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Integrating Motivational Interviewing and Brief Behavioral Activation Therapy: Theoretical and Practical Considerations

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Abstract

Behavioral Activation and specifically the Brief Behavioral Activation Therapy for Depression (BATD) has a strong record of empirical support but its focus on practical out of session activation-based assignments can lead to poor levels of adherence if efforts to enhance motivation are not prioritized. Towards this end, this manuscript describes the assimilative integration of Motivational Interviewing (MI) and BATD to improve clinical outcomes by integrating MI's focus on building and maintaining motivation to change into BATD. The manuscript provides an overview of MI and BATD, theoretical issue raised in integrating the two approaches, and examples of how this integration results in a nondirective and motivation-focused approach to conducting BATD.

Keywords

retention; homework; Motivational Interviewing; Behavioral Activation

Behavioral Activation (BA) is a well-established and effective treatment for depression (Cuijpers, van Straten, & Warmerdam, 2007; Ekers, Richards, Gilbody, 2008; Mazzucchelli, Kane, & Rees, 2009). The theoretical underpinnings of BA are rooted in early behavioral approaches to depression (e.g., Lewinsohn, 1974), and it was most clearly established through a landmark dismantling study indicating that the behavioral aspects of Cognitive Behavioral Therapy (CBT) produced results comparable to the whole treatment package (Jacobson et al., 1996). This early work was followed by subsequent development of the BA treatment approach (Martell, Addis, & Jacobson, 2001; Martell, Dimidjian, Herman-Dunn, & Lewinsohn, 2010) and further empirical work showing BA was comparable to CBT and medication, and even superior under some conditions (Dimidjian et al., 2006; Dobson et al., 2008).

Given the increasing need to develop brief, empirically-supported psychotherapies evidenced over the past decade, Lejuez, Hopko, and colleagues developed a shorter and

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more narrowly focused version of the protocol called the Brief Behavioral Activation Treatment for Depression (BATD; Lejuez, Hopko, & Hopko, 2001; Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011). This approach is typically administered in 5 to 12 sessions and focuses solely on the core aspects of activation, such as daily monitoring, identification of core life values, valued activity selection and planning, and contracting for social support where barriers to activity completion are experienced. To date there are multiple studies that indicate its efficacy reducing depression in a range of clinical samples including community individuals in outpatient and inpatient treatment (Hopko, Lejuez, 2003), older adults experiencing complicated bereavement (Acierno, et al, 2012), veterans with PTSD (Strachan, et al., 2012), substance users in the community (MacPherson, et al, 2010) and in a residential treatment setting (Madgison, et al., 2011; Daughters, et al., 2008), and among individuals with significant medical conditions including cancer (Hopko, Armento, et al., 2011).

While the evidence for BA and BATD are promising, the practical aspects of the approach and the focus on between session activities (often referred to as “homework”) raise barriers regarding the need for developing patients' motivation and willingness to engage in these important therapeutic components. Supporting this assertion, Dimidjian and Hollon (2011) identified patient motivation as one of the key factors in preventing treatment failure in BA and Baruch, Kanter, and colleagues (2011) had provided a thorough discussion of homework issues in BA. Morevoer, Hopko et al (2011) suggested that issues of motivation and adherence may be especially relevant to BATD given that, even compared to BA more broadly, BATD has a more narrow focus on activation and out of session activities that may impact patient acceptance of the approach and adherence with its content if not presented in a manner sensitive to these issues.

BA and BATD manuals include specific recommendations that support collaborative and supportive strategies to enhance patient motivation and adherence (Lejuez et al., 2011; Martell, et al., 2010) both in the introduction and review of assignments (Martell et al., 2010; Kanter, Busch, & Rusch, 2009). However, the efficacy of the recommended approaches has not been assessed. Yet, even with a strong focus on assignment adherence, the potential for nonadherence is a threat to therapy progress (Hopko, Magidson, & Lejuez, 2011). Adherence is also an issue for CBT therapies more broadly and many of the commonly used approaches to improve homework adherence in other structured therapies have shown limited efficacy (Bryant, Simons, Thase, 1999). Given these challenges, the current manuscript considers the potential benefit of integrating BATD with Motivational Interviewing (MI), an approach that directly focuses on these issues. Indeed, interventions combining MI with other treatment approaches have often resulted in improved treatment outcomes, but studies also have highlighted challenges in integrating MI with more directive therapies.

In mental health, MI has been combined with CBT to increase treatment initiation and adherence for various psychiatric disorders (Arkowitz, Miller, Rollnick, & Westra, 2008; Arkowitz & Westra, 2009; Westra & Arkowitz, 2011). MI has most often been used as a pre-cursor to treatment (Carroll, Libby, Sheehan, & Hyland, 2001; Merlo, et al., 2010; Swartz, et al., 2008; Westra & Dozois, 2006; Westra, Arkowitz, Dozois, 2009; Zuckoff, Swartz, &

Grote, 2008). Such studies have found that a pre-treatment MI intervention resulted in improved outcomes, including better treatment response (Merlo, et al., 2010; Westra & Dozois, 2006; Westra, Arkowitz, & Dozois, 2009); higher self-efficacy (Westra & Dozois, 2006), homework adherence (Westra & Dozois, 2006; Westra, Arkowitz, & Dozois, 2009), and decreased resistance (Aviram & Westra, 2011). Other studies with a pre-treatment MI intervention also added a booster session in case a patient's motivation subsides during the other treatment (COMBINE, 2003; Simpson, et al., 2010). However, these studies did not specifically assess the effects of the booster session.

More recently, there has been increased interest in fully integrating MI into other treatments in order to maximize the patient's engagement and motivation throughout the treatment and lessen resistance or non-adherence to different treatment components. In such integrations the therapist does not come in and out of an MI approach. Instead, MI is woven into the fabric of the other treatment, resulting in their seamless integration (Arkowitz & Westra, 2004). Although full integration of MI into other treatments remains in its infancy, it has shown promise. For example, an intervention that integrated MI into pharmacotherapy sessions for depressed Latino outpatients (N=50) retained 80% of the patients during 12 weeks of treatment, compared to historical controls of 40-50% retention of similar patients at 12 weeks (Balán, Moyers, & Lewis-Fernandez, 2012; Lewis-Fernandez, et al., 2012). Similarly, Barrowclough, et al, (2001) fully integrated MI into CBT for substance misuse in patients with psychosis. The integrated treatment resulted in significantly greater improvement in patients' general functioning than routine care post-treatment and at a 12-month follow up as well as a reduction in positive symptoms, symptom exacerbations, and substance use over the 12-month period from baseline to follow-up.

However, combining or integrating MI with more structured therapeutic approaches can be difficult, much like the challenges faced when integrating more collaborative aspects of CBT such as collaborative empiricisim and guided discovery (Tee & Kazantzis, 2011) into the more traditionally directive aspects of CBT, such as psychoeducation, the role of clinician as expert, and structured manualized CBT treatments (Overholser, 2011). The integration of MI with other psychotherapies can highlight differences between the approaches in what is considered to be the role of the therapist and patient, helpful patient-therapist interactions, and how to best help the patient overcome their problem.

These differences were clearly observed by Simpson, et al., (2010) who, as part of a study that added MI to Exposure/Response Prevention (EX/RP), rated the EX/RP sessions using the Motivational Interviewing Treatment Integrity rating system to assess MI consistency during EX/RP sessions. Findings showed that although the study clinicians were competent in the use of MI during the MI portion of the treatment, ratings for MI consistency during the EX/RP portions were quite low, highlighting the differences between the two treatment approaches.

Another challenge focuses on the ability of clinicians to conduct both treatment approaches effectively. For example, Moyers and Houck (2011) and Simpson et al., (2010) found that their therapists had difficulty identifying when the patient was sufficiently motivated and the treatment should move from MI to more structured components, and, vice versa, when there

were junctures in the treatment which called for a switch back to MI before continuing with the other components of the treatment.

Our assimilative integration (Messer, 1992, 2001) of MI and BATD aims to overcome the challenges faced in other interventions that combined MI and directive therapies by carefully considering the conceptual fit between the two approaches and how the specific techniques used in each approach interacts with those of the other approach. For example, how might key educational points in BATD be presented in a more evocative and autonomy supportive manner. As is typical with assimilative integrations, the interaction between MI and BATD mutually transforms them into a new, integrated approach (Lampropoulos, 2001).

The literature evidences several cases in which aspects of MI and CBT have been combined. At the same time, examples where the two approaches are fully integrated are rare and relevant work frequently overlooks the challenges that may arise, with little guidance in assessing the compatibility of the approaches. This manuscript addresses those gaps in the literature by describing a full integration of MI and BATD throughout the course of this structured treatment. In this manuscript, we provide an overview of MI and BATD, how the two approaches were integrated into MBATD, and examples (including video role plays) of how this integration results in a motivation-focused approach to conducting BATD. While this manuscript provides a strategy for addressing motivation and adherence issues in BATD specifically, we believe that, in general, the arguments presented here may also apply to other behavioral activation and related treatment approaches.

The Clinical Practice of MI and BATD

MI

MI is a collaborative, goal-oriented method of communication designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own arguments for change (Miller & Rollnick, 2013). The practice of MI is guided by four basic processes: Engagement (establishing the therapeutic relationship), Focusing (deciding the area on which to focus the work), Evocation (evocation of the patient's reasons, need, desire, ability, and commitment to change), and Planning (collaboratively developing a plan to achieve desired goals). Although these processes may proceed in a linear fashion, movement back and forth across the processes is common during treatment.

The spirit of MI, which most strongly reflects MI's grounding in Rogerian humanistic and client centered therapy, facilitates the engagement process. MI spirit is empathic, collaborative, compassionate, and evocative (Miller & Rollnick, 2013) It is also highly respectful of the expertise and wisdom that the patients have about themselves (Miller & Moyers, 2006). As such, patients are considered to be experts in how to achieve their desired goals, resulting in a dynamic that puts emphasis on patients making their own decisions with guidance, as needed, from the therapist. Consistent with this approach, the Focusing process is fully collaborative and supportive of the patient's autonomy in deciding what the focus of the treatment will be. At times, this may be obvious from the setting (i.e., someone coming to a substance abuse treatment clinic) but at other times, the setting may not dictate the focus

of the treatment or a client may be facing a multiple issues and the focusing process helps the patient prioritize certain issues.

Once there is a focus to the work, the process shifts to evocation, which aims to build motivation to change. During this process, the basic tools of standard counseling and psychotherapy--open-ended questions, reflections, affirmations, and summaries-- are used strategically to elicit and reinforce *change talk* and *commitment language*. *Change talk* is language from patients that argues against the status quo (i.e., *"I can't stand feeling like this anymore"*) or for change (i.e., *"It would be great to feel like my old self")*. *Commitment language* consists of statements from patients about their intention to implement a behavior change. Statements can vary in intensity, from low-intensity (e.g., *"I don't know, maybe I should do something about my depression"*) to high-intensity commitment language (e.g., *"I really have to do something about my depression, I can't stand being in bed all day anymore"*). Although *change talk* occurs naturally in a person considering change, the MI clinician can also use specific techniques to evoke change talk. These techniques include asking the patient evocative questions to elicit the reasons, desires, and needs of the desired change; identifying important values in a patient's life and exploring how those have been affected by the problem behavior; or exploring with the patient what life might be like without the problem behavior.

In conducting MI, the role of the therapist is to interact with the patient in a manner that selectively evokes and reinforces language in favor of change and to avoid interacting in ways that hinder it. These latter include confronting patients, giving advice, or raising concerns about patients' actions without obtaining their permission beforehand (Moyers, Martin, Houck, Christopher, & Tonigan, 2009). This is important, as research has shown that the frequency with which a patient offers change talk and commitment language during an MI session is associated with improved client outcomes (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Apodaca & Longabaugh, 2009; Gaume, Gmel, Faouzi, & Daeppen, 2008; Moyers, Martin, Christopher, Houck, Tonigan, & Amrhein, 2007; Moyers, et al., 2009).

Once the ambivalence has tipped towards change, as demonstrated by greater change talk from the patient with decreased effort by the therapist, the therapist guides the patient to a statement that they are ready to change. At this point, the planning process begins and the therapist explores with the patient their thoughts about how to go about changing the problem. The therapist can also offer suggestions to the patient, but only after securing their permission to do so (ie., *"If you would like, I can tell you about some other options to treating your depression"*). If there is only one treatment option available at the site, that can be presented to the patient, while stressing the patient's autonomy in deciding whether they would like to enter that particular treatment.

BATD

BATD (Lejuez, et al., 2001; Lejuez, et al., 2011) is a brief, relatively simple treatment, usually consisting of 5-12 sessions, whose overall aim is to increase the value of reinforcers for healthy behavior (i.e., socializing, remaining active, etc) and decrease the value of those for depressed behavior (i.e., withdrawal, substance use, etc). Instead of directly intervening to change the cognitions and emotions that can facilitate healthy behavior, BADT focuses on

changing patterns of behavior which then facilitate change in cognitions and emotions. As such, although the importance of cognition in the onset and course of a depression are acknowledged in BATD, they are not targeted directly for change. Instead, these are addressed indirectly by bringing the individual into contact with more positive consequences for overt behavior.

The initial session of BATD focuses on establishing rapport with the patient, assessing the impact and causes of the depression, introducing the treatment rationale, and discussing the importance of treatment adherence which can include a list of benefits of completing the assignments and impediments to the treatment if the assignments are not completed. The patient's understanding of the treatment rationale is a critical component, as it helps patients understand the approach of BATD, thereby helping to strengthen the therapeutic relationship (Lejuez, Hopko, Levine, Collins, & Gholkar, 2006) and helps to provide a guide for the treatment, thus improving treatment fidelity.

During the following two weeks of treatment patients are asked to monitor, but not alter, their daily activities. During the sessions, the therapist reviews the daily monitoring forms and helps the patient explore how their activities are related to their depression. These sessions also focus on exploring values and life areas (i.e., education, relationships, employment, hobbies and recreational activities, physical/health issues, spirituality) that are important to the patient. The patient is asked to identify the values they strive for in each of the life areas. The therapist then works with the patient to identity concrete manifestations of these values (i.e., activities), which are behaviors that the patient can do on a daily basis and are within the patient's current ability and resources. For each activity, the therapist and patient collaboratively determine what the weekly and final goals will be in terms of the frequency and duration of activity per week.

In Week 4 of treatment, the therapist reviews that previous week in terms of the daily monitoring form as well as the activities (both old and new) that were incorporated into the week. Challenges with implementing planned activities are also reviewed and problem-solved.

During Week 5, the concept of Contracts is introduced. Contracts are aimed at helping the patient identify: a) an activity that is difficult for them to complete, b) what would be helpful to them to complete the activity, c) up to three individuals who might be able to help, and d) what each of these individuals can do to provide help. The goal is to have patients consider how others could be more supportive of their healthy behavior and by guiding those people about how to be supportive, their unsupportive behaviors will also decrease.

After session 5, no new content is introduced. At that point, the sessions establish a pattern of reviewing the patient's activities during the prior week, reviewing important values to help the patient identify, schedule, and implement new activities, and assess the effectiveness of the contracts establish and the need to identify new contracts. This pattern typically continues for another 8-10 weeks, until the conclusion of the treatment.

In a recent update of the BATD treatment manual, Lejuez, et al., (2011) identified some challenges in providing BATD. First, is that some patients, expecting a more free-flowing

therapy where they can discuss different stressors, might resist the focus on monitoring and changing behaviors. Another challenge is the completion of the monitoring forms and planned activities during the week. To address these, they recommend educating patients about the treatment rationale and the importance of completing assigned tasks during the week. Reviewing the treatment rationale and monitoring forms during sessions also serves to reinforce the importance of these components and improve engagement and adherence in BATD.

Two other behavioral principles are key to BATD, shaping and fading (Hopko, Lejuez, Ruggiero, & Eifert, 2003). Shaping involves reinforcing successive approximations of a final desired response, whether it's completing an activity or a homework form. Thus although the final goal is full completion of homework, partial completion is reinforced so long as it is a step towards the full homework assignment. Similarly, fading involves helping the patient identify resources in their life to assist with a goal to ensure the patient isn't committing to unachievable goals, which could result in failure and reduce motivation. In the specific case of homework, this might include practicing it with the patient when it is assigned. Helping them identify people in their life who might help while they are doing it, or even completing it with the patient if they did not complete it at the subsequent session. Taken together these two principles can be used to customize BATD to fit with a patient's skills and current motivation level.

Facilitators and Challenges to Integrating MI and BATD

This impetus to integrate MI and BATD was facilitated by a number of similarities between how the two are conceptualized by their developers. For example, both approaches view working with patients as a collaboration, with the therapist and patient working together to identify goals of the treatment and how those goals can be met. Both approaches also use an exploration of values, in BATD to identify activities that will be reinforcing for the patient, and in MI to build motivation to live by important values in one's life (Miller & Rollnick, 2013). In both these interventions, the values exploration also acts to increase the understanding of the patient and what is important to the patient, versus assuming that what is important to the therapist is important to the patient. Both approaches also use self-efficacy to help move a patient towards their goal. In MI, the therapist seeks out and explores instances of success so that these are not overlooked by the patient in order to build a sense of mastery. In BATD, the therapist builds self-efficacy with the procedures of shaping and fading. The therapist works with the patient to identify simple activities that they can easily accomplish, which not only reinforces their engaging in activities, but also builds self-efficacy prior to scheduling and planning more complex actitivies. Also facilitating the MI-BATD integration is the flexibility with which BATD can be conducted, as it is a relatively adaptable treatment that does not require the therapist to be directive.

Nonetheless, as is often seen with structured treatments, there can be a tendency among therapists to employ a more directive approach in their interactions with patients. When BATD is approached from a more directive framework, the therapist may present the treatment components in ways that are inconsistent with MI. For example, psycheducation and the treatment rationale may be provided in a more directive manner and even include

imposing this information upon the patient as a matter of course. This can set up a dynamic where the therapist is seen as the expert and the patient is placed in a passive role in the treatment. This differs from the more client-centered nature of MI, which draws more heavily upon exploring the questions the patient may have about treatment. Another key issue can be the extent to which the BATD therapist approaches the assignment of homework without discussion of the patient's desires, concerns, and interest in doing the homework. Doing so assumes the patient sees the value in the assignment and creates dynamic of “do this, it will be good for your treatment” which is MI-inconsistent. Finally, while BATD does place a strong emphasis on reinforcing the patient's efforts and successes since the previous session, there can be a tendency to overly focus on the aspects of assignments not completed and the associated barriers. A discussion of these obstacles that is overemphasized, too directive, or even punative, would be highly inconsistent with MI's focus on the patient's successes and exploring how the patient's successful approach could be used more consistently—thus bulding on strengths and enhancing self-efficacy.

Thus, although there is complementarity in these approaches that suggests a possible synergy through their integration, there are also challenges in delivering a structured treatment such as BATD through an MI lens. Table 1 provides examples of standard BATD and the MI-BATD integration (MBATD), demonstrating a useful alternative approach to implementing the core components of BATD at key treatment junctures.

What MI contributes to BATD

Greater focus on the patient-therapist interaction

Although, in general, BA therapists practice in a warm and supportive manner, the BA treatment manuals tend to place greater emphasis on the techniques of treatment than the patient-therapist interaction (Lejuez, et al., 2011; Martell, et al., 2010). This is similar to what happens in CBT, even though research has shown that Rogerian therapist behaviors such as empathy, genuineness, and unconditional positive regard are associated with positive outcomes in CBT across a variety of problem areas (Horvath & Greenberg, 1994; Keijsers, Schaap, & Hoogduin, 2000). For some therapists, striking this balance between empathy and treatment techniques may come naturally, but for others, especially those with less experience, this balance may be more difficult to achieve.

The integration of MI, with is basis in Rogerian psychology, into BATD demands that the therapist pay equal attention to the patient-therapist interactions, with particular focus on the role of empathy (i.e. seeing the world through the patient's eyes) in the process of behavior change. As such, the MI therapist uses reflections regularly to assess their understanding of the patient's experience and adjust their interactions accordingly. This approach is incorporated into BATD, allowing the therapist a more accurate awareness of the experience of the patient as he/she progresses through treatment. This focus on empathic understanding can be very helpful in understanding any obstacles to treatment adherence and retention (i.e., what appears as a simple obstacle to the therapist may seem much more overwhelming to the patient) which is essential to developing solutions to obstacles faced. The goal is to gain a deeper understanding of the patient's experience in therapy in order to diminish obstacles to treatment adherence and retention and, if they arise, respond to them in a personalized

manner. Furthermore, this focus on understanding the patient's experience is invaluable in strengthening the therapeutic alliance.

Greater focus on patient motivation

While a strong treatment rationale is expected to provide sufficient motivation for patients receiving BATD, the addition of MI provides a more concrete focus on building motivation from the start of therapy, with a very specific focus on developing and highlighting the patient's change talk to build motivation for treatment. MI can also help attune the therapist to decreases in motivation that can occur throughout the course of treatment and respond accordingly. At times, this may demand just a brief focus on increasing motivation, but with patients whose motivation seems to have decreased substantially, it may require a return to a pure MI session focused specifically on augmenting motivation to change. Potential situations which can require a shift back to MI include 1) consistently not completing planned activities; 2) increased sustain talk (i.e. statements from the patient verbalizing why change is no longer important or desired); and 3) inconsistent attendance.

In these situations, where adherence to core aspects of the treatment is poor, the therapist may be tempted to directly encourage the patient to overcome the obstacles they are facing or offer potential solutions to those obstacles. Even when done in a caring and supportive manner, this would be inconsistent with an MI approach. In contrast, MI encourages the therapist to step back, re-assess where the patient is at and, if the patient expresses interest in proceeding with treatment, elicit and reinforce change talk through open-ended questions and reflections. In the example below, note how the clinician raises the issue, empathically aligns with the patient, then moves to elicit and reinforce change talk. Then there is a discussion about treatment and an autonomy supportive approach to overcoming obstacles to treatment.

> T: Over the past few weeks, I have noticed that, early on, you were really revved up in terms of overcoming your depression and doing the activities and exercises that are part of the treatment. Then, in the last couple of sessions, I noticed a bit of an easing up, maybe less focus on overcoming your depression or engaging in some of the activities you plan. This is certainly something that can happen during treatment and I am wondering if it is something that you have noticed and what your thoughts are about it?…
>
> P: No, I definitely want to get over this depression and over the last couple of weeks I have actually felt better so I think I am doing pretty well.
>
> T: You are seeing some improvements and it doesn't feel you need to continue to work so hard at getting better, like taking your foot off the accelerator a bit.
>
> P: Yes, kinda like that.
>
> T: Things are well enough.
>
> P: Yeah, well, I am not all well yet, not 100%
>
> T: Ok, you are starting to feel better, but things are not all back to normal yet, you are not feeling as well as you would like to feel.

P: No, not yet.

T: So what are we shooting for? How would you like to be feeling or living once our work together is over?

P: Well, I want to feel happy more regularly. I have that sometimes now, which I didn't before, but I want to feel good every day, not just one or two days. That would be a big change.

T: That would make life very different for you.

P: Yeah!

T: You know, it will always be your decision when to stop coming to these sessions and when to do the activities and exercises we plan. I really can't control that, it is up to you. I am wondering if you would let me provide you with some information about this treatment, when the effects tend to kick in, and what we see tends to really help people get better, is that okay?

P: Sure.

T: We have found that like you, people start to feel better pretty quickly after starting this treatment, some energy improvement, enjoying certain things, even getting a brighter outlook on life. That is the first part. The second part is helping folks incorporate these activities into their lives long-term, and that can take a little more time, it really has to become part of your routine. And sometimes, though not always, taking your foot off the accelerator too early can delay you getting to your goal. That is what we have to balance as part of this treatment. So, as you look at where you are in your treatment, where would you like to go from here?

MI can also be used to build motivation to complete therapeutic activities to be undertaken between sessions (i.e., between-session activities). Between-session activities is a more MI consistent term that helps to decrease power differentials and the perception of being assigned a task that may arise by using the term “homework.” Although there is utility in working with a patient to understand how factors such as a poor choice of activities or external constraints can impact adherence with between session activities, such efforts will have little utility if the real problem is the patient's motivation. The addition of MI can help the therapist take a step back and address issues of motivation before taking other well intentioned steps that might only counter-intuitively further lead to a reduction in motivation. Furthermore, the therapist can also build motivation and commitment to complete between-session activities by evoking change talk about the benefits of these activities—which is then systematically reflected by the therapist. This approach can be used to highlight and reinforce the benefits of activities that have been successfully completed or to explore potential benefits of planned activities. Questions such as those below are designed to elicit from the patient the benefits *they* perceive from completing between-session activities.

“What was it like for you to do this activity? How did it make you feel?” (Evocative open question). “So doing this gave you a break from feeling down, you could see that you could still enjoy something” (Reflection)

How do you think that keeping track of your activities during the week may help you overcome your depression? What do you think you might learn by keeping track of your activities?

What do you think life would be like if you were able to regularly incorporate some of these activities that you find meaningful and important into your life. How would your life change from how it is now?

Use of these targeted questions, which makes the benefits very personal to the patient, can be a much more powerful than the therapist providing the patient with a general overview of the benefits of these exercises.

A complementary approach to increasing self-efficacy

Confidence in ability to achieve a goal is important in maintaining motivation to pursue and attain that goal. To build self-efficacy, a BATD therapist works with the patient to identify and schedule simple activities so that, through accomplishing them, the patient gains self-efficacy, which continues to increase as more and more activities are accomplished during the treatment.

In MI, self-efficacy is considered a key construct of motivation; if patients do not believe that they are able to accomplish a goal, their motivation to attempt to change may be hindered. Therefore, building self-efficacy before attempting a behavior change is critical. A frequently used technique done prior to behavior change is a Confidence Ruler (Rollnick, Butler, & Mason, 1999) which asks patients to quantify their confidence about engaging in a given behavior. For example, "*On a scale of 0 to 10, where 0 is not confident at all and 10 is very confident, how confident are you that you could call one friend each day this week?"* The therapist follows up the patient's answer with another question: *"Why is it a (patient's number) and not a 0?"* This follow-up question is the most important part of this exercise because the question evokes from the patient statements of self-efficacy and commitment to accomplishing the activity (i.e., "*Because I have done much more difficult things*," "*Because once I set my mind to something I do it*"). These statements are reflected and explored further by the therapist in order to augment the patient's self-efficacy. After this exchange, the therapist can also ask the patient "*What might help move you from that number to a couple of numbers higher?*" or "*What would it take to move you up a number?*" which is often helpful in identifying solutions that might help the patient attain their goal. On the other, asking the follow up question erroneously ("*Why a ____ and not a 10*?") evokes from the patient all the reasons why they don't feel confident in their ability to attain their goal, which can reinforce a sense of futility in the patient.

As treatment progresses, the MI therapist mines for successes, even if partial, in completing activities and uses these successes to actively build self-efficacy. For example, if a patient has completed a planned exercise 1 out of 5 days it was planned, the MI therapist would not move immediately to exploring what went wrong, even if done in a supportive and problem solving manner. Instead, the MI therapist moves immediately to explore the single day of success, evoking from the patient how they motivated themselves to do it, what helped them do it, and how they felt afterwards. During this exchange the therapist uses complex reflections to selectively reinforce experiences of success and seeks opportunities to affirm

patient strengths (i.e., perseverance, effort) that contributed to success. This approach helps to build self-efficacy, evokes change talk, reinforces motivation, and identifies what the patient currently does that contributes to success and that can be done more consistently. This is in contrast to the typical approach which entails the therapist exploring with the patient what obstacles kept the patient from doing the exercise in order to develop a plan to overcome the obstacles. However, for a depressed patient, this discussion may highlight and reinforce the obstacles and difficulties in completing their activities and possibly contribute to their sense of hopelessness. In MI, the therapist could also explore obstacles to success, but this would be done after asking the patient if it would be helpful to them discuss obstacles. Once the patient agrees, this exploration would proceed by evoking the obstacles and possible solutions from the patient.

> Great, so you were able to write activities down almost every day of the week. That's great. What helped you do it on those days that you were able to do so? How did you go about remembering to do it?
>
> I can imagine that there were times that you did not feel up to doing the activities and you eventually did them anyway. Tell me a bit about that, how did you get yourself going? How did you overcome those feelings?
>
> I also noticed that it was easier for you to list your morning and evening activities than to list your activities during the middle of the day. I am wondering, what might help you fill in your mid-day activities better? How might we use some of the approaches you used to remind yourself to fill in your morning and evening activities to help you fill in your mid-day activities?

Greater focus on the patient's autonomy

Between session activities in BATD includes doing the activities planned as well as completing daily tracking forms of activities planned and accomplished, rating each activity for importance and pleasure, and establishing Contracts with others who might be helpful to the patient in completing their planned activities. These are considered essential components of BATD. When not completed by the patient, the therapist tries to engage the patient to complete them, usually by reminding them of the importance of these components to the treatment.

A core aspect of MI is its deep respect for a patient's ultimate decision of whether or not to change, or in this case, do the between session activities. As such, the therapist would refrain from urging or trying to convince the patient of the importance of doing them. From an MI standpoint, highlighting the patient's autonomy lessens the risk that a patient who is ambivalent about doing these activities will argue back against having to do them. Instead, the activities are presented as tools that are available to the patient and have been found to be effective in helping people achieve their goals in treatment. What varies from a typical approach is that the therapist explicitly states that doing the various activities is a decision that only the patient can make, emphasizing the patient's autonomy in the treatment.

> Previously, we spoke about the activities that you can do during the week as part of your treatment. We find that the daily monitoring and other activities you do

> between sessions are very important since what we are really interested in is you doing better out there and not just in this office. But, the reality is that I cannot force you to do them, it is really up to you. What do you think about this?

This focus on patient autonomy is also the basis for engaging the patient in a discussion of how to make components of BA more useful to the patient. As such, the therapist invites the patient to contribute to the design of the activities as well as the tracking forms, in hopes of making them more relevant to the patient and helping the patient achieve their goal. In this way they may be seen less as assignments from the therapist than as something that the patient is interested in tracking or doing to overcome their depression.

> Is there anything that you think might be useful for us to add to this form so that it is more useful to you—something that you think is important for us to track in terms of your depression and activities? Although you can't think of anything now, if there is anything that you think we should add to these tracking forms that you think would be particularly useful, feel free to tell me.

What BATD contributes to MI

MI is most effective when combined with another effective treatment modality (Burke, et al., 2003; Hettema et al., 2005). This is where BATD and other evidence based treatments for depression and anxiety offer a crucial contribution to MI. They offer MI an effective treatment to lead into after augmenting the patient's motivation to change. MI clinicians often incorporate aspects of CBT into their treatment with patients as part of the change plan that is developed after motivation has been heightened. However, combining MI with a more comprehensive and in-depth treatment for depression may increase the likelihood of a successful treatment outcome. For example, whereas an increase in pleasant activities may be one of the approaches a patient might identify as part of their MI change plan to overcome their depression, the systematic approach used in BATD, which has the patient track behavior to learn about patterns of activities in their life and how these relate to their mood and the systematic exploration of values in order to identify meaningful activities, considerably expands and deepens this discussion. Compared to a more superficial discussion of activities, this comprehensive approach may be more likely to result in a decrease of depressive symptoms since it provides sufficient “dose” of behavioral activation. Thus, while MI contributes a motivational component to treatment, BATD contributes an effective treatment for depression. Moreover, an approach like BATD which is known for its flexibility can be tailored to most any level of motivation, thereby allowing the same structure of treatment to continue with some modification as the patients motivation levels increase.

Example of MBATD session

Table 2 presents the outline of a twelve-session MBATD treatment, with the italicized portions highlighting specific uses of MI to build and sustain motivation to the specific tasks of BATD.

The degree to which a therapist uses MI during the session depends on the patient's motivation. For example, a patient who easily expresses their commitment to follow-up on activities and takes the lead in developing a plan typically requires less MI than a patient who is more ambivalent about the usefulness of activation or specific activities to overcoming their depression. As such, throughout the session the therapist remains empathic to the patient's experiences and alert to an ebb in motivation. We now present a more detailed description of a mid-treatment session, which provides an example and video demonstrations of how the therapist can integrate both treatment approaches during a session.

As the session beings, the therapist affirms the patient for coming to the session and her commitment to overcoming her depression, which helps strengthen the therapeutic relationship, build self-efficacy, and possibly evoke change talk regarding her commitment to change. The therapist then explores the patient's experience with adding activities into her life. Throughout, this exchange, the therapist remains vigilant for examples of activation and improved mood that could be used to highlight the goals of BATD. Once the patient mentions such examples, the therapist strategically evokes change talk regarding how the patient felt better when active, what this was like for the patient, and the benefits of engaging in this activity. Subsequently, the therapist summarizes this discussion and links it back to the treatment rationale.

The session then moves to reviewing the between-session activities, including the monitoring of activities and completion of activities that had been planned. In discussing the monitoring form, the therapist first aims to build self-efficacy by focusing on strengths and accomplishments (see Video 1). Thus, even if the patient has not consistently completed the form, the therapist focuses on the occasions in which the patient was able to complete the form and explores what facilitated their success rather than focusing mostly on the occasions in which the patient failed and exploring reasons for that failure. To highlight how monitoring of activities may be beneficial to the patient, rather than suggesting benefits, the therapist evokes realized or potential benefits from the patient, exploring and systematically reflecting each benefit so that over a brief interaction, these perceived benefits are augmented for the patient. The therapist may then engage the patient in a discussion of obstacles that prevented the patient from completing the form more consistently. Before moving to problem-solve the obstacles faced, the therapist would inquire about the patient's interest in monitoring key behaviors more consistently, while recognizing the patient's autonomy in deciding whether to do so. If the patient wishes to work on overcoming those obstacles, a plan to do so is collaboratively developed—oftentimes by using the approaches the patient used to accomplish what they did. This approach acknowledges the patient's expertise in how to achieve their goals and helps to further build their self-efficacy. Nonetheless, if a patient wants to improve their monitoring but is at a loss of how to do so, the therapist, after obtaining permission to do so, can share possible solutions with the patient. A similar approach of evoking and exploring successes then moving toward obstacles encountered is used when reviewing the patient's completion of planned activities. Again, the goal is to help the patient build the argument for the benefits of increasing their activities, either through actual experience or through perceived benefits of doing so in the future.

Standard BATD explores Life Values and Goals to help the patient identify activities that, because they are related to those values and goals, would be meaningful to the patient and motivate the patient to incorporate them into their life. MI adds another approach to using values and goals by actively exploring and reflecting the importance of those values and goals in a patient's life to build motivation to change and live by those values. This is often done by exploring what life might be like if they lived by a certain value or if they were able to achieve a certain goal. During this exploration, the therapist strategically reflects the patient's statements towards their desire to live by those values, augmenting their motivation to change and incorporate activities that will help them achieve those life goals or values. A brief demonstration of how this approach can be used to sustain motivation while reviewing between-session activities is shown in Video 2.

Once the activities are selected and the patient decides which to start to incorporate into their life, a similar evocative approach can be used to augment motivation to actually do the activities (see Video 3). Evocative questions such as “How will it feel if you are able to accomplish this?” or “Why is this activity so important to you?” evokes change talk from the patient and helps build motivation to accomplish the activity. A good mindset for the therapist is to be curious about what succeeding in this activity will be like for the patient. If any obstacles are identified during this process, the therapist and patient can work collaboratively to develop a plan to overcome them. In providing suggestions to the patient, the therapist remains MI consistent by obtaining permission from the patient before offering suggestions, working together all along and not leading the patient either explicitly or implicitly. The elicit-provide-elicit (E-P-E) approach is also helpful and consists of first eliciting solutions from the patient, then providing other solutions, and lastly, eliciting the patient's reaction to the ideas offered. Remaining respectful of the patient's autonomy and to valuing the patient's own expertise in identifying solutions is critical in these interactions.

Lastly, because low self-efficacy can impede a patient from even trying a planned activity, it is often useful for a therapist to gauge the patient's self-efficacy to assess whether there is a need to work on increasing self-efficacy prior to concluding the session. This is often done using a Confidence Ruler (which was described earlier). This approach engages the patient to identify what makes them confident at succeeding, which highlights their strengths, self-efficacy, and ability to accomplish their goals (see Video 4). Furthermore, the follow-up question of what may increase their confidence level one or two notches higher is a way to not only identify facilitators to achieving their goal, but also any previously missed obstacles that may hinder success. The discussion of how to best use facilitators or overcome those newly identified obstacles brings the session to its closure.

Although it is not typical practice and some clinic policies may not allow it, in MI the patient would typically be asked when they would consider it most beneficial to have their next appointment. This fully supports the patient's autonomy and expertise in their treatment process. While this may not be feasible in all settings, this is useful for the therapist to consider this and collaboratively make arrangements with the patient for the next session. This collaborative approach to setting the next appointment also allows for better planning between sessions since the therapist can ensure the patient has all the forms and materials necessary for the period prior to the next session.

MBATD: A Case Study

James is a 45 year-old, gay-identified, professional, who came to the clinic seeking treatment for depression, from which he had suffered for the past five years after a sexual assault. He did not meet diagnostic criteria for post-traumatic stress disorder, but did report dysphoria, decreased energy, loss of pleasure and interest in activities, social withdrawal, feelings of guilt and helplessness, and periods of passive suicidal ideation.

In the first MBAT session, which focuses on building motivation to change, the therapist explored the impact of depression on the patient's life and hopes for overcoming his depression (evocation of change talk) helping build discrepancy between his current state and his desired state. This discussion flagged one key life area where the patient sought change, interpersonal relationships. Over the next session the clinician presented the treatment rationale and discussed tracking his behavior in order to obtain a clearer idea of his activities during the week. She reviewed the activities tracking form with the patient and evoked from him the potential benefits of tracking his behavior and how the tracking might help him overcome his depression.

At the next visit, the therapist inquired about the past week and the patient's activities. He brought out the activities tracking form, which he had filled out only for the first few days. The therapist evoked from the patient what had learned from tracking activities those two days. He said these showed that he was going to work and doing things he had to do, but there were few pleasurable activities, nothing to “brighten up my week”. The therapist then explored his experience of using the tracking sheet and difficulties encountered. This discussion highlighted that the patient viewed these as work, so he completed them, but was not engaged in the process.

The therapist reiterated that the choice of completing these forms was the patient's to make and that it was just a tool for monitoring activities to learn about the impact of activities on the patient's mood. This evoked from the participant statements about how this could indeed be helpful. The therapist also offered to explore other ways of doing this that might work better for the participant. The patient and therapist worked collaborative to discover that for the patient, using the calendar on his smartphone would be a simpler approach and that he could also include a rating of pleasure and importance. Discussion then turned to exploring Life Areas and Values and identifying which to focus on first. The patient selected two areas, Relationships and Health (Physical and Psychological). Incorporating both BAT and MI approaches, the therapist not only helped the patient identify these areas of focus but build motivation by exploring what the patient aspired to in these areas and what life would be like if he attained these goals. This helped focus the patient for the next session, during which the patient and the therapist would be identifying activities related to each of the areas selected.

The patient came to the fourth session appearing brighter in affect. He reported that after the discussion last week he decided to call a friend whom he had been wanting to get together with but was worried the friend was upset because he had not called him for a long time. The patient recounted how happy he was to have made the call and how much he enjoyed the

dinner with his friend. The therapist used this opportunity to evoke change talk by exploring how this event affected the patient and his mood, reflecting his change talk throughout the discussion. A review of his weekly activities revealed that aside from this dinner, he spent some time shopping during the weekend but no other activities were added. The therapist also noted and pointed out that his tracking was more comprehensive this week using his cellphone and evoked how this experience was for the patient. He reported it worked well for him and really highlighted how little pleasurable activities he engaged in. He joked about the calendar being too empty. To reinforce the benefits of the monitoring, the therapist evoked the benefits the patient perceived from the monitoring as well as what facilitated the process for him. During the remainder of the session, the therapist and patient identified activities related to the two Life Areas that the patient wanted to incorporate during the week; identifying a variety of activities that could be done with friends or alone, regardless of weather or other potential obstacles. Capitalizing on the perceived enthusiasm, the therapist used a confidence ruler to assess the patient's confidence that he would be able to complete the activities planned. The patient responded an 8 and the therapist asked why an 8 and not a 2, evoking change talk and augmenting the patient's self-efficacy as he discussed his commitment to doing this and how the happiness he experienced after the dinner with his friend motivated him to continue adding activities.

Over the next few sessions, the treatment proceeded smoothly, and the patient continued to add activities and recognized the benefits of engaging in pleasurable and important activities in his life. During these weeks, his mood noticeably improved and he reported significant decreases in his symptoms of depression. Towards the second half of the treatment, the therapist once again noticed how the activity tracking had become infrequent. She inquired about this and the patient's thought about it. He mentioned that he saw the value in it at the beginning, as it highlighted for him what was missing from his life, but as he incorporated more activities in his life, often spontaneously, he didn't feel a need to track them so carefully. Consistent with an MI approach, the therapist reiterated that this was really the patient's decision--that the real goal was for the patient to be engaged in activities. He decided that at that point, he was fine without tracking behavior and the therapist accepted that decision, although subsequent sessions still involved a discussion of activities and the patient's reaction to them.

As treatment concluded after 12 weeks, the patient reported no longer feeling depressed. Instead, he reported a return to his usual self. He had re-established a connection with numerous friends which would be very helpful in maintaining the increased activation that he achieved during treatment.

Conclusions

The combination of MI and BATD has significant potential to improve clinical outcomes for depressed patients by motivating them to enter into and complete an effective treatment for depression. Our experience has been that BATD and MI integrate relatively easily, something that is facilitated by the flexibility that BATD affords and encourages in order to match the treatment to the patient. In many instances, MI adds an adjunctive approach to the goals of BADT. Our experience also highlights that the more directive components of BADT

are more challenging to integrate with MI. This suggest that therapeutic approaches that, in general, are more structured and regimented may not integrate as easily, as the philosophy of the approach or demands of the tasks of the treatment may prove to be incongruent with MI. Successful integrations of MI with other approaches must consider not only the content of what is integrated, but most importantly how different approaches view the therapist, the patient, and their interactions. Although these integrations can be difficult, the potential for improved outcomes highlights the need to investigate how to best integrate MI with other psychotherapeutic modalities in order to facilitate how therapists provide these treatments.

This manuscript has provided an overview of how these two modalities can be integrated, how conflicting aspects of the two approaches can be resolved, and what each approach contributes to the other. However, research testing whether the integrated treatment results in better outcomes that BATD alone or MI as a pre-treatment to BATD, is clearly needed. Such a study would also allow the comparisons of alliance, empathy, and change talk from the patient, and how these are related to treatment outcomes.

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Table 1

Comparison of BATD provided in both a standard and motivation-based framework at key treatment junctures

Standard BATD	Motivation-focused BATD (MBATD)
	A. First contact
Present the components of BATD Provide general overview of depression. Encourage patient to put aside concerns about the thoughts and feelings that are holding back progress and "act" with the expectation that motivation will follow.	Build motivation to overcome depression by: • evoking impact of depression on life • evoking vision of life without depression Build commitment to overcome depression Once commitment is built, present information about BATD • how BATD treats depression • components of BATD
	B. Introducing homework
Introduces homework forms and strongly emphasizes the importance of completing the forms. Anticipate barriers to completing homework and lead a discussion with patient to generate list of barriers and strategies to deal with each that can be tried by the patient.	Avoid use of term homework in order to facilitate a more collaborative and egalitarian relationship between provider and patient. Obtain permission from patient to explain the role of between-session activities in BATD and the ways it is useful to many patients. Proceed after permission is granted Stress that it is the patient's decision whether to complete the between-session activities. Evoke from patient how between-session activities may help them overcome their depression and how they might best motivate and remind themselves to complete homework exercises Use reflections to selectively reinforce change talk regarding completing between-session activities Offer patient the opportunity to personalize monitoring forms to make activity monitoring more useful and meaningful to them
	C. Motivating patients to complete activities
Mildly push patient to reconsider that action has to precede motivation. Review treatment rationale and role of completing activities in BATD Lead a discussion of how the patient might benefit from completing activities.	Evoke from patient how they might feel after completing an activity and how this might help them overcome the depression Use reflections to selectively reinforce change talk regarding completing homework When reviewing homework completion, evoke and explore how patient felt after completing the homework, selectively reflecting change talk. Further reinforce motivation by offering a summary of the change talk patient offered regarding benefits of completing homework.
	D. Addressing non-adherence with forms or activities
Non-completion of activities: Remind patient about the value of completing activities even if they are not feeling motivated. Encourages discussion of possible reasons/barriers and help the patient generate solutions to address those barriers. Have the patient complete a support contract in session as a role play and then assigns one contract for the patient to complete with a friend or family member. ***Non-adherence with forms:*** The first few times homework isn't completed the therapist lists possible reasons and ask the patient to what extent each contributed to the forms not being completed. Model completing forms with the patient in session Assess barriers to form non-completion. Mildly challenge patient regarding their commitment to the treatment when homework repeatedly isn't completed May indicate to the patient that BATD is not a viable treatment option if homework is not completed.	Affirm patient for occasions when they completed the homework forms or activities Evoke what help them complete homework forms or activities on those occasions and affirm patient characteristics that contribute to success Evoke how patient felt after completing forms/activities how they were useful in lessening the depression Selectively reflect patient's change talk about completing forms or activities to reinforce their experience of the usefulness of the homework Explore the patient's interest in improving homework completion. Once commitment to doing so is obtained, explore how patient might use the approaches they used successfully more regularly Problem-solve other obstacles; evoke possible solutions from patient before offering suggestions Present option of incorporating contracts (supports) and evoke from patient how this may be helpful in their treatment.

Table 2

Outline of 12-session MBATD treatment.

Session 1 (Motivational Interviewing)	
1	Review symptoms of depression and how they have been affecting the patient
2	Evoke and reinforce change talk from the patient regarding their desire, need, or reasons for overcoming their depression
3	Summarize discussion, highlight change talk & ask key evocative question about change
4	Offer MBA as a treatment option
5	Closure: Summary of session, highlighting change talk, and schedule next appointment
Session 2	
1	Check-in with patient…. *evoke and reinforce change talk about overcoming depression**
2	Provide treatment rationale using examples of low activation-depression from the patient
3	Introduce and explain Daily Monitoring of Activities
	-Evoke and reinforce change talk regarding monitoring in order to increase motivation to do it.
4	Discuss monitoring activities during following week
5	Build commitment to between-session exercises by evoking and reflecting their potential benefits to the patient
Session 3	
1	Check-in with patient….*evoke and reinforce change talk about overcoming depression*
2	Using examples from previous week, engage patient to explain rationale for BA
3	Explore experience of completing Daily Monitoring Form
	-Evoke change talk regarding using the form (i.e., how it was useful, what the patient learned, or what it highlighted for the patient). Evoke success in completing form then explore obstacles and collaboratively establish a plan to overcome them.
4	Review Daily Activities
	-Explore how patient feels doing different activities during week; help patient identify patterns related to types of activities and mood; *Use examples of pleasurable activities to evoke change talk from patient regarding improvement in mood*
5	Explore Life Areas and Values
	-Help the patient determine important values related to different life areas; *engage patient in describing what living by those values is like for them and how/why those values are important;* establish the link between these values and the meaningful activities that he/she will begin to incorporate into their life shortly
6	Review between-session exercises for next week
	-Continue to monitor activities; Think about activities that are associated with the Life Areas that were discussed.
Session 4	
1	Check-in with patient; *evoke and reinforce change talk around increasing activities*
2	Review treatment rationale (if necessary)
3	Explore experience of completing Daily Monitoring Form (as described in Session 3)
4	Review Daily Activities (as described in Session 3)
5	Continue to explore Life Areas and Values; select NEW activities for upcoming week
	-Have the patient identify new activities, related to their values, that they want to do during the week. Assist patient in planning for successfully doing the activity.
6	*Evoke change talk regarding the planned activities*
	-Explore what made patient select those activities, what it will be like for him/her to accomplish them, and how they relate to goals and values.
7	Build confidence to complete new activities

-Use Confidence Ruler to evoke statements of self-efficacy and identify what may help the patient feel even more confident of their ability to complete the planned activities.

Session 5

1 Check-in with patient; *evoke and reinforce change talk around increasing activities*

2 Review planned activities and monitoring form

-Evoke change talk regarding new insights from completing the form or the activities, achievements, and how obstacles were overcome; explore obstacles that remain and collaboratively establish a plan to overcome them.

3 Identify and plan activities for the following week

-Evoke reasons for selecting these activities and what might be helpful to patient in completing the activities.

4 Evoke change talk regarding the planned activities (as described in Session 4)

5 Introduce Contracts, people who might be helpful to patient in completing activities

-Evoke from patient how allies might be beneficial in increasing activities

6 Build confidence to complete new activities (as described in Session 4)

Session 6-11

1 Check-in with patient, *evoke change talk about sustaining increase in activities*

2 Review Planned Activities and Monitoring Form (*as described in Session 5*)

3 Identify and plan activities for the following week (*as described in Session 5*)

4 *Evoke change talk regarding the planned activities* (*as described in Session 4*)

5 *Build confidence to complete new activities* (*as described in Session 4*)

Session 12

1 Check-in with patient

2 Review Planned Activities and Monitoring Form *(as described in Session 5)*

3 Evoke treatment accomplishments and changes in how patient is feeling

4 Collaboratively explore next steps with patient; assess need for continued treatment

-depending on current symptoms, may include continuation of treatment, switch to different treatment modality, or plan to continue integrating and monitoring activities

5 Evoke change talk regarding next steps in order to build motivation for follow-up

6 Collaboratively develop plan for next steps

7 Termination

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* Sentences in italics highlight key MI components integrated into BATD.