Desiré Ruiz Aranda.
Associate Professor of Psychology at Universidad Loyola (Seville, Spain).

Healthy relationship with food:

between nutritional balance and the risk of extreme restriction

Historically, nutrition in diabetes has been approached from a prescriptive and normative model focused almost exclusively on glycemic control. However, in recent years, international guidelines have emphasized that nutritional management is a complex intervention that affects not only metabolic parameters, but also adherence, mental health, and quality of life in people with diabetes. (1, 2).

When we talk about the relationship with food, we are not referring only to the dietary pattern, but to a biopsychosocial construct that includes cognitions, emotions, and behaviors around food. It is not only about nutrients, but also about emotions, thoughts, and habits. In people with diabetes, this construct is particularly influenced by blood glucose self-monitoring, the medicalization of food, and the emphasis on numerical outcomes.

Variables such as perfectionism, anxiety, and the pressure to follow the "perfect diet" directly influence how we eat. In addition to these specific risk factors, from a transdiagnostic model, emotional regulation and perfectionism are two central variables that would explain vulnerability to eating disorders (3). Perfectionism is understood as a multidimensional personality trait characterized by the pursuit of perfection, the setting of excessively high performance standards, and extremely critical self-evaluation. In the general population, perfectionism has been identified as a risk factor for the development of eating disorders (EDs), and it is also considered a predictor of adverse treatment outcomes in these disorders.

In people with diabetes, pressure from medical teams and family members to achieve sometimes unattainable glycemic targets, avoidance of certain foods, and greater attention to weight changes are factors that contribute to the development of rigid standards around food and weight. In addition, this pursuit of absolute control is often related to the adoption of increasingly restrictive diets, which, far from improving well-being, may trigger significant psychological consequences. These include a sense of loss of control, the development of a negative relationship with food, and the emergence of a constant cycle of restriction and loss of control. In diabetes, perfectionism does not only seek to do things well; it seeks never to make mistakes. All of this may lead to demotivation and abandonment of self-care, as well as to a high mental burden associated with the permanent management of the disease. Overall, these experiences ultimately have a significant impact on quality of life and increase vulnerability to the development or maintenance of an ED. In people with diabetes, the presence of eating disorders is significantly more frequent than in the general population, with an approximately twofold prevalence. In adolescence, a particularly vulnerable stage because of physical, emotional, and social changes, it is estimated that around 7% may have an eating disorder, which is especially relevant because of its impact during a critical period of development and establishment of self-care habits.

The co-occurrence of diabetes and eating disorders is associated with poorer glycemic control, greater glucose variability, and greater difficulty maintaining stable treatment over time (4, 5). In addition, this combination is related to increased rates of both acute and chronic complications, as well as increased morbidity and mortality. This underscores the importance of early detection and comprehensive management, since this is not only a metabolic problem, but also a behavioral and emotional one that requires coordinated intervention. Understanding and taking these variables into account is essential to promote sustainable habits.

A healthy diet in diabetes should not be understood as a process of strict restriction, but as an approach based on balance, flexibility, and adaptation to individual needs. This involves moving away from rigid rules and focusing on eating patterns that can be maintained over time without generating a conflictive relationship with food. The goal is not to eat perfectly, but to eat sustainably and in a way that can be realistically integrated into the daily life of the person with diabetes.

Within this approach, regularity in meals, food variety, and therapeutic education become especially important. Maintaining a certain consistency in schedules, including different food groups, and understanding how these affect blood glucose allow the person with diabetes to make more informed decisions adapted to their daily reality. Furthermore, this shift involves stopping the search for perfection in eating and accepting that a "good enough" approach may be more realistic and effective in the long term. It is not about doing everything impeccably, but about building habits that can be maintained even in variable contexts, without small deviations leading to abandonment of the process. To this end, normalizing mistakes is key, understanding that they are part of learning and not a personal failure. At the same time, working on cognitive flexibility—that is, the ability to adapt, readjust decisions, and avoid rigid thoughts that hinder adherence—is essential.

This approach benefits from multidisciplinary management, in which nutrition and psychology work together. Eating is understood not only from a nutritional perspective, but also from the perspective of behavior, emotions, and habits, which allows for more comprehensive support. From this perspective, real adherence is not built on perfection, but on sustainability.

The current clinical practice guidelines of the American Diabetes Association and the European Association for the Study of Diabetes represent an important shift in the way diabetes management is understood in clinical practice. In their most recent recommendations, both institutions agree in discouraging rigid, uniform, or excessively prescriptive approaches to nutrition and self-care, since these models do not reflect the real variability of patients or their life context. Instead, they promote strategies centered on shared decision-making, where the person with diabetes actively participates in constructing their therapeutic plan, and on the explicit integration of mental health as part of the overall approach to the disease.

This paradigm shift is directly aligned with what has been described above: the transition from a model based on strict control to one based on flexible self-care. Evidence shows that more rigid models, although they may appear effective in the short term, are often associated with poorer medium- and long-term adherence, greater frustration, and a more conflictive relationship with food. By contrast, flexible approaches make it possible to adapt to real situations in daily life, incorporating variability without »

interpreting it as failure, which favors continuity of treatment and reduces the psychological burden associated with diabetes. In addition, flexible management models have been consistently associated with better outcomes in terms of therapeutic adherence, greater sustainability of lifestyle changes, and better psychosocial outcomes. These include less food-related anxiety, a greater sense of self-efficacy, and better perceived quality of life. Of note, these benefits are not achieved at the expense of glycemic control, but can be achieved while maintaining adequate metabolic targets when treatment is individualized and adapted to the patient's context.

Therefore, flexibility should not be interpreted as a lack of structure, but as a more realistic and effective way of structuring treatment. It involves recognizing that diabetes is not managed in an ideal environment, but in real life, where emotional, social, occupational, and cultural factors play a role. For this reason, shared decision-making becomes a key element, as it allows clinical recommendations to be adjusted to what is feasible and meaningful for each person.

Consistent with the approach described above, this model reinforces the need to integrate mental health into routine diabetes management, and not as a secondary aspect. Assessment of emotional well-being, detection of food-related distress, and coordination between nutrition and psychology professionals become essential elements for comprehensive care. Ultimately, current guidelines not only update technical recommendations, but also consolidate a paradigm shift toward a more person-centered model.

» From clinical practice, this change in approach has direct implications for how people with diabetes are supported. It is not only a matter of transmitting nutritional guidelines, but of systematically assessing the relationship that the patient establishes with food, how they make decisions in daily life, and what degree of rigidity or guilt appears around eating. In this context, the language used becomes centrally important. It is essential to avoid a moralizing approach that classifies foods as "good" or "bad," since these types of messages may promote guilt, excessive restriction, or loss of flexibility. More respectful and realistic language facilitates a healthier relationship with food and improves long-term adherence. It is also crucial to detect early warning signs, such as excessive concern about food, marked rigidity in food-related decisions, or emotional distress associated with eating. Identifying these aspects in time makes it possible to intervene before more problematic patterns become consolidated and improves the prognosis of treatment. The interdisciplinary approach should not be understood as an optional complement, but as a clinical necessity. The combination of nutrition and psychology makes it possible to address not only metabolic aspects, but also behavioral and emotional aspects, which directly influence adherence and patient well-being.

In practice, building a more humane and safe approach involves offering nutritional education without moralizing foods, providing interdisciplinary support, using respectful and realistic language, and giving explicit permission for flexibility. Ultimately, diabetes care cannot be separated from mental health, since both dimensions are part of the same therapeutic process and mutually condition each other. D

CONCLUSIONS

- Evidence shows that flexible models improve adherence, treatment sustainability, and psychological well-being without worsening glycemic control.
- In clinical practice, it is essential to move from strict control to flexible self-care, avoiding moralizing messages and promoting a healthy relationship with food.
- Diabetes management should be interdisciplinary, integrating nutrition and mental health as inseparable parts of treatment.

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