Non-Dieting, Weight-Acceptance Approaches for Clients with Weight-Associated Diseases

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Learning Objectives

After attending this presentation, psychologists will be able to:

1. Describe the evidence supporting non-dieting, self-acceptance approaches.
2. Critique recommendations to lose weight for chronic disease management.

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Funding and Disclosures

- The *Accept Yourself!* approach was developed with funding from a Geisel School of Medicine Gary Tucker Junior Investigator Research Award and a Hitchcock Foundation Scholars Career Development Award, and also supported by a Health Promotion and Disease Prevention Research Center supported by Cooperative Agreement Number U48DP005018 from the Centers for Disease Control and Prevention.
- Two books from Routledge Press describe the *Accept Yourself!* approach. Some of the material in today's workshop was adapted from material in these books. I offer consultation services to clinicians and clinical services to clients based on this approach.
- I have no other financial interest or relationship with any company to disclose.

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Before We Get Started: Some Grounding Assumptions and a Note about Language

- Some grounding assumptions:
  - Body shape and size is a human characteristic, of neutral moral value, whose cause is multiply determined but -- in general -- not under long-term individual personal control.
  - **"Fat people are worthy of respect, safety, and dignity."**[1] No matter what.
- A note about language:
  - What words should we use when we discuss clients' size?
    - Overweight? Normal Weight? Underweight?
    - Obese?
    - Fat? Thin? Average-Weight?
    - Plus-sized? Abundant? Curvy? Skinny?

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Working with Fat Clients with Chronic Diseases: The Background Against Which the Work Takes Place

- Risk for a variety of chronic diseases is associated with higher body weight, including heart disease, diabetes, and some forms of cancer.[2,3,4]
  - A conceptual problem: In some cases, "obesity" refers to overall body weight (e.g., BMI). In other cases, "obesity" refers to specific types of fat deposition, such as abdominal fat deposition, that are associated with disease risk independent of BMI.
- Higher body weight is frequently referred to as a modifiable or behavioral risk factor for chronic disease.
- Patients with diabetes, hypertension, heart disease, and other chronic diseases are frequently advised to lose weight as a keystone of treatment,

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What is the Impact of Weight-Loss-Centered Care for Chronic Disease?

- All weight loss treatments (except bariatric surgery) have poor long-term efficacy.
- An umbrella review of non-surgical and non-pharmacological meta-analyses of weight loss interventions concluded that there is:
  - "No high-quality evidence to recommend treating obesity with a specific non-surgical or non-pharmacological intervention among many available.
  - Magnitude of weight loss appear[s] small (maximum 5.1 kg in adults and 1.78 kg in children, and even these estimates may be inflated)."[5]
- Naturalistic studies find that weight loss efforts predict weight gain and onset of obesity.[6,7,8,9]
- Randomized clinical trials for medical, dietary, exercise, and mixed weight loss interventions all show poor efficacy overall.

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Weight Loss Treatment Outcomes

- Randomized Controlled Trials, continued….
  - Some meta-analyses and comprehensive reviews report that obesity treatments on average cause weight gain, especially with long-term follow up.[10,11]
  - Others report that 3-5% weight loss is possible four years later, if participants continue all aspects of treatment.[12]
    - For a 200 pound patient, this represents a 6-10 pound weight loss.
    - Clients expect to lose about 30% of their initial body weight, not 3-6%.[13-14]
  - "File-drawer" problem means that published RCTs likely overstate benefits of weight loss interventions.

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V-Shaped Outcomes

Weight loss strategies all typically have v-shaped outcomes.

- Initial weight loss then…
- Weight regain (and then some!)

Long-term trials often research strategies to help people maintain weight loss.

In all of these trials displayed in the figure, participants continued with their initial weight loss strategies, and in some cases added additional strategies.

The one trial with the most dramatic weight loss[15] excluded almost 20% of the sample for failing to lose weight in the initial 8-week diet trial.

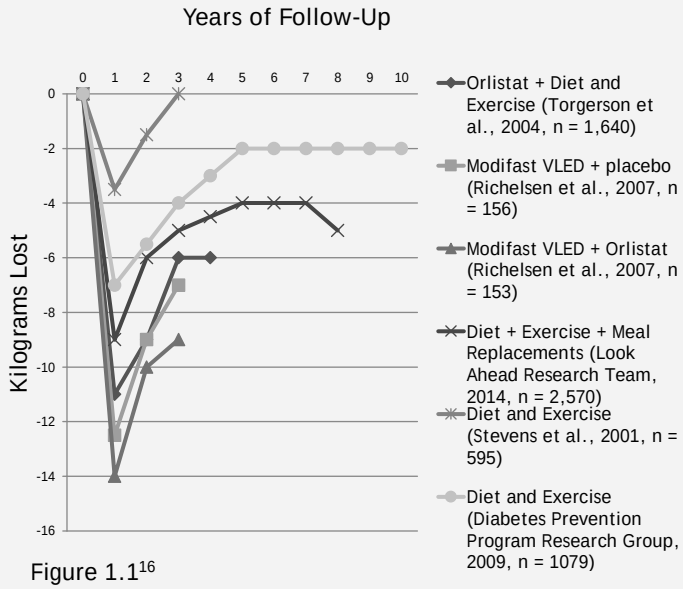

Figure 1.1[16]

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Do Weight Loss Interventions Improve Health for Patients with Chronic Disease?

- Weight loss prospectively *increased* all-cause mortality in overweight or obese patients with diabetes in a large meta-analysis.
  - Weight gain was not associated with increased risk.[17]
- Intentional, successful weight loss prior to total joint replacement (hip and knee) surgery increased risk of deep surgical site infection and readmission.[18]
  - A systematic review in this area concluded that the safety of recommending weight loss to obese patients prior to surgery was in question.[19]
- Treatment guidelines for management of chronic disease advise that weight loss cannot be recommended, because of the risk of worsened outcomes.[20]

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Do Weight Loss Interventions Improve Health for Patients with Chronic Disease?

- Even the US Preventative Services Task Force found in their most recent systematic review of the literature that there no evidence for improvement in mortality, cardiovascular outcomes, or health-related quality of life for behavioral or pharmacological weight loss programs assessed in RCTs.[21]
- Several large experimental trials over the past several decades of weight loss focused lifestyle modification in people with chronic diseases find no beneficial effect of weight loss programs on disease outcomes or mortality, even when weight loss is (modestly) succesful.[22-25]

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Weight Loss Interventions Have Significant Risks

- Weight loss efforts can harm mental health and physical health.
  - Dieting failures increase clients' risk of depression.[26]
  - Weight cycling predicts mortality and cardiovascular events.[27]
- Recommendations to lose weight and weight loss programs increase both weight and chronic disease self-stigma.[28-31]

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What Are the Alternatives? Non-Dieting, Self-Acceptance-Based Approaches to Chronic Disease Management

- Approaches and terminology vary:
  - What unites these approaches is a rejection of weight loss as a goal
  - and a rejection of strategies used to achieve weight loss.
- Some common approaches and terms:
  - Weight-Inclusive
  - Health At Every Size® (HAES®)
  - Intuitive Eating
  - *Accept Yourself!*
  - (Some but not all) Mindful Eating approaches

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What Evidence Supports These Approaches for Patients with Chronic Disease?

- Evidence supporting non-dieting, self-acceptance-based approaches for enhanced physical health in patients with chronic diseases should be considered preliminary.
- At least three systematic reviews and meta-analyses have compared weight-neutral versus weight-loss approaches in terms of their effects on lipids, blood glucose and/or HbA1c, and blood pressure, as well as weight.[34-36]
  - Both approaches caused similar, small improvements in blood pressure, lipids, and blood glucose or HbA1c.
  - Both approaches caused negligible changes in weight.
  - Non-dieting approaches are superior to weight loss in terms of psychological outcomes
  - Non-dieting approaches have substantially lower attrition.

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What Evidence Supports These Approaches for Patients with Chronic Disease?

- However, most studies in these systematic reviews and meta-analyses excluded people with diabetes or pre-existing cardiovascular disease.
- There are some hints in the literature that these approaches may hold better promise than weight-loss-approaches for management of chronic disease:
  - Intuitive Eating (as a trait) was associated with better glycemic control among patients with Type II Diabetes in one study.[37]
  - Physical fitness interventions generally cause improvements in mortality, cardiovascular disease mortality, and cardiovascular events that are larger and more consistent than those associated with (even successful) weight loss.[41]

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What Evidence Supports These Approaches for Patients with Chronic Disease?

- Overall, although research is preliminary, non-dieting, self-acceptance approaches when used with patients with chronic, weight-associated diseases appear to be:
  - Of comparable efficacy in terms of improving physical health outcomes and risk markers, with more consistent benefits, than weight loss approaches.
  - Superior to weight loss approaches for psychological outcomes.
  - Lower risk than weight loss approaches.
  - More tolerable with less risk of worsened disease and/or weight stigma for patients.

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What Does It Mean To Use a Non-Dieting, Self-Acceptance Approach?

- Non-dieting, self-acceptance-based approaches are not simply diet and exercise recommendations with a weight loss goal removed.
- What are we communicating to our patients when we focus on diet and exercise to improve chronic disease health outcomes?
- What are we missing when we focus on diet and exercise as a means to improve chronic disease outcomes?

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Are We Focusing on the Wrong Things to Promote Human Health?

Top 10 Countries for Life Expectancy (Age)[42]	Least Deaths from Ischemic Heart Disease Top 10 Countries[43]	Top 10 Thinnest Countries (Mean BMI)[44]	Lowest Sugar Consumption Top 10 Countries (Sugar Consumption Per Person, Per Year)[45]	Most Physically Active Top 10 Countries (Percent Prevalence of Insufficient Physical Activity in Adults)[46]
Hong Kong (86)	Guadeloupe	Eritrea (21)	North Korea (0.11kg)	Uganda (5.5)
Japan (85)	Martinique	Ethiopia (21)	Afghanistan (1 kg)	Mozambique (5.6)
South Korea (84)	Japan	Burundi (21)	Niger (1 kg)	Lesotho (6.3)
French Polynesia(84)	French Guiana	Bangladesh (21)	The Democratic Republic of the Congo (2 kg)	Tanzania (6.5)
Andorra (84)	France	Madagascar (21)	Chad (2kg)	Niue (6.9)
Switzerland (84)	Ecuador	East Timor (21)	Paraguay (2 kg)	Vanuatu (8)
Australia (84)	Portugal	Afghanistan (22)	Guinea-Bissau (3 kg)	Togo (9.8)
Singapore (84)	Argentina	Vietnam (22)	Central African Republic (3kg)	Cambodia (10.5)
Italy (84)	Spain	Niger (22)	Burundi (3 kg)	Myanmar (10.7)
Spain (84)	Netherlands	North Korea (22)	Burkina Faso (3 kg)	Republic of Moldova (11.5)

Yellow-shaded countries are also in the worst 10 countries for death from ischemic heart disease; *pink-shaded* countries are in the worst 10 for life expectancy.

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Social Determinants of Health

- Across studies, social determinants of health
  - economic stability
  - social and community context
  - equitable access to health care
- are associated with HbA1c, lipids, and blood pressure among patients with Type 2 diabetes.[47]
- Across studies, social determinants of health are also associated with increased risk of
  - coronary artery diseases
  - cardiovascular events
  - Strokes
  - cardiovascular deaths.[48]

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Direct Effects of Stigma and Discrimination on Diabetes

- Experiences of discrimination are associated with risk for Type II diabetes onset.[49]
- Experiences of discrimination are also associated with insulin resistance in women with Type II diabetes.[50]
- Among adults with Type II Diabetes, weight discrimination is associated with higher HbA1c levels and worse diabetes-related self-care, even when controlling for BMI and overall discrimination.[51]

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Direct Effects of Stigma and Discrimination on Cardiovascular Disease

- Across studies, experiencing stigma and discrimination is associated with cardiovascular risk among members of marginalized groups, including BIPOC, queer, and fat people, and people with multiple dimensions of marginalized identity.[52]
- Perceived weight and racial discrimination is associated with more frequent myocardial infarction, arteriosclerosis, and minor heart conditions.[53]
  - Intersectionality: Odds ratios for these diagnoses are largest for individuals reporting multiple forms of discrimination (e.g., weight, race, gender).
- Within and across cultures, groups with lower fat stigma experience less weight-associated disease mortality and morbidity.[54]

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What Does This Mean?

- When applying non-dieting, self-acceptance-based approaches with clients with chronic, weight-associated diseases, clinicians should
  - prioritize attending to the social context
  - and to protecting clients from bias, abuse, and discrimination *over and above*
  - attending to individual health and self-care behaviors.

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Case Example 1*

All case examples are composites.

- Tamara is a 55-year-old African-American nurse midwife (DNP, CNM) serving in a hospital-affiliated birth center and also as a clinical professor in a nurse midwifery training program. She identifies as lesbian, lives alone, and has not had a partner in many years. She was referred by her PCP for depressive symptoms, but describes her presenting concern as "really struggling with my health, mental and physical." She was diagnosed with Type II diabetes about a decade ago; her mother and grandmother both died in their early 60s from complications of diabetes. She began taking insulin two years ago, which makes her feel ashamed and anxious. She works 12-hour shifts five days a week, with some rotating shifts, and also teaches two evenings a week during the academic year. She reported that her work is active and physical and she is always on her feet, but she had difficulty identifying any recreational activity or anything she enjoys doing or looks forward to apart from work. She does not have time to eat, take insulin, or self-monitor her blood glucose during her workday and does not want her colleagues to know she is diabetic. She reported having a "good breakfast" of a 3 egg-white omelet with vegetables each day before work, and she drinks black coffee during the workday. At the end of the workday, she reports that she usually intends to make a salad with grilled chicken, but more commonly gets takeout on the way home from work; she noted binge eating about 3 times a week, usually fast food or Chinese buffet takeout. She reported that she knows she "should" check her blood glucose more frequently, but "I don't want to know, most days." She noted feeling lonely, tired, and hopeless, especially about controlling her diabetes: "It's just a matter of time." She reported that she gets regular medical care, but feels her PCP sees her as "a fat old diabetic lady" first; she reported that her visits are often rushed, and her PCP seems to rely on her as a fellow medical professional to educate herself about her diabetes management.

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Case Example 2

- Ben is a 62-year-old White former carpenter not working due to disability. His only income is SSDI; he is on Medicaid. He lives in a high-crime area and his home health nurse has expressed concerns about the repair, cleanliness, and safety of his home. He is heterosexual and a widower; his wife died about a decade ago and he misses her intensely. He has a variety of serious chronic health concerns: he has heart failure, Type II diabetes, and two years ago had a stroke which left him with some apraxia, making it impossible for him to do the skilled carpentry work which had been his livelihood. He reports that he used to be "very fat," but has lost substantial weight in recent years and now is at a BMI his medical chart describes as "normal weight." He also has a history of being an avid runner and was and is very active in the local running community; his most significant source of social support is fellow runners who are involved with him in charity fundraising runs in the community. He is able to run short distances now and continues to attend fundraising runs as a volunteer: "I'm not one of those lazy fat people." Ben expresses sadness and frustration at his physical condition; his hospital social worker has referred him to you as part of his rehab plan to address lack of social support, poor nutrition, and perhaps depression or complicated grief.

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Working with Clients for Systemic Change

- What systemic barriers are harming Tamara and Ben's mental and physical health and/or making their chronic diseases worse?
- How could you intervene with those barriers?
  - Actions you take personally.
  - Advocacy actions you can take.
  - Actions you can encourage Ben and Tamara to take.
  - Interventions you can use with Ben and Tamara to support those suggested actions.
- How are you and your practice setting creating systemic barriers for clients like Tamara and Ben?
  - How can you address those barriers?
- What forms of discrimination are Tamara and Ben facing?
- How can you help clients advocate against discrimination they experience in health care? How can you be an advocate?
  - Weight-based, disease and disability based, racism, sexism, ageism, homophobia, class-based discrimination.

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HAES® Principles and Framework for Care

- There are a variety of non-dieting, self-acceptance-based approaches; HAES® is not the only one.
- However, HAES® is compatible with all non-dieting, self-acceptance approaches, and centers systemic factors.
- Health At Every Size® and HAES® are registered trademarks of the Association for Size Diversity and Health (ASDAH); Clinicians working from a self-acceptance-based approach should join ASDAH.
- The HAES® Principles and Framework for Care have recently substantially changed; the current evidence base about HAES doesn't necessarily reflect the new principles fully.

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HAES® Principles

1. Healthcare is a human right for people of all sizes, including those at the highest end of the size spectrum.
2. Wellbeing, care, and healing are resources that are both collective and deeply personal.
3. Care is fully provided only when free from anti-fat bias and offered with people of all sizes in mind.
4. Health is a sociopolitical construct that reflects the values of society.

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Working with Tamara and Ben from a HAES® Lens

1. HAES® Principle 1: Healthcare is a human right for people of all sizes, including those at the highest end of the size spectrum.
   - People of all sizes, including those at the largest end of the size spectrum, have the right to healthcare without exception. Fat people's access to compassionate & comprehensive healthcare should not depend on obtaining a certain BMI, pursuing weight loss, and/or holding health as a value or pursuit.
- How are Tamara or Ben experiencing barriers to their rights to excellent health care?
- How could you help Tamara and Ben better access their rights in this area?

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Working with Tamara and Ben from a HAES® Lens

- HAES® Principle 2: Wellbeing, care, and healing are resources that are both collective and deeply personal.
  - Because health exists on a continuum that varies with time and circumstance for each individual, Health at Every Size® aims to focus on wellbeing, care, and healing. These are resources from which we can all pull to meet our needs. And we get to have others pour those resources into us and vice versa. Community care and mutual aid is key. Health at Every Size® providers and advocates must work to promote and create the conditions that support wellbeing i.e. environmental care, clear air & water, equitable access to food, and more. Each person is the expert of their own body and should have the right to make autonomous decisions about their health and wellbeing, including how they value or prioritize health among all the other important aspects that make up a life.
- How could you support Tamara or Ben's bodily autonomy?
- What wellbeing, care, and healing resources do these two patients have? Need?
- What advocacy behaviors will you need to engage in for or with Tamara and Ben?

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Working with Tamara and Ben from a HAES® Lens

- HAES® Principle 3: Care is fully provided only when free from anti-fat bias and offered with people of all sizes in mind.
  - Anti-fat bias, and fatphobia are detrimental to the health and wellbeing of all people, especially fat people. When health research, health policy, health education, and the provision of care does not include the full human size spectrum, it harms people of all sizes and is the antithesis to Health at Every Size®. Those who provide Health at Every Size®-aligned care must strive to dismantle anti-fat bias personally and systemically in order to provide care for all bodies.

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Working with Tamara and Ben from a HAES® Lens

- How might anti-fat bias in your practice harm Tamara and Ben?
  - Clinician implicit and explicit anti-fat biases
  - Systemic issues: How size inclusive is the environment of care?
  - How size inclusive is the evidence base from which you are drawing interventions?
  - How size is inclusive are the health policies that affect their care?
- Both Tamara and Ben express some internalized weight self-stigma; how does this affect their care? How should you address it in treatment?
- What advocacy work is needed from you to support them in other care venues?

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Working with Tamara and Ben from a HAES® Lens

- HAES Principle 4: Health is a sociopolitical construct that reflects the values of society.
  - How our society currently defines health is rooted in white supremacy, anti-Black racism, ableism, and healthism. As the values of our society become more rooted in collective liberation, we have the opportunity to critically examine and redefine health, disease, and illness. Regardless of the definition of health, however, access to care must never depend on an individual's or community's health status, pursuit of health, or compliance with health recommendations.
- What would vibrant health and well-being look like for Tamara and Ben now?
- What would liberation look like for these two clients?
- How will you work with Tamara or Ben's multiple intersecting identities in treatment? How do ableism, ageism, racism, heterosexism, class prejudice, and capitalism impact their health?

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HAES® Framework of Care

These HAES Principles are grounded in a Framework of Care that includes 10 core elements considered required for HAES-aligned care.

1. Grounding in liberatory frameworks
2. Patient bodily autonomy
3. Informed consent
4. Compassionate care
5. Critical analysis, application, and execution of research and medical recommendations related to weight

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HAES® Framework of Care

6. Skills and equipment to provide compassionate and comprehensive care for fat people's bodies.
7. Provider roles and responsibilities
8. Addressing your anti-fat bias
9. Tools that support well-being and healing without contributing to oppression
10. Addressing systemic anti-fat bias.

❖ Notice that this framework of care does not focus on - or even mention - movement and food.

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Isn't Lifestyle Change the Cornerstone of Chronic Disease Self-Management?

- What are our interventions to induce changes in diet quality and physical activity?
- How will those interventions work for Tamara and Ben?
- Even if improved diet quality and increased physical activity are essential for chronic disease management, focusing on stigma, discrimination, and social determinants of health first removes barriers clients face to implementing lifestyle changes.
  - Improved diet quality in diabetes benefits from blood glucose data: If patients don't have equitable access to self-monitoring tools (e.g., continuous glucose monitors) or experience stigma-based shame about self-monitoring, dietary changes become more challenging.
  - If patients lack social support, access to high-quality food, and ability to prepare it, offering dietary recommendations reinforces shame and harms the working alliance.
  - Similarly, offering physical activity recommendations to clients who are overwhelmed, overworked, experiencing physical disabilities and comorbidities, and exposed to stigma and discrimination when exercising also reinforces shame and helplessness.

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Q&A

- Your questions and thoughts?
- After today: I work with clients in private practice using these approaches and also train and consult with clinicians.
- Feel free to contact me if you'd like to chat more: https://margitberman.com/
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Bonus Slides

(If time permits)

45

Weight-Based Abuse and Discrimination Also Affects Weight-Loss-Adjacent Health Behaviors

- Non-weight-focused behaviors commonly prescribed to improve chronic disease, like exercise and diet changes, can become linked to weight and weight loss in ways that increase shame and exposure to weight-based abuse and discrimination.
  - Fat people experience traumatic weight-based abuse in sport and exercise settings.[32]
  - Internalization of weight self-stigma and exposure to health provider weight discrimination is associated with fat patients decreasing physical activity and diabetes self-management behaviors.[30,33]

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Additional Effects of Weight Stigma on Diabetes

- Diabetes stigma is associated with poorer HbA1c, diabetes distress, and diabetes self-management, and diabetes stigma is associated with weight stigma in patients with Type II diabetes.[38-39]
- Prenatal weight stigma predicts the onset of gestational diabetes, and is a stronger predictor than BMI.[40]

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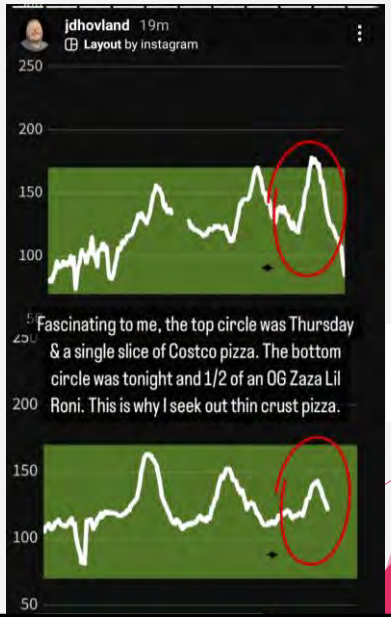
Working with Eating Behaviors When Clients Have Chronic Diseases

- De-stigmatizing and de-moralizing food.
- Attending to body cues as you eat: How does it feel to eat this food? Before, during, after?
- Using data as another source of information for short-term (e.g. blood glucose monitoring) and longer-term (e.g., lipids, blood pressure) food experiments.
- Abandoning experiments that do not bear fruit or do not feel right.



Example from food writer JD Hovland. Used by permission.

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Working with Movement When Clients Have Chronic Diseases

- Stigma, shame, and the problem of the disembodied head.
- My body has betrayed me: Anger and chronic disease and disability.
- Attending to bodily cues for movement desires and needs.
- Movement as (one form of) self-care: Does the client have opportunities for recreation? For exploring new things? For enjoyment of life?
- Coping with structural discrimination against fat and/or disabled clients seeking recreational opportunities.
- Coping with interpersonal discrimination and abuse (and the fear of it).
- Coping with internalized stigma.
- Avoiding exercise as punishment and exercise moralism; delinking weight, shape, and disease management from movement and recreation.
  - Your dog does not have a fitbit.
- Not every client wants to engage in movement; movement is recreation; not a moral requirement or a prerequisite for care.

49

What About Semaglutide and Tirzepatide?

- Many clinicians have been asking about the new GLP-1 agonist drugs used for both diabetes and weight loss.
- Many clients with diabetes are on one of these medications.
- Both drugs are efficacious for lowering glucose in patients with Type II Diabetes.
- These drugs are also now FDA approved as weight loss treatments (usually at a higher dose than for the diabetes indication).
- Most published trials (e.g., STEP 1-4 trials[55-58]) assess outcomes up to 68 weeks.
- The recently published SELECT trial followed participants who had cardiovascular disease and BMI of ≥27 kg m^{-2} for four years to evaluate the longer-term effects of semaglutide on cardiovascular and weight outcomes.

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What About Semaglutide and Tirzepatide?

- Both drugs cause greater initial weight loss than other non-surgical weight loss interventions.
  - For semaglutide, mean initial weight loss is about 10%.[60]
  - For tirzepatide, mean initial weight loss is about 12%.[61]
  - Most of this weight loss occurred in the first year of trials.
- In the SELECT trial, initial weight loss was maintained over 4 years of taking the drug.

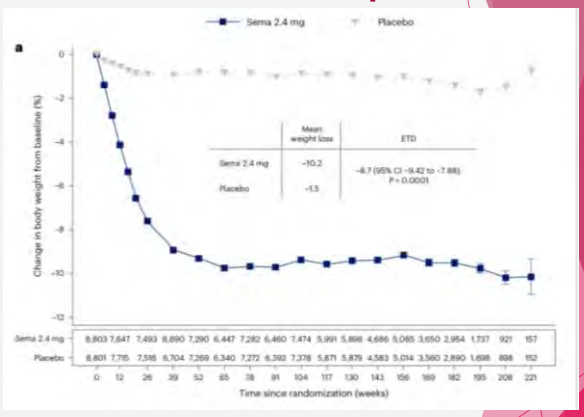

Figure 1a from SELECT Trial[59]

- Weight loss interventions in general are less efficacious for patients with diabetes.
- This is true for these medications as well: patients with Type II diabetes lose about 1/3 less weight than other patients.[62]

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What About Semaglutide and Tirzepatide?

- If patients stop taking these medications, they rapidly regain the lost weight even if they maintain lifestyle changes.
- Intensive lifestyle intervention doesn't increase the efficacy of the drug, or prevent weight gain following discontinuation.
- In the U.S., Semaglutide costs about $1,300 per month[63]; in the U.K., it's available at low or no cost, but only for 2 years of treatment.[64]
- Side effects and risks include gastrointestinal distress, and increased risk of thyroid cancer.

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What Would Be Informed Consent for Semaglutide for Weight Loss?

- Patients should expect no more than about a 10-12% weight loss.
  - Clinicians should help patients calculate and visualize this amount.
  - Patients should be advised that after about 1.5 years, they will not keep losing weight even if they keep taking the drug, even if they make other lifestyle changes.
  - Patients with diabetes or cardiovascular disease should understand that their expected weight loss is as much as 1/3rd less.
- However, this drug is still a long-term commitment.[65]
  - Patients should understand that they must take (and budget for) this expensive drug indefinitely in order to maintain that initial weight loss.
  - Patients should also understand that we do not have much data about the long-term safety or efficacy of this medication.
- Is this worth it?

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Case Example 1*

- Tamara is a 55-year-old African-American nurse midwife (DNP, CNM) serving in a hospital-affiliated birth center and also as a clinical professor in a nurse midwifery training program. She identifies as lesbian, lives alone, and has not had a partner in many years. She was referred by her PCP for depressive symptoms, but describes her presenting concern as “really struggling with my health, mental and physical.” She was diagnosed with Type II diabetes about a decade ago; her mother and grandmother both died in their early 60s from complications of diabetes. She began taking insulin two years ago, which makes her feel ashamed and anxious. She works 12-hour shifts five days a week, with some rotating shifts, and also teaches two evenings a week during the academic year. She reported that her work is active and physical and she is always on her feet, but she had difficulty identifying any recreational activity or anything she enjoys doing or looks forward to apart from work. She does not have time to eat, take insulin, or self-monitor her blood glucose during her workday and does not want her colleagues to know she is diabetic. She reported having a “good breakfast” of a 3 egg-white omelet with vegetables each day before work, and she drinks black coffee during the workday. At the end of the workday, she reports that she usually intends to make a salad with grilled chicken, but more commonly gets takeout on the way home from work; she noted binge eating about 3 times a week, usually fast food or Chinese buffet takeout. She reported that she knows she “should” check her blood glucose more frequently, but “I don’t want to know, most days.” She noted feeling lonely, tired, and hopeless, especially about controlling her diabetes: “It’s just a matter of time.” She reported that she gets regular medical care, but feels her PCP sees her as “a fat old diabetic lady” first; she reported that her visits are often rushed, and her PCP seems to rely on her as a fellow medical professional to educate herself about her diabetes management.

All case examples are composites.

Case Example 2

- Ben is a 62-year-old White former carpenter not working due to disability. His only income is SSDI; he is on Medicaid. He lives in a high-crime area and his home health nurse has expressed concerns about the repair, cleanliness, and safety of his home. He is heterosexual and a widower; his wife died about a decade ago and he misses her intensely. He has a variety of serious chronic health concerns: he has heart failure, Type II diabetes, and two years ago had a stroke which left him with some apraxia, making it impossible for him to do the skilled carpentry work which had been his livelihood. He reports that he used to be "very fat," but has lost substantial weight in recent years and now is at a BMI his medical chart describes as "normal weight." He also has a history of being an avid runner and was and is very active in the local running community; his most significant source of social support is fellow runners who are involved with him in charity fundraising runs in the community. He is able to run short distances now and continues to attend fundraising runs as a volunteer: "I'm not one of those lazy fat people." Ben expresses sadness and frustration at his physical condition; his hospital social worker has referred him to you as part of his rehab plan to address lack of social support, poor nutrition, and perhaps depression or complicated grief.