

The Division of Responsibility and Child Diabetes

Ellyn Satter Institute Webinar
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Managing diabetes is like riding a bike - - -
you have to keep adjusting.



Adjustments


- The whole family
- Present blood sugar reading
- Future blood glucose levels
- Parent's involvement
- Child's abilities and readiness
- And how I practice as a dietitian/ diabetes educator



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Goals for child and family

- Child is competent with eating: Has positive eating attitudes and behaviors
- Feeding the child is rewarding for the parent
- Family dynamics around feeding are healthy and positive
- Long-term: Raise an adolescent/young adult who is responsible & capable with feeding him- or herself




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Ellyn Satter's Division Of Responsibility In Feeding

- Parent: *What, Where, When*
- Child: *How much, whether*

I liked the division of responsibility from the first, and applied it in my well-child appointments.


Why did I make an exception with diabetes?




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My Worry List

- My Persistent NPH Mentality
- Hypoglycemia
- Blood glucose excursions
- Limited time in clinic
- Talking about and charting DOR
- Giving up *getting* others to....
- Letting go of the "perfect meal" (low-fat, low-salt, moderate carb)
- Co-morbidities




I, too, was wobbly.



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Green beans every night.



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No child ever ate according to a formula.....Ellyn Satter

Satter, *Child of Mine*, Chapter 2, "Children know how to eat and grow."
www.ellynsatterinstitute.org/




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DOR is not just for meals!

Letting go of *getting* others to.....

BLUE = Questions you are invited to think about. What is your experience? Your thoughts? At the end you will be asked to vote on how you feel about the DOR in type 1 diabetes management.




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Bringing DOR into Diabetes Clinic

- Normal Eating
- Supportive Parenting
- Meal Planning
- Shifting Responsibilities from Parent to Child

We have used commercial photographs; no patient photos appear in this presentation

Resources:
ellynsatterinstitute.org



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Our job:
 describing diabetes self care so that it is doable.




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Doable means that:

- Diabetes treatment is adjusted to the child
- The family's preferences and traditions are respected
- Eating is enjoyable
- Feeding is rewarding
- Parents are helped with parenting through sDOR feeding




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ADA Position Statement 2014
Treatment Guidelines for Type 1 Diabetes
 Goal for Children under 18 years old: **A1c <7.5**

It is my view especially with the young children, that we not add further pressure to already stressed caregivers. Rather, providers should support incremental improvements as the child with diabetes moves toward the stated goal of 7.5 percent without significant hypoglycemia.

Fran Cogen, MD, CDE
 Children's National Health System



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AIC BY AGE
The average A1C by age of T1D Exchange Clinic Registry members, 2003

“The T1D Exchange Spurs Research”
Rawlings Diabetes Forecast June 2014

17 years old
6 years old
30 years old

**Chest-high A1c
~ 15-20 y/o**

What is possible?

- Physiologically possible?
- Developmentally appropriate?
- Supports Eating Competence?

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Treatment Goals for Diabetes:

- Improve or maintain *quality of life*, nutritional status and physiological health
- To prevent and treat the acute and long-term complications of diabetes and associate co-morbid conditions

Canadian Diabetes Association Clinical Practice Guidelines

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We bring good tidings!

Behavior Research: We CanTrust Children with Their Eating

- Children will eat
- They know how much to eat
- They will eat a variety
- They will grow predictably
- They will mature with eating

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TO BE CAPABLE EATERS, CHILDREN MUST HAVE SUPPORT FROM ADULTS

- Choose and prepare **healthy** food
- Provide regular meals and snacks
- Make eating time pleasant
- Give appropriate mastery expectations
- Not let the child graze for food or beverages between times
- Accept the child’s size and shape

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GROWTH AND DIABETES

- Stable, consistent growth is normal
- Abrupt, rapid crossing of growth percentiles is unlikely to be normal
- Disruption in growth is likely to indicate disruption in feeding, possibly other causes
- Optimizing feeding, addressing other causes will restore child’s own regulatory abilities, consistent growth

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CHILDHOOD OVERWEIGHT REDEFINED

- The problem is not high weight *per se*, but abnormal weight divergence *for the individual child*
- Only longitudinal growth pattern can determine a child’s normal weight
- Specific cutoffs appropriate only population-wide, *not for the individual child*

Satter, *ESI Position Statement*, 2003
www.ellynsatterinstitute.org

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MANAGEMENT OF CHILD DIABETES

Conventional model

- Insulin Rx
- Food Rx to cover insulin
 - Calories
 - Foods
 - Portion sizes
- Child to eat food Rx
 - Meal-by-meal
 - Day-by-day

Feeding dynamics model

1. Parents maintain a division of responsibility
2. Child regulates with hunger, appetite and satiety
3. Child follows consistent growth trajectory
4. Insulin covers food eaten
5. Adolescent gradually learns independent food management
6. Family dynamics around feeding—and the child—are healthy and positive



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OFFER A VARIETY, LET CHILD PICK & CHOOSE YOU DON'T HAVE TO EAT "X" TO GET TO EAT "Y"

- Protein source
- Two carbohydrate foods
 - Rice, potatoes, noodles, etc
 - Handy carbohydrate: bread, tortillas, pita, crackers etc
- Fruit or vegetable or both
- Milk or water
- Butter, margarine, salad dressing, gravy etc



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CHILDREN EAT UNPREDICTABLY : Food acceptance

- Children eat what they like & what tastes good
- They don't eat a square meal but only 2-3 foods
- They sneak up on new food and learn to like it
- What they eat one day they reject another
- They tire of even favorite food and eat something else



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How do families deal with their child's not wanting to eat the family meal?



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BE CONSIDERATE, DON'T CATER WITH MEAL PLANNING (FOR CHILDREN AND OTHER PEOPLE)

- Offer a variety of *good-tasting* food
- Let children (and other people) pick and choose *from what's on the table*
- Pair foods
 - Familiar foods with unfamiliar
 - Favorite with not-so-favorite
- Don't make children (or other people) eat
- Don't limit the menu to foods children (and other people) readily accept



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PLANNED STRUCTURED SNACKS

- At least two items
- Provide carbohydrate, protein and fat
- Suggested limit of carbohydrate to 15-30 grams without additional insulin injection (more carbs if insulin given)
- More if anticipated increase in activity
- Eat low carbohydrate foods to hunger

How do you handle this?



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FEEDING PRESSURE BACKFIRES

Forcing, bribing, coercing, applauding, rewarding, explaining, teaching, restricting

- Getting children to eat certain foods
- Getting children to eat more or less
- Getting children to avoid certain foods



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CHILDREN EAT UNPREDICTABLY : Food regulation

- One child eats a lot more—or less—than another
- Children eat a lot one day or one meal, not much the next
- Children don't clean their plates or eat standard portions unless adults insist
- Children stop eating when they are full even if they haven't eaten much



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CHILDREN ARE EXCELLENT REGULATORS

- Calorically dense food—get filled up faster and eat less
- Large portions—don't eat it all
- Children make up for errors in eating



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FAMILY MEALS ARE CRITICALLY IMPORTANT

- Meals reassure children they will be fed
- Going to the table hungry and eating until satisfied is key to food regulation
- Meals help children learn to like new foods
- Meals give children emotional reassurance: Access to parents, structure and limits
- To do well with eating, children must get their emotional needs met



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A comment to a parent in clinic can change everything:

“Your child knows how much to eat.”



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CHILDREN WITH REGULAR FAMILY MEALS DO BETTER

- Nutritionally, socially, emotionally, academically & with respect to resistance to weight management drug abuse and early sexual behavior
- Family meals more instrumental in positive outcome than SES, family structure, after-school activities, tutors, or church

References: Eisenberg; Gillman; Hofferth; Videon; Council Economic Advisors; Taveras; Mayfield, CASA

Do a web search: “family meals”



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FEEDING IS PARENTING




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PARENTING WITH FOOD

- **Authoritative:** “Here’s what I made. You can decide what and how much to eat.”
- **Authoritarian:** “Eat this food in this amount at this time”
- **Permissive:** “What do you want? When do you want it?”
- **Neglectful:** “Don’t bother me. You find something to eat.”


Ellyn Satter’s *CHILD OF MINE*, Chapter 9, Feeding your preschooler



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FEEDING DYNAMICS MODEL Of child diabetes management


1. Parents maintain a division of responsibility in feeding
2. The child regulates food intake with hunger, appetite and satiety
3. Child follows consistent growth trajectory
4. Insulin covers the food eaten
5. Adolescent gradually learns independent food management
6. Family dynamics around feeding are healthy and positive



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“FORBIDDEN” FOODS- What to do

- *Not* unlimited access
- Instead, give access within the structure of meals & snacks
 - Potato chips with the lunch-time sandwiches (enough to have leftovers)
 - Give *one* dessert with the meal (so it doesn’t compete)
 - Occasionally have unlimited cookies & milk for sit-down snack



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My Job: Blessing All Food



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Beverages

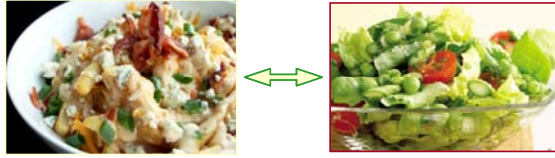
Can sweet beverages be managed like a dessert?

What if you want a soda with your pizza?




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Trusting Parents and Kids to Find “Just Right”



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The Middle Road in Dealing with Co-morbidities

- Start with getting grounded in regular, dependable meals and snacks
- Emphasize what might be added to the meal, rather than taken away
- Step by step, emphasizing good taste



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GOALS FOR CHILD AND FAMILY

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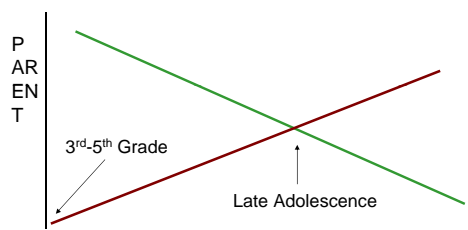
Shifting Diabetes Management Responsibilities Between Parent and Child

Adapted from Understanding Diabetes
H. Peter Chase and David M. Maahs
Barbara Davis Center for Childhood Diabetes



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Shifting Responsibility: Food Management and Diabetes Care



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Turning Over Diabetes Tasks to the Child




Challenge without overwhelming,
provide support without controlling,
give independence without abandoning.

Ellyn Satter



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Child Under 3 Years of Age



Parent

- Performs all care
- Reads and responds to child's signals
- Administers insulin after feedings
- Varies treatment schedule to normal changes in feeding & sleeping patterns

continued >>





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Child Under 3 Years of Age

Parent (continued)

- Identifies hypoglycemia vs age-appropriate tantrum
- Teaches others about diabetes care and identification of hypoglycemia
- Provides feedings, meals and snacks at regular times over the day
- Allows child to eat as much or little as child wants






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Child Under 3 Years of Age


Child

- Is unable to recognize hypoglycemia
- Gets used to daily tasks (testing and insulin administration)
- May pick site for blood test
- Takes as much or as little of a feeding or meal or snack as desired

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Child 3-5 Years of Age



Parent

- Performs almost all diabetes tasks
- Identifies hypoglycemia vs behavior issue
- Helps child to put a name to symptoms of hypoglycemia like, "head feels like a bubble"
- May start transition to administering insulin before meal

continued




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Child 3-5 Years of Age

Parent (continued)

- Teaches others about diabetes care
- Starts teaching child to advocate for herself
- Provides child meals and snacks similar to those eaten by siblings and friends
- Avoids becoming a short-order cook




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Child 3-5 Years of Age




Child

- Unable to recognize hypoglycemia
- Unable to understand the importance of eating, blood tests and insulin
- More involved in blood sugar testing
- Knows how much, of the foods offered by adults, to eat: none, some or even a lot

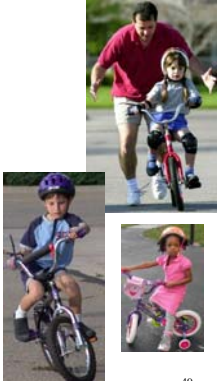



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Child 5-8 Years of Age

Parent

- Continues to help child describe and caregivers identify and treat hypoglycemia appropriately
- Begins to turn over some diabetes self-management tasks to child
- Delegates some diabetes management to school personnel
- Does not expect child to fully understand the interplay of food, medicine and testing

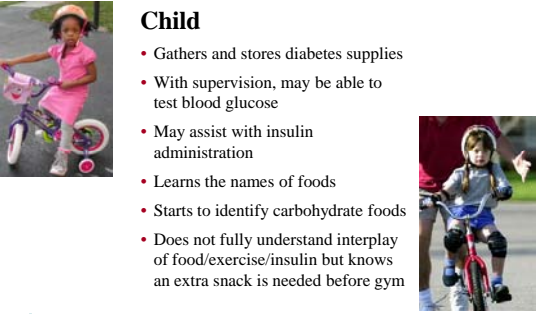




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Child 5-8 Years of Age

Child

- Gathers and stores diabetes supplies
- With supervision, may be able to test blood glucose
- May assist with insulin administration
- Learns the names of foods
- Starts to identify carbohydrate foods
- Does not fully understand interplay of food/exercise/insulin but knows an extra snack is needed before gym






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Youth 8-12 Years of Age

Parent

- May need to require a blood sugar check if hypoglycemia suspected
- Parent and youth work out what diabetes tasks each will do and how parent will be kept up on overall care
- Continues to review blood sugar patterns
- Plans and prepares food with family input
- Determines menu/eating out and timing of meals and snacks around activities
- Parent attends to how she or he talks about own body and dieting
- Continues to offer opportunities for fun physical activities






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Youth 8-12 Years of Age

Youth

- Monitors blood glucose
- Around 10 years of age, is able to prepare and administer insulin
- Decides what to eat of food offered
- With assistance, starts to apply label information to count carbohydrates
- With supervision, some youths will be able to participate in insulin dose decisions
- States type, dose and timing of medication
- Stores insulin properly







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Youth 12-15 Years of Age

Parent

- Is clear about expectations, especially for safety, when negotiating diabetes tasks with child
- Provides physical and emotional support and problem solving, as needed
- Continues providing meals and snacks at home
- Expects teen to manage after-school eating and come to the dinner table hungry
- Teach teen skills in food planning, shopping and cooking

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Youth 12-15 Years of Age

Younger Teen

- Continues to negotiate with parent about diabetes tasks and how readings will be shared with parent
- Administers insulin
- Continues to *need* parental involvement
- Able to count carbohydrates and make own food choices
- Continues to work on skills: shopping, cooking





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Youth 15-18 Years of Age

Parent

- Gives privileges and autonomy as teen becomes skilled and responsible
- Continues to be informed on how diabetes management is going
- Discusses with youth and diabetes team transition to adult care at 18 years or older
- Continues helping teen with his skills in food selection, planning, shopping and cooking so that he can provide for himself after he leaves home
- Does not support dieting-neither motivating talk, limiting family food selection, nor requiring exercise




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Youth 15-18 Years of Age

Older Teen

- Participates with parents and health care provider in arriving at a shared understanding of acceptable glycemic control
- Deals with adult issues (driving, relationships, alcohol, drugs, etc.)
- Takes responsibility for most diabetes tasks and keeps parents informed
- Discusses with parent and team transition to adult care at 18 years or older
- Take on more of the what, when and where of eating



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Parenting the adolescent with diabetes

Parents of the child with good control

- Maintain clear leadership
- Give the child warmth and respect
- Give child responsibility based scope for independence
- Give realistic mastery opportunities and expectations

Parents of the child with poor control

- Are either domineering or neglectful
- Find diabetes management to be burdensome
- Pressure children to manage their own diabetes

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SATTER FEEDING DYNAMICS MODEL

- Child's eating capabilities are supported
- Insulin matched to CHO intake
 - Basal
 - Bolus dose
 - Correction dose

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WHAT YOU KNOW STILL APPLIES

- Food management
 - Menu planning
 - Food composition
- Carbohydrate counting

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SATTER FEEDING DYNAMICS MODEL OF Child Diabetes Management

Supports good parenting

- Supports child's mental and physical health
- Supports parents' satisfaction and reward from parenting
- Support family's social and emotional development

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Goal: To raise a resilient child



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Thank you from my heart.

Children and Adults with Diabetes whom I've had the honor to know

Fellow Diabetes Team Members, Diabetes Educators & ESI
Ellyn Satter, Ines Anchondo, Carol Danaher, Pam Estes,
Anne Blocker, Kerry Regnier

Edie Applegate, who 1st presented on DOR and Child Diabetes
and walked, talked and lived DOR wherever she went

Consultants: Gail Kellberg and Kathy Cashin

Adaption of Responsibilities for Parent and Child with Diabetes from
Understanding Diabetes, H. Peter Chase & David M. Maahs
Barbara Davis Center for Childhood Diabetes



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FOR FURTHER READING...

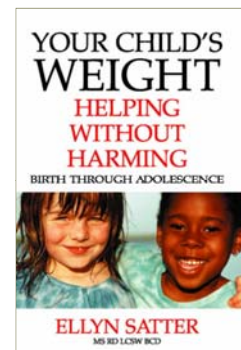


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Applies feeding
dynamics principles
to child overweight

Addresses

- Parenting
- Birth through adolescence
- Activity
- Social & emotional health



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