The 5A Model for Sustainable Well-Being: A Biopsychosocial Framework for Self-Regulation and Behavior Change

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ABSTRACT

Health-related intentions do not necessarily produce sustainable action. The 5A model, developed within health coaching and elaborated in Il codice del benessere, organizes everyday well-being around five domains: self-directed care, allies and environment, nutrition and the relationship with food, physical activity and training, and mental attitude. This conceptual article specifies the model's intended contribution without claiming a new causal theory or established effectiveness. A purposive, non-systematic examination of the source manuscript and selected primary, theoretical, and methodological publications distinguishes a domain map from behavioral determinants, candidate mechanisms, and outcomes. The proposed A-lever is operationalized as a documented decision process: identify a relevant constraint, compare feasible actions, select an acceptable initial action, state its anticipated enabling effect on a different target behavior, and define when the formulation should be revised. A comparative table locates this proposal alongside COM-B, the Health Action Process Approach, and self-determination theory. Earlier uncontrolled health-coaching reports are contextualized by recruitment, duration, analytic denominators, and limitations; participant overlap cannot be determined from the published reports. The earlier Wheel and the book's educational version are not assumed to be psychometrically equivalent because item wording, response anchors, and scoring comparability remain incompletely documented. Four propositions and a staged evaluation plan specify practitioner agreement, feasibility, burden, adverse effects, independently measured behavior, and comparisons with credible personalized planning. Independent replication and transparent commercial-interest disclosure are priorities. The intended contribution is an auditable way to connect everyday domains with intervention sequencing, not evidence that the framework improves outcomes. Incremental effectiveness of the integrated 5A model and its A-lever heuristic has not been demonstrated; educational usability, decision reliability, and practical benefit require separate evaluation.

Keywords: well-being; health coaching; self-regulation; behavior change; biopsychosocial framework

INTRODUCTION

Il codice del benessere presents well-being as something constructed through relationships, bodily care, interpretation, and repeated action rather than a permanent state attained through motivation alone. Its organizing framework comprises five Italian terms sharing the initial A: Amare sé stessi, Alleati, Alimentazione, Allenamento, and Atteggiamento mentale. The expanded formulation Alleati e Ambiente makes social and material context explicit. The source proposes multiple entry points rather than five simultaneous changes or a fixed sequence (Pipio & Corbara, 2026, pp. 207–214).

Existing approaches already address interacting personal and contextual determinants. COM-B distinguishes capability, opportunity, and motivation; the Health Action Process Approach (HAPA) distinguishes motivational and volitional processes; self-determination theory (SDT) concerns motivational quality and support for autonomy, competence, and relatedness (Michie et al., 2011; Schwarzer, 2008; Ryan & Deci, 2000). Social cognitive theory likewise incorporates goals, self-efficacy, environmental facilitators, and impediments

(Bandura, 2004). The 5A framework therefore does not introduce the general ideas of personalization, context, self-regulation, or interdependence.

The intended contribution is narrower: a domain-based formulation interface coupled to a documented rule for selecting an initial action because it might enable a different health-related action. This is an operational proposal about the organization of decisions, not a demonstrated theoretical advance over established mechanisms. Its practical incremental value would require better decisions or outcomes, or comparable outcomes with demonstrably lower burden, relative to a credible personalized comparator. Memorability or favorable practitioner opinion alone would not establish that value.

The model has appeared in earlier health-coaching publications. This article is a conceptual elaboration, not its first description, a new intervention study, or a reanalysis of participant data. It specifies what the A-lever heuristic would require to be reproducible and useful, while identifying what the available reports cannot establish. Incremental effectiveness of the integrated 5A model and the A-lever heuristic has not been demonstrated.

CONCEPTUAL APPROACH AND SOURCE BOUNDARIES

The primary conceptual source is the authors' 288-page manuscript, particularly its domain descriptions, integrated-system chapter, and personal planning chapter. Page citations refer to that supplied version, not to an assumed published edition. The A-lever and educational 5A Wheel are retained in substance, while their operational specification is developed here. Translation does not imply construct equivalence: self-compassion, for example, is relevant to Amare sé stessi but does not exhaust that domain.

The literature examination is purposive and non-systematic. During preparation and revision in October 2026, targeted checks used publisher pages, PubMed records, and accessible author or university sources. The revision specifically checked the two cited 5A-related reports, foundational COM-B, HAPA, and SDT publications, a social-cognitive account, and methodological publications on content validity, reliability/agreement, implementation outcomes, and complex-intervention evaluation. Searches used the publication titles and named constructs; they were not a reproducible exhaustive database review. Sources were retained for direct relevance to a defined comparison, measurement distinction, or evaluation problem, not as a representative sample from which effectiveness could be estimated.

No registered review protocol, duplicate independent screening, formal risk-of-bias synthesis, or pooling was undertaken. The comparisons are illustrative rather than a ranking of all relevant theories. Targeted inclusion of competing explanations reduces neither publication bias nor selection bias to zero; contrary evidence and other personalized approaches may remain underrepresented. Consequently, failure to identify a competing formulation is not evidence that none exists, and this article cannot establish comparative effectiveness through literature selection.

Three levels of claim are separated: source-derived descriptions, findings reported by identified studies, and untested extensions proposed here. Component-level evidence is not evidence for the integrated model. Changes in questionnaires are not demonstrations of neural, endocrine, or immune mechanisms. The source's autobiographical and composite narratives are not used as empirical cases; its animic vocabulary concerns meaning and values and is not recast as a neurobiological entity (Pipio & Corbara, 2026, pp. 100–106, 250).

THE FIVE DOMAINS AND THEIR EXPLANATORY STATUS

3.1. Amare sé stessi: self-directed care

This domain concerns recognizing needs, respecting limits, and granting care without making personal worth contingent on productivity or a perfect routine. Candidate operationalizations include non-punitive responses to difficulty, help-seeking, recovery protection, and appropriate boundaries; they are not presumed to form a validated common factor. Experimental work connects self-compassion with motivation to improve after setbacks, but does not establish long-term effects of this 5A domain (Breines & Chen, 2012). Its formulation must distinguish actual care practices from favorable self-description.

3.2. Alleati e Ambiente: support and opportunity

The domain includes people and arrangements that make chosen actions possible: accessible spaces, time, resources, agreements, and support that does not become surveillance. A supportive relationship, an available route, and protected time are different exposures and must be recorded separately. Employment, income, caregiving, disability, and unsafe environments can restrict opportunity beyond individual control; the target may therefore be organizational rather than motivational (Pipio & Corbara, 2026, pp. 159–169, 268–269). The label "environment" does not identify which constraint is causal or who can change it.

3.3. Alimentazione: nourishment and the relationship with food

Alimentazione includes adequate nourishment, food access and timing, sensory experience, and meanings attached to eating. It is not a standardized diet or a judgment of dietary purity. Physiological hunger, pleasure, social participation, and emotional needs may coexist (Pipio & Corbara, 2026, pp. 170–187). Preparing an accessible meal, noticing hunger, and questioning a rigid rule are different targets with different candidate mechanisms. The domain is not reducible to weight or restraint, and its use does not replace nutritional treatment or eating-disorder assessment by qualified professionals.

3.4. Allenamento: activity, adaptation, and recovery

Movement is formulated as engagement with bodily capability, not punishment for eating or an aesthetic obligation. Its unit is a specific, appropriate activity with an identifiable context, demand, and recovery requirement (Pipio & Corbara, 2026, pp. 188–197). A randomized trial in older adults reported increased anterior hippocampal volume after aerobic exercise relative to a stretching control group; improvement on the spatial-memory task did not differ significantly between groups (Erickson et al., 2011). Such a finding illustrates biological responsiveness in a particular design; it neither establishes neurogenesis from imaging nor validates the 5A program's proposed pathways.

3.5. Atteggiamento mentale: interpretation and action

This domain concerns attention, language, expectations, appraisal, and planning, not compulsory positivity. A missed activity can be interpreted as information about the plan or as a verdict on personal worth. The proposed relevance lies in the next feasible response, not in wording alone (Pipio & Corbara, 2026, pp. 198–206). Reappraisal must remain compatible with facts; some difficulties require practical support, protection, or treatment rather than a different narrative.

3.6. Cross-cutting conditions and levels of analysis

Sleep is a cross-cutting condition, not a sixth A. Identity, relationships, rituals, environment, and meaning are lenses for understanding continuity rather than an additional taxonomy (Pipio & Corbara, 2026, pp. 134–149, 242–244). Four levels must remain distinct: domains identify where a resource or difficulty appears; determinants identify what permits or obstructs a particular action; processes specify how an intervention might operate; outcomes identify what changes. A walking group can involve two domains, alter social opportunity, support repeated activity, and produce either useful functioning or additional burden. Labeling these elements as a "system" does not establish their causal relationships.

OPERATIONAL CONTRIBUTION OF THE A-LEVER

4.1. Intended output and selection rule

The source defines the A-lever as an initially manageable entry point that may support another dimension, not necessarily the lowest Wheel rating (Pipio & Corbara, 2026, p. 268). Here it is an unvalidated heuristic producing a written formulation, not an optimization algorithm or clinical decision tool. Its output is a linked record: a client-valued target behavior; an observed or reported constraint; a selected enabling action; the predicted downstream effect; and a review condition. The action and its proposed consequence must be measured separately.

The decision sequence has six steps. First, identify safety needs and scope of competence; clinical urgency overrides leverage. Second, specify one target behavior, its context, and the person's preference. Third, examine the five domains to identify a plausible modifiable constraint, documenting whether the evidence is observation, self-report, or inference. Fourth, compare at least two candidate actions where alternatives exist, recording feasibility, expected burden, acceptability, and anticipated enabling effects; unavailable alternatives are recorded rather than invented. Fifth, agree on an initial action and state the expected sequence: if condition X changes, behavior Y should become more feasible within interval T. Sixth, prespecify what will trigger continuation, adaptation, referral, or abandonment of the hypothesis.

No numerical weights or universal cutoff for "leverage" are justified at this stage. When candidates appear comparable, the person's preference and lower burden can guide a provisional choice; genuine uncertainty is documented. Refusing a change, needing more information, or obtaining structural support can be appropriate outputs. The map should not manufacture a personal deficit when housing, care responsibilities, resources, or treatment needs are the relevant constraint.

4.2. Comparison with established approaches

Table 1 separates constructs, decision logic, intended outcomes, and the type of evidence relevant to each approach. It compares organizing purposes rather than similarly validated treatment packages. The A-lever's distinguishing specification is the mandatory documentation of an upstream action–downstream behavior hypothesis across everyday domains. This documentation is not claimed to be exclusive to 5A: a well-conducted COM-B assessment, HAPA intervention, or other personalized formulation may reach the same decision.

Table 1. Conceptual and operational comparison; intended outcomes are not claims of universal effectiveness.

Approach	Core constructs	Decision logic	Intended outcomes	Relevant existing evidence
COM-B / Behaviour Change Wheel	Capability, opportunity, motivation; intervention functions.	Analyze a specified behavior and its determinants; select functions addressing relevant barriers.	Change in the target behavior through altered determinants.	Original framework development includes intervention-classification agreement tests; effectiveness depends on the intervention and setting (Michie et al., 2011).
HAPA	Intention, risk perception and outcome expectancies, phase-specific self-efficacy, planning, action control.	Distinguish intention formation from enactment and maintenance; match support to volitional needs.	Initiation, maintenance, and recovery of health behavior.	Theory-driven predictive and intervention research discussed in the foundational account; not evidence about 5A (Schwarzer, 2008).
SDT	Autonomy, competence, relatedness; autonomous and controlled motivation.	Support need satisfaction and internalization; adjust the interpersonal context rather than impose compliance.	Autonomous engagement, persistence, and well-being.	Foundational account synthesizes experimental and applied work on motivation; no universal cross-domain priority algorithm (Ryan & Deci, 2000).

Approach	Core constructs	Decision logic	Intended outcomes	Relevant existing evidence
5A + proposed A-lever	Five everyday domains; a documented constraint and hypothesized enabling relationship.	Compare feasible actions; select an acceptable entry point; record the downstream hypothesis and review rule.	Hypothesized improvement in decision clarity, enactment, or burden relative to active personalized planning.	Uncontrolled program reports only; no direct A-lever agreement, feasibility, or incremental-effectiveness test (Pipio et al., 2025, 2026).

Self-determination, cue-linked planning, and repetition already have established theoretical formulations (Ryan & Deci, 2000; Gollwitzer & Brandstätter, 1997; Lally et al., 2010). The 5A proposal does not relabel them as newly discovered mechanisms. If an explicit A-lever record adds no decision information, predictive accuracy, acceptable efficiency, or behavioral benefit beyond such planning, the defensible claim would be limited to an alternative educational organization. Evidence of theoretical increment would require additional discriminating predictions and successful tests, not merely a different vocabulary.

4.3. Worked illustration and biological boundaries

Consider a hypothetical person who wants to resume activity but loses the planned opportunity to unshared household responsibilities. Candidate actions could include negotiating protected time or choosing a shorter activity that fits an existing interval. The selected A-lever is not “improve allies”; it is a specific agreement that should create an observable opportunity. The record distinguishes whether the agreement occurred, whether time became available, and whether activity followed. If opportunity improves without enactment, the original constraint was insufficiently specified. If the shorter alternative works with less burden, the negotiation-first decision may have been unnecessary. No participant or treatment result is represented by this illustration.

Biological findings justify examining specific pathways, not a general 5A causal network. Sleep extension affected energy intake in a randomized trial of adults with overweight and habitually short sleep; handholding modulated responses to laboratory threat in a small study (Tasali et al., 2022; Coan et al., 2006). Research on allostasis and interoception also situates bodily regulation and experience within interacting neural systems (Kleckner et al., 2017). None maps the five A labels onto five neural networks or tests the A-lever. The proposed links may be beneficial, absent, or conflicting: activity can compete with recovery, support can become pressure, and tracking can increase self-criticism.

4.4. Propositions and disconfirming observations

P1 — Constraint-targeted selection. An A-lever selected to change a documented constraint is hypothesized to improve a prespecified downstream behavior relative to selection based solely on the lowest domain rating. This limited comparison tests the selection rule, not superiority to established personalized approaches. Separate measurement of the constraint and behavior is necessary. No meaningful difference under adequate implementation would weaken the rule; comparison with an active established approach is additionally required to claim increment.

P2 — Resource-sensitive sequencing. When actions compete for scarce time or support, a limited sequence is hypothesized to reduce burden and sustain a meaningful behavior dose better than simultaneous escalation. Coordinated change may instead be easier or safer in some circumstances. Equivalent or superior results from simultaneous change, without increased burden or harm, would restrict the sequencing claim. Counting minimal actions without tracking their dose cannot establish benefit.

P3 — Conditional usefulness of awareness. Reported bodily awareness is hypothesized to support action when interpretation is non-catastrophic and a feasible response exists. The interaction, not merely an overall awareness

increase, is the prediction. Interoceptive accuracy, subjective sensibility, and metacognitive awareness are distinct (Garfinkel et al., 2015). Failure to observe the predicted interaction would challenge the conditional model; increased distress would challenge safety. Neither finding should be redescribed automatically as insufficient commitment.

P4 — Appraisal is not enactment. Wheel improvement is not interchangeable with observed action or functioning. A more accurate formulation may initially lower a self-rating, but lower scores do not themselves prove insight. The intended educational contribution predicts improvement in independently assessed formulation quality and/or useful action, not simply positive ratings. If neither improves relative to credible comparison conditions, the proposed utility is unsupported even when participants like the map.

PRIOR STUDIES AND WHEEL COMPARABILITY

5.1. What the 2025 and 2026 reports document

Pipio et al. (2025), Health coaching: A model for enhancing quality of life (Journal of Psychiatry, Depression & Anxiety, 11, 056; DOI: 10.24966/PDA-0150/100056), was published on 13 May 2025. It describes a prospective uncontrolled pre–post evaluation of a 10-month Mastercap program, using a convenience sample of consenting first- and second-year learners. The reported sample was 149, but paired denominators varied: 138 for quality of life, 133 for stress, sleep, self-esteem, and psychological well-being, and 109 for the Wheels. Training combined multiple educational and coaching components. Calendar dates for recruitment and assessments are not specified in the report. Favorable questionnaire changes were reported; selective completion and the absence of a comparator limit interpretation.

Pipio et al. (2026), Impact assessment of structured health coaching intervention on perceived stress and sleep quality (Journal of Psychiatry, Depression & Anxiety, 12, 065; DOI: 10.24966/PDA-0150/100065), was published on 3 March 2026. It reports a single-group pre–post design, described as quasi-experimental, with 153 paired participants assessed in January and November 2025 over a program described as 11 months. Recruitment was by convenience from the same academy; reported course categories include an advanced group. Workshops, lifestyle education, and five individual coaching sessions were combined. Reported stress and sleep changes are self-reported program-level observations, not controlled effects, A-lever tests, or independent validation of the Wheel.

Neither study isolates the five-domain map, the proposed decision rule, practitioner attention, or other program components. Regression to the mean, concurrent experiences or care, expectations, natural change, and selective participation are alternative explanations. Statistical significance within a group does not establish comparative benefit or clinical importance. These reports provide context for hypothesis development; they do not demonstrate efficacy of the integrated model.

5.2. Cohort overlap: what remains unresolved

The published reports do not supply a participant crosswalk or an explicit count of people appearing in both studies. Recruitment from the same multi-year training environment makes overlap possible, but neither overlap nor independence can be inferred from sample sizes or publication years. Their number of unique participants therefore cannot be calculated from these reports, and the samples are not added together or treated as independent replications. No participant identifiers or archived recruitment logs were examined for this conceptual revision.

Resolution requires authorized linkage of study records, reporting recruitment windows, course membership, the number and proportion of shared participants, prior exposure, and whether any assessment occasions or outcomes were reused. Aggregate disclosure can protect confidentiality. Until that reconciliation is available, independence remains unverified and the evidential contribution of the reports must not be overstated.

5.3. Educational Wheel versus a measurement instrument

Table 2 reports only properties recoverable from the 2025 publication and the supplied book. Their broad domain content overlaps, but identical items, anchors, recall periods, and scoring procedures cannot be established. The book version is therefore treated here as an educational profile with its own specified instructions, not as a psychometrically equivalent form of the earlier measure. The 2026 stress/sleep report does not resolve the missing instrument documentation.

Table 2. Version audit of the 5A Wheel. "Not reported" means not specified in the inspected publication, not that the procedure did not exist.

Feature	2025 published report	Book version discussed here
Number and content	Five items; broad labels: Love, Attitude, Training, Nutrition, Allies/Environment. Full administered wording is not reproduced.	Five domain ratings: Amare sé stessi; Alleati e Ambiente; Alimentazione; Allenamento; Atteggiamento mentale. Domain labels organize the educational profile.
Response scale and anchors	Numerical item range and verbal endpoint anchors are not specified.	Integers 0–10. At 0 the dimension is almost absent or consuming the person; at 10 it is experienced with continuity, balance, and satisfaction.
Recall and reassessment	Wheel-specific recall instructions are not specified; outcomes are compared before/after the program.	Initial instructions refer to the last two weeks; the Wheel is repeated after 30 days. Equivalent recall instructions should be fixed explicitly in any research version.
Scoring and display	An aggregate Wheel result is reported; its derivation, transformation, and missing-item rules are not specified.	Plot the five ratings and inspect the profile. No validated aggregate score, radar area, diagnostic cutoff, or missing-item rule is established here.
Evidence and equivalence	Exploratory PCA and internal consistency are reported for the five-item set.	Those statistics are not transferred to this version. Item-level documentation and fresh validation are required before equivalence is claimed.

Sources: Pipio et al. (2025), Materials and Methods and Results; Pipio & Corbara (2026), pp. 263–267. English anchors above are descriptive translations of the Italian instructions, not a validated English questionnaire.

The 2025 report describes principal component analysis (PCA), one retained component explaining 63% of variance, and Cronbach's $\alpha = .855$ for five items. PCA is a variance-reduction procedure, not a test of a causal five-domain structure. Internal consistency does not establish content, construct, criterion, or longitudinal validity. One item per domain cannot separately estimate the measurement properties of five latent dimensions without additional indicators or assumptions. These limitations remain even if the reported calculations are correct.

Before using the Wheel as a research endpoint, an item/anchor/scoring archive should specify version, language, administration mode, recall period, handling of missing data, and the intended measurement model. If the domains are distinct practical ingredients, high internal consistency is not the central validation target; if a common latent construct is claimed, that measurement model requires explicit testing. Content relevance, comprehensiveness, and comprehensibility should be assessed with intended users, following principles such as those developed in the COnsensus-based Standards for the selection of health Measurement INstruments (COSMIN) methodology (Terwee et al., 2018). Test–retest agreement, responsiveness, and language or subgroup comparability require separate designs. None of this validation is performed in the present article.

EVALUATION AND INDEPENDENT REPLICATION

6.1. Construct clarification and practitioner agreement

Development should begin with interviews and cognitive testing across backgrounds and professions, including people facing material constraints. A versioned manual should define the domain map, six-step decision record, acceptable alternatives, safety overrides, and minimum training. It should also distinguish a descriptive domain label from an inferred constraint and an action from an expected outcome. Independent users must be able to reproduce the procedure without relying on informal explanations by its originators.

For an initial agreement study, multiple practitioners with different experience levels would independently assess the same standardized, de-identified or purpose-built scenarios after equivalent training. Before discussion, record the constraint, proposed action, expected downstream behavior, referral decision, and confidence. Report exact agreement and a prespecified chance-corrected statistic suitable for multiple raters and nominal categories, together with confidence intervals and category frequencies. Quantitative ratings can be assessed with a prespecified absolute-agreement intraclass correlation model. Sampling and analysis must account for practitioners rating multiple scenarios; precision, not an arbitrary headcount, should guide study size (Kottner et al., 2011).

Agreement is not decision correctness. Several initial actions may be defensible, and patient preferences can legitimately change the choice. Accordingly, exact agreement should be accompanied by blinded evaluation of whether the record is complete, logically coherent, feasible, and within competence, using a rubric defined before rating. Safety errors and unsupported causal inferences should be reported separately. A delayed reassessment can examine within-practitioner consistency without treating the developers' preferred answer as an unquestionable gold standard.

6.2. Feasibility, intervention burden, and adverse effects

A feasibility study should examine ordinary practice rather than only highly motivated learners in developer-led courses. Record recruitment and refusal, training time, consultation duration, documentation completion, retention, adaptations, support needs, and reasons for non-use. Practitioner and participant views should be collected separately. The Acceptability of Intervention Measure (AIM), Intervention Appropriateness Measure (IAM), and Feasibility of Intervention Measure (FIM) may inform assessment of acceptability, appropriateness, and feasibility where language and context fit; they do not establish 5A effectiveness or substitute for observed delivery data (Weiner et al., 2017). Progression criteria should be set prospectively with stakeholders and justified for the service, not presented as universal validated thresholds.

Burden includes time, money, monitoring, emotional effort, displaced activities, and demands placed on allies. It should be measured in both intervention and comparator conditions, including reasons why a seemingly small action was not feasible. Safety monitoring should actively solicit worsening distress, shame, excessive self-monitoring, restrictive or compensatory eating, inappropriate activity persistence, interpersonal pressure, and delayed access to care. These are anticipated risks to monitor, not adverse effects demonstrated by this article. Record onset, severity, seriousness, duration, plausible relatedness, and action taken; reporting no spontaneous complaints is not evidence of safety. An independent clinical pathway should permit modification, stopping, and referral when indicated.

6.3. Temporal relationships and meaningful behavior

Within-person repeated observation can examine whether a proposed enabling condition precedes the target action. Prespecify the outcome, observation interval, expected lag, and concurrent contextual changes or treatment. Time-varying confounding, reverse causation, and missed observations remain concerns; temporal ordering alone is not mediation or causation. A thirty-day educational exercise is not a biological time constant, an established intervention dose, or proof of maintenance.

Meaningful behavioral outcomes must be distinct from liking the model, completing a consultation, or increasing Wheel scores. For an activity-focused study, a primary endpoint could be change in device-assessed weekly

activity at a prespecified follow-up, using fixed valid-wear and missing-data rules. A meaningful difference should be justified for the population before analysis. Other targets require their own direct indicators. Opportunity-adjusted enactment and time to appropriate resumption after interruption can be secondary measures, with illness-related suspension recorded rather than punished. Absolute activity dose and functional outcomes must also be reported to prevent apparent adherence gains from being created simply by lowering the target.

Perceived stress, sleep quality, and interoceptive experience can be secondary constructs when relevant, assessed with instruments suited to the language, population, recall period, and permissions (Cohen et al., 1983; Buysse et al., 1989; Mehling et al., 2018). They must not be renamed direct measures of "nervous-system regulation." Table 3 links the principal evaluation questions to observable metrics; all entries describe proposed research, not completed validation.

Table 3. Proposed evaluation matrix for the A-lever; criteria and outcomes require prospective specification.

Question	Proposed observations or metrics	Interpretive safeguard
Can practitioners apply the rule reproducibly?	Independent scenario ratings; exact/chance-corrected agreement with confidence intervals; blinded rubric-based quality; repeat ratings.	Agreement is not correctness; allow defensible alternatives and report safety errors separately.
Is it workable in ordinary services?	Recruitment, refusal, training and consultation time, complete records, retention, support needs; acceptability/feasibility reports.	Positive opinions alone do not demonstrate feasible delivery or effectiveness.
What does participation cost?	Time, expenses, monitoring demands, emotional effort, displaced activities, burden on allies, and withdrawal reasons in both arms.	A nominally small action can be costly or inaccessible in context.
Can it produce harm?	Active adverse-event questions; onset, intensity, seriousness, duration, relatedness, response, and referral.	The absence of complaints does not establish safety; independent review of serious concerns.
Does behavior improve meaningfully?	Prespecified independent behavior measure, absolute dose, opportunity-adjusted enactment, functioning, follow-up, missing-data accounting.	Do not substitute Wheel ratings or lowered targets for meaningful change.
Does it add value?	Active-comparator trial; between-group effect and confidence interval; delivery fidelity, burden, safety, and costs.	A null superiority test does not establish equivalence, non-inferiority, or mechanism.

6.4. Testing incremental value

A credible comparison would provide both groups with personalized behavior-change support of comparable contact time and competence, equivalent access to ordinary care, and opportunities for goal adjustment. One group could receive COM-B-informed planning; the other the same planning plus the structured 5A map and A-lever record. This tests an add-on, not an unsupported comparison between rich support and no support. An optional third condition using the map without the decision record could help distinguish educational presentation from the hypothesized selection contribution.

Randomization should concern the formulation strategy, not access to necessary treatment. Individual or cluster allocation should be chosen in light of contamination between practitioners. Prespecify the primary behavioral endpoint, meaningful difference, follow-up sufficient to examine maintenance, sample-size assumptions, missing-data strategy, and intention-to-treat analysis. Assess delivery fidelity independently and report the contrast actually achieved. Between-group effects and confidence intervals, rather than within-group

significance, address incremental effectiveness. A claim of similar outcomes with lower burden would require a prospectively justified non-inferiority or equivalence design; a non-significant superiority result is insufficient.

Mechanism evaluation requires demonstrating that the intended constraint changed and examining its relationship to subsequent action while accounting for alternatives. A positive overall effect alone does not identify the A-lever as the mediator. Failure to deliver the selection rule and failure of a faithfully delivered rule should be distinguished without making the theory immune to refutation. Development, feasibility, process evaluation, and comparative testing should remain linked to a prespecified program theory and context (Skivington et al., 2021).

6.5. Independent replication priorities

The first priority is independent replication of construct interpretation and practitioner agreement using a frozen manual and scenarios not selected only by the developers. The second is external feasibility testing in non-academy services, including diverse literacy, economic resources, disabilities, and professional backgrounds. The third is a preregistered active-comparator study, followed by replication in another setting. These steps are proposed priorities, not registered or completed studies.

Independent evaluation should place recruitment, outcome assessment, analysis, and publication decisions outside the developers' commercial control. Any training or funding they provide must be disclosed. Protocols, materials, scoring specifications, deviations, and analysis code should be accessible where lawful; de-identified data sharing requires consent and governance. Null results, harms, and implementation failures must be reportable without sponsor veto. Development of a branded framework and evidence supporting it should remain institutionally distinguishable.

DISCUSSION AND LIMITATIONS

The contribution is an explicit operational specification: a five-domain map is linked to a documented, revisable enabling hypothesis. It may help organize conversations or make decisions easier to inspect, but neither usability nor effectiveness follows from that description. Much of its content can be expressed within existing theory. A defensible research question is whether the added formulation structure changes decision quality, burden, action, or functioning beyond well-delivered personalized support. No present evidence establishes this increment.

The five domains are not established as exhaustive, uniquely necessary, culturally invariant, or the most parsimonious taxonomy of well-being. Their overlap may help communication while complicating measurement. The literature is selective; the comparison does not eliminate omitted competitors or contrary findings. Earlier studies are uncontrolled, cohort independence is unresolved, and instrument equivalence is not established. Proposed mechanisms, practitioner agreement, feasibility across services, and adverse-effect rates have not been tested here. The authors' intellectual and commercial involvement further strengthens the need for independent investigation.

The framework remains educational and bounded by professional competence. It must not turn structural disadvantage into personal blame, portray recovery as failure, or treat adherence to a branded lifestyle as well-being. Independent behavioral outcomes should be considered alongside autonomy, access, burden, and harm. An apparent adherence gain obtained through shame, coercion, unsafe persistence, or delayed treatment would not justify adoption of the model.

CONCLUSION

The 5A model can be specified as an educational domain map coupled to an A-lever decision record: identify a relevant constraint, select a feasible and acceptable action, predict a distinct downstream change, and revise the formulation when observations do not support it. This operational specification does not establish a new causal mechanism or superiority over existing personalized approaches. Existing uncontrolled program reports and exploratory Wheel statistics cannot validate the integrated framework, instrument equivalence, or the selection rule. Incremental effectiveness has not been demonstrated. The next priorities are transparent instrument

documentation, resolution of cohort overlap, independent agreement and feasibility studies, active safety monitoring, and adequately designed comparisons of meaningful behavior and burden.

DECLARATIONS

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Competing interests. Antonio Pipio and Romina Corbara are contract lecturers at the universities listed in their affiliations and are co-founders of Health Coaching Academy, with professional activities in training and coaching. They co-developed the 5A framework and coauthored its source manuscript. The source manuscript identifies H.C.A. Health Coaching Academy S.R.L.S. as the owner of the registered Protocollo 5A® mark. The authors therefore disclose intellectual, professional, and commercial interests in dissemination of the model and associated training, from which they may benefit. These interests may influence framing and interpretation and do not constitute evidence of validity. The authors declare no other relevant financial or non-financial competing interests.

Author contributions. Antonio Pipio and Romina Corbara jointly developed the source framework and coauthored Il codice del benessere. The present conceptual contribution builds on that shared intellectual work. Both authors take responsibility for the conceptual argument, interpretation of sources, references, and declarations, and for the final version submitted for publication. Generative-AI assistance is described below.

Ethics and consent. Not applicable to this conceptual article. No participants were recruited, no animal research was conducted, and no new participant-level data were collected or reanalyzed. Hypothetical illustrations are explicitly non-empirical. Proposed future studies would require the relevant ethical review, consent, and data-governance arrangements before implementation.

Data availability. No new empirical dataset was generated or analyzed. Published reports and the supplied author manuscript are identified in the references; Tables 1–3 are conceptual and documentary syntheses, not new participant data. Original recruitment records, participant identifiers, and the administered 2025 Wheel form were not accessed for this revision. Their absence limits verification of cohort overlap and instrument equivalence. The conceptual source is an author manuscript, not a publicly archived dataset or a claimed published book edition.

Generative artificial intelligence disclosure. ChatGPT (OpenAI) assisted with literature discovery, organization and drafting of text, critical revision, translation, and language editing. It was not used to create empirical observations, participant data, or purported validation results. The listed human authors retain responsibility for interpretation, accuracy, originality, references, disclosure completeness, and approval of the submitted version. AI assistance does not confer authorship or transfer those responsibilities to the tool.

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