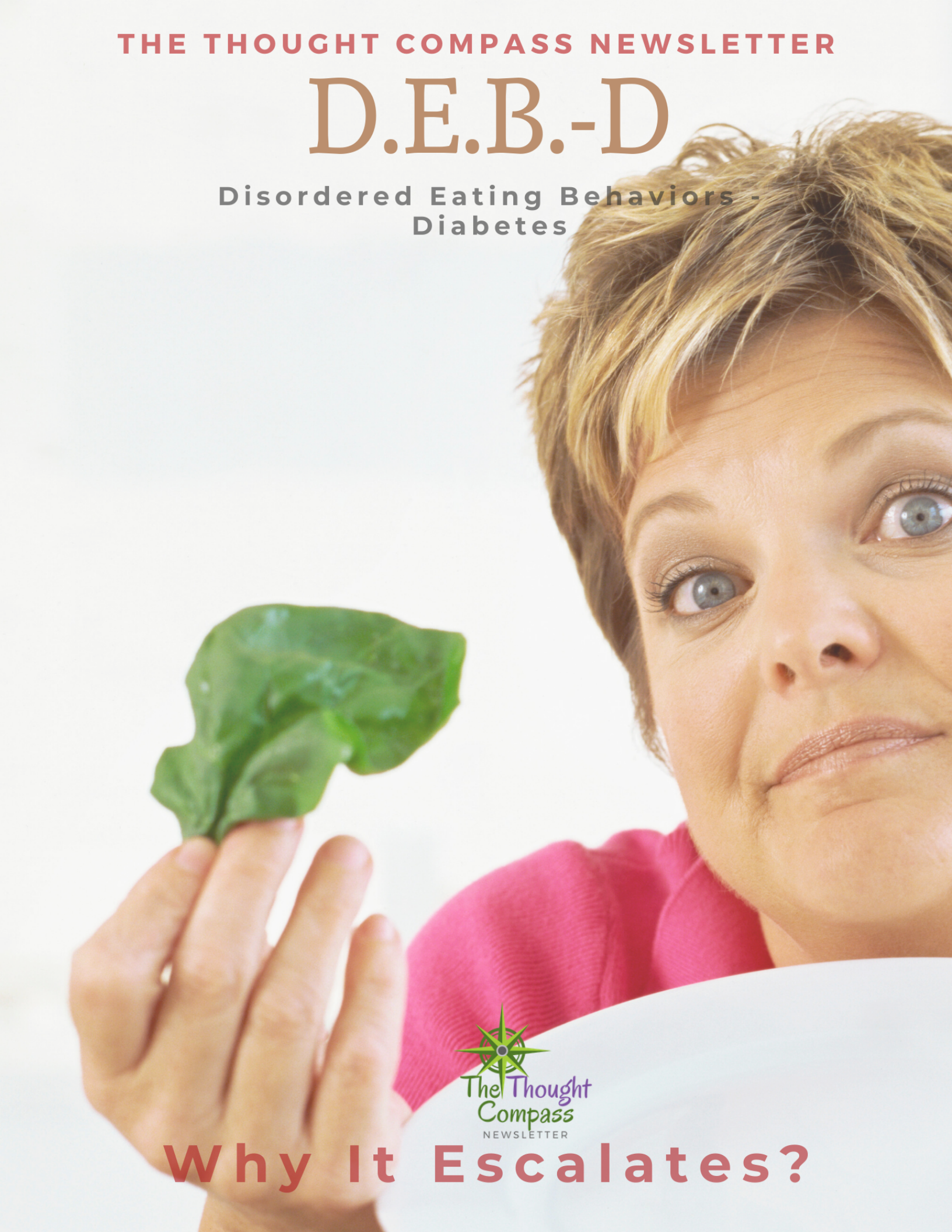
THE THOUGHT COMPASS NEWSLETTER

D.E.B.-D

Disordered Eating Behaviors - Diabetes



The Thought Compass NEWSLETTER

Why It Escalates?

A quarterly newsletter from Megrette.com

DEB-D:

About the theme - *D.E.D.-D How They Escalate*

Introduction

This issue of *The Thought Compass* will continue to focus on Disordered Eating Behaviors in Diabetes, or DEB-D, specifically how DEB-D escalates. This escalation is even more evident with the rise in anxiety due to the COVID-19 pandemic.

The goal is to add to your understanding of DEB-D, from the winter issue, which explained what it is and how it affects up to 40% of patients with type 2 diabetes mellitus. This sobering statistic is from Dr. Garcia-Mayer's 2017 research on Disordered Eating and Diabetes. How could so many clients slip under the radar? There are a number of reasons, including clients who are currently coping with increased stress because of the pandemic.

Interestingly, the predominant clinical forms of disordered eating are actually the lesser-known concerns, including Other Specific Feeding or Eating Disorder (OSFED), Night Eating Syndrome (NES), and Binge Eating Disorder (BED).

The presence of DEB-D is inescapable. Recently, while providing telemedicine to a client, the issue presented in the last 10 minutes of the appointment. While summarizing, the client mentioned, "Well, I'm binging after the kids are in bed." When we circled back on this comment, I asked, "What is it about your binge eating that concerns you?" The client explained she was doing it to cope with the many changes in her life--including working full time, while homeschooling her two children and assisting her older parents. Now more than ever, DEB-D is likely to increase.

The impact that Disordered Eating Behaviors (DEB) has on diabetes care is challenging to quantify because disordered eating isn't a static occurrence. Inconsistent blood sugars result from erratic eating, limited consistency with medication, fear and guilt from

adverse reactions to medication, eroded provider/client trust, and a decreased desire to seek medical care due to shame, self-blame, and guilt. These things obscure the issue, complicate the scope, and contribute to clinical inertia.

Understanding DEB-D takes time because it impacts care in overt and subtle ways. This issue of *The Thought Compass* will explore why DEB-D escalates by unpacking weight stigma, and the impact of restriction in diabetes care. For more information, check out "Understanding Stigma Theory," "How to spot DEB-D," "Can We Create A Model Visualizing DEB-D?" "Interested in learning about Medication? The Missing Piece in Weight Neutral Diabetes Care," "Five Ways To Make Diabetes Worse," and other blogs of interest at https://wn4dc-symposium-2019.teachable.com/blog

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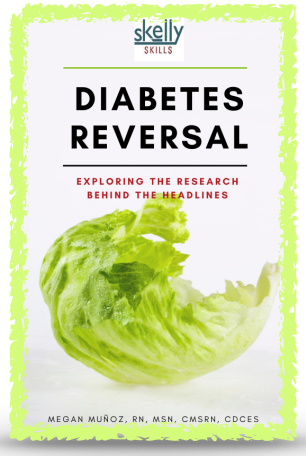
Medications: The Missing Piece in Weight Neutral Diabetes Care

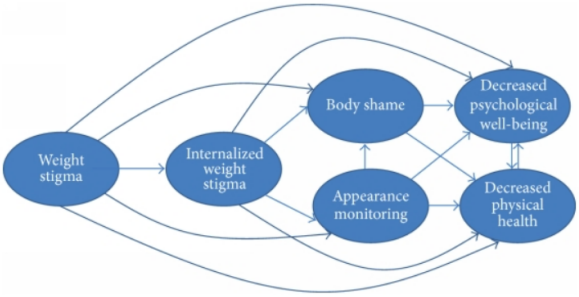


Medications: The Missing Piece in Weight Neutral Diabetes Care is a four class course that is completely self-paced. It will provide you with effective teaching tools to explain the pathophysiology of diabetes with playful ease that your clients will love! When your clients understand why medications are needed, the fear, self-blame, and stigma associated with diabetes medication disappears from the appointment, clearing the way for learning. Included in the course purchase is a very interesting e-book titled, Diabetes Reversal: Exploring the Research Behind the Headlines. This e-book provides a detailed review of research to help you effectively talk to clients about risks, benefits, and sustainability of intensive lifestyle change.

Early Bird is going on until April 17th. Save 30% on this 5-CPE course and enroll for only $69.

Weight Stigma

Many professionals are looking for research that explains weight stigma. There are two articles to help professionals understand the concept. The first is a 2-page paper, *Addressing Weight Bias: A Call to Action* from the Ontario Dietitians in Public Health. The second is a research article which provides a conceptual model for weight bias titled, *The Weight-Inclusive versus Weight-Normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss* The image below provides at a quick glance a model of the many ways weight stigma impacts health. Advancing your understanding of weight stigma will increase your understanding of Health at Every Size (HAES) and the weight neutral diabetes movement.



Weight Stigma: The Common Denominator in Disordered Eating in Diabetes

To understand what makes DEB-D escalate, we must begin by understanding how weight stigma, DEB and diabetes are connected. This begins with some very basic definitions about weight stigma and how it impacts diabetes care.

What is Weight Stigma?

Weight stigma is the prejudice and discrimination towards higher weight individuals. This vanilla definition can include repeated weight-related teasing, bullying, harassment, violence, hostility, pressures to lose weight/be thin, negative appearance commentary, and weight-related micro-aggressions in general. Looking at examples of weight stigma in a medical session can include an unwillingness to wait for a patient who ambles, failure to have adequate-sized gowns, chairs, or blood pressure cuffs for higher weight individuals. Another example might be to suggest weight loss for a client who came in for a concern unrelated to weight. While these examples of weight stigma may appear insignificant, the negative impact of weight stigma is more signifi-

cant in a medical setting, due to the implicit trust between provider and patient. A failure to consider the needs of higher weight individuals erodes this trust with each poor interaction.

Eroding Trust

Weight biased interactions erode confidence and damages the provider-client relationship because they reinforce the weight-centered stereotype. This places the higher weight individual on alert, creating or reinforcing a stress response. Being "on alert" means that these individuals are more likely to be aware of the possibility of rejection or derogation, which creates a cycle of harm.

The higher weight individuals who have experienced weight stigma want to avoid this shaming experience and may become fearful it will happen again. This preoccupation increases sensitivity and reaction to common weight-centered approaches associated with diabetes care. This desire may be documented in the medical chart as, "The client wasn't receptive to dietary changes," "The client will not engage in weight loss behaviors," or "Non-compliant."

It is easy to see how the higher weight client and the weight-centered provider are already not on the same page, creating the conditions for resistance or avoidance of clinical care. This is especially true if the patient perceived their body weight will be a source of embarrassment in that setting.

Looking at the Long-Term Impact of Weight-Centered Care

The long−term result of this conflict is avoidance and postponement of care, which has a significant impact on health outcomes. Research confirms that because higher weight individuals avoid stigmatizing situations, including seeking medical care, they, thus, present with more advanced and more difficult to treat conditions. In fact, individuals who experience more obesity stigma report less health utility or they place a lower value on health.[1] This is a suspected cause of the low utilization of DSMES services,

[1] Wee, C.C., Davis, R.B., Huskey, K.W., Jones, D.B., Hamel, M.B. (2013). Quality of life among obese patients seeking weight loss surgery: the importance of obesity−related social stigma and functional status. *J Gen Intern Med 28*: 231-238.

which are less than 10% for insured clients.

Why Do They Continue to Avoid Care?

"Why don't they [the patient] come in, don't they know they have diabetes?" This is a question I have heard many times. While it seems benign, there is an invisible bias that may elude many medical professionals. To unpack this, let's begin with the assumed value of medical care and health.

It makes sense that healthcare professionals value wellness and clients receiving medical care. This is what we do! Yet, our values may not be our client's values. Assuming this is a shared experience and we share values is often why appointments fail to create behavioral change.

During a coaching session with Susan Dopart, RD, MI Instructor, she explained, "Research shows our ability to remain neutral and free of judgment pulls clients towards change." This means that our values get in the way of our clients changing. Why? Our clients may value other things such as work, caring for family, or self-reliance just to name a few. While receiving medical care appears to be beneficial, for many higher weight individuals who have internalized weight stigma, weight centered medical care is a harming, not a helping, experience. Being told over and over again to lose weight or that being fat is bad reinforces the narrative that a problem is their fault.

Let's unpack two counseling examples, "You have diabetes. Your weight is a risk factor." For someone who has experienced weight stigma and is sensitive to weight-related comments, stating that weight is a risk factor is likely to feel like blame to the client. Emotions can run high and interpret this comment to mean, "You have diabetes. Because of your weight, you now have diabetes. You caused the diabetes." Here is another example, "You have diabetes. You should lose 10% of your body weight to improve your blood sugar." Again, this might be interpreted as "You caused this problem and now you HAVE to go on that XYZ diet [a suggestion that carries its own pain and past experience] and never eat foods you enjoy or you will never be healthy."

Many providers have confessed confusion, frustration, and resentment that

clients can't hear them. "What am I supposed to say? I am giving them the facts, which I get isn't *fun*, but I don't have another choice."

How to Talk to Patients

Counseling clients is imperfect. It is both an art and a science. Approaches, such as Motivational Interviewing (MI), suggest that the emphasis should shift from offering solutions to listening to the client. For example, shifting the initial statement, "You have diabetes. Your weight is a risk factor." to "You have diabetes." [Silence] "What thoughts are you willing to share with me?" or "What are you thinking?" Here is another example of how to rephase the previous example, which was, "You have diabetes. You should lose 10% of your body weight to improve your blood sugar," to become, "You have diabetes. What ideas do you want to explore to improve this condition / your blood sugar?"

Why Include the Patient?

Patients have said to me, "My PCP thinks that I overeat, but I am not overeating. They think that I am not exercising or that I am lazy. They just don't believe me, and it is frustrating because they stop listening." Poor communication is often at the heart of outcomes. Failure to talk about the underlying pathophysiology of diabetes, including that weight gain often precedes the diagnosis[2] is often missing. Also, much evidence suggests that insulin resistance is a product of an underlying metabolic disturbance that predisposes the individual to increased fat storage due to compensatory insulin secretion. In other words, obesity, may be an early symptom of diabetes as opposed to its primary underlying cause.[3]

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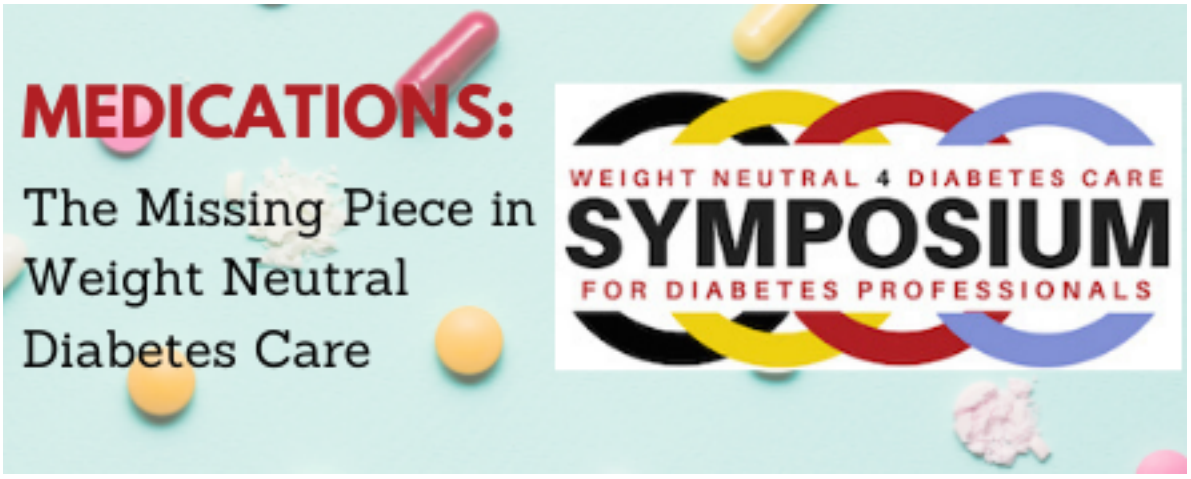
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038351/

[3] https://link.springer.com/article/10.1186/1475-2891-10-9

Weight changes are not limited to disease; they include limited food access, poverty,[4] aging, medication, decreased physical activity, chronic dieting, experiencing weight stigma,[5] increased calorie intake, secondary weight stigma, triggered eating behaviors,[6] and ending restrictive eating.[7]

While weight stigma initially appears to be a social or psychological phenomenon, it is the common denominator in all disordered eating behaviors, including DEB-D which makes it a medical issue. Weight stigma impacts access, trust, communication, and how a patient values health care. Providers who take the time to understand and unpack weight stigma will have improved patient-care interactions.

A more in-depth understanding of DEB-D and how weight stigma impacts diabetes care is available by enrolling in the *WN4DC Symposium*. The symposium offers healthcare professionals a chance to systematically learn about weight neutral care, counseling, and disordered eating in diabetes. To learn more visit www.wn4dcsymposium.com



[4] https://scholar.google.com/citations?user=amlWTvUAAAAJ&hl=en&scioq=Type+2+Diabetes:+Poverty,+Priorities+and+Policy.+The+Social+Determinants+of+the+Incidence+and+Management+of+Type+2+Diabetes.&oi=sra#d=gs_md_cita-d&u=%2Fcitations%3Fview_op%3Dview_citation%26hl%3Den%26user%3DamlWTvUAAAAJ%26citation_for_view%3DamlWTvUAAAAJ%3A70eg2SAEIzsC%26tzom%3D300

[5] https://www.sciencedirect.com/science/article/abs/pii/S0195666316300678

[6] https://onlinelibrary.wiley.com/doi/full/10.1038/oby.2011.204

[7] https://psycnet.apa.org/record/2006-23340-013

Four Ways to Spot Disordered Eating Behaviors in Diabetes Care

Disordered Eating Behaviors in Diabetes (DEB-D) is more common than many professionals realize. Research conducted in 2017 by Garcia-Mayer noted that as many as 20-40% of patients with type 2 diabetes present with disordered eating. This startling statistic caused me to reflect on what might be a red flag for DEB-D.

"My diabetes is improving because, WITHOUT TRYING, I am losing weight." While this comment might indicate diabetes out of control, it also can confuse the client who might think that any weight loss is good. Having a weight loss focus in diabetes care drives disordered eating behaviors.

"My loss of appetite is a good sign." Again, elevated blood sugar can depress appetite just as an improvement in overall A1C and medication may moderate hunger/fullness. Associating the change in appetite as beneficial is another example of how weight-centered care dominates a client's perception of diabetes care. In this example, the individual is thinking that a loss of appetite, which could result in a decrease in nutrition, is beneficial. Additionally, as mentioned earlier, a decrease in appetite as the result of elevated blood sugar--a condition coined 'glucose toxicity'--is not helpful. This erroneous belief that eating less will be enough to improve their diabetes, may delay medical care or contribute to clinical inertia.

I was curious about the experiences of other professionals, so I reached out to the WN4DC professional group and asked, "How do you spot DEB-D?" This group identified four key behaviors which were red-flags for DEB-D, including villainizing food, weight, the fear of eating, and self-blame.

1. Villainizing Food (Carbohydrates). Megan Muñoz, RN, MSN, CMSRN, CDCES, and creator of the Type 2 and You, with Meg podcast explained, "Someone told me after she had two blueberries, two tablespoons of full-fat yogurt, and one small square of her husband's cereal that, 'My body is so sensitive to carbs. I used to be able to handle them, but now anything I eat will shoot my blood sugars up.'" Megan continued, "I hear

this type of comment all the time." Why would this comment be a red flag for DEB-D? Clients are surprised, disappointed, and have an unrealistic expectation regarding blood sugar fluctuation when eating. Seeing blood sugars rise at all appears to be at the heart of the fear and, instead of learning more about diabetes and what causes blood sugar fluctuation, the client is now blaming themselves for eating or blaming their body for having blood sugar fluctuations.

2.Emily Opthof, RD, BScFN, shared the following red flags: “I can't eat XYZ because it's so bad." This classic example of villainizing food is part of the shame binge cycle.(8) In the shame-binge cycle, 'bad' foods are often eaten to comfort the client after experiencing an emotionally challenging experience. However, by eating 'bad food,’ the client is now burdened with guilt, which is internalized as them being 'bad.’ It isn't hard for the client to feel an increase in shame energizing shame and setting the client up to binge. If weight gain and/or an increase in blood sugar accompanies eating, this is often used as evidence to the client and the health care professional that the client is at fault.

3."I stopped eating XYZ." In this example, we see the preoccupation with food increasing. For individuals with disordered eating, thoughts of food, eating, and weight begin to occupy more and more of their mental energy. In some cases, clients may actually dream of eating, causing the amount of time consumed by disordered eating to exceed 100%! Now, for someone with type 2 diabetes, this preoccupation is magnified by blood sugar, society's misunderstanding of diabetes, and standard diabetes care medical appointments, which often focus on weight and A1C and not on the psychological stress associated with the disease. Clients with DEB-D have experienced a double-sided burnout, one from disordered eating and the other from diabetes.

4.Weight. "I absolutely need to lose weight, I'm desperate." "I would feel so much better if I could just be back at my college weight." Denise DelPrincipe MS, RDN, LD, identified, as a red flag, the statement, "I know my blood sugar will be better if I just lose weight." This, again, is suggesting that

[8] https://books.google.com/books?hl=en&lr=&id=rpy54R7ash8C&oi=fnd&pg=PA219&dq=shame+binge+cycle&ots=Mzo55-wObc&sig=pagHUzA-A6KA8eWgOqgs5XI0_Cs#v=onepage&q=shame%20binge%20cycle&f=false

weight change, often achieved by engaging in extreme, unbalanced, restrictive eating, and exercise behaviors improves health is the hallmark of DEB-D.

5. Fear of Eating. Courtney G. Riedel, MS, RDN, LDN, identified the fear of eating such as, "Eating anything with carbs scares me," or "I'm so mad at food because I know it will hurt me," as being a red flag for DEB-D.

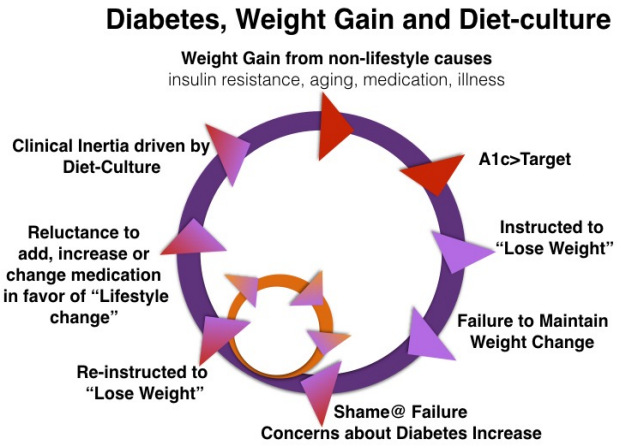
6.Self-blame. Holly Paulsen RD, CEDRD-S, LD, explains that, over time, clients develop the habit of engaging in self-blame. They see their inability to maintain a level of preoccupation with food, restricting their intake, being hypervigilant with what, when, and how much they eat as a personal failure. They don't see these behaviors as physically, mentally, and emotionally sustainable. Holly explains, when I hear, "I know what to do, I just can't do it," I know there is more to unpack.

It is helpful to see that DEB-D, is gaining more awareness and that healthcare professionals are starting to identify key behaviors that impact both disordered eating and diabetes care. This article identifies four key thoughts, Villainizing Food, Weight, The Fear of Eating, and Self-blame and gives specific examples of how these thoughts might manifest. You can learn more about DEB-D by checking out the articles, resources, or courses available at the *Weight Neutral for Diabetes Care Symposium* at www.wn4dcsymposium.com

Can Diet-culture's Impact on Diabetes Care Be Depicted in A Model?

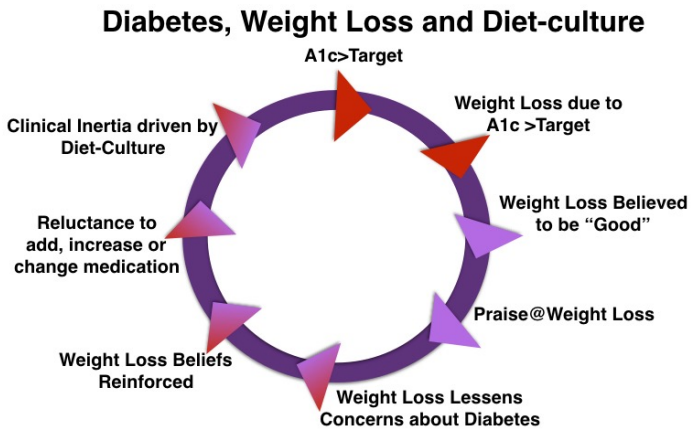
Have you ever considered how diet-culture impacts diabetes care? This question was asked by some experts in the field at a recent brainstorming meeting. While no definitive answer was identified, Megrette Fletcher M.Ed., RDN, CDCES, attempted to describe how diet-culture can impact diabetes care by creating four models. These initial models are offered with the intent to open the conversation regarding the impact of diet-culture, diabetes and disordered eating behaviors.

Starting with the **Diabetes, Weight Gain and Diet-culture Model**. This model has eight points, and a sub-circle exploring shame, failure, and concerns about increasing diabetes care.



The model starts with weight gain from non-lifestyle causes, such as insulin resistance, aging, decreased calorie needs, medication, or illness. This change in weight proceeds an increase in A1c which is represented by the second point. With an increased A1c, the client is instructed to lose weight. This instruction may initially be successful but ultimately fails to be maintained which is the fourth point in the diagram. The fifth point is the shame associated with an inability to lose weight. This perceived failure is misunderstood, because for people with diabetes we have not found a way to sustain a weight loss of >10% and yet the current national recommendations continue to suggest weight loss efforts. This adds to the over distress associated with diabetes, creating a sub-cycle of yo-yo dieting, weight loss, weight gain, and internalized shame, which is reinforced by diet culture. The seventh point simplistically depicts a patient and provider 'dance' where there is a reluctance to add, increase or change medication in favor of 'Lifestyle change' leading to the final point, clinical inertia to adjust diabetes medication.

Clinical inertia associated with diabetes contributes to worse outcomes, and disproportionately affects higher weight individuals.

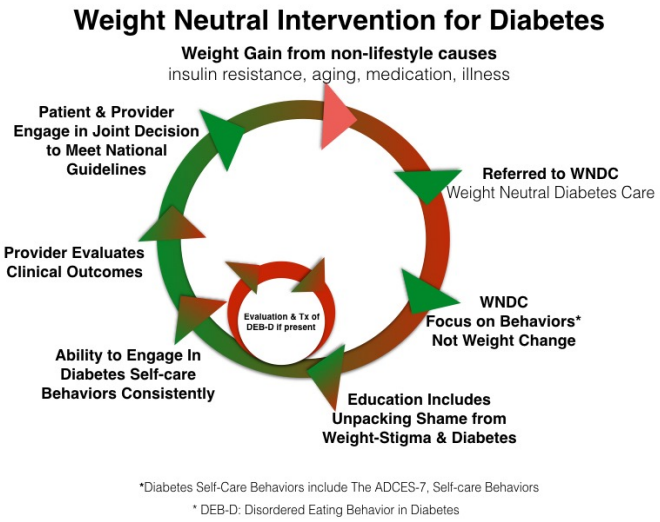


The next model called **Diabetes, Weight Loss and Diet-culture**. This model looks at how elevated blood sugars may contribute to weight loss, which is often misinterpreted by clients. It steps through eight points to show how weight loss associated with elevated blood sugar, can be influenced by diet-culture contributing to clinical inertia.

The initial point is an elevated A1c, which may contribute to weight loss. This weight loss is believed to be 'good' by the patient and is praised by society or within a medical setting. This praise lessens the overall concern about diabetes, and patients may select information, resources, and treatments which reinforce this belief creating a resistance to add, increase or change medication in favor of lifestyle change. This resistance is part of the larger diet culture within our society, which reinforces the belief that 'food is medicine' and that 'dieting can cure diabetes.'

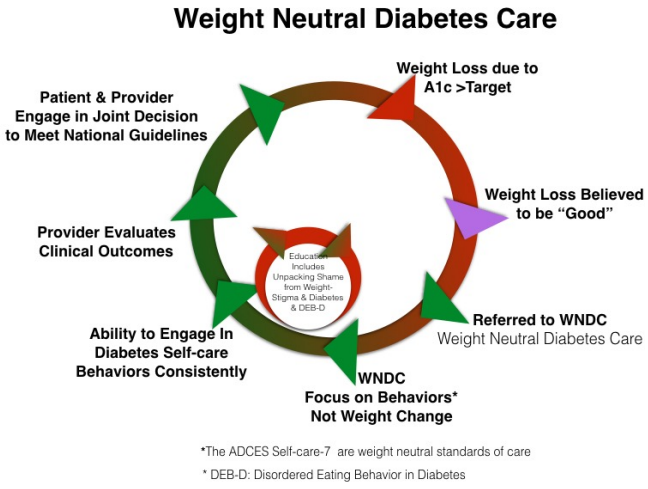
The following two diagrams describe how Weight Neutral Diabetes Care could be used to avoid the influence of diet culture and improve clinical outcomes.

In the **Weight Neutral Intervention for Diabetes Diagram**, there are seven points and as with the previous model starts with weight gain from non-lifestyle causes. Here the client is referred to weight neutral diabetes care, WNDC. In these sessions the focus is on diabetes self-care behaviors, which are the ADCES-7 Self-care Behaviors. The education includes unpacking shame from weight and diabetes stigma and requires the healthcare professional to evaluate and treat any DEB-D disordered eating behaviors



associated with diabetes. In time, the client has an increased ability to consistently engage in Diabetes Self-care Behaviors. The ability to consistently engage in Diabetes Self-care Behaviors, not weight loss, is reinforced to the patient and shared with the provider. This shift provides a clear behavioral focus and, together, the patient and the provider engage in joint decisions to meet national guidelines.

The Weight Neutral Diabetes Care (WNDC) with Weight Loss model also has seven points. Like the initial model, the first two points are the same and the shift begins at the third decision point where the client is referred to WNDC. WNDC education includes a sub-cycle which focuses on behaviors not weight, and education includes addressing weight, and diabetes stigma and addressing DEB-D behaviors if present. Success, as indicated by the fifth point in the cycle, is identified as the ability to engage in Diabetes Self-care behaviors consistently. The sixth point evaluates clinical outcomes and the seventh point is engaging the client in joint decision making to meet national guidelines.



These initial models provide the framework for the larger diabetes community to begin to see the complex interaction between weight stigma, diet culture and diabetes care. The increased awareness of the impact of diet culture on diabetes care creates many

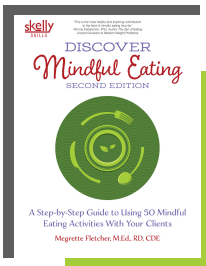
opportunities for research and the development of validated models to reduce diet culture while treating diabetes and weight stigma in our health care system.

Fellowship with Other Weight Neutral Diabetes Professionals!

Did you know that there is a “secret” group of healthcare professionals who talk about weight neutral diabetes care? This private Professional Facebook group also provides Facebook Live chats! This is a great way to discuss clinical issues surrounding WNDC. Recently, I offered a Facebook Live Chat, where I reviewed the *Five Steps to a Client-Centered, Non-diet, Counseling Model (CNCM)*.

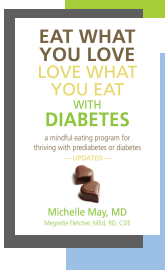
You can download the handout and watch the Facebook live video on the WN4DC Professional Facebook Group. Once you are in the group, select VIDEO on the left-hand navigation bar. Here you will have access to all the Facebook live chats that have been created! There are over 25 to choose from!

BOOKS FROM MEGRETTE.COM



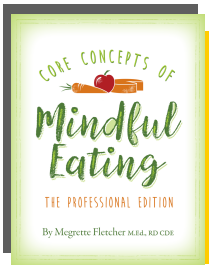
DISCOVER MINDFUL EATING

This bestseller was expanded and updated in 2019. It is filled with easy to use handouts explaining mindful eating and weight neutral teaching resource.



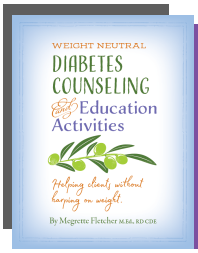
EAT WHAT YOU LOVE, LOVE WHAT YOU EAT WITH DIABETES

Pair mindful eating with diabetes self-management to hear your clients say "Ah ha!". This ground breaking book is filled with compassion, humor and real life solutions.



THE CORE CONCEPTS OF MINDFUL EATING

Your one stop book to understand what and how mindful eating is so effective in building understanding, empathy, motivation, insight, and supporting change.



DIABETES COUNSELING & EDUCATION ACTIVITIES

This rich, how-to book provides you with 14 activities to teach your clients about diabetes care without harping on weight.

CONTINUING EDUATION CREDITS ARE AVAILABLE FOR ALL OF THESE BOOKS

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Mindful eating made easy