

The Improbability of Lifestyle Change

Wayne C. Miller, PhD

Most everyone in clinical practice or health promotion will agree that the biggest barrier to intervention for healthy weight is lifestyle change. Whether the client is a person with diabetes, a patient with cardiovascular disease, an overweight client, or a person with an eating disorder, successful intervention centralizes on behavior change. The disheartening fact for those of us in clinical practice, however, is that a large percentage of persons who present with a weight-related problem are unsuccessful at long-term lifestyle change. It does not matter whether you embrace the paradigm of “size acceptance” or that of “a healthy weight is a low weight”; the desired change in measured outcome variables depends on successful maintenance of the behaviors that affect those variables. For example, if you accept the traditional paradigm of “weight loss is necessary for improved health,” then the behavioral intervention focuses on maintaining a reduced body weight through maintenance of an energy-restricted diet and a rigorous exercise program. If you accept the “health at any size” paradigm, then the behavioral intervention focuses on decreasing eating pathologies while maintaining intuitive eating and spontaneous or enjoyable physical activity. In either paradigm, the desired outcomes are achieved and maintained only through successful lifestyle change, and that is not easy. Why, then, are people so resistant to lifestyle change?

Today in the field of dietetics and nutrition, it is recognized that the reasons most people do not eat what they “should” have little to do with basic science, knowledge, or the information that is available.¹ Similarly, the reasons people are not more physically active have little to do with their knowledge about exercise. There appears to be a multitude of reasons people have difficulty changing their eating and activity habits. These may include but are not limited to the following:

- The large time and energy commitment required to change one’s lifestyle
- The lack of immediate desirable results

- General feelings of anxiety, depression, anger, or frustration
- Interpersonal relationships that may be threatened by change
- The fear of change itself or fear of the expectations associated with change
- A way of denying or hiding the existence of problems
- The inability to uncover the driving force behind the unhealthy behaviors

It is obvious that to become effective, the professional needs to have knowledge and skills on how to help people overcome these barriers to lifestyle change. As clinicians and practitioners, we need to go beyond teaching people “how to behave” and teach them “how to change behavior.”² How can this be done?

Most, if not all, of the reasons people struggle with changing behavior relate to their feelings about their behaviors.² Even if the presented barrier to behavior change seems like a concrete problem, it is

generally the perception or cognition of the problem that really prevents a change in behavior. For example, many people state that their biggest obstacle to regular exercise or eating healthfully is time, fitting it into their busy schedule. At the same moment, however, they will tell you that we all have time in our lives for the things we feel are most important. So the question then is what are the feelings that support the cognition that “I don’t have time to exercise” or “I don’t have time to eat healthfully?” Once these feelings are explored and the issues resolved, the chance for successful behavior change is augmented. The natural flow of events leading to either compliant or non-compliant behavior is (1) think, (2) feel, and (3) do.

Burns stated that all of our moods are created by our cognitions or thoughts and that we feel the way we do right now because of the thoughts we are thinking at this moment.³ Negative thoughts, which cause emotional turmoil, nearly always contain gross distortions. A significant key to helping people overcome their individual barriers to healthful eating and exercise then is to help them change the cognitions

As clinicians and practitioners, we need to go beyond teaching people “how to behave” and teach them “how to change behavior.”

that are the source of their emotional turmoil surrounding the behavior in question.

Haven't we all heard a patient or client say that they are "struggling" with changing a certain behavior? This "struggling" is really the emotional turmoil created by the negative cognitions associated with the behavior. As Miller described it, successful behavior change is simply a matter of ending an internal battle going on between the emotional self and the intellectual self.² The intellectual self is struggling to adopt a new, more healthful behavior, whereas the emotional self is struggling to maintain the current behavior because of distorted cognitions and feelings surrounding the new behavior.

This is to say that we, as professionals, will be most successful if we help our clients/patients change their cognitions and feelings about healthful eating and exercise. I don't mean to infer that we all need to be licensed psychologists or professional therapists, but in our own atmosphere of influence, we can do some cognitive restructuring. Let me illustrate the point by demonstrating how an exercise physiologist can explore the cognitions and emotions surrounding a client's exercise behavior:

Professional: Good to see you again, Jane. Remember a week ago we set some personal goals for exercise. How did you do this past week?

Jane: I exercised three times this week. My goal was three, so I met my goal.

Professional: That's wonderful. How do you feel about your exercise?

Jane: Oh, I don't know. Okay, I guess.

Professional: Sounds like it may not have been as pleasant as it could have been. What are you feeling right now about your exercise sessions?

Jane: I am feeling a little disheartened. I was all excited about attending my aerobics class, but when I arrived, I discovered I was the fattest one in the class. I felt ashamed of my body and wanted to hide. I didn't think it was going to be that difficult to get back into shape. However, I set a goal to exercise three times this week and was determined to meet that goal. So, I toughed it out and attended the other two sessions as I promised.

You can see from this dialogue that there was an internal battle going on within Jane. Her intellectual self was determined to change her behavior, but her emotional self was in turmoil. She had certain cognitions about her aerobics class, her body image, and expectations for exercise. These unmet expectations led to negative emotions. Although she met her goal

through intellectual determination, her prognosis for lasting behavior change is dismal because of the emotional turmoil. Nonetheless, through exploration of Jane's feelings, the exercise physiologist now has a clearer idea of where the real barriers to exercise compliance lie. He/she can now help Jane resolve these negative cognitions and feelings so that the chances for lifestyle change are augmented.

Another simple approach to a session like this could be to use 1 to 10 scaling as an easy way to enter into the exploration of cognitions and feelings about specific behaviors. For example,

Professional: Good to see you again, Jane. Remember a week ago we set some personal goals for exercise. How did you do this past week?

Jane: I exercised three times this week. My goal was three, so I met my goal.

Professional: That's wonderful. On a scale of 1 to 10, with 1 being I never want to exercise again and 10 being I am now an exercise goddess, how would you describe your experience with exercise this week?

Jane: Oh, probably about a three.

Professional: Sounds like it may not have been as pleasant as it could have been. What caused you to rank your exercise experience at a three?

Jane: Well...[a discussion follows about Jane's cognitions and feelings about her exercise experience].

As professionals, we need to help our clients make successful behavior changes if we expect to make a lasting impact on their health. Simple cognitive restructuring tools that are within the grasp of all professionals can help our clients make these changes. The most critical of these is to explore the client's cognitions and feelings about the desired behavior and then follow up with strategies to eradicate distorted thinking patterns and diminish negative emotions.

References

1. Curry KR, Jaffe A. Nutrition counseling & communication skills. Philadelphia: WB Saunders; 1998.
2. Miller WC. Negotiated peace: how to win the war over weight. Boston: Allyn & Bacon; 1998.
3. Burns DD. Feeling good: the new mood therapy. New York: Avon Books; 1999.

Wayne C. Miller is a professor of exercise science and nutrition at the George Washington University Medical School and the director of the Healthy Weight Management Programs.

