1

Shame and Diabetes:
Practicing Resilience in a Culture of Weight Stigma, Disordered Eating, and Healthism

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2

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- Notice of Requirements For Successful Completion
  - Please refer to learning goals and objectives
  - Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours
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Objectives

- To define shame and recognize the impact of shame on people with diabetes
- To identify shame triggers as they relate to diabetes
- To understand weight bias and its impact
- To learn strategies and skills for practicing with a weight neutral, shame resilience-based approach

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What is Shame?

The intensely painful or experience of believing that we are flawed and therefore unworthy of love and belonging. (Brown, 2006)

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Speaking Shame:
Comparing Self-Conscious Affects

	Embarrassment	Humiliation	Guilt	Shame
Emotions	Fleeting Funny	Threatening Degrading	Regret and discomfort due to being out of alignment with values	Physiological experiences
Thoughts	"I'll laugh about this later."	"I didn't deserve this."	"I did something bad." (focus on behavior)	"I am a bad parson." (focus on self)
Connection	Aware that we're not alone	May feel alone in the moment	Motivates us to make amends	Feel alone, flawed, unlovable
Behaviors	Shared openly	Seek support Stand up for self	Work to realign with values	Fight, Flight, Freeze, Perfectionism

Marek, A. (2013) based on Brown, B. (2012)

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9

Shame Cuts the Tightrope

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Weight Stigma Definition + Prevalence

"The social devaluation and denigration of people perceived to carry excess weight and leads to prejudice, negative stereotyping and discrimination toward those people." (Tomiyama, 2014)

- Weight discrimination has increased by 66% in the last decade
- Seen as the last "socially acceptable" form of bias
- For women, weight discrimination is more common than race discrimination (Andreyeva, Pul, Brownell, 2008; Brochu & Esses, 2011; Puhl & Heuer, 2009)
- People in larger bodies are perceived as lazy, lacking willpower and control, unattractive (Brochu & Esses, 2011)

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Weight Stigma in Healthcare

- Medical professionals perceive larger patients as lazy, lacking willpower, personally to blame for their weight/health, non-compliant
- Patients physicians blame weight for all problems and are not taken seriously
- Parents of larger children feel blamed and dismissed
- Medical providers spend less time building rapport, less time in appointments, provide less education, and are less likely to perform tests and screenings

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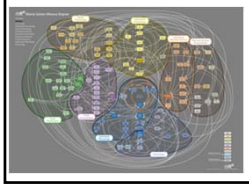
12

Weight Determinants



"The genetic contribution to BMI may be about 70%" (NIH Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults)

"BMI is a highly heritable human trait. Despite legitimate concerns about the environmental forces responsible for recent changes in its prevalence, this fact has not altered." (O'Rahilly, S. 2006)

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Dangers of Dieting

For every 10 people who diet, after 5 years, 1 will maintain weight loss, 5 will regain back to original weight, and 4 will weigh more than original weight

95% of diets fail - meaning at 5 year follow-up most have regained weight

"Weight regain to pre-intervention weight occurs regardless of whether the participant has overweight or class I, II or III obesity, and in participants with normal blood sugar, prediabetes and type 2 diabetes." (NHMRC 2013)

"…the high rate of relapse among people with obesity who have lost weight has a strong physiological basis and is not simply the result of the voluntary resumption of old habits."

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Impact of Weight Stigma

- Children as young as 3 describe overweight children as "mean, stupid, lazy, or ugly" (Cramer & Steinwert, 1998)
- Overweight or obese children experience up to twice the bullying risk than normal weight children (Brixval, Rayce, Rasmussen, Holstein, & Due, 2012)
- Parents are less likely to financially support overweight children, especially daughters (Crandall, 1991; 1995)
- Substantial evidence of discrimination in employment (hiring, wages, promotion), health care, education, mass media (Puhl & Heuer, 2009)

Adults who experience weight stigma are more likely to engage in binge eating and other maladaptive eating patterns and are more likely to have a diagnosed eating disorder.

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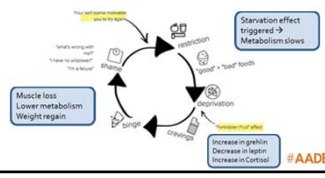
Eating Disorder Risk Factors + Diabetes

	What it's like...	With diabetes...
Diet Mentality	Cutting out food groups Fad diets Restrict/binge cycle	Eating at certain times leads to loss of hunger and fullness cues Media messages about what a PWD can and cannot eat Must know the macronutrient content of foods, particularly grams of carbohydrate "Should you be eating that?" - food choices become open to scrutiny
Perfectionism	Drive for success Numbing, avoiding, escaping feelings	Message that life is dependent on being the "perfect diabetic" "I can't let this impact anything in my life."
Trauma	Creates need for control and difficulties with trust	Trauma of diagnosis and of medical emergencies Medical emergencies Feeling as though "my body betrayed me." How other people reacted to the diagnosis and how supported the PWD felt.
Anxiety and Depression	Excessive worry Difficulty controlling the worry Depressed mood Fatigue or loss of energy Worthlessness or excessive guilt Recurrent thoughts of death	Constant vigilance on blood sugar and health Anxiety of asking for help Death anxiety Out of range blood sugars and blood sugar variability leads to depression Shame for having diabetes Greater awareness of mortality at a developmentally inappropriate age (particularly t1d)
Body Image + Weight Stigma	Thin an ideal, media, societal pressure, not seeing body the way that others see it	Comments from friends, family, and media about weight and diabetes Victim-blaming and stigma even within the diabetes community (t2d) Rapid weight loss and weight gain around onset and diagnosis (particularly t1d) Visibility of insulin pumps, continuous glucose monitoring systems (mainly t1d)

16

Binge/Restrict Cycle



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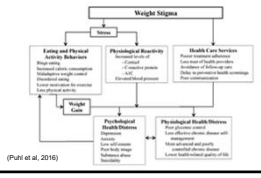
17

Impact of Weight Stigma on Diabetes Care



(Puhl et al, 2016)

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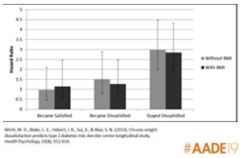
18

Weight Stigma: T2D Risk Factor

Chronic weight dissatisfaction, **regardless of BMI,** increased and predicted type 2 diabetes risk.



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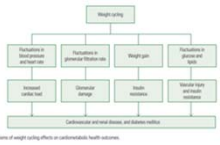
Weight Stigma → Weight Cycling → T2D Risk Factor

Cardiometabolic harms of weight cycling:

- Enhanced weight gain
- Hyperinsulinemia and insulin resistance
- Hyperlipidemia and Hypertension
- Repeated Overshoot Theory
- BWV was associated with high increased likelihood of heart failure, death, and microvascular events in persons with Type 2 DM across all BMI categories



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20

Healthism

"Healthism is a belief system that sees health as the property and responsibility of an individual and ranks the personal pursuit of health above everything else, like world peace or being kind. It ignores the impact of poverty, oppression, war, violence, luck, historical atrocities, abuse and then environment from traffic, pollution to clean water and nuclear contamination and so on. It protects the status quo, leads to victim blaming and privilege, increases health inequalities and fosters internalized oppression." - Lucy Aphramor

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Healthism → Diabetes Stigma

- A majority of patients with type 1 or type 2 diabetes using an online survey reported stigma (76% in type 1 and 52% in type 2, higher in type 2 using insulin)
- Experience of stigma disproportionately affects those with a higher BMI, higher A1c, and poorer self-reported blood glucose control, suggesting that those who need most help are also those most affected by stigma
- Blame for developing diabetes, needing insulin, or having complications
- Ignoring environmental factors

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Adverse Childhood Experiences

ACEs produce neurobiological alterations including volumetric and functional changes in the amygdala and hippocampus affecting gene/DNA/cellular level expression changes.

- Adverse Childhood Experiences Score of 4 or greater increases risk of developing diabetes
  - With every additional ACE, there was an 11% increase in odds of diabetes via depressive symptoms and cardiometabolic dysregulations
- Children with t1d often experience higher ACEs in the 2 years preceding diagnosis
- The higher the ACES score, the higher the mortality due to diabetes

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Strengthening the Tightrope

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Health at Every Size™ (HAES™)

1. Weight Inclusivity: Accept and respect the inherent diversity of body shapes and sizes

2. Health Enhancement: Support health policies that improve and equalize access to information and services

3. Respectful Care: Acknowledge our biases and work to end weight discrimination, weight stigma,and weight bias

4. Eating for Well-Being: Promote flexible, individualized eating based on hunger, satiety, nutritional needs and pleasure

5. Life-Enhancing Movement: Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement

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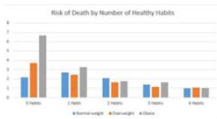
HAES™: High BMI ≠ Mortality

Healthy Behaviors are more important than weight across all BMI categories.

Habits:

- > 5 F+/V servings/day
- > 12x month leisure time
- Physical activities
- Not smoking
- More than 0 and up to 1 alcoholic drink/day for women and 2 for men



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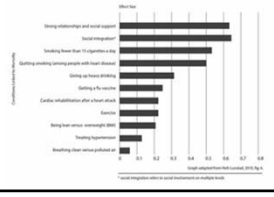
26

What Reduces Your Chances of Dying the Most?



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27

Weight-Neutral Diabetes Care (WNDC)

Focuses on establishing self-care behaviors. It DOES NOT promote restriction, endorse unsustainable exercise, or encourage disordered eating as a way to "get healthy."

- Focus on Healthy Behaviors instead of Weight Loss
- Refrain from blame
- Change Dehumanizing Language
  - Say, "Person in a Larger Body." Only use the term "fat" if the term has been chosen by the client and has been neutralized.
  - Eliminating use of overweight/obese.
- Create an Inclusive Space
  - Remove posters and brochures that fear monger or shame about obesity or imply that weight loss is a cure-all
  - Have adequate seating and clinical equipment for larger bodies
  - Have education materials represent all bodies

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28

WNDC: *Behaviors* Reduce Diabetes Risk

- Dietary quality and physical activity can postpone diabetes development independently of weight change (Malmo Sweden 5 year follow up)
- Dietary intervention, exercise and both dietary intervention and exercise reduced the risk of diabetes development in people with impaired glucose tolerance, independent of weight status or weight change (China, 6 year ollow up)
- Quoted in a systematic analysis by Hu (2007) Physical activity reduced DM2 incidence significantly in studies of adults in USA, Malta, Britain, Sweden, Finland, Japan
- 33% reduced incidence in women who do vigorous exercise once a week vs never (Nurses Health Study, 87000 women, 8 yr follow up)

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29

WNDC Results

- Weight stability (at 5 yrs)
- Improved biochemical markers (Cholesterol, blood sugar, blood pressure, CRP)
- Sustained healthy behaviors
- Improvement in:
  - Disordered eating patterns
  - Dietary quality
  - Psychological states
  - Self esteem
  - Depression

Alysse Dalessandro, www.readytostare.com

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Non-Judgemental Food Choice

- Using food neutral language will lessen shame and increase self-efficacy
- All foods fit - no good foods or bad foods
- Unconditional permission to eat uses these two phrases to help people develop non-judgemental curiosity
  - I can have it if I want it.
  - Does my body feel like it?

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31

Non-Judgemental Food Choice

Example of Non-judgemental choice:

- Good food/bad food mentality: Pancakes made my blood sugar high → pancakes are bad → pancakes are carbs → carbs are bad → I can never have pancakes again → "Binges on pancakes after enough exposure to others enjoying pancakes in front of patient"
- Non-judgemental/food neutral: carbs are supposed to raise my blood sugar, pancakes when eaten alone increase more than I'd like, maybe I'll use strategies to lessen this (combine with protein, review carb count, insulin dose timing, listen to hunger fullness cues)

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Flexibility in Diabetes Management

Diabetes management is not static.

The same food, insulin, or activity could yield different blood sugars and different results each time, each day

Important for the individual to learn their body's response to food, activity, stress, and insulin. This can be achieved by safely experimenting, observing, and creating a repertoire of responses

- Ex: "Rule of 15" to treat low blood sugars

Because food and diabetes management is dynamic, we cannot assign black and white values to them.

- Ex. "Eating a pancake made my blood sugar go up, therefore pancakes must be bad"

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33

Elements of Shame Resilience (Brown, 2012)

- Speaking Shame ✔
  - Defining Shame ✔
  - Comparing Self-Conscious Affects ✔
- Recognizing Shame
  - Identifying Shame Triggers
  - Physiological Signs of Shame
  - Understanding Shields and Armor
- Critical Awareness (of Fat Phobia, Diet Culture, etc.) ✔
- Self-Compassion
- Empathy + Vulnerability

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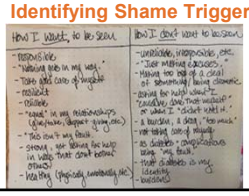
34

Recognizing Shame: Identifying Shame Triggers



Where do these identities come from?

If I go through life trying to ensure that I am or am not seen in these ways, the price I pay is _____.

How would my life be different if I risked being seen in these ways?

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Recognizing Shame: Identifying Shame Triggers (Brown, 2012)

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Shame Shields (Brown, 2012)

"Affect regulation and attachment brain circuitry are negatively impacted by regular and prolonged shame states. With neglect, rejection, and 'shunning,' the amygdala understands relationships to be unsafe." -Shelley Uram, MD

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Armored Heart (Brown, 2012)

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Armored Heart (Brown, 2012)

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We can't selectively numb emotion. (Brown, 2012)

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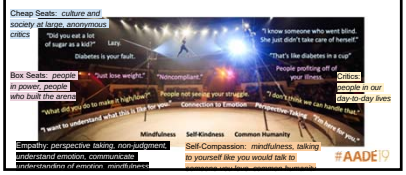
Recognizing Shame: Identifying Shame Triggers



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41

Empathy: Anatomy of Trust

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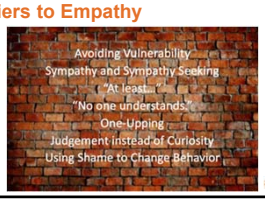
42

Barriers to Empathy



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Barriers to Empathy

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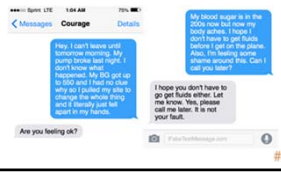
44

Vulnerability



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Case Study:

- 51 yo female, new prediabetes diagnosis, co-occurring Binge Eating Disorder and PTSD, living in larger body
- **Initial Treatment:** Completed intensive outpatient treatment for BED, where she was provided education on HAES and WNDC. Patient also participated in shame resilience group.
- **Values identified:** 1) new experiences 2) health 3) freedom
- **Values Driven Goals:** 1) workout with HAES informed personal trainer 2 times per week, walk 15-30 min 3-4 times per week 2) Increase F&V intake 3) Work on hunger/fullness attunement 4) Attend to hunger promptly to prevent bingeing 5) Cope with shame and anxiety without using food
- **Outcome:** 1) A1c went from 6.0 to 5.5 over 6 months 2) Mobility improved and patient was able to go on cruise and climb stairs 3) Developed body awareness/attunement and remission of binge eating

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46

Be the Change

We must consider your own weight bias, societal body privilege, the experience of weight stigma, and cultural and medical weight based prejudice and oppression.

Implicit Attitudes Test:
https://implicit.harvard.edu/implicit/selectatest.html

We must identify our own shame triggers and shame warning signs as people and as practitioners.

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47

48