if they move toward planning. The first style of BAP-MI is just to probe with a version of the first question of BAP: "Is there anything you would like to do for your health in the next week or two?" At times this insertion of the "bookend" maybe be enough. The client will take the cue and partner through setting an action plan. Video demonstrations of Mr. Carlson, Mr. Peters, and Mr. Weiss are available, with public access, at www.BAPPN.org.

Fig. 8 Bookend metaphor

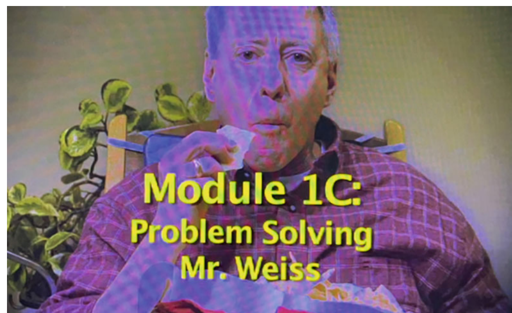
Consider Two Metaphors/Symbols:

BAP ≈ Bookends
MI ≈ Books

https://bapprofessionalnetwork.org/resources/bap/bap-demonstration-videos/



https://bapprofessionalnetwork.org/resources/bap/bap-demonstration-videos/



https://bapprofessionalnetwork.org/resources/bap/bap-demonstration-videos/

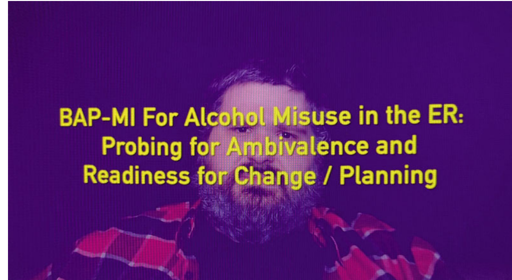
Other times, this probe will be met with distress or discord. The client is not ready because of some form of ambivalence, including emotional frustrations around some aspect of life related to change. In this case, the clinician would utilize relational skills of MI, using OARS until ambivalence seems to have resolved, and only probing with BAP-related techniques when the client appears ready. This example is the full expression of a bookended BAP-MI approach; probing first with BAP (first bookend). Some books in the middle (ambivalence requiring MI) and another bookend holding the books up (return to BAP again once ambivalence resolves).

Video demonstration of Mr. Vanguard is available (public access, at www.BAPPN.org).

https://bapprofessionalnetwork.org/resources/bap-mi/videos/

The third way BAP-MI is often used is in a scenario where it is obvious that the client is ambivalent, and the clinician knows that it is not the time to lead with planning. In this type of case, MI would be utilized sufficiently until the signs of ambivalence resolve. Once sustain talk has decreased, the provider can probe with BAP. This scenario is like the image of books being held up with one bookend on the right side. Video demonstrations of Mr. Stabler and Mr. Dowd are available for public access at www.BAPPN.org.

https://bapprofessionalnetwork.org/resources/bap-mi/videos/



https://bapprofessionalnetwork.org/resources/bap-mi/videos/

Ultimately, the analogy of the bookends illuminates various ways a clinician can utilize BAP-MI, depending on clinical circumstance and need. As clinicians become more comfortable and fluid in these approaches, they may begin to move back and forth between the two sets of skills. These skill sets can come together as their own intervention that is not exactly MI and not exactly BAP. Ultimately, BAP-MI stands as an independent construct with intrinsic value of its own for many clients who experience ambivalence or other difficulties in considering and attempting change.

5.2 Using MI and BAP: Smoking Cessation Clinic

To illustrate fluid use of skills of MI and BAP, the authors highlight their own clinical work in a smoking-cessation, university-affiliated VA hospital setting. All VA medical centers have smoking-cessation programs as part of larger health-promotion, illness-prevention initiatives (https://www.prevention.va.gov). Individual programs differ based on local resources, needs, and patient populations. The authors' "Commit to Quit Clinic" uses a model where no appointment is necessary beforehand, though appointments are scheduled afterward in order to support continuity of care. Veterans can attend up to twice a week for an hour. Groups can range in size from 3 to 12 veterans on any given day. The group is formatted as a shared medical appointment (SMA), with both a preventative medicine resident or attending (who can prescribe Nicotine Replacement Therapy (NRT)) and a psychologist or psychology trainee at each session. Understandably, veterans may be at various stages of the change process. Among those who attend, there are often one or two "champions" (those who have been quit for 3 months or more), along with veterans who are actively trying to quit, as well as those who recently relapsed. With this in mind, all group facilitators have training in BAP and MI. The psychologist and psychology trainees often have had a more in-depth BAP-MI training, as well as more group facilitation experience, and therefore take on the lead-facilitator role more easily.

Commit to Quit utilizes two group models of MI. The "hub and spoke" model suggests that the facilitators are the central hub of a metaphoric wheel of the group, positioned to offer MI intervention out to each member or select members who are "spokes" around the hub of the wheel. It is like having a segment of a 1:1

conversation with each group member around the room. The "relational" model is more fluid and offers the option for the facilitator to step back and encourage or evoke participants to connect and relate to one another using MI-consistent communications, including open, nonconfrontational, accepting, and empowering interventions. The tobacco-cessation group of the Commit to Quit Clinic uses a blend of these two models, emphasizing relational group interactions. Facilitators affirm and encourage MI group-member conversations with each other. For instance, if a group member asks an evocative question to another group member, affirms another group member, or emphasizes the autonomy of another group member, the facilitator reflects and affirms this behavior to the group. This "positive reward" of affirmation is intentionally designed to strategically encourage more of MI-consistent behaviors among group members themselves, empowering them to help one another in resolving ambivalence.

Within this blended framework, veterans will often share triggers, successes, and failures from the week, while the facilitators help group members respond to one another in an MI-consistent manner. There is strategic guidance or redirection away from giving advice, strategic modeling around how to exchange information, affirm, and ask for change talk, along with other skills of MI. Providers also share information, where relevant, about various topics related to smoking, health effects, medication, and behavior change.

Of unique importance for this chapter, the authors have begun introducing BAP in many threads throughout group conversations in many ways. Commonly, veterans who are moving through the arc of readiness to change might begin to talk about steps they are taking or use other mobilizing change talk. This is often a cue to facilitators to probe with Question One of BAP. Moving between the "relational" and "hub and spoke" group models, facilitators may model much of the eight core competencies in the group setting, while inviting others to think through it as it relates to their own action plans. Other times a probe results in discord and a spike of sustain talk. In this case, facilitators would step back and begin to use MI skills once more; perhaps inviting in relational components and asking others if they can relate to the given struggle, or using MI to come alongside the veteran.

Toward the end of group sessions, the authors now typically offer all members a chance to set a goal, or a specific action plan. A facilitator may offer a group version of the Question One probe, "I'm wondering if anyone here today may be interested in making a specific plan for change in the next week or two?" This open probe to the group invites any and all group members to consider change and action planning, regardless of the level of readiness with which they entered the group that day. Lastly, the Commit to Quit Group offers members built-in accountability to one another week to week in a gentle way, especially since attendance is optional and variable. Often, at the top of the hour, facilitators and other group members will check in about goals set in the previous group organically, providing naturalistic follow-up. However, if group members desire different types of accountability they have the space to articulate that and think it through. Below are example dialogue:

Facilitator: *So, just checking in with anyone who made a plan or set a goal for themselves last week, wanting to see how that went?*
Veteran 1: *I set a goal but I'm not sure how well it went.*
Veteran 2: *That's okay, Tom. I bet it's not as bad as you think.*
Veteran 1: *Well, my goal was to smoke less than 10 cigarettes a day. I've been counting the butts.*
Facilitator: *Yes, I remember, we might have adjusted that goal to 10 cigarettes a day on average for the week.*
Veteran1: *Yeah that's right, we made it "less ambitious."*
Facilitator: *That's right, more doable.*
Veteran 3: *Let's hear your numbers, Tom.*
Veteran 1: *Ok, on Monday was 3, not sure what happened that day, maybe I slept all day, hahaha. Tuesday 8, Wednesday 8, Thursday 13 Friday was another good one 4. Ok then there was the weekend… not too bad Saturday 6 and Sunday 8.*
Facilitator: *Wow, Tom! Seems like every day except Thursday you actually beat your goal. You are really making changes here. Ok if I average them for you?*
Veteran 1: *Let's have it.*
Veteran 2: *Tom, you're doing great! How are you able to do it?*
Veteran 1: *Well, I've just been counting them, which makes me think more about it. I really don't want to be doing this forever.*
Facilitator: *Great question, George. Tom, sounds like you really want to put this behind you and being more aware of your habit is helping you on your way.*
Veteran 1: *Yeah, something like that.*
Facilitator: *Ok we got your numbers here and the average is 7! Wow that's 3 under your goal on average. What are your thoughts about that?*
Veteran 4: *Great job, Tom!*
Veteran 2: *Yeah that's really good.*
Veteran 1: *Thanks. Well I don't know really. I am glad I am getting there.*
Facilitator: *You really are getting there. What's next for you?*
Veteran 1: *I want to see if I can keep up this trend. Then maybe I will finally put on that patch.*
Facilitator: *Ok, you're getting ready for the patch. You want to see if you can keep this momentum going for another week. What about others? Would anyone else here like to make a change in the next week or two?*
Veteran 4: *Yeah, I have been trying to cut down, similar to Tom. I have started counting my cigarette butts each night.*
Facilitator: *Would you like to make a specific plan about that? What, how long, how often, etc.?*
Veteran 4: *Ok.*

This exchange illustrates exciting ways the authors have begun field testing the usefulness of using BAP and MI together in group smoke-cessation clinics in a university-affiliated VA. Uptake by clinicians and patients has been positive and results seem promising.

5.3 Applications in Bariatric Psychology/Medicine

As the above description suggests, MI and BAP can be helpful independent or integrated approaches for many health behavior changes. The work of the authors in weight management further highlights the utility of these approaches across clinical settings, including many of the individuals who present to weight-loss clinics, bariatric surgery centers, or other providers for weight loss (i.e., PCPs). In particular, although most clients verbally endorse a desire to lose weight, many of them express marked ambivalence around their motivation and confidence to actually initiate and sustain complex lifestyle changes. For this reason, MI and BAP can also be effectively used for individuals struggling to engage in consistent changes with food and exercise.

The authors' clinical work with "Sara" underscores the potential utility of these approaches when working with weight management and bariatric surgery patients. Sara was a 39-year-old Caucasian female presenting to bariatric psychology, 3 years post-gastric sleeve surgery. She was referred to bariatric psychology due to significant weight gain over the past 6 months secondary to lack of motivation, along with the return of emotional eating and nocturnal ingestions. At her initial intake, it was clear that Sara was struggling with ambivalence and resistance to change. While she expressed marked distress around her weight gain and poor body image, she described feeling overwhelmed by the thought of "having to start over again." Sara further described attempting to restart food logs numerous times; noting a pattern of her motivation dipping due to feelings of stress and anxiety, resulting in her discontinuing her weight-loss attempts. Sara further recognized often feeling distressed when stepping on the scale, acknowledging that this often served as a trigger for low motivation and resistance to continued change. Upon further questioning, Sara expressed marked fear around her perceived inability to cope with significant external stressors without food.

Together, these data points suggest that an action-oriented approach may not be ideal for the initial stages of behavioral treatment with someone experiencing ambivalence like Sara. In fact, a meta-analysis conducted by Armstrong et al. (2011) found that the use of MI was associated with significantly greater reduction in weight and BMI compared to controls. Given this research, along with Sara's inconsistent motivation, one of the author began sessions with Sara focused on utilizing the Spirit of MI. Within this framework, the author focused on helping Sara to examine and resolve her ambivalence, increase the importance of change, and bolster self-efficacy.

A sample of the dialogue using MI techniques is described below:

Sara: *I am feeling so frustrated. I can't imagine myself being able to make healthy choices consistently like I used to. Food feels like my only thing I have to deal with the stress as my mom goes through her cancer treatment.*

Psychologist: *You can't live your life without using food to cope. It's such a big part of who you are, and perhaps you will continue to use it in this way no matter what it costs.*

Sara: *I don't like what my out-of-control eating and weight has done to my health and self-esteem, but it is the only thing that reduces my stress immediately.*

Psychologist: *On the one hand, emotional eating brings you relief, and on the other hand, you're concerned about how you're eating and weight affect your health... I can see you are feeling stuck. What is going to have to change?*

Sara: *Well I have been feeling horrible. I have to change this. I just need to start and do it, like I did before. I have no option, but I just feel so stuck and overwhelmed, especially at night after everyone goes to bed.*

Psychologist: *What do you think will happen if you don't change anything?*

Sara: *That's not an option. If I don't change anything I will continue to gain weight and go from prediabetes to diabetes.*

Ultimately, given Sara's ambivalence, it was clinically appropriate to utilize an MI framework across several sessions prior to focusing on BAP and action behaviors. However, once Sara began to express increased motivation and change talk, BAP techniques were subsequently used to support the creation of a specific action plan (as demonstrated below).

Psychologist: *It sounds like you are wanting to change your eating. Would you like to make a specific plan about that together today?*

Sara: *Yeah, I really want to do that.*

Psychologist: *Great! Let's make a specific plan together. What were you thinking?*

Sara: *Well, I really want to focus on closing the kitchen at 8 pm because I tend to eat out of emotions after everyone else goes to bed.*

Psychologist: *How often would you want to do this?*

Sara: *Well, I would like to do it every day.*

Psychologist: *Great! When will you start doing this?*

Sara: *I think I can start tonight…*

——————————A few minutes later——————————

Psychologist: *How confident do you feel that you can carry out this plan on a scale of 0 to 10, with 0 equal to not likely at all and 10 being extremely likely?*

Sara: *I would say a 6.*

Psychologist*: A confidence of a 6 is great … a lot higher than a 3 or a 2. We know that plans with a confidence of 7 or higher have a greater chance of being carried out. Would you be willing to work with me to see if we can get your plan to a 7 or higher?*

Sara: *Yeah, I think that would be good.*

Psychologist: *Great. Some patients find it helpful to make their plan less ambiguous or find someone to help them, or maybe you have another idea?*

Sara: *Humm… Maybe I should start with closing the kitchen by 8 pm 4 days per week. I am more confident that I can do that.*

As this case shows, BAP and MI can effectively be utilized together to appropriately address ambivalence and support the creation of a targeted behavior plan once a client expresses readiness.

6 Conclusion and Future Direction

MI has been well established in the scientific literature as a gold standard for client-centered and patient-centered approaches to health behavior change, especially in the context of individual ambivalence about lifestyle changes. This approach can be used to resolve ambivalence and guide clients toward healthier behaviors. BAP is gaining increasing evidence and support as an effective MI-consistent clinical tool for facilitating self-management and behavior change into and through the 4th MI "task" of Planning. BAP can also be used alone or in conjunction with MI techniques. Evidence is broadening and deepening, but more studies, especially randomized controlled trials are needed to encourage more widespread training, development, dissemination and implementation within and across healthcare and health psychology settings.

Given escalating burdens of chronic illness and lifestyle comorbidities around the world, the authors believe that more widespread dissemination and implementation of the concepts and skills of Motivational Interviewing, especially enhanced by the use of BAP, either independently or synergistically, holds great promise for improving health and wellness of individuals and communities.

7 Cross-References

► BAP-MI
► Innovative Integrative Strategies

Competing Interest Declaration The author(s) has no competing interests to declare that are relevant to the content of this manuscript.

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