A PROFESSIONAL GUIDE EMBRACING

# A WEIGHT NEUTRAL APPROACH FOR TYPE 2 DIABETES CARE

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Diets Don't Work · Health At Every Size ·
Understanding Type 2 Diabetes ·
Getting Support ·
Translating Concepts into Action ·
Promoting Self-acceptance

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# Five Steps

## To Weight Neutral Diabetes Care

Thank you for being interested in the non-dieting, weight neutral movement. I admire your willingness to learn how to help the more than 370 million people worldwide with diabetes move away from the scale and unsustainable restrictive eating patterns to find better glucose control by focusing on size-acceptance, consistent self-care behaviors, and diabetes care.

If we haven't met, my name is Megrette Fletcher. I am a Certified Diabetes Educator, Registered Dietitian, author of five mindful eating, weight neutral books and the co-founder of The Center for Mindful Eating. For the last twenty years I have been passionate about providing a non-judgmental, compassionate care to people with diabetes or in other words, a Weight Neutral Approach to Diabetes.

But before we begin, lets acknowledge the amazing work of the Health At Every Size, HAES community, The Association for Size Diversity And Health, ASDAH, and National Association to Advance Fat Acceptance, NAAFA, The National Eating Disorder Association, NEDA, Binge Eating Disorder Association, BEDA, and the International Association of Eating Disorder Professionals, IAEDP. This document wouldn't be possible without these amazing organizations!

Here are the five steps to guide you.

**Step 1:** Gather evidence to support your belief in a weight neutral approach for type 2 diabetes. This guide will point you to key documents and resources.

**Step 2:** Understand what the term "weight neutral" means to the respective diabetes and Health at Every Size, HAES community.

**Step 3:** Clarify how you are going to provide weight neutral education. The book, *Diabetes Counseling & Education Activities: Helping Clients without Harping on Weight* may assist you in this step.

**Step 4:** Garner support for yourself by finding groups of like-minded, out-going thinkers as you shift to a weight neutral approach for type 2 diabetes.

**Step 5:** Translate the Weight Neutral Message for Clients. The book *Eat What You Love, Love What You Eat with Diabetes* and the resources at Am I Hungry - including the Eat What You Love, Love What You Eat with Diabetes plate are available to help you.

# Step 1

## Gather Evidence to Support a Weight-Neutral Approach to Type 2 Diabetes

Because the "evidence" in support of weight loss for treating diabetes appears overwhelming, most of us struggle with this step in the process. Yet, like you, many researchers are questioning the benefit of weight loss as the focus of type 2 care and intervention. As Marion J. Franz, M.S., RDN, LDN, explains, "There are unanswered questions about the amount of weight loss needed to achieve beneficial outcomes, achievability of needed weight loss, and types of weight-loss interventions that result in beneficial outcomes on hemoglobin A1c (HbA1c), lipids, and blood pressure. The ideal macronutrient composition of weight-loss interventions is also controversial." Franz et al. completed a detailed analysis to answer these questions, published in 2015 in the Journal of the Academy of Nutrition and Dietetics[1]. This research offers a thorough review of the complex and often misunderstood topic of weight loss.

How can weight-loss results be misunderstood? When evaluating research about the benefits of weight loss, there are at least ten errors in weight science as it relates to diabetes care.

1. Weight loss isn't a behavior. It is an interrelated, complex outcome of many behaviors.
2. Weight-loss studies may not account for how a disease, specifically diabetes, impacts the ability of a person with diabetes to lose weight.
3. Weight-loss studies may detail how patients change behaviors, but may not show whether they can sustain a behavioral change.
4. Weight-loss studies often confuse correlation with causation.
5. Weight-loss studies may not account for how the management of a chronic disease like diabetes changes over time, and therefore, the impact of when

the dietary intervention occurred will skew outcomes and generate inaccurate statements about interventions.

6. Weight-loss studies fail to acknowledge that diabetes is a chronic disease that is managed, not cured.
7. Weight-loss studies fail to report specific details, including the percentage of individuals who can achieve non-surgical remission from diabetes.
8. Weight loss achieved by restrictive eating has physical, psychological, and medical consequences that contribute to poor health outcomes.
9. Weight cycling, which is a repeating pattern of weight loss and weight gain, complicates blood glucose management.
10. Weight stigma and weight bias impact health, the utilization of diabetes care, and the well-being of the client.

# A closer look at ten errors in weight science as it relates to diabetes care.

## Weight loss isn't a behavior. It is an interrelated, complex outcome of many behaviors.

One of the biggest issues in diabetes care is the belief that weight is a behavior. The Health At Every Size (HAES) website offers the following example using Paula Deen, a television food-show personality, who was diagnosed with type 2 diabetes.

- She received medical care.
- She doubled up on veggies and changed how she cooked.
- She began walking every day.

Her diabetes improved! WHY?  Blood glucose begins to improve immediately when behaviors, such as eating more vegetables or exercising are adopted. This improvement is likely due to many variables: the timing of the intervention; the

| Research Questioning Weight Loss & Type 2 Diabetes | Title | Date |
|---|---|---|
| An intensive lifestyle intervention focusing on weight loss did not reduce the rate of cardiovascular events in overweight or obese adults with type 2 diabetes. | The Look Ahead Trial | 2013 |
| These preliminary findings show weight stigma associated with greater biochemical stress, independent of level of adiposity. It is possible weight stigma may contribute to poor health underlying some forms of obesity. | Associations of Weight Stigma with Cortisol and Oxidative Stress Independent of Adiposity. | 2014 |
| Chronic weight dissatisfaction increased type 2 diabetes risk. Weight dissatisfaction, regardless of BMI, represents a potentially important psychophysiological modifier of the relationships between BMI and risk of type 2 diabetes and warrants greater attention in future studies of chronic disease risk. | Chronic Weight Dissatisfaction Predicts Type 2 Diabetes Risk: Aerobic Center Longitudinal Study | 2015 |
| In this population based cohort of overweight patients with type 2 diabetes, successful therapeutic intentional weight loss, supervised by a doctor over six years, was not associated with reduced all cause mortality or cardiovascular morbidity/mortality during the succeeding 13 years. | Intentional Weight Loss and Longevity in Overweight Patients with Type 2 Diabetes: A Population-Based Cohort Study | 2016 |
| Individuals with obesity who self-stigmatize may have heightened cardiometabolic risk. Biological and behavioral pathways linking WBI and metabolic syndrome require further exploration. | Association Between Weight Bias Internalization and Metabolic Syndrome Among Treatment-Seeking Individuals with Obesity. | 2017 |
| In this population based cohort of overweight patients with type 2 diabetes, successful therapeutic intentional weight loss, supervised by a doctor over six years, was not associated with reduced all cause mortality or cardiovascular morbidity/mortality during the succeeding 13 years. | Intentional Weight Loss and Longevity in Overweight Patients with Type 2 Diabetes: A Population-Based Cohort Study | 2017 |

inclusion of activity; a reduction, but not a restriction, in calories; and accessing medical care.

## Weight-loss studies may not account for how a disease, specifically diabetes, impacts the ability of a person with diabetes to lose weight.

It is more difficult for individuals with diabetes to lose weight and/or maintain weight loss[2],[3],[4]. This level of effort required to lose and maintain weight loss may be desirable for only a small number  of individuals. Patient-centered care involves the client and acknowledges that  he has the right to decline weight-loss counseling due to work schedules, economic limitations, past experience,

and personal values. Unfortunately for the patient, declining weight-loss counseling often means he or she declines diabetes care.

## Weight-loss studies may detail how patients change behaviors, but may not show whether they can sustain a behavioral change.

Diabetes is a chronic illness, which requires all research to focus on the sustainability of a suggested change, not just the change in weight, eating, exercise, or medication. When evaluating research, consider if the intervention is desired and sustainable for an individual.

## Weight-loss studies often confuse correlation with causation.

An important concept for understanding weight science is the difference between correlation and causation.

- Correlation: a connection between two or more things
- Causation: an action that makes something happen.

In diabetes care, it is easy to mistake correlation for causation. Research has shown that balanced eating, not weight loss, improves glucose levels.[5] Therefore, balanced eating -- specifically when the energy equation is neutral but not at an energy deficit -- improves blood glucose and may not produce weight loss.[6] Attributing weight loss as the cause of improved blood sugar is an example of how correlation is confused with causation.

## Weight-loss studies may not account for how the management of a chronic disease like diabetes changes over time, and therefore, the impact of when the dietary intervention occurred will skew outcomes and generate inaccurate statements about interventions.

The ability to lose weight continues to be questioned by HAES advocates because of the low percentage of individuals who can maintain weight loss for more than five years. The progressive nature of type 2 diabetes complicates the effectiveness of weight loss for blood glucose management, which depends on how long the client has had diabetes. Franz explains, "A weight-loss intervention implemented earlier in the disease process as was done in the Mediterranean-style study group may be more effective, especially if implemented before some

diabetes medications (e.g., insulin secretagogues) are needed that have weight-gain side effects." Therefore, the standard recommendations to "lose weight" are in question. Asking that clients not gain weight when living with diabetes may be more effective than asking for and expecting weight loss." At this point, preventing weight gain rather than losing weight often becomes a goal of nutrition therapy.[7] The shift from weight loss to weigh maintenance lends support for a weight-neutral approach to diabetes care, since dieting is linked to weight gain, not weight loss.

## Weight-loss studies fail to acknowledge that diabetes is a chronic disease that is managed, not cured.

Medical advice that recommends weight loss is not advocating for all clients, but for a solution achievable by only 5% to 15% of the population. A weight-neutral professional promotes the management of diabetes, regardless of weight. This means that in response to the statement, "When I lose weight…," a weight-neutral professional will say, "When you lose weight, you will ***still have to*** manage your diabetes."

Good diabetes care takes a comprehensive view of a person's health. It includes everything from preventing problems and being healthy to living a full and vibrant life.

## Weight-loss studies fail to report specific details, including the percentage of individuals who can achieve non-surgical remission from diabetes.

Non-surgical remission from diabetes was defined in 2009 by the American Diabetes Association as a return to normal glucose levels in the absence of antihyperglycemic therapy, or an HbA1c < 6% and FG < 100 mg/dl. Partial remission is hyperglycemia below the diagnostic level for diabetes in the absence of antihyperglycemic medication, or an HbA1c < 6.5% and FG 100–125 mg/dl.[8] A 2012 study[9], which looked at the rate of remission of type 2 diabetes from the Look AHEAD Trial, concluded that of the 2,262 individuals from the intensive lifestyle intervention (ILI), 11.5% or 260 participants were able to achieve either partial or complete remission. The ability to achieve any level of remission decreased after the initial year to 7.3%, and in the fourth year it was

| Weight Focused | Weight Neutral |
|---|---|
| Don't assume your client with type 2 diabetes is not eating well, because of his/her weight. A person's weight does not indicate unbalanced eating habits. | If your client with type 2 diabetes is not eating well, discuss food and nutrition without linking it to weight. |
| Focusing on calories, weight, and weight loss for the management of type 2 diabetes. | Focusing on balanced meals, and developing awareness of hunger and satiety, cues to guide food selection and portion choices. |
| Suggesting unsustainable, extreme, or unhealthy ways to change weight or physical fitness to improve diabetes care. | Focusing on sustainable health gains by encouraging self-care practices, including self-kindness. |
| Offering unsolicited weight loss advice to fat clients. | Encouraging clients to talk about what is working in maintaining their health. |

2.0%. The research concluded that, "The absolute prevalence of remission through years 2-4 was relatively rare: Even among those with fewer than 2 years since diagnosis, average remission was 3.6% for the ILI compared with 1.9% for the Diabetes Self-Education. Among those who had remission, about one-third in the ILI group returned to a clinical diabetes status each year. Therefore, the definition, the timing of the intervention, and the temporary nature of non-surgical remission from diabetes needs to be included in research designs and conclusions.

## Weight loss achieved by restrictive eating has physical, psychological, and medical consequences that contribute to poor health outcomes.

As previously stated, the ability to achieve weight loss for greater than five years is limited to less than 15% of individuals without diabetes. The rate of this outcome for individuals with diabetes has not been determined, but it is likely a lower rate than that of a non-diabetic population.

Dieting, or restrictive eating, is associated with a number of issues, including the development of disordered eating. Binge-eating disorder (BED), a syndrome characterized by recurrent uncontrollable overeating [10], [11] affects ~3% of the general population, however, this rate increases 10- to 20-fold in

patients seeking treatment for obesity.[12] Promoting weight loss as the primary and continued treatment of type 2 diabetes may be promoting disordered eating.[13] More research is needed to fully understand the rate of disordered eating and diabetes.

Depression is a common side effect of diabetes. Diabetes and depression occur together about twice as frequently as would be predicted by chance alone and present  a major clinical challenge: The outcomes of both conditions are worsened by the other. [14]

The burden of diabetes care coupled with a weight-loss expectation presents an unreasonable behavioral outcome and can create conditions for depression and disordered eating  to arise.  It is critical to remember that a client engaging in disordered eating cannot possibly maintain blood glucose control. Recognizing the effect of disordered eating on blood glucose management is necessary for all professionals working in diabetes care.

## Weight cycling, which is a repeated pattern of weight loss and weight gain, complicates blood glucose management.

Weight cycling complicates diabetes management because as diets and exercise patterns change, so does the medical management of the disease.  For example, if a client were to participate in a fast or a cleanse or choose to restrict a macronutrient such as carbohydrates from the diet, the management of the diabetes care needs to be adapted to prevent hypoglycemia and to improve quality of life. The same is true for vigorous exercise, which often starts and stops. There is no evidence to support the notion that clients will engage in intensive exercise behaviors indefinitely.

Many individuals with diabetes attempt these radical changes without adequate support and medical supervision, resulting in hypoglycemia, fear of hypoglycemia, and fear of medication. These outcomes often prompt the individual to make changes to his/her diabetes care without communicating these changes with his/her diabetes team.

Additionally, fear of hypoglycemia can fuel disordered-eating thoughts and behavior, complicating diabetes care and management. The development of disordered eating and shame is correlated with depression even in individuals without diabetes.[15]

## Weight stigma and weight bias impact health, the utilization of diabetes care, and the well-being of the client.

The impact of weight stigma on health is complex. Weight bias impacts people across the weight spectrum. [16] The impact of weight stigma and weight bias begins in childhood and continues into adulthood and is associated with adverse health outcomes including anxiety, stress, depression, low self-esteem, and body image issues. [17], [18], [19] In addition, research has found that shaming individuals for their body weight does not motivate positive behavior change. In fact, it appears to lead to the development of disordered eating and obesity.[20]

The National Association to Advance Fat Acceptance, NAAFA reports: "Studies have found that labeling someone as 'overweight' – irrespective of their actual weight – is associated with increased body dissatisfaction, internalized weight stigma, negative affect, and reduced perceived health. Labeling people as 'overweight' also predicts dysregulation in cardiovascular, inflammatory, and metabolic functioning, and blood pressure independent of actual weight. "[21]

Dieting is often accompanied by weight cycling or "yo-yo" dieting — repeated periods of weight loss and weight gain, which by itself impacts diabetes care. The medical consequences of weight cycling were identified by Brownell and Rodin[22] and include metabolic, and psychological health outcomes. [23] The Framingham Heart Study found that when individuals engage in radical weight shifts, there is an increase in mortality and morbidity related to coronary heart disease.[24] These findings were similar in the ERFORT cohort study conducted in Germany.[25]

Tracy L. Tylka states: "Since dieting has been associated with the onset and maintenance of eating disorders, and the cessation of dieting is a crucial step in the treatment of eating disorders, encouraging higher-weight patients to enter a

weight-suppressed state by dieting is likely physically harmful and hence violates professional codes of ethics."[26]

Professionals working in diabetes care are advised to learn more about the errors in weight science by reading the following key documents:

- Tylka, Tracy L., et al. "The Weight-Inclusive versus Weight-Normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss." Journal of Obesity, vol. 2014, 2014, pp. 1–18., doi: 10.1155/2014/983495. https://www.hindawi.com/journals/jobe/2014/983495/
- Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents, and Children in Australia (2013) — https://www.nhmrc.gov.au/guidelines-publications/n57
- American Psychologist 2007, "Medicare's Search for Effective Obesity Treatments: Diets Are Not the Answer." Mann, Traci; Tomiyama, A.J.; Westling, E.; Lew, A.M.; Samuels, B Chatman. https://escholarship.org/uc/item/2811g3r3NAAFA(2017) Guidelines for healthcare providers with fat clients. www.naafa.org

And visiting international organizations including:

- The Association for Size Diversity and Health — https://www.sizediversityandhealth.org/content.asp?id=34
- Health At Every Size, HAES community -- https://haescommunity.com/
- National Association to Advance Fat Acceptance, NAAFA, -- https://www.naafaonline.com/dev2/about/
- The National Eating Disorder Association, NEDA, -- https://www.nationaleatingdisorders.org/
- Binge Eating Disorder Association, BEDA, https://bedaonline.com/
- The International Association of Eating Disorder Professionals, IAEDP -http://www.iaedp.com/

# Adopting a Weight-Neutral Approach for Diabetes Care

The nutrition recommendations for overweight and obese individuals with type 2 diabetes should continue to focus primarily on encouraging a healthful-eating pattern with careful attention to and support of the individual to nourish the body by eating an amount of food that feels satisfying and nourishing. Dietary advice that focuses solely on restriction, elimination, or weight change can create counseling barriers, decrease access to care, and lead to weight bias.

When health-care professionals shift their counseling focus to what the client is doing well, engagement in care improves.[27] Learning about the client's efforts and successes regarding the management of their total health, not focusing only on weight loss, is an important step. This can be done by asking open-ended questions such as "What is working?" or "How are you managing your health?" which allow the client to participate in the conversation. Professionals can affirm the client's choices and explain the benefit of continued support.

It is the consistent support for the individual with diabetes that appears to be the unifying constant in improving outcomes for people with both type 1 and type 2 diabetes. The physical, mental and emotional drain that this disease can exact hasn't been accurately measured in a research study. The added expectation of weight loss and the weight bias that results when clients are not able to achieve this rare outcome only increases this heavy burden.

Adopting a weight-neutral approach to diabetes care can ease the disease burden and create a supportive counseling relationship that allows clients to explore the deeper complexities surrounding food, eating and diabetes care.

Empowering clients to recognize their direct experience, to use hunger and fullness as guides to moderating portion size and balancing the distribution of

energy through the day; encouraging their participation in regular physical activity; providing  support for their daily self-care and for obtaining regular medical care – these offer the best outcomes for people with diabetes.

# Key points for Weight-Neutral Diabetes Care

- Weight-neutral diabetes care encourages individuals to engage in health-promoting behaviors, such as taking medication, monitoring and managing stress, eating balanced meals, engaging in regular and consistent activity, and seeing medical professionals to manage their diabetes care
- A weight-neutral/Mindful Eating/HAES approach directs clients to the practices possible to maintain in his/her day-to-day life, rather than in the pursuit of weight loss.
- Weight-neutral practices for diabetes care encourage body trust and acceptance.
- Weight-neutral diabetes care advocates for the use of weight-neutral medication when medically and financially possible to build trust in the body.
- Weight-neutral diabetes care works to minimize the need for non-hunger eating due to high or low blood sugar and hypoglycemia in patients who experience these conditions.
- Weight-neutral diabetes care works to recognize non-hunger triggers, including medications that mimic hunger, by developing strategies to overcome these side effects and to promote body trust.
- Weight-Neutral/Mindful Eating/HAES approaches for diabetes care focus on behaviors. They make no promises about the resulting weight a person will be because of any behavioral change and therefore do not set goals surrounding weight or weight change.

# Step 2

## What Weight Neutral means to Diabetes and Health At Every Size, HAES community

What does the counseling term weight neutral mean in the diabetes community and how is it different than Health at Every Size (HAES)?

Some medications have the side effect of weight gain. A medication which does not promote weight gain, is called weight neutral. In diabetes care, there are medications which are not weight neutral and cause weight gain. These medications are used to treat many conditions including elevated blood sugar, hypertension, depression, and existing illness such COPD, asthma, cancer, and other psychiatric illness.

Should you advocate for your clients to shift to weight neutral medications whenever medically and financially possible . Yes, here is why. The goal of mindful eating/HAES is to build your client's trust in his/her body.  A weight-neutral counselor understands when a client experiences hypoglycemia, the treatment requires them to eat for medical reasons, not in response to hunger which undermines body trust control and decreases the quality of life.

A weight-neutral educator works with clients to address concerns regarding medications that mimic hunger without focusing on weight. Counseling and education identify physical and emotional hunger and develop effective, patient centered strategies to distinguish these two signals while promoting blood sugar control.

For Diabetes Care, the term *weight neutral* is referring specifically to medication. Medication management and patient training is needed to promote attuned listening and body trust when taking specific medication.

As a weight neutral educator you want to improve confidence, decrease fear, and embrace self-care. As your client lets go of the diet-mentality and can listen to the

body, and nourish it; medication changes and adjustments (regardless if these are increased or decreased) are evaluated to improve blood sugar and quality of life.

In counseling, the term weight neutral refers to something different. Being weight neutral requires the counselor to place no value on a change in weight. Therefore a person is not "good" for losing weight or "bad" for gaining weight, or vice versa.

A common misconception is being weight neutral encourages people to be fat. A weight neutral approach for diabetes care supports clients in listening and trusting their bodies, regardless of their current size. It embraces size diversity, and lets go of the notion health is defined as a number on a scale. It encourages clients to giving up weight cycling or "yo-yo dieting" and the inherent negative health problems associated with it by practicing self-acceptance and reinforcing the basic principle that self-worth and self-value are not found on a scale.

What is the difference between being "Weight Neutral" and the Health at Every Size, HAES movement? One of the underlying principles of HAES is a weight neutral

**The Basics of Health at Every Size**

"A Health at Every Size approach is weight-neutral. We encourage people to accept and care for their bodies, whatever size they are."

approach. The HAES movement features other principles including size advocacy. To find support and remove weight bias from promoting health and well-being visit the HAES and National Association to Advance Fat Acceptance, NAAFA websites.

# Step 3

## Garner Clarity on Your Approach to Provide Weight Neutral Education

The good news is the above steps will help you and, now, you are well on your way to creating a weight neutral diabetes approach. Diabetes is a complex disease. In fact, there are eight defects[28] associated with diabetes. These defects are hard to explain even with an advance degree. They include:

- An increase in a hormone called glucagon which raises blood sugar
- An increased glucose production by the body
- An increased reabsorption of glucose by your kidneys
- A decrease in the hormone insulin
- A decrease in a blood glucose lowering hormones called incretins
- A decrease in the effectiveness of insulin due to an inability of your body to breakdown fat
- A decrease in the ability of your muscles to use glucose
- A decrease in brain chemicals which increases hunger, cravings, and delays the sense of fullness prompting overeating.

Many professionals that do not specialize in diabetes are unaware of how to communicate the complexity of type 2 diabetes. If you face that challenge and are looking for more ideas, consider purchasing *Diabetes Counseling and Education Activities: Helping Clients without Harping on Weight*. This book is a weight neutral guide to explaining type 2 diabetes without harping on weight. The book covers 14 activities including:

1. Embracing a **Weight Neutral Approach to Diabetes Care** - This discussion is designed to help you understand why the Health at Every Size (HAES) movement is important for diabetes care. It continues to offer suggestions on how to avoid common counseling pitfalls and concludes with providing four points for bringing HAES into your MNT/DSMT program.

2. **The Insulin Knife: Part 1** - This handout and teaching activity explains the complexity of type 2 diabetes without the confusion. If you have been looking for a way to talk about insulin production, insulin resistance, and diet without weight loss, then the Insulin Knife is a perfect activity to learn. The activity breaks type 2 diabetes into three questions, each answer building on the next to provide a whole view of diabetes care.
3. **The Insulin Knife: Part 2** - **A Deeper look into Insulin Resistance** - This activity builds on the Insulin Knife handout. After presenting the Insulin Knife, many clients have questions and want to explore one of the three aspects of this concept in greater detail. The Insulin Knife: Part 2 focuses on the different factors contributing to insulin resistance allowing you to unpack this concept with confidence.
4. **Thermostat: Understanding the Cause of Insulin Resistance -** This handout and teaching activity explains the role of environment and lifestyle changes and how blood sugar levels shift as a result. Using a thermostat as an example, clients raise and lower their carbohydrate levels by changing the many variables contributing to or improving insulin resistance.
5. **Blood Sugar Rocket** - This activity reviews the role of macronutrients and fiber in the diet. It explains in a simple way why some foods have little effect on blood sugar and others make them rise. The blood sugar rocket activity explains the concept in an interactive, kinesthetic way. Using this model, you can have clients change their rocket's direction by shifting food choices or change the distance traveled by shifting the amount of food consumed. It is a fun, easy to understand analogy which helps clients establish a more balanced diet.
6. **How Much Work? A Deeper Dive into Diet –** This activity explores the last concept in the Insulin Knife handout which is the question "How much work?" Breaking this question into four key concepts: distribution of calories, portions, carbohydrate load, and the glucose-blunting effects of a mixed meal, it helps clients easily understand lifestyle changes. In addition, this activity reinforces why restriction isn't the answer for long-term diabetes care.

7. **Food Choices** – This teaching activity will help clients who may be confused AND fearful of expanding their food and eating choices. Food exchanges and "those lists" have been a staple of diet culture, and when your client is a chronic-dieter casualty this fear comes from years of dieting (or trying to diet, but feeling like a failure). Chronic dieters, or partners of chronic dieters, need nonjudgmental, weight neutral education about food and nutrition choices focusing solely on how to nourish the body and not on weight or weight loss.
8. **Using Food Labels** - Many clients have considerable confusion regarding how to read and interpret nutrition labels. There are many reasons for this confusion, the primary being the belief there is a diabetic diet in which they must choose specific foods (typically diet), or only have specific foods (typically diet, low fat, calorie modified). These beliefs come from society's obsession with restrictive eating and the surrounding diet culture, which targets those with type 2 diabetes.
9. **Hypoglycemia, Hunger, and Fullness with Diabetes** - This handout uses a hunger and fullness scale for diabetes care. This handout includes a counseling dialog for clients who are at risk of hypoglycemia due to medication or who may be experiencing hypoglycemic symptoms due to a poor diet.
10. **What About Weight?** - Understanding the concept of weight neutrality is different than teaching it to clients. In this activity, you will explore how to help clients be more aware of moving from weight loss goals, and keeping their attention clearly focused on behaviors they believe are promoting health, blood sugar control, balance, and well-being.
11. **Inactivity and Exercise Resistance** - Inactivity and exercise is a surprisingly complex topic to discuss with patients. This activity reviews three basic issues including: time management, the benefits of exercise, and self-doubt about the ability to exercise.
12. **Blood Sugar Experiments** - **Using the Meter** - These counseling dialogs look at seven different situations which would benefit from blood glucose monitoring including: Getting a Meter, Elevated A1c, Not Testing, Blood Sugars

All Over the Place, Blood Sugars Patterns, Experiments, Experiments 2 - Alcohol, Experiments 3 - Dinner and Experiments - Hunger/Fullness

13. **Liver Sponge** - **Explaining Hepatic Glucose Release** - This teaching activity explains how to teach and counsel a client to understand the Dawn phenomenon, Somogyi Effect, Exercise and Alcohol, and the role of the liver in diabetes care.
14. **Emotional Eating and Disordered Eating in Type 2 Diabetes** - Prior to developing type 2 diabetes, clients may have a history of disordered eating due to dieting or a previous diagnosis of an eating disorder. In this activity learn how to unpack emotional eating with diabetes in a compassionate, weight neutral way.

The cost of this book is $39 for print and $29 for the eBook. It also includes four handouts. There is a CME program available from Skelly Skills, and a separate webinar series to walk you through each of the activities.

If you are looking for a comprehensive Training for prediabetes and diabetes consider the *Am I Hungry? Mindful Eating for Diabetes* program. To learn more about this amazing Diabetes Self-Management Training Program, visit https://amihungry.com/train-with-us/mindful-eating-for-diabetes-facilitator-training/

# Step 4

## Gather Support for Yourself

As educators, we must bear witness to our clients' courage, their efforts, their strength, their fears, and their fatigue, as we help them advocate for self-care present in the here and now. This is a difficult task and we, as human beings, need help.

We need support to be the voice of reason, and counter the perfectionist thinking surrounding food, eating, and type 2 diabetes. We need support to be the voice of compassionate self-care, not perfect, ideal, or statistically significant behaviors. We need support to advocate for what is kind, sustainable, and self-care.

There are a growing number of resources for professionals. The Center for Mindful Eating can provide you with support to develop and deepen a mindful eating mindfulness practice. Resources are available in English and Spanish. The National Association for Fat Acceptance, NAAFA, and Association of Size Diversity and Health, ASDAH offer programs, resources, training, and guidance in the use of the HAES principles. The Mindful Dietitian *website* and private Facebook group provide discussion, training, and resources for nutrition and health professionals. Programs including ED/RD Pro, Be Nourished, Am I Hungry?, and Intuitive Eating provide in depth training for professionals. Helpful and supportive podcasts designed for professionals include The Mindful Dietitian, Food Psych, and Dietitians Unplugged.

# Step 5

## Translate the Weight Neutral Message for Clients

Type 2 diabetes is a complex disease. Despite what has been reported in the tabloids, there are eight defects in type 2 diabetes[29]. These defects range from decreased insulin secretion, decreased incretin effect, decrease glucose uptake by the muscle, lipolysis, neurotransmitter dysfunction, increased glucagon secretion, increased glucose reabsorption, and increased hepatic glucose production. These defects are challenging to explain to clients. *Eat What You Love, Love What You Eat with Diabetes: A Mindful Eating Program for Thriving with Prediabetes and Diabetes, Second Edition* is the first mindful eating book to outline a weight neutral approach specifically for diabetes care.

Your clients have a lot of questions about diabetes and are going to need a plan to bring a weight neutral approach to diabetes care. The *Eat What You Love, Love What You Eat with Diabetes* book, on demand client program, and Am I Hungry? community can help them.

*Eat What You Love, Love What You Eat with Diabetes* is divided into six parts, each based on a key mindfulness skill: Awareness, Curiosity, Nonjudgment, Being Present, Letting Go, and Acceptance.

On this foundation of mindfulness, clients are provided with the process of diabetes self-management that is weight neutral and guides them through a series of manageable, sustainable steps which can be mastered one at a time. Each of the six parts is divided into four chapters:

- **Think**: Conscious decision making using the Mindful Eating Cycle.
- **Care**: Information about diabetes and how to prevent complications associated with uncontrolled diabetes.
- **Nourish**: Nutrition from a nonrestrictive, all-foods-fit perspective.
- **Live**: Physical activity to be enjoyed and integrated into daily life.

To learn more about these resources, please visit https://amihungry.com/.

# Closing Thoughts

The process of bringing weight neutral counseling to individuals with type 2 diabetes is a journey I am excited to share with you. As you can see there are a number of steps on this road, and together we can make a difference in the lives of 29.1 million Americans and 371 million people globally. This eBook is laid out as five steps. These steps are the beginning of a road with no end in sight.

The next steps needed include funded, well-designed weight-neutral research that examines HAES programs for diabetes care. These programs will meet the HAES guidelines and have a clear focus on evaluating the effectiveness of specific behaviors to improve blood glucose control.

As we wait for this research please continue to promote autonomy, body acceptance, mindfulness, and self-care for all your clients with type 2 diabetes. Your willingness to advocate for the client and to focus on his/her moment to moment decisions that support self-care is where change happens.

Your unyielding support and compassion not only changes the lives of people living with this disease, it opens the minds of those working in the field. As Margaret Mead said, “Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.”

## CITATIONS

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