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The ABCDs of Lifestyle Counseling

Tobacco, physical inactivity, and poor diet cause more than a third of all US deaths.¹ During the past half decade, great progress has been made on tobacco control, with cigarette smoking rates reaching an all-time low of 16.8% in 2014.² However, during roughly the same period, the prevalence of overweight and obesity among US adults has increased to an all-time high of 69% in 2012.³ The US Department of Health and Human Services addressed smoking cessation in their practice guidelines; a key recommendation was for clinicians to help smokers quit by using the 5 A's model for treatment of tobacco use and dependence: *ask* all patients about tobacco use, *advise* current smokers to quit, *assess* willingness to quit, *assist* with quitting, and *arrange* for follow-up.⁴ Similarly, the 2013 American College of Cardiology/American Heart Association lifestyle guideline recommended that adults consume a healthier diet and engage in regular aerobic activity.⁵ However, unlike the 5 A's model, a similar model for integrating treatment of poor diet and physical inactivity into the clinical setting has not been specifically recommended and none is in widespread use, to our knowledge.

A diverse set of interventions may be necessary to curb rising obesity rates, including public health education campaigns, and environmental changes. However, for the busy clinician operating at the individual patient level, what is sorely needed is a simple model for diet and activity counseling that organizes much of what we know about behavior counseling and adapts it for practical use. We propose an organized approach: the ABCDs framework for lifestyle counseling in which clinicians (A) *assess* a patient's readiness for change, (B) identify potential *barriers* to change, (C) encourage patients to *commit* to measurable goals, and (D) help them *demonstrate* progress by selecting an appropriate self-monitoring strategy (Table).

Assess

The first step in conducting a conversation about lifestyle modification should be to assess the patient's perception of his or her current lifestyle as well as motivation to change. Understanding patients' perceptions allows clinicians to glean important information about health literacy and education, after which information can be provided. In addition, it allows the clinician to assess patients' motivation to change, an important principle of motivational interviewing. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence. Motivational interviewing has been shown to be an effective intervention to promote lifestyle changes in adults.⁶ The motivational interviewing framework acknowledges that the patient is ultimately responsible for overcoming his or her ambivalence toward change and that direct persuasion is not effective. If a pa-

Table. Suggested Discussion Points for Clinician-Patient Conversation on Lifestyle Modification

Step	Questions
Assess	Are you concerned about the effects your diet and/or exercise is having on your health?
	Do you believe that you need to make a change to your diet and physical activity?
	On a scale of 1-10, how important is it to you to change your diet and/or physical activity?
Barriers	On a scale of 1-10, how confident are you in your ability to change your diet and/or physical activity?
	What do you believe are the barriers to making a change in your lifestyle?
Commit	What would it take to overcome the barriers to lifestyle change that you mentioned?
	What plan makes sense to help you with lifestyle change?
Demonstrate	How do you suggest we monitor your progress regarding your lifestyle change?
	Do you own a smartphone and, if so, would you be interested in using a mobile application to track your diet and/or exercise habits?

tient is not motivated, the clinician can ask questions like "On a scale from 1 to 10, how important is it for you to change your diet/exercise?" The clinician can then assess why the patient is at that level and what it would take to be higher. The framework also acknowledges that patient motivation is dynamic, and it supports asking about lifestyle modification at each clinic visit.

Many patients may already be motivated to change but lack the self-confidence to get started. As such, rather than beginning the conversation with a confrontation on the importance of eating less and/or exercising more, focusing on self-efficacy may be more effective. *Self-efficacy* is defined as one's ability to organize and execute a course of action given internal and external resources. Highlighting past successes (such as overcoming a personal or professional challenge) may help to boost patients' self-efficacy and lead to more effective lifestyle modification. Some propose that physical activity counseling be used as a vital sign before each encounter, allowing the clinician to accurately track progress and motivation.⁷ This fits nicely in our ABCDs framework.

Barriers

The next step is to discuss potential barriers toward successful change. Despite initial high motivation for lifestyle change, ultimate goal attainment is typically much lower. This may reflect the well-established tendency to magnify immediate gratification and minimize more distant consequences. As such, helping patients problem solve around predictable challenges may help them achieve longer-term goals.

Barriers to lifestyle change conflict with the patient's self-efficacy, and low self-efficacy is strongly correlated with perceived barriers.⁸ Using this premise in our

ABCDs framework, we suggest that preemptively addressing potential barriers allows the patient to better prepare for successful lifestyle modification by maximizing self-efficacy. In addition, exploring the barriers to change helps develop the patient-physician relationship and allows for a better understanding of the patient's situation. Common barriers to consider include competing demands on time from work; family; perceived or real financial stress; and social situations focused on food. In addition, depression should be identified and treated as it can otherwise limit the energy needed to change.

Commit

Next, the clinician should challenge the patient to commit to a specific, measurable, and attainable goal along with a plan designed to achieve that goal. Goals should focus on health behaviors rather than other health factors like blood pressure and cholesterol levels. In addition, goals should be set as specifically as possible. For example, rather than setting a goal to simply exercise more, consider a goal to run 1 mile per day or to walk 10 000 steps per day on most days of the week. Also, lifestyle goals should be attainable. A goal that is too difficult simply creates frustration, while one that is too easy may not be taken seriously. The patient should be involved in setting these goals, using their self-efficacy to determine what is attainable. Asking patients what it would take to overcome barriers can be a useful step. Goals should be proximal, 1 to 2 weeks if possible, to aid in their attainability. We encourage a written contract to make the agreement more tangible and memorable. Most electronic medical records have secure email functions that make this feasible and part of the medical record.

Demonstrate

Patients should be asked to demonstrate progress toward their goals. This reinforces self-monitoring and helps establish more frequent

and consistent follow-up. Self-monitoring between visits is a critical tool for successful behavior change. It increases patient awareness of health behaviors and helps to identify internal and external factors that influence goal attainment. Numerous weight loss studies have demonstrated greater weight loss among participants randomized to dietary self-monitoring compared with those who were not asked to self-monitor.⁹ Mobile applications may ultimately represent a major breakthrough as they ease the burden of self-monitoring and facilitate real-time feedback. These have been shown to positively correlate with successful short-term risk factor modification.¹⁰

Demonstrating change through self-monitoring allows the patient to evaluate progress between visits and allows the clinician to make specific recommendations at follow-up. Communication between visits through secure email or other communication allows for positive reinforcement or reevaluation of goals. This makes clinician-patient contact an important factor in establishing more permanent change in health behavior. Future encounters are needed to monitor development and to deal with setbacks.

Conclusions

While lifestyle modification represents a major target for improvement in patient health, it also represents a daunting challenge. The ABCDs framework of lifestyle counseling provides an organized approach for busy clinicians who may have had little formal training in lifestyle counseling. This model is meant to be a guide not only for physicians but also for nurses, nurse practitioners, and all other health care professionals who regularly engage in lifestyle counseling. Lessons learned from prior behavior change studies can be used in the context of this framework to empower clinicians and their patients to commit to and demonstrate healthy behavior change.

ARTICLE INFORMATION

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