The type 2 diabetes crisis: Is emotional eating the missing link?

Jen Nash

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Article points

1. The association between diabetes and obesity is a growing problem and whilst the current health education message focuses on diet and exercise, some people may struggle to lose weight (Brotons et al, 2003).
2. The author suggests that a missing link may be emotional eating, which is very prevalent in the general population and in people with diabetes, in particular (Colton et al, 2009).
3. The aim of this article is to empower diabetes professionals with the knowledge that they need to address emotional eating in routine clinical consultations.

Key words

- Diabetes
- Emotional eating

Author

Jen Nash, Clinical Psychologist, Diabetes Unit, Hillingdon Hospital, Central and North West London NHS Foundation Trust and Director at Positive Diabetes.

The current health education message for people who have diabetes and obesity is focused on diet and exercise; yet as professionals involved in the care of people with diabetes we know that there are many who struggle to implement this advice. The role of emotions in eating behaviour is often not addressed when discussing diet and weight with people with diabetes This article outlines the reasons why patients may engage in emotional eating, how the diabetes professional can address the issue and advice to offer people to encourage change. A brief introduction to a seven-step approach to managing emotional eating is presented and future directions for intervention are discussed.

We are in the midst of a type 2 diabetes and obesity epidemic. The current health education message is focused on diet and exercise; yet as professionals involved in the care of people with diabetes, we know that for every person with diabetes who can implement this advice, there are many who struggle (Brotons et al, 2003). This can lead to a sense of failure, increased hopelessness and decreased motivation, for both the person with diabetes and the healthcare professional (Hörnsten et al, 2008). However, there is a missing link that often does not get addressed, which is the role of emotions in eating behaviour.

This is not simply a problem of motivation; emotional eating (classified as binge eating disorder when clinical levels of symptomatic behaviour are reached) is very prevalent in the general population and the diabetes population, in particular (Colton et al, 2009). Traditionally, conversations about emotional eating have been limited to the psychologist's domain (Diabetes UK, 2008); however, this need not be the case.

The aim of this article is to empower diabetes professionals with the knowledge they need to address emotional eating directly within routine clinical consultations. Whilst there are many time pressures faced by diabetes professionals in the clinic or general practice environment, I am often told that diabetes professionals can struggle once the standard health education is delivered and yet weight change still fails to occur. In these instances, it is possible that emotional eating may be a factor.

The article will outline the reasons why patients may engage in emotional eating, how diabetes professionals can begin to address this sensitive area in routine consultations and what advice to offer patients to encourage change. The strategies are based on principles of cognitive behavioural therapy (CBT) for binge eating disorder, the treatment of choice for individuals with binge eating behaviour (NICE, 2008).

The reasons behind emotional eating

There are numerous reasons why the relationship with food and weight may be more complex than the straightforward "eat less and move more" health message. These can be divided into biological, psychological and social factors.

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1. There are many reasons why the relationship between food and weight may be complex. A biological reason is that we have evolved to seek out food in times of plenty in order to sustain us when food is scarce.
2. Psychologically, in some people a behavioural pathway has developed causing the impulse to reach for food as a means to calming, distracting or comforting against the ordinary emotional upsets of life.

Biological factors

Biologically, we are fighting against our evolutionary history; our bodies have evolved to seek out and store food in times of plenty to sustain us in times of scarcity and this contradicts our modern day lives in which food is readily available. Our bodies simply have not caught up with our contemporary Western world. However, educating people with diabetes that there are valid biological reasons why they may be struggling to resist the temptation of available food can provide a release from self-blame, which only compounds the problem and decreases motivation for change (Heaner and Walsh, 2013).

Psychological factors

Psychologically, the connection between emotion and food is one that is established from birth – from the very first time a child cries and is comforted with milk. The food–emotion link continues as the child matures; it is common (particularly in Western cultures) for adults to offer food items to soothe upsets. Food is therefore not just a fuel, it has been conditioned as a pacifier of emotions for many years. By adulthood, a behavioural pathway exists for the impulse to reach for food as a means to distracting or comforting against the ordinary emotional upsets of life such as a relationship conflict, a stressful day at work, or frustration at the impact of diabetes (Carnell et al, 2012).

Case study

Anna is 45 years old and was diagnosed with type 2 diabetes 3 years ago. Intelligent and articulate, she had been referred to the dietitian for dietary advice and understood the changes she needed to make, but her weight had not changed. Upon referral to clinical psychology, she explained that she often ate for non-hunger reasons such as upset at work, conflict with her partner, a sense of emptiness at the thought of not being able to have children and even excitement at the news of her promotion.

When asked about her earliest memories of eating for non-hunger reasons, Anna described starting secondary school aged 11 years and being told by her mum not to cry. She felt isolated and started to eat chocolate bars in secret. Food had helped young Anna cope with feelings of loneliness that she did not know how to fix; it was therefore a strategy that worked. Food made her feel good and lessened the upset she was going through. As an adult Anna was still using this same strategy, although now using food in this way was adding to her problems.

A simple strategy was devised. When she noticed the urge to eat for non-hunger reasons she would say internally, "Oh look, here is young Anna again". She would then consider what she could do to manage her emotions directly. For example, she found it difficult to express herself with her boss and would often comfort eat the evening before her weekly meeting with him. We examined ways she could express herself more easily and how to react if she felt she was being criticised. Becoming aware of the reasons why she was eating made it less confusing and her behaviour more understandable.

As in Anna's case, there is often a moment in childhood or adolescence in which authentic emotional expression did not occur and food was used to cope. This often starts at a time of high emotion when the demands of the situation outstripped the usual coping mechanisms. This frequently happens at a transition point such as starting secondary school, the loss of someone important, illness or major change in the family.

Children have yet to develop the full range of strategies to deal with emotional distress due to their limited cognitive and emotional processing capacity so food is one that they have access to that is effective, temporarily at least (Wade et al, 2013). By adulthood, this behavioural response has often become automatic and unconscious and can therefore feel quite uncontrollable (Sinha and Jastreboff, 2013). What was originally a way of coping has now become a problem of its own. We can therefore understand food as a symptom of an underlying emotional distress; if the person can learn to identify the emotional distress and develop strategies for dealing with it, the need for comfort eating fades away (Danner et al, 2012).

A further psychological factor is that being able to limit food intake to maintain a socially desirable slim body shape is valued in today's Western societies. Eating choices are not just made on nutritional content, availability or taste but are complicated by their connection to personal sense of self-worth.

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1. The goal is for the person with diabetes to make a decision about whether or not to eat when they are feeling emotional, rather than it just being an automatic response
2. The author outlines a seven-step approach to use when working with people who are struggling with emotional eating. The first step is to explain the reasons why people engage in emotional eating.
2. The next step is to gain control over eating behaviour by noticing the conditions in which eating occurs and to consider the reason behind the urge to eat.

Social factors

Shared eating experiences are a way of bonding and celebrating within our families and communities. Births, deaths, marriages and other occasions are marked by food. Family members may offer food as a substitute to show their love when it is difficult for them to express love in other ways.

The challenge

A diagnosis of diabetes suddenly shifts focus on to food and the need to change or limit previously enjoyed food choices. Many people with diabetes will know what they should be doing but it is hard to break away from the conditioning and pattern of food as an instant route to pleasure, distraction and satisfaction. Despite understanding at an intellectual level that healthy eating is one of the crucial elements of optimal diabetes control, given the link between food and emotions, it is hardly surprising that encouragement to cut down on unhealthy food is sometimes difficult to implement.

However, this pattern can be changed. The goal is for the person with diabetes to make a decision about whether or not to eat when they are feeling emotional, rather than it just being an automatic response. An important point to remember is that everyone can use food to deal with their emotions and occasionally it can be fine to use food in this way. The difficulty is when food becomes the only way to deal with emotions. The next section of this article will discuss how to talk about emotional eating in routine clinical consultations.

Conversations about emotional eating

The following are some suggested conversation-starters that you can adapt to suit your own style:

- "I wonder if we can talk about the non-hunger reasons why we sometimes choose to eat. Is that OK with you?"
- "It is very common for all of us to use food to distract ourselves from the stresses of life, or when we are feeling emotional. Are you aware that you ever do this?"

If the patient responds positively, you can respond:

- "Thank you for sharing that with me. The most important step towards tackling it is self-awareness. Is it something you would like us to think about together?"
- "We are going to discuss lots of different strategies over the next few times we meet; some will be relevant and helpful to you and some will not apply to you and can be disregarded. Everyone is unique and some strategies work well for some and not for others. We will be treating this like an experiment. It is therefore not about getting anything right or wrong."

Manage the person's expectations. Overcoming emotional eating will also take time. Each day they are aware of eating for emotional reasons is a step in the right direction. In these conversations, keep your tone of voice light, in a way that conveys that what the person is telling you is not a problem; in fact, reassure them that it is an excellent step towards recovery and regaining control.

Advice to encourage change

The following is a guide to the seven-step approach I use with people who are struggling with emotional eating (Nash, 2013) and diabetes professionals can use this in their routine clinical consultations. As there is a great deal of information to convey, it is fine to deliver one simple insight per meeting.

Step 1: Normalise emotional eating

Provide education about the biological, psychological and social reasons why emotional eating is very common.

Step 2: Gaining control over emotional eating

The first step to gaining control over eating behaviour is to simply notice the conditions in which eating occurs. Much of our eating behaviour happens on auto-pilot. There is a distinction between mindless eating versus mindful eating, for example snacking in front of the TV beyond the point of noticing or food-related habits such as always having a biscuit with tea. It is helpful to ask about the times that they are likely to engage in mindless eating.

There are three steps to gaining control of mindless eating, also known as the three Ps: pause, ponder, proceed. This can described in the following way:

- Pause: Suggest that the person pauses as they are reaching for the food, heading to the kitchen or going to the shop or café. They can

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1. There are three steps to gaining control of mindless eating, also known as the three Ps: pause, ponder, proceed. This encourages the person to take time to consider the reasons why they are wanting to eat and then make a mindful decision.
2. The author suggests that finding an alternative pleasurable activity can replace the urge to eat for non-hunger reasons.
3. The author also suggests that people can become aware of unhelpful thoughts, challenge them and replace them in order to change their behaviours around food. Being aware of emotions and environmental cues is also helpful.

use reminders, such as notes on the kitchen cupboard or wearing an elastic band on the wrist as an associative reminder.

- Ponder: The person can ask themselves some helpful questions, such as "Is food what I really want right now?","How hungry am I on a scale of 1–10?" or "What problem am I hoping food will solve?". Whatever the answer, pausing and asking themselves this question allows them to create a space between the usual impulse to eat and the actual act of eating. Just creating this space is an important step towards change
- Proceed: The person can then take action; if they are hungry they should eat (hunger rating of seven or more). If they are not hungry and still choose to eat, that is fine. Change takes time and by simply pausing and thinking about the reasons behind their actions they are making a great start. At least if they eat this time it is a choice rather than a default response.

The steps that follow will help people increase their flexibility to choose between a range of responses to food.

Step 3: Increasing pleasure levels

Eating is a pleasurable activity and if the person with diabetes does not have enough routes to pleasure in life then the default response is to turn to food for pleasure and entertainment. The challenge is to help that person to increase their access to pleasure so that food is not the dominant one.

Help them to build a list of pleasurable activities to engage in when they are feeling the urge to eat for non-hunger reasons. Things to consider include connecting with others, physical self-care, changing their emotional state, practical distraction, intellectual stimulation and having "me" time. Practical examples could be to stroke their pet, research a day out with the family, do a puzzle, engage in a hobby or have a nap.

Another strategy is to use delaying tactics; encourage the person to halt the craving for 10 seconds, stay with the feeling and do not try to fight it. After 10 seconds they have permission to eat. The time delay can then be increased to 15 seconds, 30 seconds, 1 minute and so on. They could put a timer on their kitchen counter to remind them.

Step 4: The role of thoughts

We all have thousands of thoughts every single day and they play a significant role in contributing to decisions regarding eating behaviour. If the person can become aware of the thoughts that are not helpful, challenge them and replace them with more helpful thoughts; they can change their behaviour around food. There is a CBT-based five-step thought-challenging process that can simply be explained to patients (Nash, 2013) but this is beyond the scope of this article.

Step 5: Authentic emotional expression

The person with diabetes may be aware that they hide their emotions behind food rather than expressing them openly and authentically to themselves and others.

Invite them to try to identify which emotion they are feeling as they reach for the food. It may be positive or negative. Start by labelling it: is it anger, sadness, fury, excitement, hurt, boredom, loneliness, feeling unattractive or not good enough?

Use the following template to help them understand their emotional experience:

"I am [insert emotion] at [insert situation/person/trigger for emotion] because [insert reason]". For example:

- I am upset at my partner for forgetting our anniversary.
- I am hurt at my friend for sharing something I had told her in confidence with another friend.
- I am cross with myself because I didn't go to the gym.

Encourage the person to develop strategies to express strong emotions rather than dull them with food; for example, punch a pillow, talk to someone about them, have a cry or write a letter or email.

Step 6: Manage the environment

Eating behaviour rarely happens in isolation; it occurs in the context of the person's physical, emotional and social environment:

- Physical environment: How to manage the physical presence of food in their surroundings, keeping tempting foods out of reach and so on.
- Emotional environment: Learn how to spot the signs of possible sabotage; examine the support of family, friends, colleagues who may have a vested interest in their loved one not changing

"Setbacks need to be reconceptualised as an integral and important part of change."

- Social environment: In social settings the person may have less control over the food context and may be persuaded to prioritise others needs and expectations over their own. Invite the person to talk to those they live with and ask for their support. For example, ask them to keep distracting food out of reach, give a hug when needed and encouragement when they are finding it tough.

Step 7: Stepping in to the future

Setbacks need to be reconceptualised as an integral and important part of change. A polarised approach to weight loss, in which the person is being either "good or bad" in relation to their weight loss goals is common and contributes to an unhelpful mind-set for tackling emotional eating. Instead, the important difference between a lapse, a relapse and a collapse can be explained. The key point here is that a lapse is a usual part of healthy eating behaviour. A relapse occurs when the lapse turns into an all or nothing attitude. A collapse is when the person returns to the starting point, reverting to their unmindful eating behaviours. However, even a collapse can be reframed.

Staying solution focused is an important fundament of this step. This may involve reflecting on what has happened and being thoughtful about what could be done differently if the same circumstances were to occur again. In this way, what was before a mistake or a problem is reconceptualised as an opportunity for learning.

A final part of this step is the important role of accountability and access to further support. Having a goal in mind and making this goal real by sharing it with another person who will gently encourage progress is helpful. Family members and friends may serve this purpose, but are also at times too close to the person to stay objective when needed. Encourage the individual to look beyond their existing network, perhaps to a commercial weight loss programme, in which peer support is an integral part of the change process.

Conclusion

This article has begun to address emotional eating and how it can be understood and discussed within routine clinical consultations. Diabetes professionals may feel that this is yet another task to add to the already time-pressured consultation but this is not my intention. It is hoped this article provides a different context for understanding people who struggle to lose weight, whether or not it is currently possible to find time in consultations to have these conversations directly.

To date, referral pathways to access appropriate psychological support are lacking and it is hoped that the newly established clinical commissioning groups will alter this climate. Certainly, a psychologist-led structured education programme for patients who are struggling with emotional eating would be an exciting direction to move towards. NICE (2008) guidance for the treatment of binge eating disorder also recommends a possible first step as an evidence-based self-help programme. I am currently piloting such a self-help programme and would be very pleased to receive referrals. ■

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