Diabesity: What have emotions got to do with it?

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Article points

1. The role of emotional eating, a common reason people with diabetes struggle with weight loss, is often overlooked in the food–weight conversation.
2. The are many causes of emotional eating, including biological, psychological and social factors.
3. This article offers practical suggestions to open up conversations about emotional eating and a guide to the "seven-step approach" diabetes professionals can use to encourage change.

Key words

- Emotional eating
- Obesity
- Type 2 diabetes

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We are in the midst of a diabesity epidemic. Among the many reasons people with diabetes struggle with weight loss, emotional eating is one of the most common. The emotional and social motivations for eating behaviour are rarely discussed with people who are overweight. This article explains the valid reasons why many people engage in emotional eating, how healthcare professionals can begin to address this sensitive area within routine consultations, and what advice to offer people to encourage change. A brief introduction to a seven-step approach to managing emotional eating is presented. Future directions for interventions are also discussed.

Weight loss for people with type 2 diabetes can be particularly difficult for a variety of reasons, and having poor dietary habits is perhaps one of the most important. As professionals involved in the care of people with diabetes and obesity, we know that for every overweight or obese person who can implement the "eat less, move more" health education message, there are many who struggle (Brotons et al, 2003). A sense of failure, increased hopelessness and decreased motivation can ensue for both the person with diabetes and the healthcare professional (Hörnsten et al, 2008). However, there is a missing link that is often overlooked in the food–weight conversation – the role of emotions in eating behaviour.

Emotional eating (also known as binge eating or comfort eating and classified as binge eating disorder when clinical levels of symptomatic behaviour are reached) issues are very prevalent in the general population and, in particular, people with diabetes (Colton et al, 2009). Traditionally, conversations about emotional eating have been limited to the psychologist's domain (Diabetes UK, 2008); however, it need not be exclusively so.

The aim of this article is to empower diabetes professionals with the knowledge they need to address emotional eating directly within routine clinical consultations. I am, of course, acutely aware of how time-pressed healthcare professionals are, and the luxury of the 50-minute therapeutic hour is a far cry from the pressurised clinic or general practice environment. However, I hear time and time again of the experience of diabetes professionals who feel "stuck" once the standard health education messages promoting diet and exercise are delivered and they are understood by their patients, and yet weight change still fails to occur. In these instances, it is likely that emotional eating is playing a role. Therefore, in this article I am hoping to equip diabetes professionals with some practical steps that can open up helpful conversations for change, and empower both clinicians and patients.

This article will outline the reasons why patients may engage in emotional eating, how healthcare professionals can begin to address this sensitive area within routine consultations

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1. Our relationship with food and weight is complex; the reasons for this can be divided into biological, psychological and social factors.
2. 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, and this is at odds with our modern day lives in which food is readily available and more than abundant.
3. Psychologically, in some people a behavioural pathway has developed from the food–emotion connection since birth, causing the impulse to reach for food as a means to calming, distracting or comforting against the ordinary emotional upsets of life.

and what advice to offer patients to encourage change. The strategies are based on principles of cognitive behavioural therapy (CBT) for binge eating disorder, and the treatment of choice for individuals with difficulties coping with binge eating behaviours (NICE, 2008).

Why do people emotionally eat?

There are numerous reasons why our 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.

Biological factors

Our bodies have evolved to seek out and store food in times of plenty to sustain us in times of scarcity, and this is at odds with our modern day lives in which food is readily available and more than abundant. Our bodies are still fighting against our evolutionary history, and simply have not caught up with the contemporary Western world. Helping your patients to understand that there are valid biological reasons why they may be struggling to resist the temptation of available food can be very "permission-giving" and provide release from guilt and self-blame, which only compounds the problem and decreases motivation for change (Heaner and Walsh, 2013).

Psychological factors

Psychologically, the connection between emotions and food is one that is established from birth – from the very first time the 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 calming, distracting or comforting against the ordinary emotional upsets of life such as a relationship conflict, a stressful day at work, or, somewhat ironically, frustration at the impact of diabetes (Carnell et al, 2012). Let us examine a case study to understand this further.

Case study

Rachel is 53 years old and was diagnosed with type 2 diabetes 5 years ago. 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, Rachel explained that she often ate for non-hunger reasons: besides on days out with the family when she was enjoying herself, she would also eat as a distraction from caring for her mother with dementia, being unemployed following a redundancy, and boredom during the day when her husband and children were out of the house.

When asked about her early memories of eating for non-hunger reasons, Rachel described her experiences of being bullied at school and excluded from her friendship group. She felt lonely and different, and food had helped young Rachel cope with these feelings that she didn't 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, Rachel was still using this same strategy, which was only adding to her problems, when in fact she had access to a number of creative ways of dealing with her emotions.

In working together, we formulated a simple strategy through introspective conversations. When she noticed the urge to eat for non-hunger reasons, Rachel would say internally, "Oh look here is young Rachel again". She would ask what "adult Rachel" could do to manage her emotions more directly. For example, she found it difficult spending much of the daytime alone and would often graze throughout the day before the family arrived home. We examined ways she could manage these feelings of loneliness and create a new feeling of purpose and direction. Becoming aware of the reasons why she was eating made it less confusing and her behaviour more understandable.

As in Rachel'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 transition point such as starting secondary school, the loss of someone important in life, major changes in the family or sudden

illness – a time of high emotions when the demands of the situation outstripped the usual coping mechanisms. 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 which can be effective, at least temporarily (Wade et al, 2013).

By adulthood, this behavioural response has often become automatic and unconscious and can therefore feel uncontrollable (Sinha and Jastreboff, 2013). What was originally a way of coping has now become a problem of its own. Overeating can be seen as a symptom of an underlying emotional distress; if the person can learn to identify the emotional distress and develop alternative 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; therefore eating choices are not just made on nutritional content, availability or taste but are complicated by their connection to personal sense of self-worth.

Social factors

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

The challenge

Thanks to greater public health education, most overweight or obese people do understand that they should be changing or limiting previously enjoyed food choices, 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 weight control, given the link between food and emotional regulation, it is hardly surprising that encouragement by healthcare professionals to cut down on unhealthy food is sometimes difficult to implement.

However, with raised awareness and self-insight, this pattern can be changed. The goal is to reach a stage in which the person can make a conscious decision about whether or not to eat when they are feeling emotional, rather than reaching for food as an automatic response. An important point to remember is that everyone, of every shape and size, can use food to deal with their emotions, and it is fine to do so occasionally; it becomes an issue when food is the only way to deal with emotions.

This article will move on to discuss how to raise the topic of emotional eating within routine clinical consultations.

Opening up conversations about emotional eating

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

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

If the patient responds positively, you could say:

- "Thank you for sharing that with me. The most important step towards tackling the issue 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, gathering information about what has helped and what has not so we can adjust our strategies accordingly. It is therefore not about getting anything 'right' or 'wrong', but about the spirit of 'getting curious together'."

You would also need to manage your patients' expectations. Emotional eating has been around for a long time and the process of overcoming

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1. Eating for non-hunger reasons can happen on social occasions when family members may offer food as a substitute to show their love when it is difficult for them to express their feelings in other ways.
2. Given the link between food and emotional regulation, cutting down on unhealthy food can be difficult; the goal is for the person with diabetes to make a conscious decision about whether to eat when they are feeling emotional, rather than reaching for food as an automatic response.
3. The author suggests a list of conversation-starters that other healthcare professionals can adapt to initiate discussions on emotional eating.

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1. 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 that emotional eating is common.
2. The second 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.
3. The third step is to help the person with diabetes to increase their access to pleasure so that food is not the dominant one.

it will also take time. Each day they are aware of eating for emotional reasons is a step in the right direction.

In these conversations, remember that your tone of voice is important. Keep it light, in a way that conveys that what your patient is telling you is not a problem; in fact, talking about emotional eating is an excellent step towards recovery and regaining control.

Advice to encourage change

The following is a brief guide to the "seven-step approach" I use with people who are struggling with emotional eating, and diabetes professionals can begin to use this within their routine clinical consultations. Since there is a great deal of information here, it is recommended to deliver one simple insight or message per meeting.

Step 1: Normalise emotional eating

It is important for healthcare professionals to provide education to overweight or obese people with diabetes about the biological, psychological and social reasons why emotional eating is common as outlined above.

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 autopilot. Different from mindful eating, mindless eating includes snacking in front of the TV beyond the point of noticing, or food-related habits such as always having a biscuit with a tea or coffee. It is helpful to ask the person about the times that they are likely to engage in mindless eating.

Furthermore, eating also happens as a response to emotional upsets, such as a bad day at work, an argument with a family member, and a feeling of sadness or loneliness.

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

- Pause: Suggest that the person pauses as they are reaching for food, heading to the kitchen, or stopping by the shop or café. They can use reminders, such as sticky notes on the kitchen cupboard and fridge doors, or an elastic band worn on the wrist as an associative reminder.
- Ponder: Suggest that they ask themselves some helpful questions, such as "Is food what I really want right now?", "Am I hungry? On a scale of 0–10, what is the level of hunger I am experiencing right now?", "What need am I fulfilling?", or "What problem am I hoping food will solve?". Whatever the answer, pausing and asking this question allows them to create a space between the usual impulse to eat and the actual act of eating. Just creating this space alone is an important step towards change.
- Proceed: The person can then take action. If they are genuinely hungry (hunger level rating of 7 or more), they can eat; if they have decided that they are not hungry and still choose to eat, that is fine, too. 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, and the link between eating and their internal world has been made present.

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, entertainment and recreation. The challenge is to help that person to increase their access to pleasure so that food is not the dominant one.

As healthcare professionals, we could help them to build a list of pleasurable or distracting activities to engage in when they are feeling the urge to eat for non-hunger reasons. Things to consider include connection with others, physical self-care, their emotional state, practical distraction, intellectual stimulation and having "me time". Practical examples could be to stroke their pet, investigate something interesting on the internet, phone a friend, research a day out with the family, do a

puzzle, paint their nails, 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 try not 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, 2 minutes and so on. They could put a timer on their kitchen counter, or use a stopwatch on their phone 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 our decisions regarding eating behaviour. If the person with diabetes can become aware of the ones that are unhelpful, challenge them and replace them with more helpful thoughts, it is possible for them to change their behaviour around food.

A CBT-based five-step thought-challenging process (Nash, 2013) can be applied here, but a detailed explanation of this is beyond the scope of this article.

Step 5: Authentic emotional expression

The person with diabetes may be aware that they "stuff down" their emotions with food rather than express them openly and authentically to themselves and others.

Invite them to try and 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, disappointment, triumph, boredom, loneliness, shyness, or 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 angry at my boss for asking me to work late again.
- I am frustrated at my ex for changing the childcare arrangements.
- I am impatient with my partner as she is always interrupting me.
- I am tired after my commute because it has been a stressful day at work.

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 their feelings, have a cry, or write a letter or email (even if they do not send it).

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: The person with diabetes needs to learn how to manage the physical presence of food in their surroundings, keeping tempting foods out of reach.
- Emotional environment: Help them to 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.
- Social environment: Communicate what the person needs in restaurants or other social settings where they have less control over the food context and can be persuaded to prioritise others needs and expectations over their own. Invite them to talk to those they live with and ask for their support – can they do anything differently that might help? For example, they could keep distracting food out of reach, give a hug when needed and encouragement in tough times. It always helps to know that they are not in it alone.

Step 7: Stepping into the future

A polarised approach to eating behaviour in which the person is considered as being either "good" or "bad" in relation to their weight loss goals is common and contributes to an unhelpful mindset for tackling emotional eating. Instead, setbacks need to be reconceptualised as an integral and important part of change.

The difference between a lapse, a relapse and a collapse in emotional eating can be explained in a simple way. A lapse is a usual part of healthy eating behaviour. A relapse occurs when the lapse turns into an "all or nothing" attitude, a common excuse being "I have gone off my plan by eating this, so I will give up for today and start again tomorrow". A collapse is when the person returns to the starting point, reverting to their mindless eating

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1. If the person with diabetes can become aware of the thoughts that are unhelpful, challenge them and replace them with more helpful ones, it is possible for them to change their behaviour around food.
2. Identifying which emotion people are feeling as they reach for the food is helpful; the author suggests a template to help them understand their emotional experience.
3. Eating behaviour occurs in the context of the person's physical, emotional and social environment, which needs to be managed appropriately.

"A psychologist-led structured education programme for people who are struggling with emotional eating would be an exciting direction to move towards."

behaviours. The good news is that even a collapse can be reframed.

Staying solution-focussed is important in this step. This may involve the person reflecting on what has happened and being thoughtful about what could be done differently if similar circumstances were to occur again. In this way, what was before a mistake or a problem can be reframed as an opportunity for learning.

A final part of this step includes 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 addressed emotional eating and how it can be understood and discussed within routine clinical consultations.

The author is intensely aware of how overloaded many healthcare professionals are, and examining issues related to emotional eating may feel like another onerous task to add to the already time-pressed consultation. This is not the intention. It is hoped that the present article provides a different context to aid diabetes professionals to understand those who struggle to lose weight, whether or not there is any opportunity to have these conversations directly during routine consultations.

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 people 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. The author is currently piloting such a programme, as well as offering local workshops to healthcare professionals. ■

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