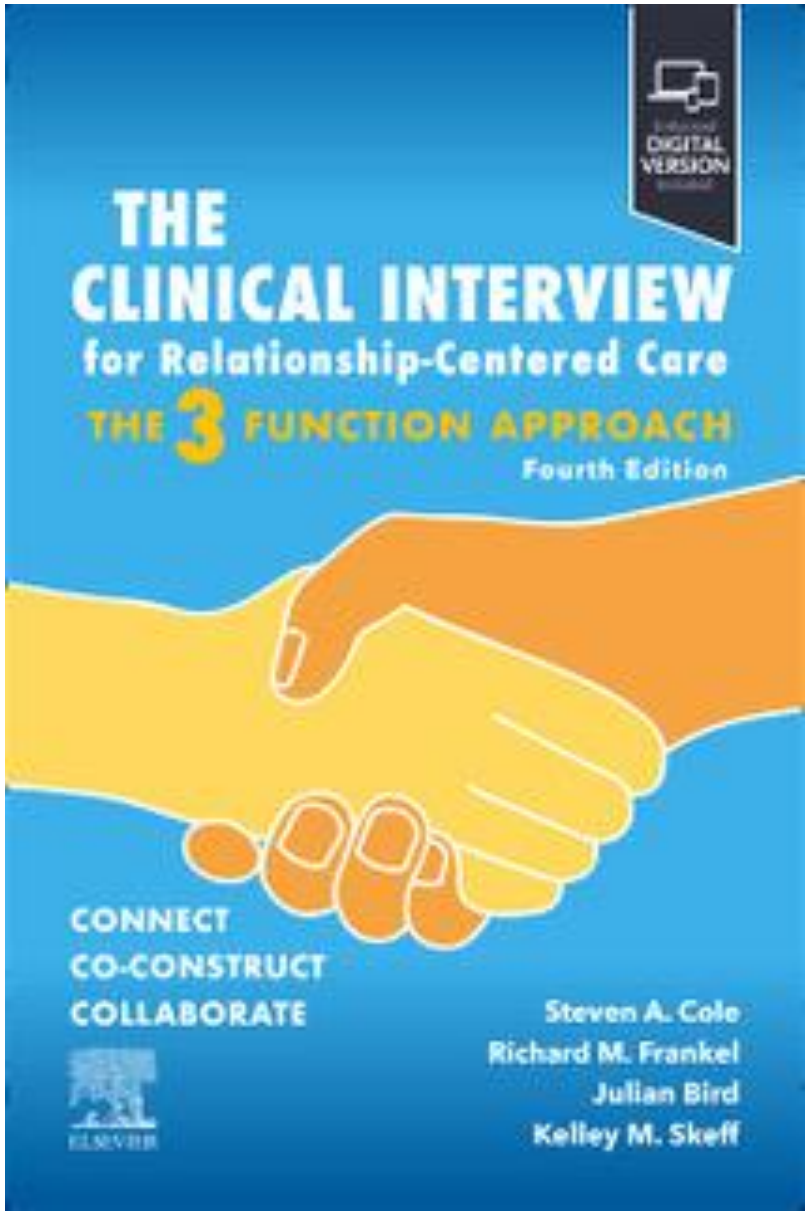

DIGITAL VERSION
THE CLINICAL INTERVIEW
for Relationship-Centered Care
THE 3 FUNCTION APPROACH
Fourth Edition
CONNECT
CO-CONSTRUCT
COLLABORATE
Steven A. Cole
Richard M. Frankel
Julian Bird
Kelley M. Skeff

The Clinical Interview:

The Three Function Approach for Relationship-Centered Care

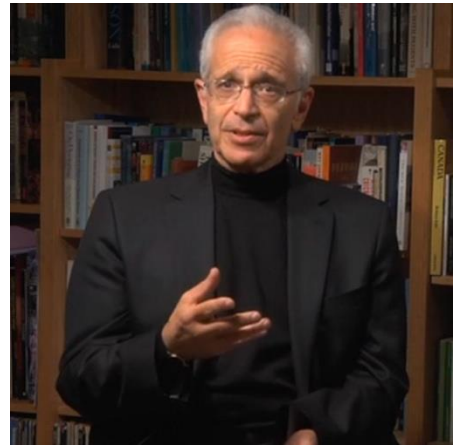
4th Edition, Elsevier, June 2026

Introduction and Overview

Cole SA, Frankel RM, Bird J, Skeff KM

February, 2026

My Background

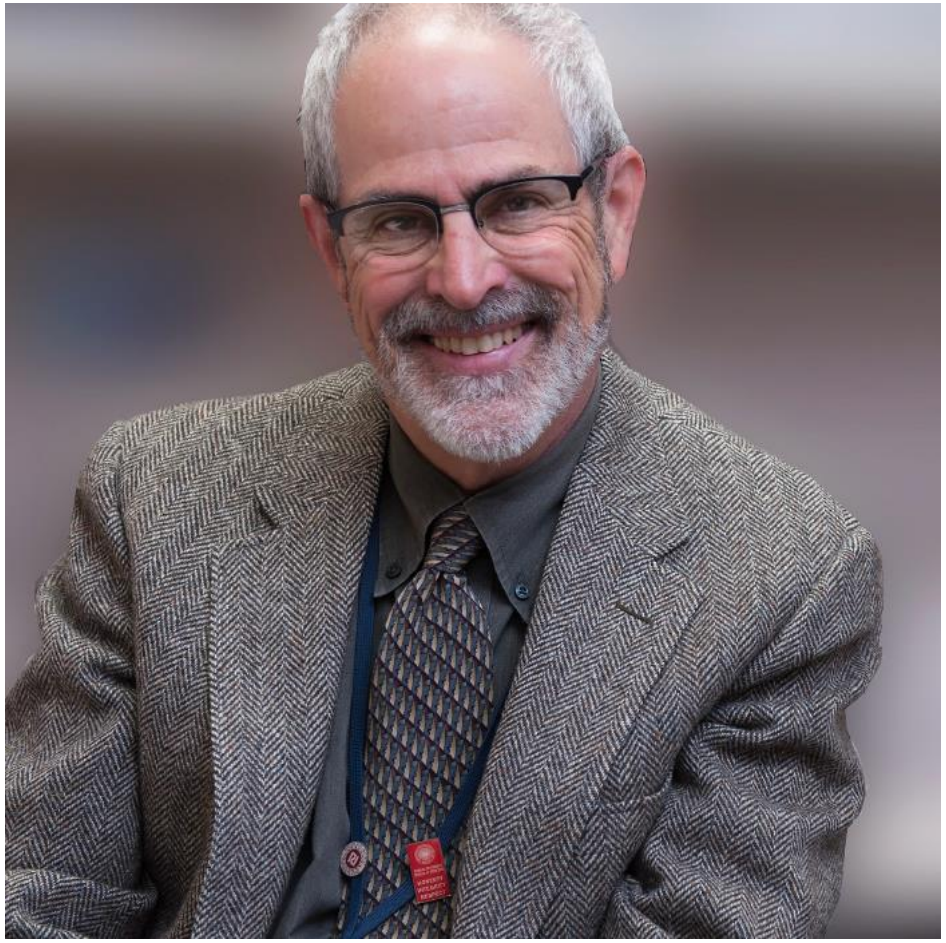


Steven Cole, MD, MA (Sociology)
Professor of Psychiatry, Emeritus, Stony Brook University SOM &
Clinical Professor of Scientific Education and Psychiatry, Zucker SOM at Hofstra/Northwell

- Training: Harvard, Duke, University of North Carolina
- Orientation (Clinician-Educator): Dynamic/Relational, Family, Delivery Systems, MI
- 1978-2012 – UAB, Emory, LIJ, Stony Brook -- C-L, Geriatrics, Public Sector, Managed Care
- Healthcare Communication
  - 1980s– Collaborated with Rochester (George Engel)-trained internists/family physicians – BPS model & medical interviewing
  - 2009 – MINT – *Motivational Interviewing Network of Trainers* – Founded "MI-MED"
- 2002-2005 - Chair, Depression in Primary Care, 98 Federally Qualified Health Centers/HRSA
- 2020 – Founded **BAP Professional Network** – not for profit - www.BAPPN.org
- 2026 – Cole S, Frankel R, Bird J, Skeff K:

  The Clinical Interview for Relationship-Centered Care, 4th Edition, Elsevier, in press

Richard M. Frankel, PhD (Sociology), MD (Hon.)



Professor of Medicine and Geriatrics, IU SOM

- Core Investigator in the VA Health Services Research & Development Center for Health Information and Communication and Senior Research Scientist at Regenstrief Institute
- > 250 research and review articles, books, and chapters on communication in healthcare
- Editorial boards

  Journal of General Internal Medicine, The Permanente Journal, BMC

  Education, Communication and Medicine
- American Academy on Communication in Healthcare

  George Engel Award and Lynn Payer Award

Kelley M. Skeff, MD, PhD (Education)

Professor of Internal Medicine, Stanford

- Co-Director of the Stanford Faculty Development Center (SFDC)
- Internal medicine residency program director - 20+ years
- Awards/Recognitions
  - Gores Award for Outstanding Teaching
  - AAMC/AOA Glaser Distinguished Teacher Award
  - Career Achievement (Med Educ) from Society of General Internal Medicine
  - Association of Program Directors in Internal Medicine's Distinguished Medical Educator Award
  - AMC Flexner Award for Distinguished Service to Med Educ
  - ACP Regent
  - Macy Scholars Advisory Board
  - Master of the American College of Physicians

Acknowledgements

- Julian Bird
- Richard Frankel
- Kelley Skeff
- Joseph Weiner
- authors of individual chapters throughout the text

My Hopes Today

- You will share my enthusiasm for the vision/mission of TFA-4

- You will share my enthusiasm for the potential of TFA-4 to enrich the interpersonal dimension in
  - current healthcare communication and care
  - psychiatric interviewing and psychiatric care

George Engel: 1913-1999

8 April 1977, Volume 196, Number 4286 SCIENCE

The Need for a New Medical Model: A Challenge for Biomedicine

George L. Engel

At a recent conference on psychiatric education, many psychiatrists seemed to be saying to medicine, "Please take us back and we will never again deviate from the 'medical model.'" For, as one critical psychiatrist put it, "Psychiatry has become a hodgepodge of unscientific opinions, assorted philosophies and 'schools of thought,' mixed metaphors, role diffusion, propaganda, and politicking for 'mental health' and other esoteric goals" (1). In contrast, the rest of medicine appears neat and tidy. It has a firm base in the biological sciences, enormous technologic resources at its command, and a record of astonishing achievement in elucidating mechanisms of disease and devising new treatments. It would seem that psychiatry would do well to emulate its sister medical disciplines by finally embracing once and for all the medical model of disease.

But I do not accept such a premise. Rather, I contend that all medicine is in crisis and, further, that medicine's crisis derives from the same basic fault as psychiatry's, namely, adherence to a model of disease no longer adequate for the scientific tasks and social responsibilities of either medicine or psychiatry. The importance of how physicians conceptualize disease derives from how such concepts determine what are considered the proper boundaries of professional responsibility and how they influence attitudes toward and behavior with patients. Psychiatry's crisis revolves around the question of whether the categories of human distress with which it is concerned are properly considered "disease" as currently conceptualized and whether exercise of the traditional authority of the physician is appropriate for their helping functions. Medicine's crisis stems from the logical inference that since "disease" is defined in terms of somatic parameters, physicians need not be concerned with psychosocial issues which lie outside medicine's responsibility and authority. At a recent Rockefeller Foundation seminar on the concept of health, one authority urged that medicine "concentrate on the 'real' diseases and not get lost in the psychosociological underbrush. The physician should not be saddled with problems that have arisen from the abdication of the theologian and the philosopher." Another participant called for "a disentanglement of the organic elements of disease from the psychosocial elements of human malfunction," arguing that medicine should deal with the former only (2).

The Two Positions

Psychiatrists have responded to their crisis by embracing two ostensibly opposite positions. One would simply exclude psychiatry from the field of medicine, while the other would adhere strictly to the "medical model" and limit psychiatry's field to behavioral disorders consequent to brain dysfunction. The first is exemplified in the writings of Szasz and others who advance the position that "mental illness is a myth" since it does not conform with the accepted concept of disease (3). Supporters of this position advocate the removal of the functions now performed by psychiatry from the conceptual and professional jurisdiction of medicine and their reallocation to a new discipline based on behavioral science. Henceforth medicine would be responsible for the treatment and cure of disease, while the new discipline would be concerned with the reeducation of people with "problems of living." Implicit in this argument is the premise that while the medical model constitutes a sound framework within which to understand and treat disease, it is not relevant to the behavioral and psychological problems classically deemed the domain of psychiatry. Disorders directly ascribable to brain disorder would be taken care of by neurologists, while psychiatry as such would disappear as a medical discipline.

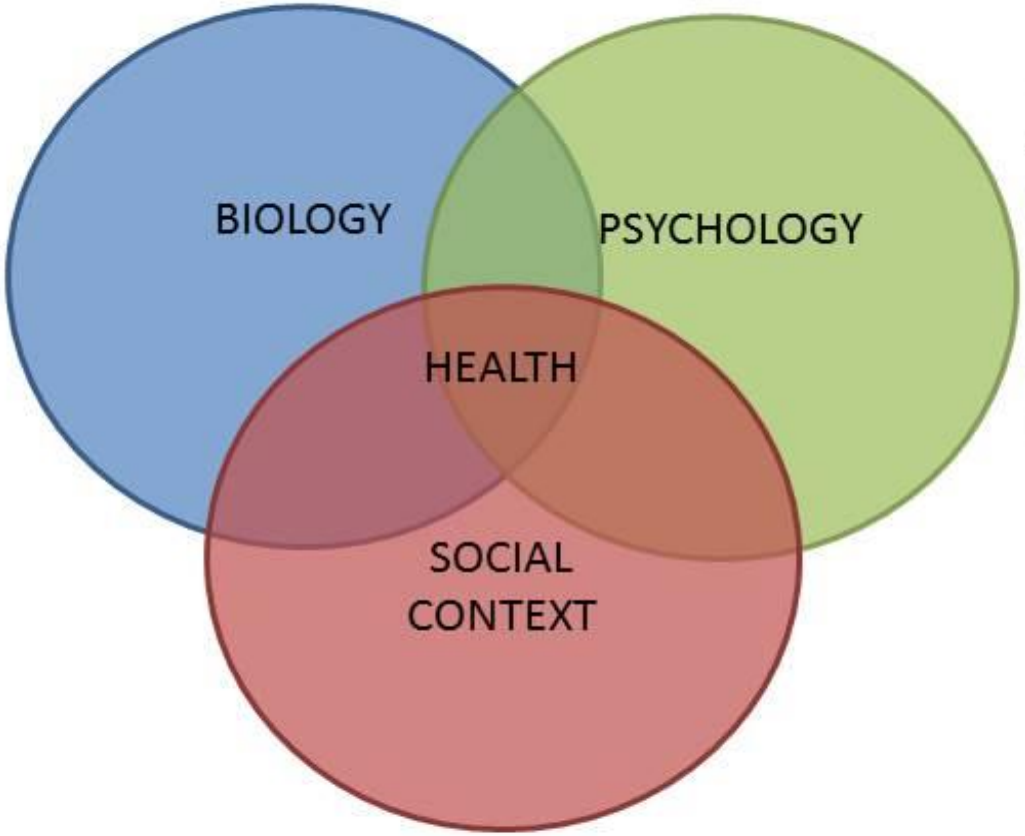
The contrasting posture of strict adherence to the medical model is caricatured in Ludwig's view of the psychiatrist as physician (4). According to Ludwig, the medical model premises "that sufficient deviation from normal represents disease, that disease is due to known or unknown natural causes, and that elimination of these causes will result in cure or improvement in individual patients" (Ludwig's italics). While acknowledging that most psychiatric diagnoses have a lower level of confirmation than most medical diagnoses, he adds that they are not "qualitatively different provided that mental disease is assumed to arise largely from 'natural' rather than metapsychological, interpersonal or societal causes." "Natural" is defined as "biological brain dysfunctions, either biochemical or neurophysiological in nature." On the other hand, "disorders such as problems of living, social adjustment reactions, character disorders, dependency syndromes, existential depressions, and various social deviancy conditions [would] be excluded from the concept of mental illness since these disorders arise in individuals with presumably intact neurophysiological functioning and are produced primarily by psychosocial variables." Such "non-psychiatric disorders" are not properly the concern of the physician-psychiatrist and are more appropriately handled by nonmedical professionals.

The author is professor of psychiatry and medicine at the University of Rochester School of Medicine, Rochester, New York 14642.

The Need for a New Medical Model: A Challenge for Biomedicine

1977

BIOPSYCHOSOCIAL APPROACH TO UNDERSTANDING HEALTH



Gender
Physical illness
Disability
Genetic vulnerability
Immune function
Neurochemistry
Stress reactivity
Medication effects

Learning/memory
Attitudes/beliefs
Personality
Behaviours
Emotions
Coping skills
Past trauma

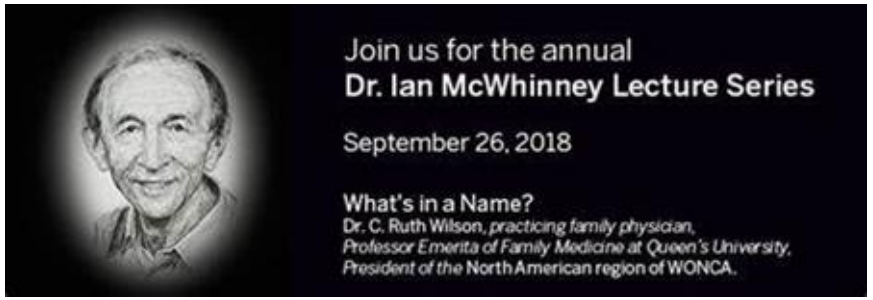
Social supports
Family background
Cultural traditions
Social/economic status
Education

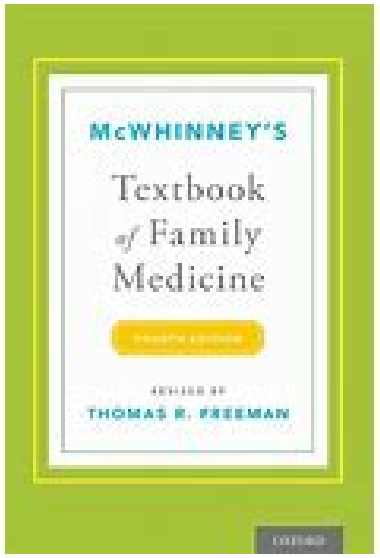
Courtesy Richard Frankel, PhD

The BPS Medical Model "Needs"

A NEW CLINICAL METHOD

Ian McWhinney: 1926-2012





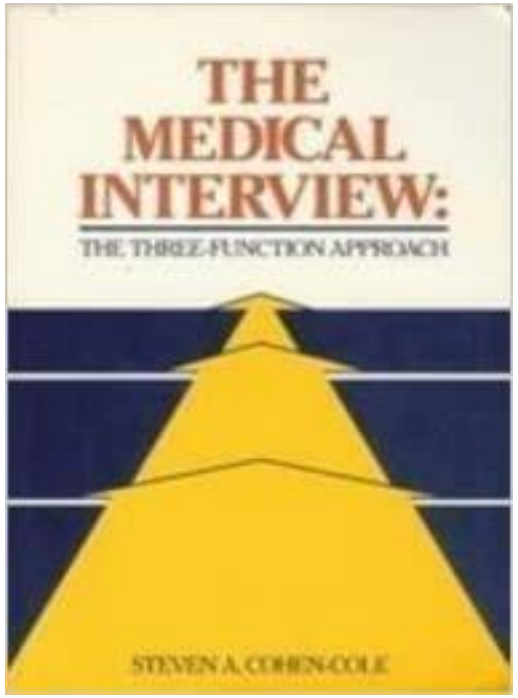
Levenstein JH, McCracken EC, McWhinney IR et al:
*The patient-centered clinical method: A model for the doctor-patient interaction in family medicine. Fam Pract*1986

Bird J, Cohen-Cole S (aka Cole)

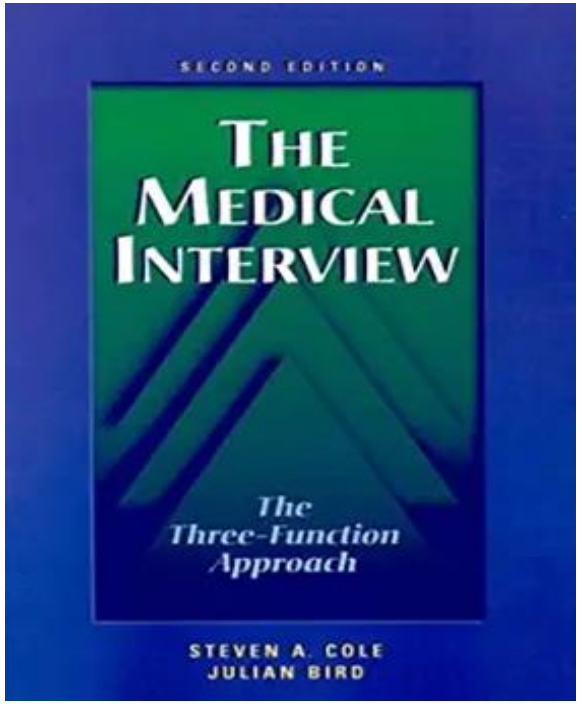
The Three-Function Model of the Medical Interview: An Educational Device

Adv Psychosom Med 1990

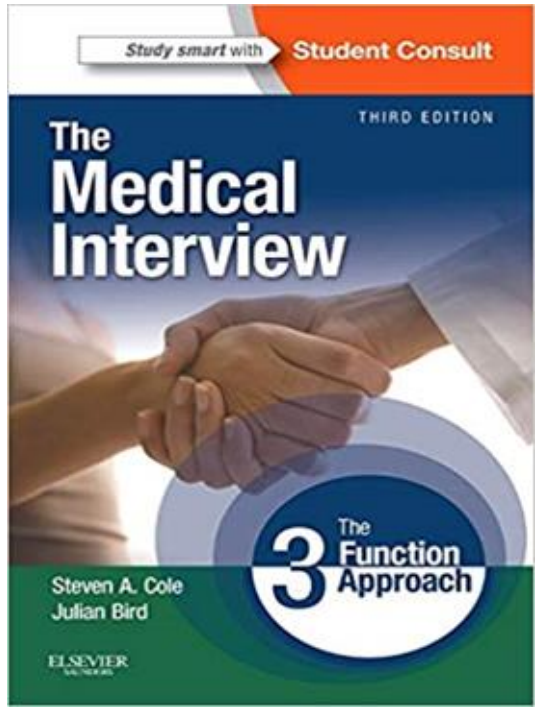
1991



2001



2013



Three Function Approach: Conceptual Evolution

FUNCTION	1991	2001	2013	4th Edition, in press
One	Respond to Emotions	Develop Rapport	Develop the Relationship	Connect
Two	Gather Data	Assess	Assess & Understand	Co-Construct the Narrative
Three	Educate… Motivate	Manage Problems	Collaborate for Management	Collaborate for Care

Rationale: TFA-4 Offers Novel, High Face-Validity Integration of Diverse Evidence-Based and Evidence-Informed "Frameworks"*

- Roter & Hall "Doctors Talking w/Patients…" (1992)
- **Patient/Relationship-Centered Care (2001, 2006)**
- Kalamazoo Consensus (2001)
- **Narrative Medicine (2001)**
- **Four Habits (2003)**
- Patient-Centered Medical Home (2002)
- Calgary-Cambridge Model (2003)
- **Self-Management Support (Chronic Care Model 2003)**
- **Humanistic/Holistic Care (2013)**
  (Gold/Schwartz Foundations + others)
- Patient and Family Engaged Care (Planetree, 2017)
- **Presence 5 (Stanford/2020)(Review)**
- Rome Foundation (2021) (Review)
- ALPS – Coaching - (2023)

- **Motivational Interviewing (MI)**
- **Brief Action Planning (BAP)**
- SBIRT
- **5A'S**
- Mindfulness
- Appreciative Inquiry
- **Patient Experience ("What Matters to You?")**
- **Sharing Information/Shared Decision-Making**
  - ATA, EPE, SHARE, BRAN, **ARTS**
- Coaching (Health; Life; others)
- Human Factors Engineering **(Cognitive Load)**
- **Psychology/Psychotherapy**
  - Dynamic-Relational Psychology & Therapy
  - Client-Centered Psychology & Therapy
  - CBT
  - Family Theory and Therapy
  - Self-Efficacy Theory and Self-Determination Theory
  - Positive Psychology

* "Framework" = paradigm, approach, model, theory, style

The Three Functions -- TFA-4

- Connect
- Co-Construct the Narrative
- Collaborate for Care

3 Heuristic Elements

- Identifies “functions” of the interview
- Describes behaviorally-defined ”micro-skills”
- Utilizes educational theory and methodology (including *“teaching with role play”*)

Qualities of All Three Functions

- Bidirectional
- Interactive, interdependent, iterative
- Continuous throughout the encounter
- Sequential & synchronous

Function One: Connect

- Meta-Skills

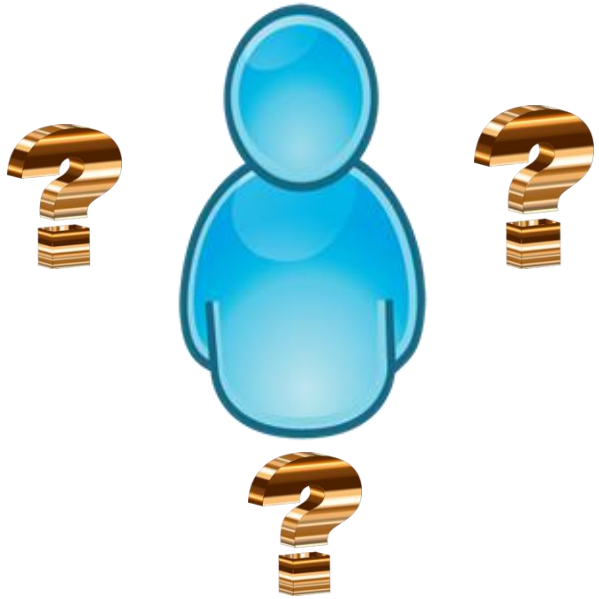
  (higher-order skills that facilitate learning and mastery of core competencies)

  - Connect to Self in Context
  - Connect with Values (Attitudes/Mindset)
  - Connect Non-Verbally

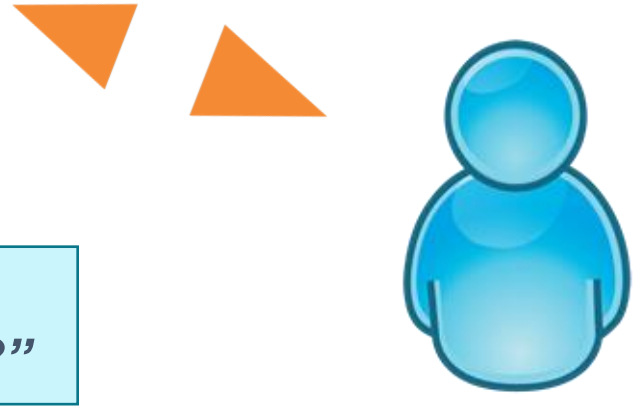
Function One: Connect (Meta-Skill)

Connect to Self in Context

Mindfulness
"Am I fully present in this moment?"



Personal Awareness
"Who am I to this patient?"
"Who is this patient to me?"



Situation Awareness
"What is going on around us?"

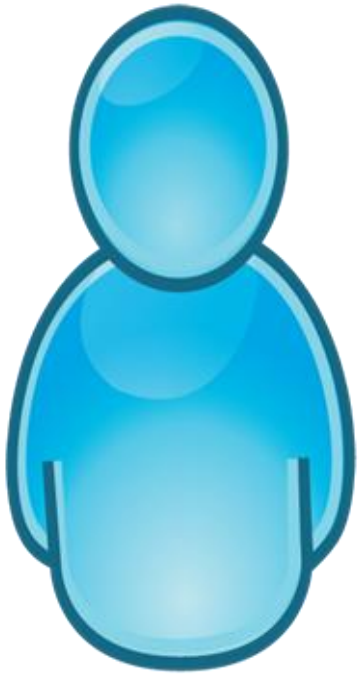
Function One: Connect

Connect with Values

Connect to Self in Context

Connect Non-Verbally

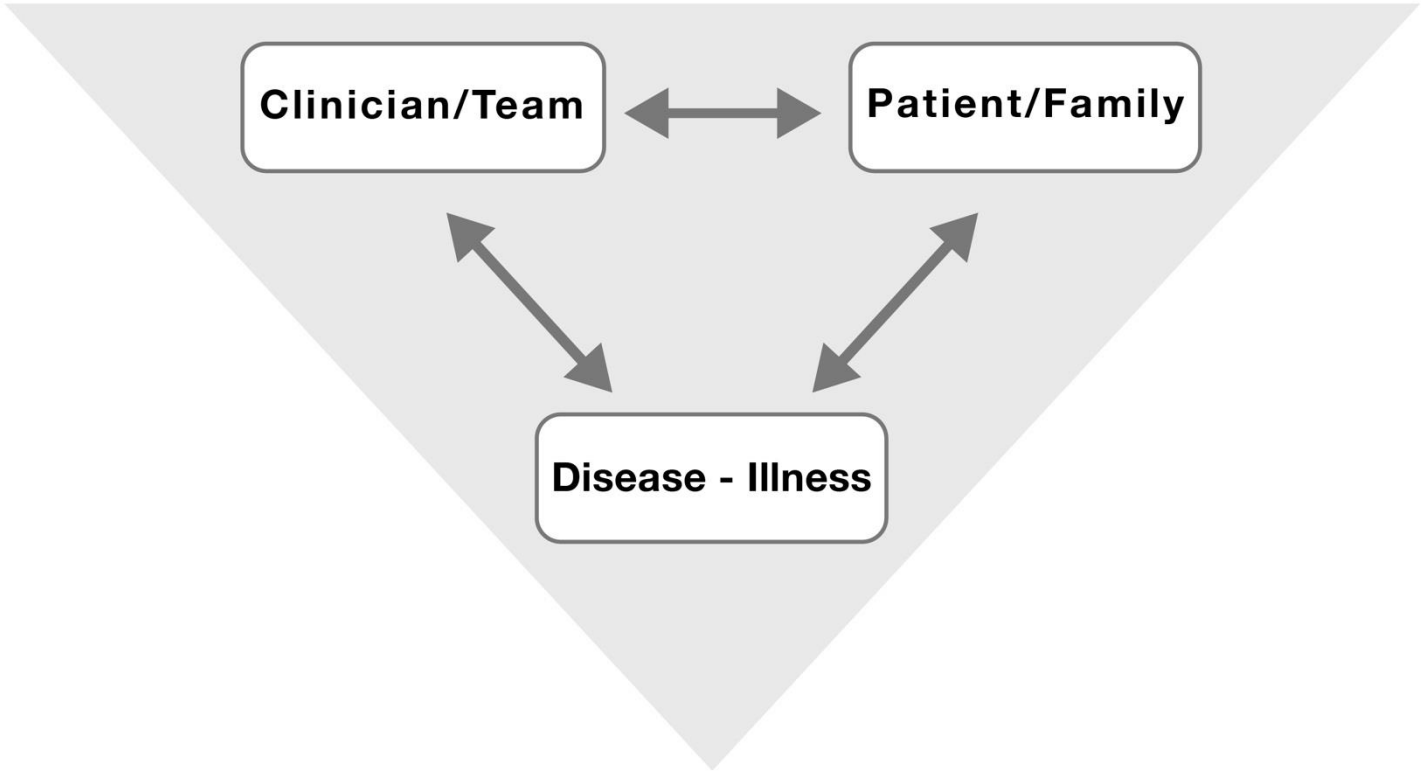
Invest in the Beginning



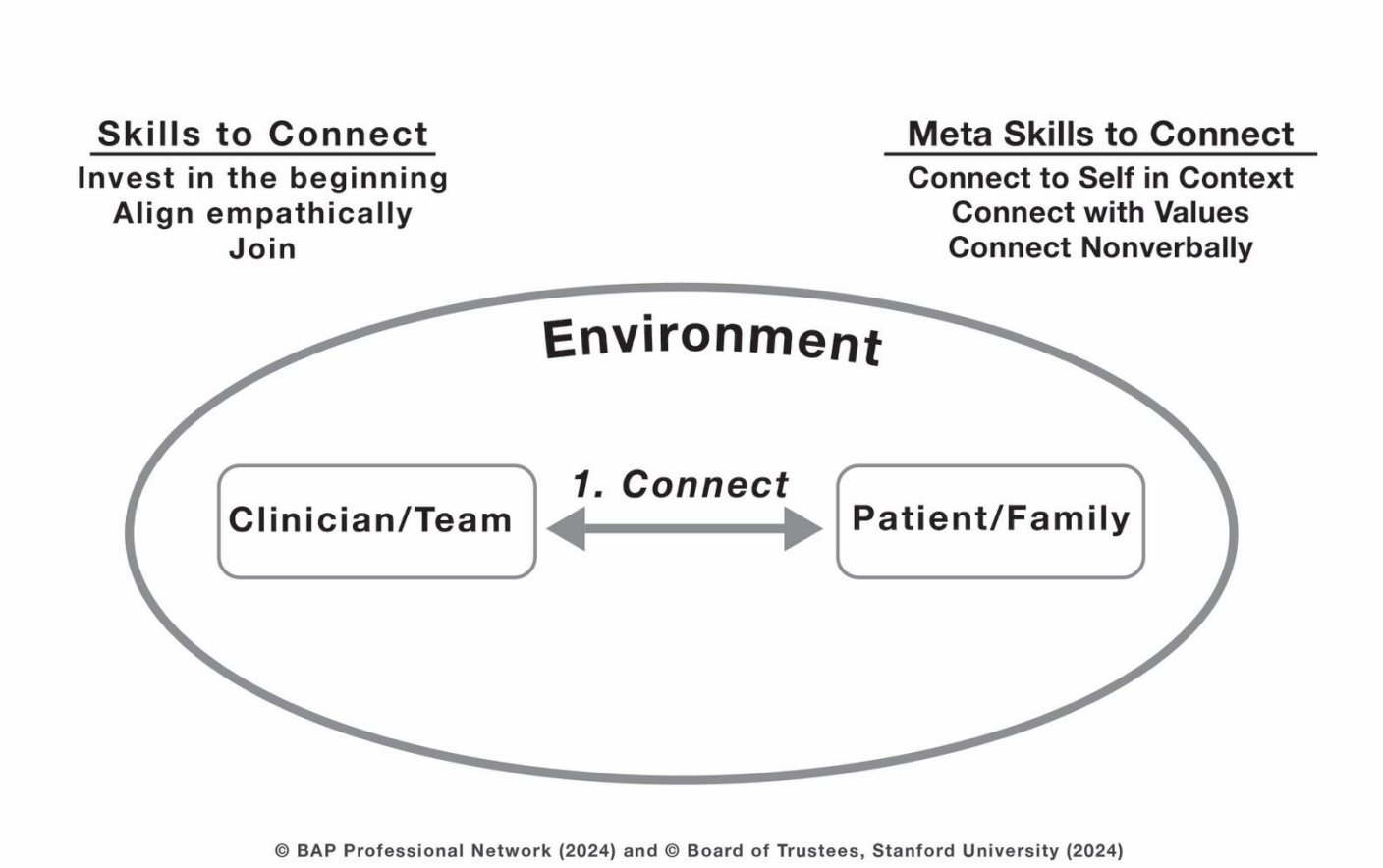
Align Empathically

Join

Patient Care Triangle



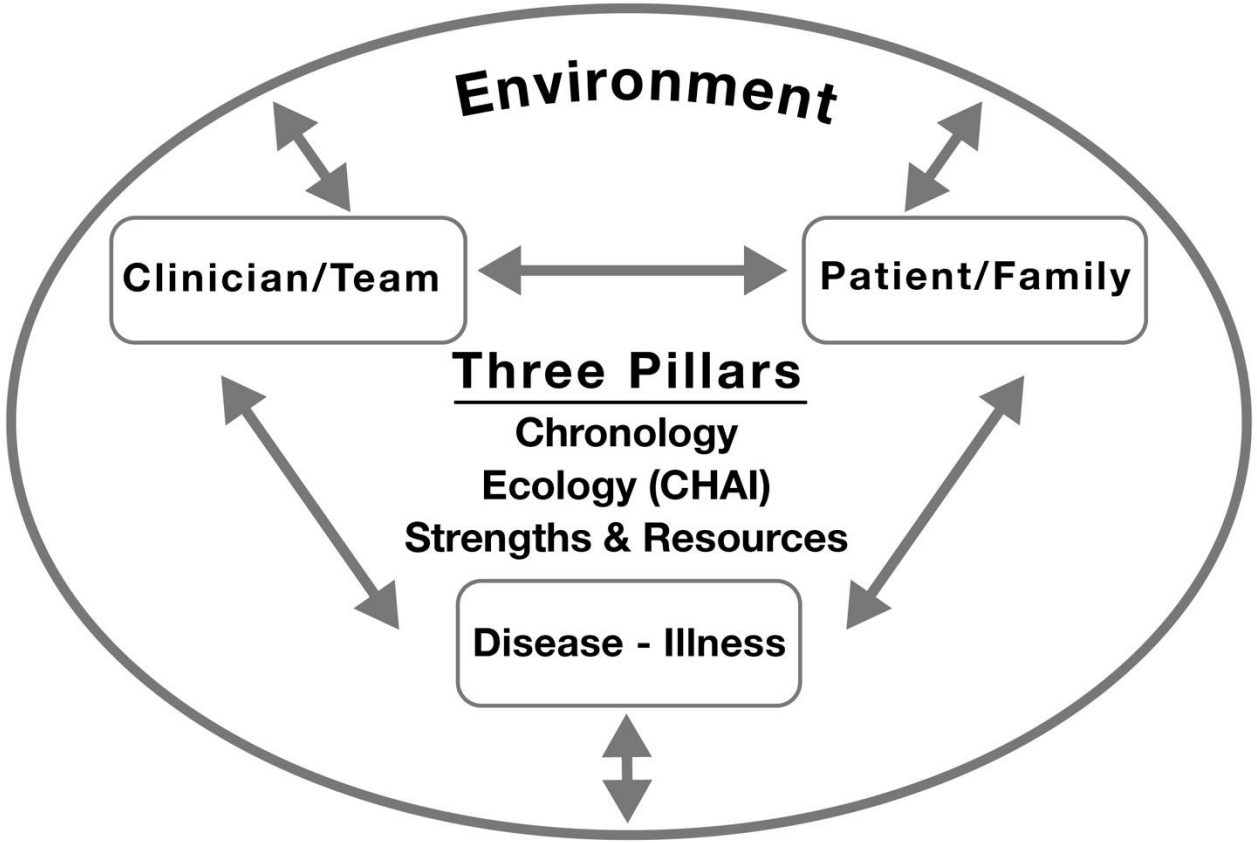
Function One: Connect



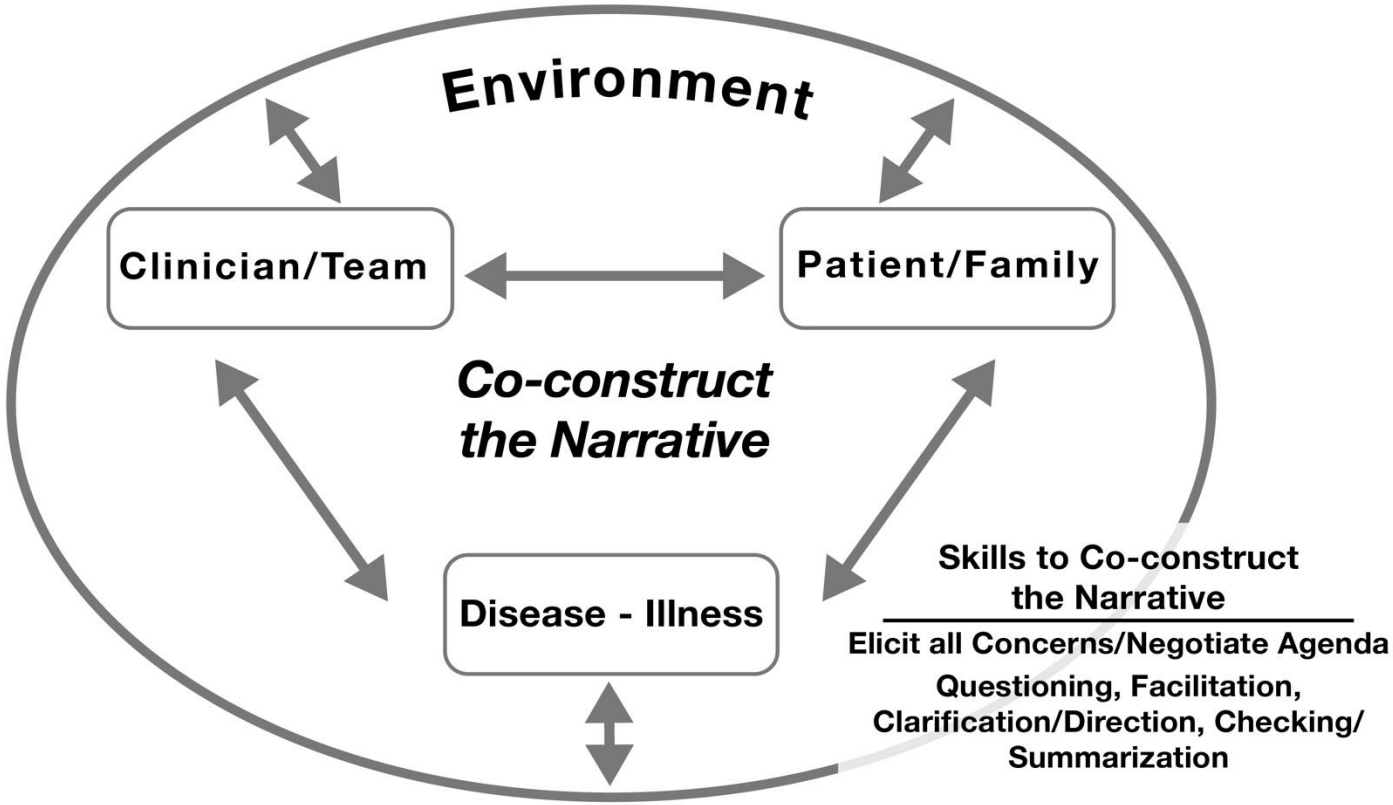
Function Two: Co-Construct the Narrative

- Elicit the Health History
- Explore the Ecology of the Illness ("CHAI")- Context, Hopes/Expectations, Attributions, Impact
- Identify/Affirm Strength & Resources

Function Two: The Three Pillars



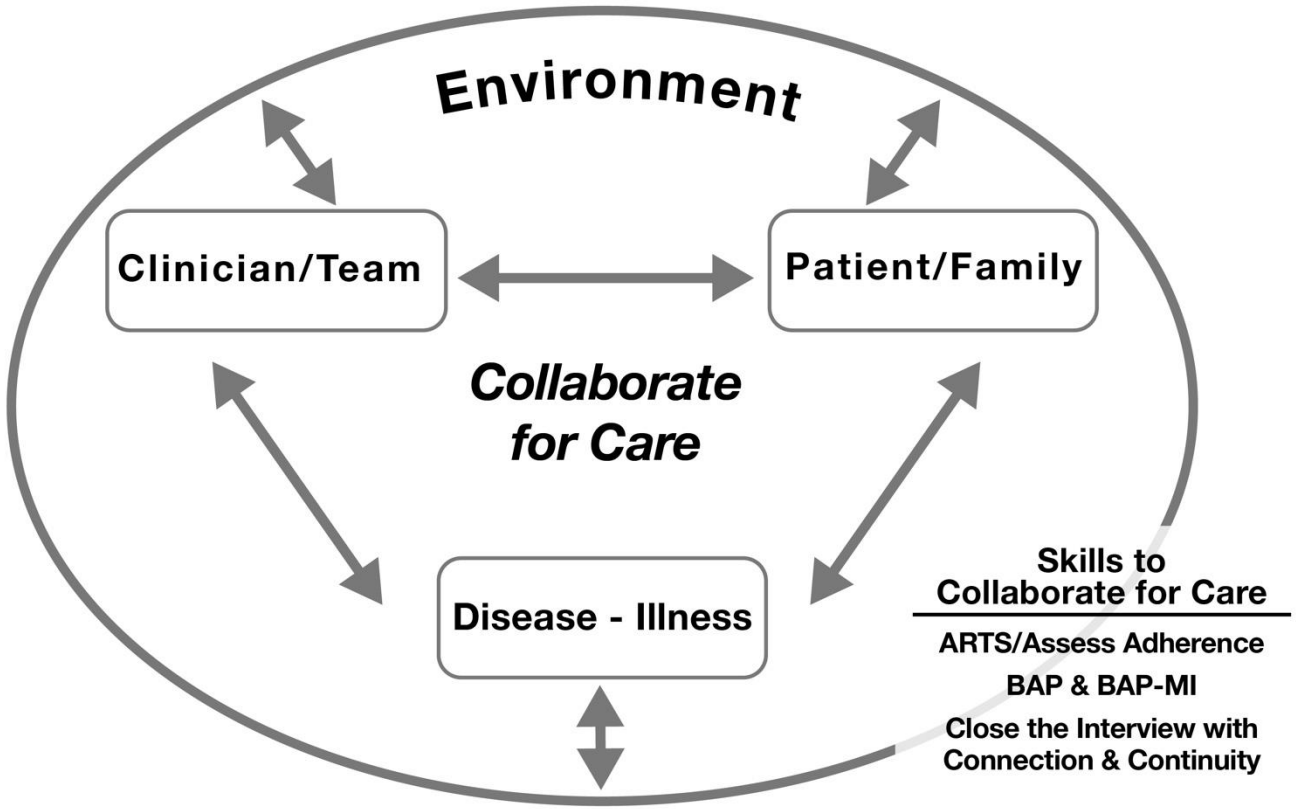
Function Two



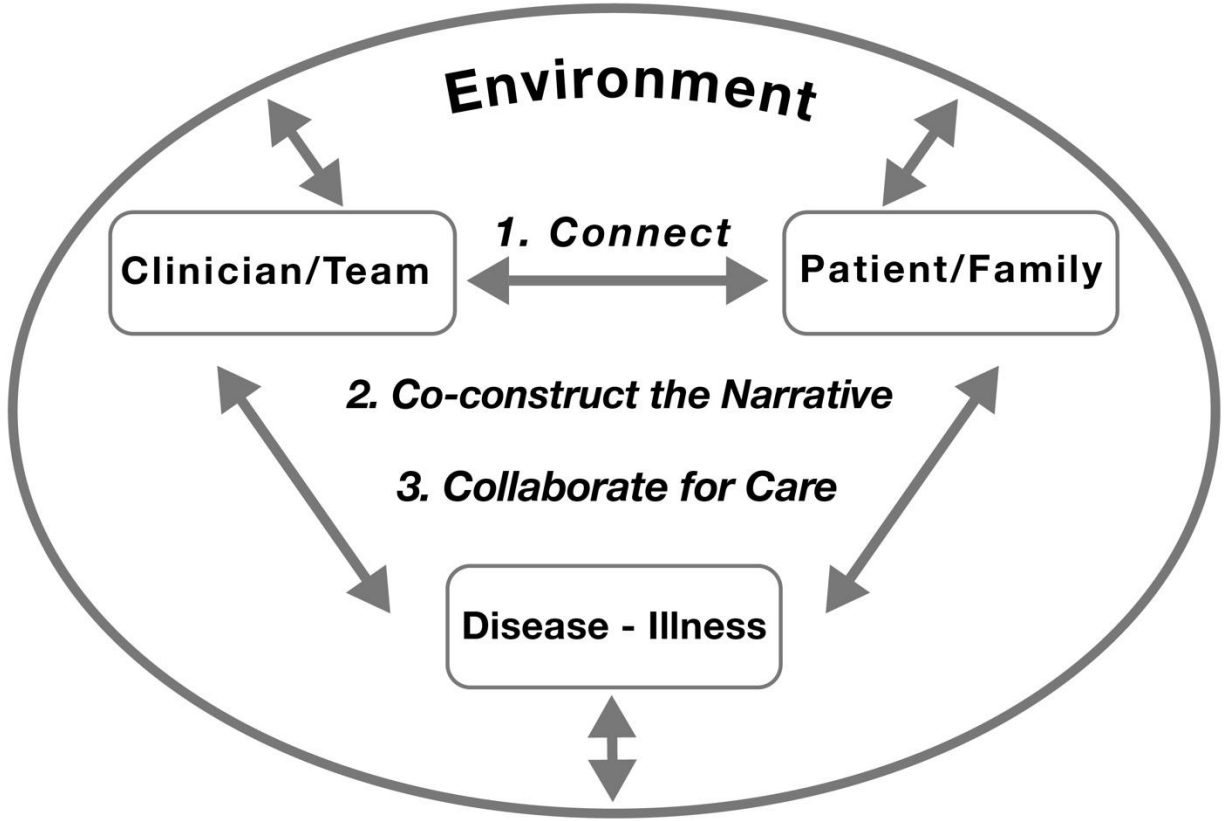
Function Three: Collaborate for Care

- Assess Adherence
- Provide Diagnostic Information & Share Decision-Making
  - *ARTS (Assess, Respond, Tell/Teach-back, Seek Solutions)*
- Support Patient Self-Management; Facilitate Behavior Change
  - *BAP (Brief Action Planning)*
  - *BAP – MI (Motivational Interviewing)*
- Close the Interview with Connection and Continuity

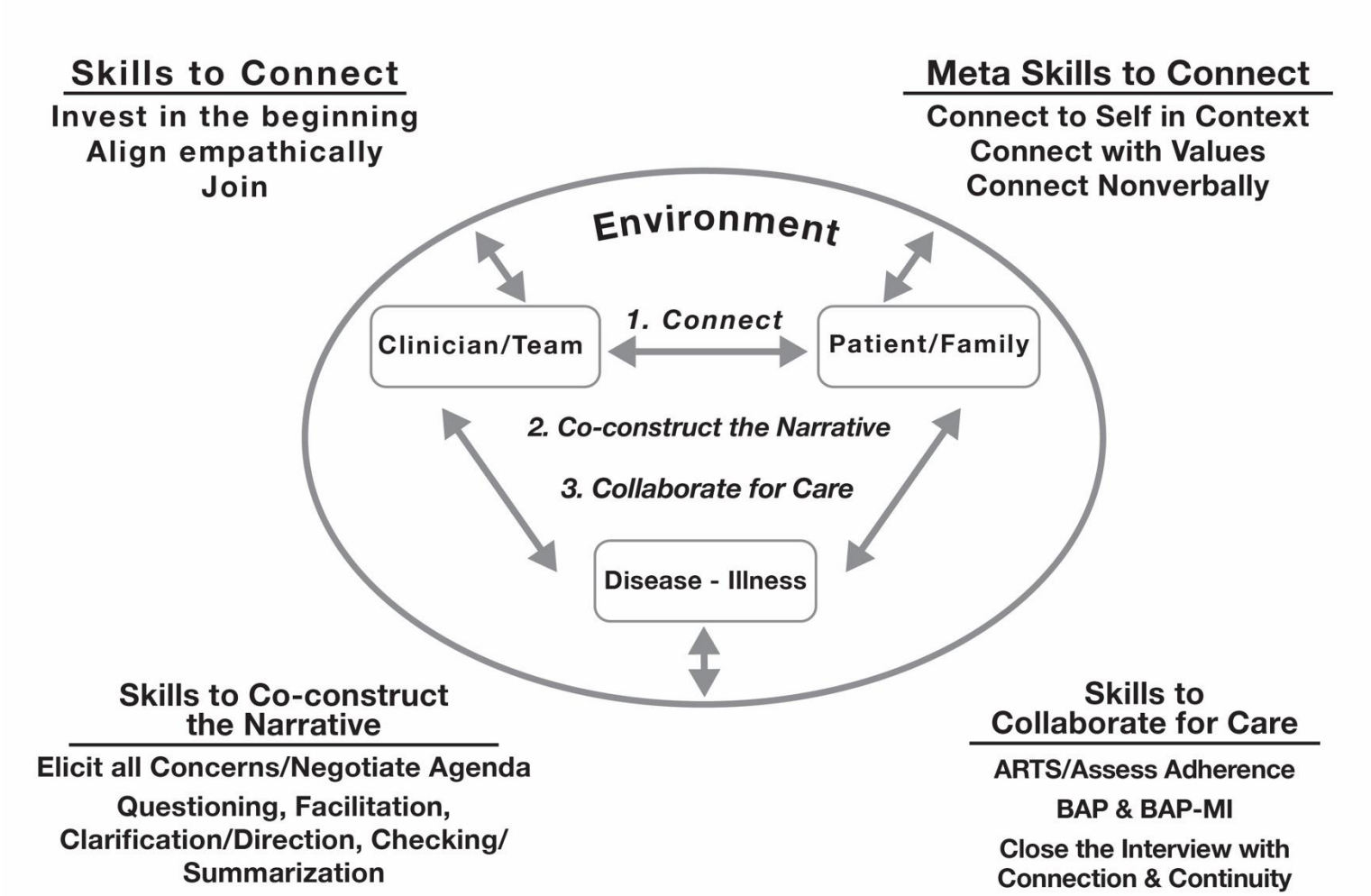
Function Three



The Three Functions



All Functions + All Skills



What is Brief Action Planning (BAP)?

BAP is a versatile MI-consistent skill set to support patient/client self-management & facilitate health behavior change for people ready or nearly ready for change.

What is BAP-MI?

BAP-MI is a stepped-care integration of BAP and MI to support patient self-management and facilitate health behavior change for patients with persistent unhealthy behaviors and ambivalence about change.

MINT
excellence in motivational interviewing

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11:00am - 12:30pm EDT / 3:00pm - 4:30pm UTC

BAP: Update and Exploring "Generative Closed Questioning"


Steven Cole


Bob Jope


Milos Rankovic


Deirdra Frum-Vassallo


Hillary Logan

BAP
PROFESSIONAL NETWORK

Brief Action Planning (BAP) for Medical Practice

A Motivational Interviewing (MI) Consistent Tool for Self-Management Support and Health Behavior Change

Cole S, Blatt B, Jadotte Y, Romero C, Sannidhi D

Annual Meeting of the American College of Preventive Medicine
Washington DC, April 19th, 2024

AMERICAN PSYCHIATRIC ASSOCIATION

Medical leadership for mind, brain and body

BRIEF ACTION PLANNING (BAP)

FOR LIFESTYLE CO-MORBIDITIES AND BEHAVIORAL COMPLEXITIES OF SMI:

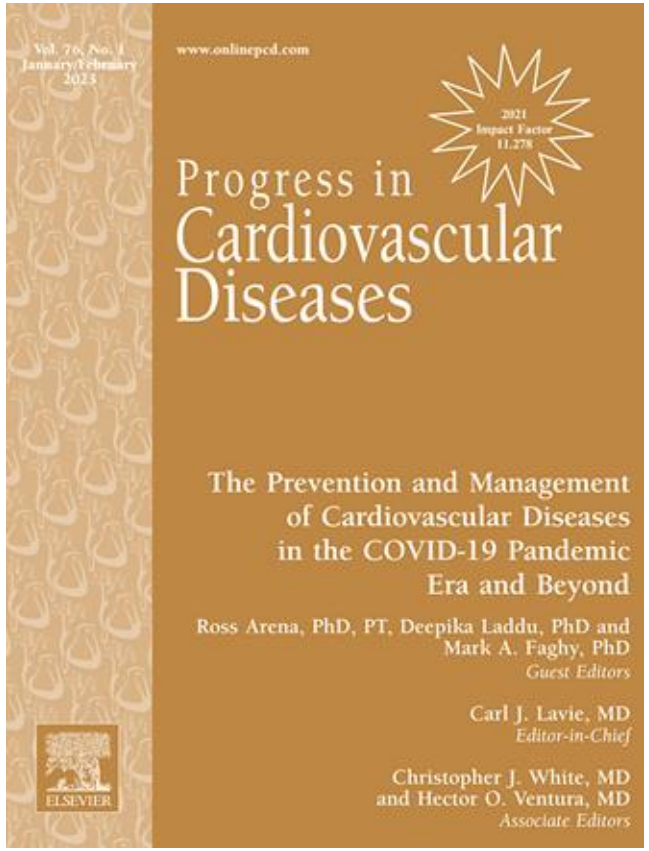
A Motivational Interviewing (MI) Consistent Tool

Cole S, Palanci J, Cotes, R

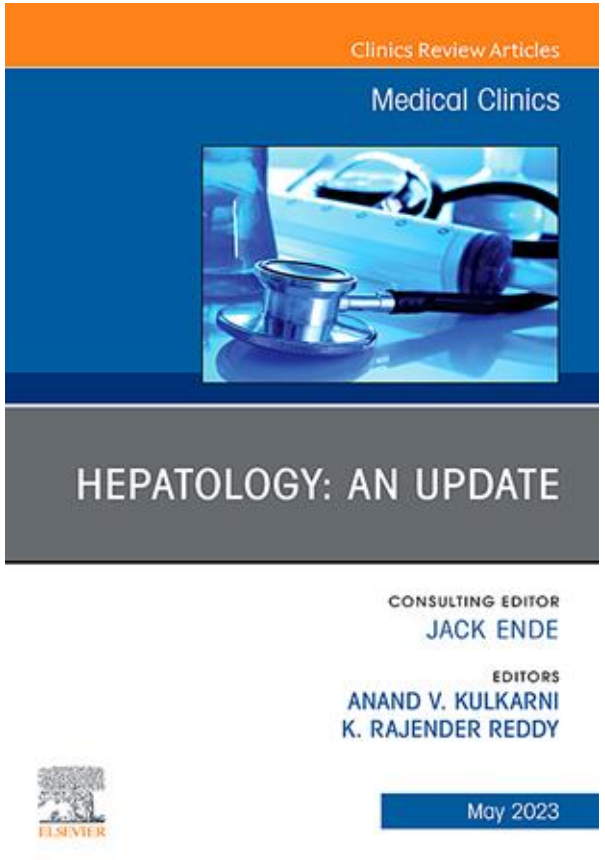
Mental Health Services Conference

Baltimore, September 27, 2024

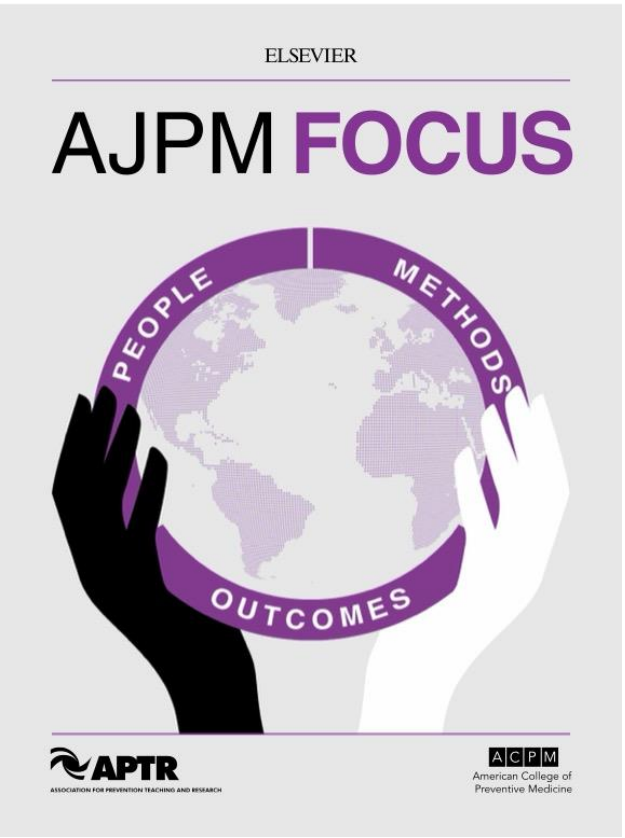
Recent Peer-Reviewed Publications



***Using motivational interviewing and brief action planning for adopting and maintaining positive health behaviors*, March-April 2023.**



***Brief Action Planning (BAP) in Health and Healthcare: A Scoping Review*, November 2023.**



***BAP- MI: A Novel Stepped-Care Integration of Brief Action Planning and Motivational Interviewing to Optimize Outcomes*, September 2023**

BAP in Health and Healthcare:
A Systematic Review and Meta-Analysis

Meta-analysis showed statistically significant and clinically meaningful effect of BAP as stand-alone intervention

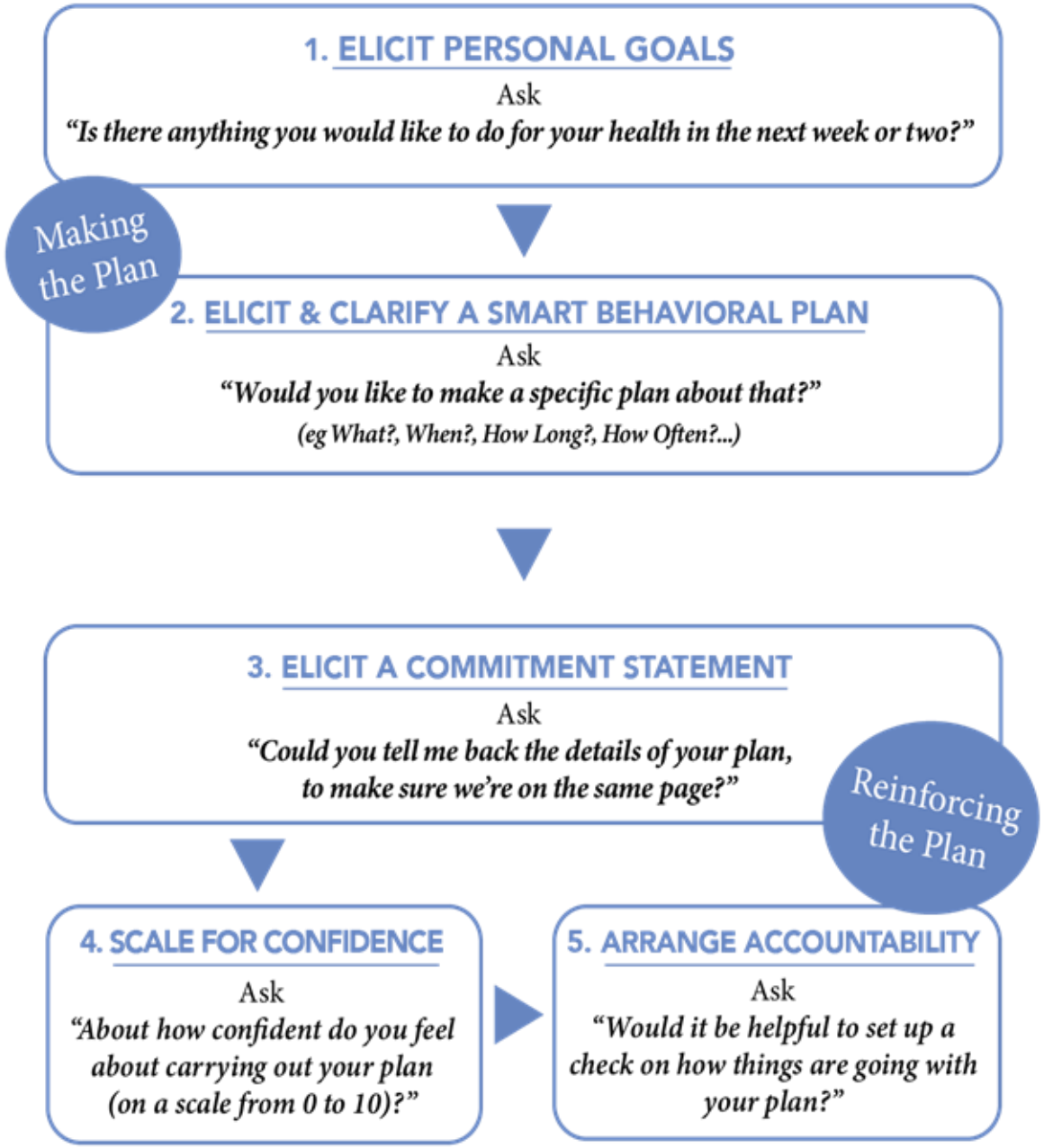
Jadotte YT, Carroll W, Buchholz B, Wingood M, Cole SA:

Annual Meeting of APTR (Association for Prevention, Teaching, & Research)

March 10, 2025

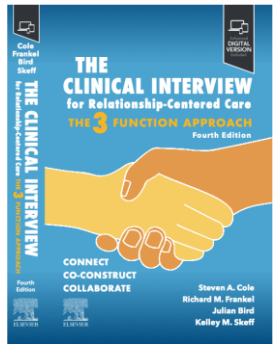
Publication, in press

BAP Flow Chart

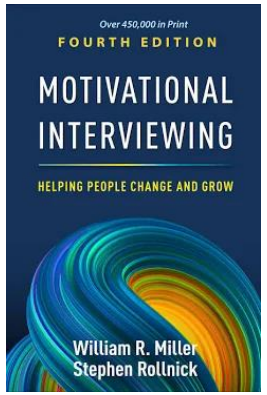


* Revised from Cole, Gutnick, Davis, & Reims: "Brief Action Planning Flow Chart," 2016

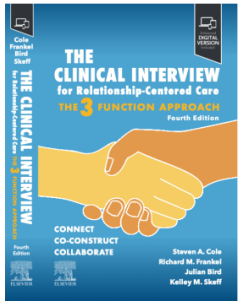
BAP-MI Recognizes Ambivalence

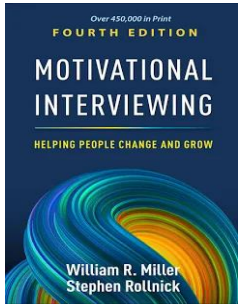


As Common and "Normal"
In Context of Persistent Unhealthy Behaviors



BAP-MI
De-Constructing Linguistic Dynamics



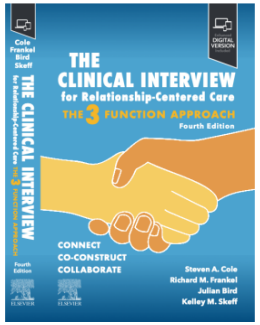


Advanced Skills

MI

BAP-MI

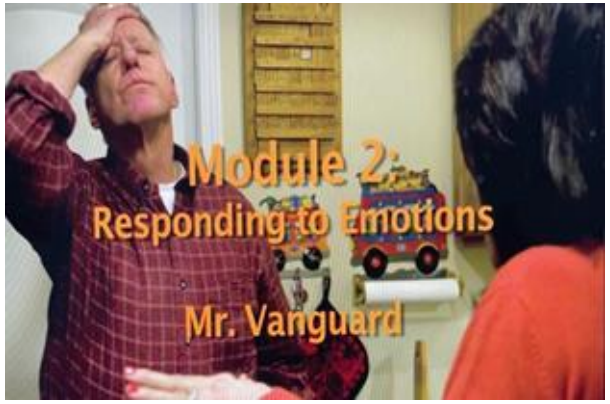
A Stepped-Care Approach to Behavioral Change



BAP-MI:

A Stepped-Care Model for Teaching, Learning, and Using Motivational Interviewing and Coaching in Health Care

Mr. Vanguard



https://www.youtube.com/watch?v=OpIrhu53Ga4

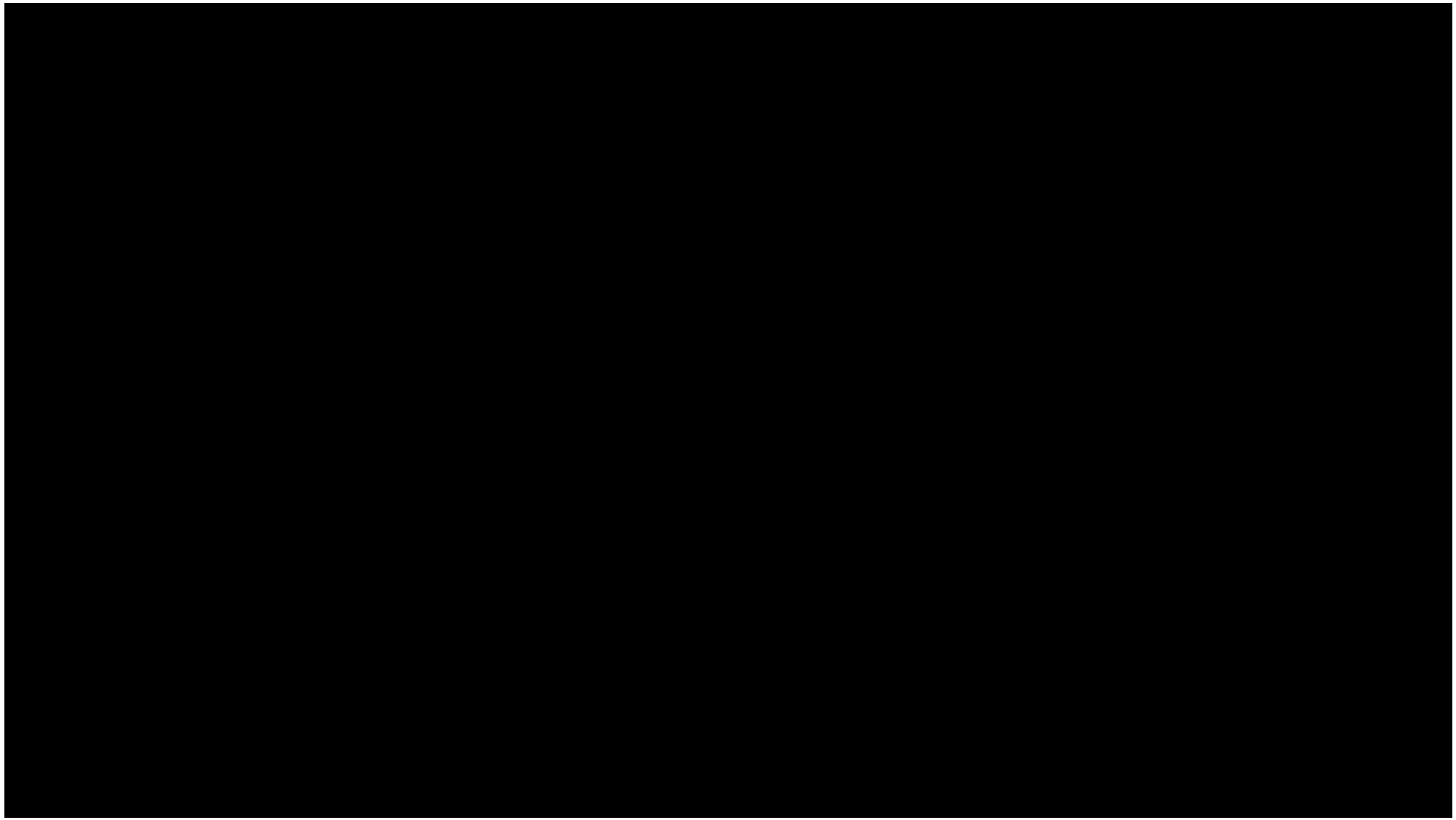
Mr. Stabler

https://www.youtube.com/watch?app=desktop&v=an08oPVGcUw

Mr. Dowd

https://www.youtube.com/watch?app=desktop&v=aymb_ndzZ8c

BAP-MI: Mr. Dowd



Learning BAP

Option for Train-the-Trainer Co-Facilitation

BAP Core Competencies

Self-Directed Online Only: 8 hours CE/CME*

Online + 4 Practicums – 90 minutes each: (14 hours CE/CME)

March-April and September-October 2026

https://shorturl.at/yFVeQ

CE – American Psychological Association, MI Center for Change
CME - Stony Brook Office of Continuing Medical Education

www.BAPprofessionalnetwork.org

Learning BAP-MI

Option for Train-the-Trainer Co-Facilitation

BAP-MI (Advanced Skills)

Self-Directed Online Only: 8 hours CE/CME*

Online + 4 Practicums – 3 hours each: (20 hours CE/CME)

July-August 2026

CE – MI Center for Change

CME - Stony Brook Office of Continuing Medical Education, in process

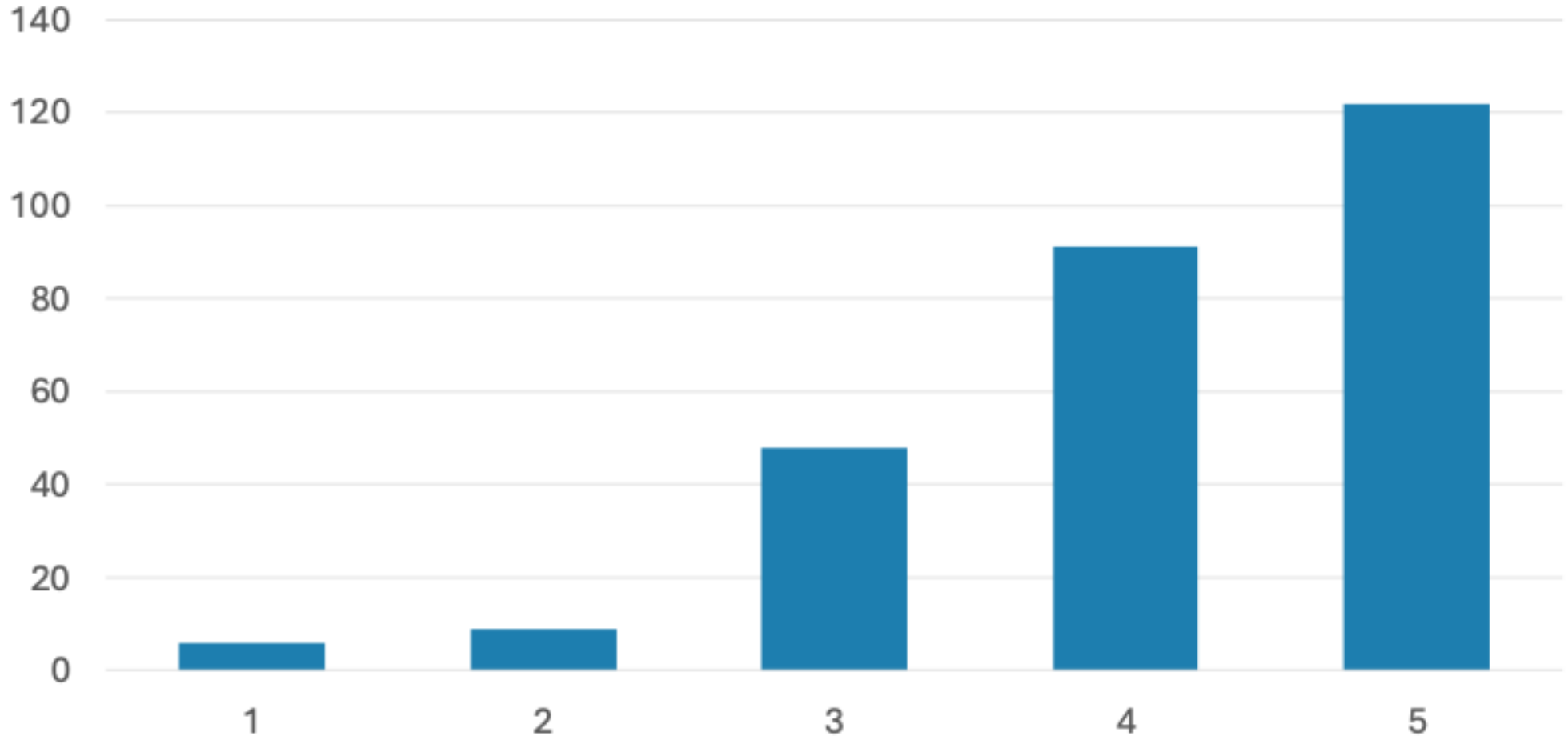
www.BAPprofessionalnetwork.org

Evaluation of BAP Online Learning Program

How useful do you feel this module will be in your current or future practice?

N = 276

(2016-2025)



Mean = 4.14

Learning BAP: Comments

Fellow, Health Psychology, Northport VA 2023	***I think it was easy to follow and kept me engaged. I learned a lot just from the online course itself. I also really enjoy the role plays we do during the zoom meetings.***
Resident in Preventive Medicine, University of California, San Diego, 2024	***I think the program was very interesting and helpful. I liked the small groups during the breakout sessions to practice. Thank you for your program and sharing this wonderful information with everyone.***
Oncology Nurse, Stony Brook SOM, 2024	***No changes needed – I liked the hybrid approach of in person and work on line.***
Internal Medicine Faculty, Stony Brook, 2024	***Everything was well organized and easy to navigate.***
Resident in Geriatric Psychiatry, Stony Brook, 2024	***I think the way it is designed is quite astute; as an introductory course the foundational materials are clear, concise and paired with great examples. I think it has been developed perfectly.***
Social Worker, Online learner, 2024	***I really appreciated the simplicity and effectiveness of using BAP and MI. I got a lot out of the program and wouldn't have changed anything.***
Justin Palanci, MD Medical Direcor, Emory-Grady ACT Team, 2024	***BAP provides a framework to treatment planning that is focused, and person-centered. The workshops made the approach accessible to our multidisciplinary staff, allowing them to utilize it in a way that aligned with their specific roles on the team.***

BAP & BAP-MI: MODELS OF LEARNING & IMPLEMENTING

Academic medical centers currently training BAP & BAP-MI, including train-the-trainer programs*

Location	Disciplines
Northport VA *	Health Psychology Fellows, Internal Medicine & Preventive Medicine Residents
Stony Brook SOM *	Nurse Practitioners (Psychiatry and Others), Nursing (Oncology), Geriatric Medicine, Preventive Medicine, and Internal Medicine Residents
University California San Diego *	Medical students, Residents in Preventive Medicine, Lifestyle Medicine, Family Medicine
Zucker SOM at Hofstra/Northwell	Medical students
University of North Carolina SOM	Medical students, psychiatry residents, Addiction Medicine Fellows
UCLA SOM	Medical students, internal medicine faculty
George Washington University SOM	Medical students
Emory University/Grady Memorial Hospital *	Psychiatry ACT Team

Summary, Conclusion, Discussion

Thank You!