The Many Dimensions of Diet Counseling for Diabetes

MILDRED KAUFMAN*

Every day approximately 1.7 million people in the United States are vitally concerned about controlling their diabetes. Each year this number increases by 150,000 to 200,000. As methods of detection are improved and extended, the number of people who will require treatment and care will also increase. In almost every case, the treatment and care will involve some dietary modification. Weight reduction with a calorie restricted diet may be the only treatment required by many overweight adults who are found to have diabetes. However, for others, medication may be ordered. For those taking oral hypoglycemic agents, physicians often prescribe a controlled diet, constant in the number of calories and amounts of carbohydrate, protein and fat. For those using insulin, a “normal diet without concentrated sugar” is suggested if the objective is clinical control or freedom from symptoms. More rigid dietary controls of calories, carbohydrate, protein and fat are imposed when the objective is chemical control or relatively normal blood sugar levels. Appropriate distribution of food intake throughout the day is essential to avoid repeated insulin reactions and subsequent damage to the central nervous system. Proneness of those with diabetes to long-range degenerative complications, and the possible association of the kind and amount of fat in the diet to atherosclerosis, have suggested to many physicians the desirability of controlling the dietary fat.

WHAT DIETARY MODIFICATIONS MEAN FOR THE PATIENT

The problem of dietary control in diabetes is not a simple one for the patient. When he is presented with the dietary facts of life, he is usually expected to (1) avoid overeating or undereating; (2) exercise control in his use of alcohol; (3) avoid the use of concentrated sweets such as candy, table sugar or pastries; (4) maintain a nutritionally adequate diet which, when balanced with his usual physical activity, will help him to achieve or maintain a desirable weight; (5) eat meals and snacks at about the same time every day, including weekends, holidays and vacations; (6) never omit or delay meals; (7) maintain a diet of the same composition each day, by selecting suitable meals at home and away from home; (8) adjust his diet with medication during periods of unusual exercise, acute illness or other emergency; and (9) use concentrated sweets of appropriate kind and quantity only in an emergency for the treatment of hypoglycemia.

In general, patients are provided with meal plans which are designed to meet nutritional needs, compensate for the metabolic defect and overcome weight problems. Although a variety of food value tables are used to calculate diets, the vast majority of meal plans now are based on the six food exchange lists.

An educational tool developed to assist both...
the patient and professional worker, the booklet "Meal Planning with Exchange Lists," has simplified the calculation and interpretation of diet tremendously. It has standardized calculations, terminology and teaching material. Despite these worthwhile accomplishments, it should not be viewed as an end in itself but as a tool to meet that end.

Too often we tend to discuss diet therapy in the abstract when it must be considered in relation to the individual who must apply diet modification to his everyday life. Food holds a special place in our culture and everyone wants to enjoy his daily meals. He wants to be able to participate in social events where "good" food and drink are part of the fun. He wants to eat according to his own food preferences and his family's tastes.

As a result of this only too human characteristic, many physicians, dietitians, nutritionists and nurses are discovering that dietary control of diabetes falls far short of their objectives. A recent survey\(^2\) indicated that of a 160 patients with diabetes, 126 were poorly regulated primarily because the patients failed to adhere to the prescribed diet. Lack of knowledge about diet was cited as a major factor, but social and emotional problems also played an important role. Much more investigation is needed to determine the food choices, eating patterns and diet problems of patients with diabetes. New approaches to counseling and education must be demonstrated and assessed in order to provide better help for those who need it.

Unfortunately, the dietary treatment of diabetes is introduced to many patients in the form of a perfunctory statement and a printed meal plan that bears little or no resemblance to their life-long pattern of eating. Often the meal plan is presented before the patient has recovered from the shock of his diagnosis. Although he is offered the opportunity to ask questions, his mind is reeling with thoughts of a relative who became blind from diabetes or the necessity of daily insulin injections or what his family's reaction will be.

When the newly-diagnosed diabetic patient carries his meal plan home and takes a closer look at it in the presence of his family, it often causes even greater consternation. He and his family may not understand the new words or may be unable to figure out the many food lists. The meal plan may call for milk as a beverage but the patient may not drink milk; unfamiliar foods may be included and he may be unable to find familiar foods. At this point, the patient may be seriously tempted to file his meal plan away in the back of a drawer and try to "get away" with just avoiding "sweets."

Even for the patient who understands the meal plan, living within its confines can be most trying. Eating on schedule, saying "no" to appealing foods and selecting the proper food, at home or away, for breakfast, lunch or dinner 365 days a year, including weekends, holidays and vacation requires a continuous struggle against temptation. Solicitous friends and relatives who plead "just a little bite won't hurt you" constantly contribute to his distress and feelings of guilt.

**ASSESSING THE PATIENT AND MEETING HIS NEEDS**

Since it is not easy for the diabetic patient to adhere to a prescribed diet in our society today, all those guiding him—physicians, nurses, dietitians and nutritionists—must be aware of the problems that he must face. They must work with him in designing his diet plan and setting realistic goals. As Dr. Frank N. Allen states, "make the dietary treatment suit both the patient and his disorder."

To improve the patient's performance with a prescribed diet, both the physician and the patient must be convinced that lifelong dietary control is vital in managing diabetes. Once the patient understands and accepts the diagnosis, he and his doctor must seek ways to control food intake within the patient's pattern of living. Learning the principles of the modified diet, understanding comparative food values and acquiring the ability to select foods for meals and snacks is within the ability of most patients if they receive suitable and sympathetic guidance.

That many diabetic patients are looking for such guidance is attested to by the large volume of mail received by the Diabetes and Arthritis Program, U. S. Public Health Service, and by the many phone calls to state and local health
Many Dimensions of Diet Counseling for Diabetes

It is evident that these people have many questions which require answers, and numerous problems which demand solutions. They are quite willing to weave the procedures required for diabetes control into the fabric of their daily lives, if given the opportunity.

Many factors influence the patient's behavior and his ability to adhere to a controlled routine of food selection and eating. The following questions are suggested to help the dietary counselor look at the patient, objectively, in his present situation, and to understand his problems.

Is the patient motivated to achieve adequate control of diabetes?

Is he willing to admit that he requires a restricted diet?

Is he emotionally stable enough to handle a rational approach to food without indulging in frequent "food binges" or impulsive eating?

Is his meal plan tailored to fit his food preferences, daily routine, ability to prepare food and available kitchen equipment?

Is his appetite satisfied by the kind and amount of food included on the meal plan at the times when meals and snacks are scheduled?

Has his cultural and religious background been considered in preparing the meal plan?

When printed materials are used, are they in a language that either the individual or a member of his family can read with ease?

Are family members or others with whom he eats willing to incorporate suitable foods into their daily menu?

Do the patient and his family have an adequate food budget to purchase the required foods and are they available? Or, if the patient and his family are receiving donated commodity foods or public assistance, has this aspect been considered in preparing the meal plan?

Does the patient eat most of his meals at home or carry meals prepared at home? If he eats in a restaurant, cafeteria, school lunchroom or college dormitory, does it provide suitable foods?

A negative answer to any of these questions indicates the need for further diet counseling or for referral to other professional assistance. It also illustrates that placing a printed meal plan into a patient's hand can be only a token acceptance by the professional worker that diet is a necessary part of treatment. These questions point up the necessity of tailoring the diet to the individual to meet needs that go far beyond the physical and nutritional. Answering these questions can help the diet counselor to understand the patient's own perception of his condition, and how it can be mobilized to motivate and control his disease.

By assessing the patient and his environment, the diet counselor can help him to learn how to select and prepare his food in whatever situation he might find himself. The diet counselor must be ready to answer questions about the wide variety of regular and "dietetic" food available in modern food markets and about the choice of foods offered on restaurant menus in order to help the patient to adjust to and accept his meal plan. Methods of preparing foods appealingly for festive occasions and participation in social affairs must be discussed. In general, the more the patient understands about food values, the wider his range of choice.

Sustaining the patient with continuing encouragement and support is a facet of dietary counseling that is frequently neglected. Diet problems must be discussed periodically and human frailties taken into account in order to help the patient carry out his resolve to continue this often tedious aspect of care.

IMPROVING AND EXTENDING DIET COUNSELING SERVICES

Effective dietary counseling requires time, background, skill and respect for fellow human beings. It requires the cooperative efforts of professional workers with a variety of skills, including the physician, dietitian, nutritionist, nurse and social worker. Even though some patients can accept and adjust to the most cursory diet instruction and others cannot adapt to a diet despite the most painstaking counseling, it is believed that better dietary control could be achieved by more patients if better counseling were given to them. Good dietary counseling, if begun early, may prevent future complications and much patient suffering.
Those diabetic patients treated in the hospital should be introduced to the concept early in their stay that controlling food intake is an important part of treatment. The physician in charge should help the patient understand that diet is an important part of treatment and ask the dietitian to use every opportunity at her disposal to teach the patient about food selection. This can be accomplished through demonstration and practice. For example, the patient's meals, served on a tray three times a day, can provide the dietitian with an opportunity to teach the patient about meal planning, portion sizes and methods of preparing food in an appetizing manner. By using a varied menu or through the patient cafeteria, she can guide the patient in the selection of his food. By planning for continuity of care and through inter-agency referral forms, the dietitian and public health nursing coordinator or social worker can plan for supportive assistance to the patient after his discharge from the hospital. Guidance undertaken initially in the hospital can be supplemented and further interpreted at home where the patient must practice what he has learned.

Diabetes outpatient clinics with a staff dietitian provide individual diet counseling and, in some instances, group classes. Again, referral to a public health nurse for continued guidance at home may provide the patient with additional dietary help.

The one who probably has the least access to diet counseling is the patient under the care of the private physician. Some physicians take the time and have the “know how” to provide adequate diet counseling. Those who do not have the time or the skills, should refer the patient to a diet counselor. Public health nurses are skilled in providing realistic guidance to patients and can help the person with diabetes to learn about the many aspects of treatment, including diet. Public health nutritionists in state and local health departments or in voluntary health agencies can provide diet counseling to patients, or give appropriate individualized diet information to the public health nurse who visits the patient. A great many patients of private physicians could benefit from agency services, which are available in their own communities, if they were referred by their doctors.

In some communities new services may be needed. In a few cities, dietitians are in private practice or are employed by physicians in a group practice to provide diet counseling to patients referred to them. In several large cities, health insurance plans employ dietitians to serve their patients. In one state, under the sponsorship of a variety of community agencies, seven communities have dietary counseling services to which patients can be referred by their physicians.

Several communities offer group education and counseling to persons with diabetes. Sharing their experiences, problems and solutions with other members of the group has helped many to understand and accept their condition, as well as to obtain information about it. Classes are sponsored by hospitals and outpatient clinics, by health departments, by diabetes associations and by dietetic associations. The program is fairly uniform and generally covers such subjects as diet, medication, exercise, personal hygiene, complications and other aspects of care that must be assumed by the person with diabetes.

To assist patient education classes, a new slide and filmstrip series is being prepared by the Diabetes and Arthritis Program, U. S. Public Health Service. Recognizing that there are advantages in group interaction to convey information and to motivate, these teaching aids will provide the basis for six classes, two of which are primarily concerned with diet. The theme of the six classes is “It’s Up to You.” It places direct responsibility on the patient for adjusting to balanced living—diet, medication and physical health (exercise, personal hygiene, etc.). These aids should provide the impetus needed to increase the number of communities that have educational programs for diabetic patients.

Recognizing the shortage of professional personnel in all disciplines, some new educational technics need to be explored. Programmed instruction is one possibility. An evaluation of the use of the teaching machine in educating the diabetic patient has shown that it can be effective in providing information to the
Many Dimensions of Diet Counseling for Diabetes

Patients. Used in conjunction with continuing individualized counseling by a professional staff, the potential for conveying factual material and testing the student until he learns is great.

The time has come to take a second look at dietary treatment in diabetes. Although more research may be needed to define the therapeutic role of nutrition, some dietary control measures are already in use. It is true that the practical application of these is often made difficult by the capriciousness of human behavior. But in most communities the efforts made to help the person with diabetes to live with his diet have been inadequate. Better use should be made of existing community resources, and some new approaches in motivating, educating and guiding diabetic persons should be explored. Physicians, dietitians, nutritionists, nurses, social workers and educators together must cooperate, plan and seek imaginative solutions to help persons with diabetes understand and control their diets, and thus their disease.

REFERENCES
People with Type 2 diabetes can reverse their condition with diet and exercise, although remission is not very common, according to a new study from the Centers for Disease Control and Prevention. After one year of regular counseling sessions to encourage weight loss and physical activity, 11.5 percent of obese adults with Type 2 diabetes saw their condition at least partially reverse — meaning their blood sugar levels decreased to those of a prediabetic, without the need for medication. Just 2 percent of those who did not receive intensive counseling partially reversed their diabetes. After f