An Introduction to the Lifestyle Patterns Approach

Overview

Lifestyle modification, which includes the three components of diet, physical activity, and behavior change, is the standard of care for treating overweight and obesity (1). Although clinicians generally know this, the concept of a lifestyle modification program may be new to many patients, especially those who are “chronic dieters” who have tried and failed popular, food-only fad diets.

Commonly, lifestyle modification is delivered to patients either individually or in small groups, in a series of planned lessons or using another standardized format, and by professionals who have differing skills. Because every clinician tries to “connect” with his or her patient to provide pertinent and meaningful guidance, the most significant challenge is to deliver obesity care specific to the patient’s lifestyle—that is, provide a treatment that is tailored and individualized to each person’s preferences, habits, priorities, time availability, likes and dislikes, style, attitudes, abilities, and culture. When general medical patients were asked to rank 28 expectations of care prior to seeing their clinician, Kravitz found that “discussion of [the patients’] own ideas about how to manage [their] condition” was ranked as the highest item (2). As explained in Chapter 1, an individualized approach uses “patient-centered” or “relationship-centered” communication (3). This chapter describes the process by which our patient-centered Lifestyle Patterns Approach was developed. Although this approach offers clinicians a new way to think about and manage overweight clients, all of the treatment strategies used reflect evidence-based recommendations for weight loss and behavior change.

Development

For more than two decades, Robert Kushner, MD, has been counseling overweight and obese patients about how to choose more healthful behaviors and incorporate them into their lifestyle. From the start of his career, he has been using an individualized, collaborative-care approach based on each patient’s strengths and goals. He listened to the weight gain, loss, and regain stories of thousands of overweight
adults, and even though they were on different diets, he began to identify common themes in their stories. Patients would go on a new diet and initially lose weight. Then, before they knew it, their old lifestyle habits (or patterns) would slowly creep back into their lives and they would regain the weight.

For some time, clinicians have understood how recidivism and weight regain affect overall weight-loss outcomes. In the publication *Weighing the Options: Criteria for Evaluating Weight-Management Programs*, Thomas states that “those who complete weight loss programs lose approximately 10% of their body weight, only to regain two thirds of it back within 1 year and almost all of it back within 5 years” (4, p.1). Thus far, behavior and obesity specialists have primarily focused on defining the high-risk situations (emotional and physical events) that cause recidivism and developing relapse-prevention strategies (effective coping response and increased self-efficacy) (5-7). Additional research has centered on the identification of overall dietary intake pattern structures (combination of food groups) that are associated with either weight gain or weight loss (8-10).

In 2001, Dr. Kushner took a different diagnostic and therapeutic direction. Rather than only looking at high-risk situations, teaching relapse-prevention techniques, or counseling on prudent nutritional food group choices, he looked at the lifestyle habits or patterns of individuals who drifted away from their weight control program. From his experiences at both Northwestern Memorial Hospital and the University of Chicago, he realized that these recidivist patients always slid back into old habits—they seldom, if ever, slid back into new habits. Dr. Kushner theorized that patients tended to return to ingrained, unhealthful habits at unguarded moments, particularly in times of stress and poor planning. Based on his understanding of the literature pertaining to one’s eating, exercise, and emotional coping patterns of behavior, along with his empirical observations, he categorized these patterns or habits into distinct eating, exercise, and coping lifestyle patterns that contributed to weight gain—a central theme that had not been previously addressed in the recidivism literature. Figure 2.1 displays how Dr. Kushner has organized the 21 identified lifestyle patterns within the three lifestyle dimensions (definitions and descriptions of each pattern are explained in Chapters 4, 5, and 6).

![Figure 2.1 Lifestyle Patterns organizational chart.](image-url)
Dr. Kushner proposed that the key to helping people take control of their body weight was not simply to instruct them on a new diet or a new behavior, but rather to help them first identify and then learn to manage their unique and relapsing lifestyle patterns that kept derailing their success. Furthermore, if a lapse did occur, Kushner believed his approach would prepare patients to be on guard for the reappearance of their old habits and be ready to take corrective action. He called this new method the Lifestyle Patterns Approach (11).

Key Principles of the Lifestyle Patterns Approach

The Lifestyle Patterns Approach is based on the following four principles:

- We live in an obesogenic society that causes people to develop specific weight-gaining lifestyle patterns or habits.
- Each person has his or her own personal weight-gain story to tell based on his or her own life events.
- A lifestyle pattern–specific approach (modeled after a symptom-pattern approach used in medicine) lets clinicians give individualized care to their overweight and obese clients.
- Treatment must be multidimensional.

Principle 1: We Live in an Obesogenic Society

Many people tend to blame themselves for being overweight or obese. However, as we have seen in Chapter 1, behavior and obesity researchers have tried to understand the epidemic of overweight and obesity using an ecological approach (12,13). Knowing that people adapt to and harmonize with their environment, it makes sense to expect that energy imbalance and weight gain will occur when large portions of high-calorie food are available 24/7 and technology has essentially engineered activity out of our daily lifestyle. Thus, overweight, obesity, and an unhealthful lifestyle could be considered the norm rather than the exception. As discussed previously, this supposition is supported by the latest statistics that show that people who can maintain a healthful body weight are in the minority.

As shown in Figures 2.2–2.4, the availability of inexpensive, unhealthful food, the advances of technology, and the pressures of time often trump patients’ intentions to make healthful choices. Patients know that they need to eat more healthfully and be more active, but the pressures to do the opposite are sometimes too hard to overcome.

The Lifestyle Patterns Approach provides patients with specific strategies so they can tackle these pressures head-on. In accordance with the ecological approach to weight management, it’s important that patients focus on three different settings that can affect their weight: their home, work, and social environments. As you will see in the case studies and patient dialogue examples presented in Chapters 4, 5, and 6, lifestyle pattern–specific strategies can easily target a patient’s environment and be applied differently, depending on the patient’s home life, work situation, or social circumstance.

Principle 2: Each Person Has His or Her Own Weight-Gain Story to Tell

The average American adult gains 1 to 2 pounds each year due to a subtle imbalance in the amount of calories consumed and the amount expended (14). The imbalance has multiple causes, including genetic, biological, environmental, social, cultural, and psychological factors. In Dr. Kushner’s publication for consumers (15), he coined the term “Scaling Up Syndrome” to reflect the constellation of factors that adults experience throughout life that cause them to gain weight. This syndrome occurs while people are
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Should eat healthy foods
Should watch portion sizes
Should cook more
Should eat only when hungry

Food availability
Abundance
Snacking
Convenience stores
Vending machines
Processed foods
Cooking infrequently
Eating out often
Large portions
Fast-food choices
Value meals
Food courts
All-you-can-eat buffets

Healthy Choices

Unhealthy Environment

Figure 2.2  Food pressures favor unhealthy eating.

Should use stairs
Should park car farther away
Should be more active
Should watch television less
Should do fewer passive activities

Elevators
Escalators
Telephones
Snow blowers
Remote controls
Cars, buses, trains
Computers
E-mail
Drive-thru society
Television
Cable channels
Video games
DVDs

Healthy Choices

Unhealthy Environment

Figure 2.3  Technological advances favor a sedentary lifestyle.

maturing through the stages of adult life, focusing on their families and jobs, and putting their health on the backburner. Before they know it, with each passing year, they find themselves “scaling up” their weight (15). This weight gain is unintentional and unplanned.

Most patients can recall their approximate weight at different stages of life—upon entering college, when getting married, after each pregnancy, when starting a new job, when suffering an illness, quitting smoking, or going through menopause—the list goes on. Epidemiological and clinical studies have confirmed that weight gain is associated with key life events, including:

• Freshman year in college (16,17)
• Marriage (18,19)
The Lifestyle Patterns Approach helps people appreciate how specific life events have affected their lifestyle habits and weight gain. This awareness is key to helping people get control of their weight, as certain life events can be a red flag for weight regain. Chapter 3 provides examples of this syndrome in graphical form and explains how this information is used to begin the counseling process and establish a treatment plan.

Principle 3: Care Must Be Individualized

When helping patients lose weight, one size does not fit all in terms of treatment. For example, why should a 52-year-old traveling salesman who eats most meals on the road and hates exercise be given the same program as a 35-year-old mother of three who finishes her children’s food and wants to exercise but can’t find the time? Clearly, these individuals have different lifestyles, responsibilities, support systems, and obstacles. The Lifestyle Patterns Approach offers each patient a weight management program that fits his or her lifestyle.

The American Dietetic Association (ADA) and other reputable organizations (30,31) support individualized care as part of lifestyle modification counseling. ADA’s Adult Weight Management Evidence-Based Nutrition Practice Guideline (published in 2006) discusses making a thorough clinical assessment to develop a more individualized therapeutic approach (32). An individualized treatment approach is also recommended for the management of people with diabetes who require counseling on lifestyle modification. The 2006 American Diabetes Association Standards of Medical Care states that “the management
plan should be formulated as an individualized therapeutic alliance among the patient and family, the physician, and other members of the health care team” (33).

The use of pattern recognition to individualize treatment is an established therapeutic modality in medicine, but it has not been previously applied to the management of obesity. For example, diabetes management routinely includes a review of blood glucose patterns in relation to meal times, carbohydrate intake, and administration of diabetes medication. Individuals with asthma are routinely questioned about their symptom patterns of wheezing, coughing, or shortness of breath brought on by exercise or exposure to environmental allergens, cold air, or tobacco. In both examples, patterns are used to identify the problem, develop strategies to control or resolve the problem, and monitor response and progress. For example, if a blood glucose pattern reveals higher levels in the afternoon, the patient is instructed to limit the amount of carbohydrate consumed at lunch or increase the amount of short-acting insulin. The effect of the interaction is a normalized blood glucose pattern, and the result is improved diabetes control. In the case of asthma management, a bronchodilator may be prescribed for use prior to exercise. A beneficial response to treatment is confirmed by improvement in the exercise-induced symptom pattern, and the result is symptom-free exercise. Exacerbation of either condition can be explicitly monitored by a reoccurrence of the symptom patterns. This would then prompt the patient and clinician to take action. Using a patient’s eating, exercise, and coping habits for symptom pattern recognition follows the same principles.

**Principle 4: Treatment Must Be Multidimensional**

Losing weight and living a more healthful lifestyle are not just about finding that perfect ratio of carbohydrate and protein in the foods on one’s plate. Many patients can successfully lose weight following a food-only diet program, but successful weight maintenance over the long term usually requires addressing one’s overall lifestyle habits and paying attention to how easily lifestyle habits can fluctuate with the normal ups and downs that life can bring.

Weight-management clinicians know very well the multiple influences that can quickly derail a dieter’s program: for example, family or work stress can lead to emotional eating; a new job may require a long commute that steals away one’s needed time for exercise; hosting family guests for a holiday celebration disrupts day-to-day eating and exercise routines. It is not unusual to find that yo-yo dieters can finally stop cycling once they learn to better cope with these types of stresses of daily life.

**Use in Interdisciplinary Teams and Virtual Teams**

The Lifestyle Patterns Approach is specifically designed to address the eating, exercise, and coping problems that health care providers are likely to encounter when working with patients. Many clinicians find that they do not need to work with other providers to use this holistic approach to help patients gain control of their weight. However, the complex health and psychosocial needs of overweight and obese adults often require services of more than one type of health care professional. Establishing an integrative team approach can be a useful strategy.

Effective counseling of overweight and obese adults requires that health care providers know when to refer patients to additional resources, such as a primary care physician or nurse practitioner, weight-loss surgeon, certified diabetes educator, registered dietitian (RD), health psychologist, psychiatrist, exercise specialist or personal trainer, commercial weight-loss group, or online program. Methods for working with other team members and when to refer patients will be discussed throughout the book.

Two key features of successful teams are communication and a shared philosophy. Teamwork entails coordination and delegation of tasks among providers and staff (34). A sense of “groupness,” defined as
the degree to which the group practice identifies itself and functions as a team, will enhance the quality
and efficiency of care (35). As you learn the workings of the Lifestyle Patterns Approach, you will also
learn a common language that can be used among professionals, how to foster continuity of care, and
when to refer patients to other team members—even if the “team” you are working with is off-site.

Dr. Kushner’s Lifestyle Patterns Approach has been used and studied in two different team-type set-
ing: an interdisciplinary team setting in a hospital-based wellness program and an online virtual team
setting. The Lifestyle Patterns Approach was used from 2001 through 2007 at Northwestern Memorial
Hospital’s Wellness Institute in Chicago where Dr. Kushner and Dawn Jackson Blatner both worked—
Dr. Kushner as medical director and Jackson Blatner as an RD. The Wellness Institute was an interdisci-
plinary team setting of physicians, RDs, a nurse practitioner, exercise physiologists, and health psychol-
ogists who treated people with lifestyle-related disorders. Most of the initial research was done in this
setting. Since leaving the Wellness Institute in August 2007, Dr. Kushner continues to use the Lifestyle
Patterns Approach in his Lifestyle Medicine program at Northwestern Memorial Hospital.

Since June 2004, Dr. Kushner’s Lifestyle Patterns Approach has been adapted as an online program
on Diet.com (http://www.diet.com), where Dr. Kushner is medical director of the Diet.com premium
program. Adapting the program to an online format required Dr. Kushner to change some of the original
lifestyle-pattern names published in the Personality Type Diet book (15) to make them more user-
friendly for a mass media, online format. These pattern name changes are included for your reference in
Appendix D. The Diet.com virtual team includes Dr. Kushner, an RD, and a community support leader.
This team is available by e-mail and on the message boards to answer member questions and guide them
through the program. Diet.com also offers diet buddies and weight-loss challenge groups to provide
social support.

Research

The Lifestyle Patterns Approach has been systematically studied. Validation of the patterns questionnaire
was done with a convenience sample of 100 overweight and obese patients from the Wellness Institute (36).
A 70-item self-assessment questionnaire was developed by Dr. Kushner to characterize the 21 eating, exer-
cise, and coping patterns that were empirically identified in clinical practice. Participants were asked to use
a six-point Likert scale to indicate their level of agreement or disagreement with each statement. Partici-
pants were then asked to complete a second questionnaire, which presented a brief description of all 21
lifestyle patterns and requested participants to identify their top three eating, exercise, and coping patterns.
Agreement between the patterns questionnaire and validation measure was done using $\chi^2$ tests. Statistically
significant positive correlations were seen between body mass index (BMI) and number of patterns scored
by both questionnaires. Agreement between subscales scored by both self-identified patterns was observed
for 14 of 21 lifestyle patterns. Internal consistency reliabilities for the 21 lifestyle pattern subscales ranged
from .35 to .90. On the basis of this analysis and further item analysis, seven items were deleted and three
items were added to generate a revised 66-item questionnaire that has been used since 2003. To increase
specificity, the questionnaire has been further refined to 50 items, as presented in this publication.

A prevalence study was subsequently done among 335 patients in the Wellness Institute who com-
pleted the lifestyle-patterns questionnaire (37). Seventy-eight percent were women with a mean age
of 44 years and mean BMI of 40.3. For this study, a patterns scoring cutoff of 33% was designated as
having a clinically meaningful pattern. The most prevalent set of patterns was related to the coping
symptoms. All seven clinically relevant coping patterns were endorsed by more than 50% of the patients,
compared with five eating patterns and three exercise patterns. These results suggest that while over-
weight and obese patients use a wide range of coping styles, their number of expressed eating and