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Understanding the Dietary Habits of Black Men With Diabetes

Loretta T. Lee, PhD, FNP-BC[1], **Seung E. Jung, PhD, RD**[2], **Pamela Bowen, PhD, FNP-BC**[3], **Olivio J. Clay, PhD**[4], **Julie L. Locher, PhD**[5], **Andrea L. Cherrington, MD, MPH**[6]

[1]University of Alabama at Birmingham, School of Nursing, Acute, Chronic, and Continuing Care, Birmingham, AL USA. 1-205-996-5826 llee@uab.edu

[2]The University of Alabama, Department of Human Nutrition and Hospitality and Management, Tuscaloosa, AL USA. 1-205-348-6560 sejung@ches.ua.edu

[3]University of Alabama at Birmingham, School of Nursing, Acute, Chronic, and Continuing Care, Birmingham, AL USA. 1-205-934-2778 pbowen@uab.edu

[4]University of Alabama at Birmingham, Department of Psychology, Birmingham, AL USA 1-205-934-2728 oclay@uab.edu

[5]University of Alabama at Birmingham, School of Public Health, Department of Health Care Organization and Policy, Birmingham, AL USA. 1-205-934-7542 jlocher@uabmc.edu

[6]University of Alabama at Birmingham, Department of Medicine, Division of Preventive Medicine, Birmingham, AL USA 1-205-996-2885 cherrington@uab.edu

Abstract

Diabetes is highly prevalent in African American men. To provide nurse practitioners with practice strategies we explored African American men's perceived needs for dietary health and diabetes self-management using the Social Cognitive Theory. Twenty-five African American men participated in four focus groups. The data were analyzed using a combination of inductive/deductive content analysis approach. Focus group analysis identified personal, behavioral and environmental barriers to and facilitators for diabetes self-management. Nurse practitioners may need to provide extra emotional support in the absence of informal social support from families for diabetes self-management and dietary health in African American men with diabetes.

Keywords

nurse practitioner; diabetes; eating practices; Social Cognitive Theory

Type 2 diabetes is a complex and burdensome disease accounting for 90–95% of all diabetes cases in the United States (US) and contributing approximately $327 billion annually to

Corresponding author: Dr. Loretta T. Lee is an Associate Professor at the University of Alabama at Birmingham. All communication about this manuscript should be directed to Dr. Lee by llee@uab.edu or phone at 1-205-996-5826.

health care expenditures.[1] Diabetes prevalence in African Americans (AA) is nearly 15% compared with 8% for Whites.[2] Moreover, it is 3 % higher in men than in women across all races in the US.[2] The Deep South region (i.e., Alabama, Mississippi, Georgia, Louisiana, and South Carolina) compared to other parts of the US has the highest prevalence.

Healthy eating behaviors are an effective strategy for glycemic control. Intuitive Eating (IE) also known as mindful eating is a healthy dietary strategy that has been used in many populations with chronic diseases such as obesity and type 1 diabetes.[3,4] This holistic approach focuses on physiologic body signals for eating, improving self-image, and coping with emotions, as well as focusing less on unhealthy cues for eating (e.g., societal norms, dieting, TV commercials).[5] In a previous study, Wheeler et al. (2016) showed an inverse association between IE scores (a measure for IE practices) and glycemic control in adolescents with type 1 diabetes.[4] Their findings echo those from study of populations with other chronic diseases and make IE practices potentially relevant to those with T2DM. Despite such evidence, healthy eating practices, such as those consistent with IE, are a daily struggle for some AA men.[6]

A majority of diabetes care is provided in primary/outpatient care settings by nurse practitioners (NPs). Therefore, it is imperative that NPs are educated about factors (e.g., eating practices) that impact diabetes health for AA men. We sought to gather information about the perceived needs for successful diabetes management, specifically healthy dietary practices for AA men and to provide NPs with the information needed to successfully deliver tailored diabetes-care in a primary care setting. Understanding the dietary habits of AA men living in the Deep South along with their perceived needs for successful diabetes self-management could inform NP-developed tailored strategies aimed at decreasing obstacles to health among this population.

METHODS

Sample and Setting

The study was approved by a public safety-net health system and the University of Alabama at Birmingham Institutional Review Board. Participants were recruited through flyers and outreach at a public safety-net health system diabetes clinic. To participate in this study, AA men needed to be 20 years of age, have a diagnosis of T2DM, and a documented hemoglobin A1c level drawn within three months prior to recruitment. Participants all provided informed consent and were given pseudonyms during data collection and for the transcription phase. Consent forms and contact information were securely kept in a separate file. All data were stored on a password-protected computer and/or locked filing cabinet in keeping with the National Institutes of Health data security guidelines. Participant demographic characteristics are presented as aggregate data only.

Design

A qualitative methodology was chosen because it provides a way for researchers to study behaviors or responses by having a group of participants discuss a given topic. Although qualitative methods (e.g., surveys, phenomenology) may include non-conversational

approaches, focus groups are commonly used and are an effective strategy to obtain information about an individual's reactions and behaviors, and to understand the individual's reasoning behind behaviors and reactions.[7] Focus group questions were developed based on Bandura's Social Cognitive Theory (SCT).[8] This theoretical framework was selected for this study because of the focus on individual cognitions and perceptions influencing behavior. Behavioral, environmental, and personal factors of SCT were chosen to explore the effect of internal and external factors on AA men's diabetes self-management practices, specifically eating habits. Four focus group sessions were used to collect a rich and detailed set of data about perceptions from the study participants.

Data Analysis

Focus group analysis revealed the following categories using the constructs of the SCT: 1) why we eat, 2) ways to manage diabetes, and 3) barriers of and strategies for diabetes health. A combination of inductive and deductive approaches were used by three researchers to conduct content analysis to identify major themes.[9] Transcripts were read by three independent researchers while listening to audio files to check for accuracy and gain a global sense for the conversation and then identify substantive units in the form of phrases and sentences. These units were then condensed with codes created and assigned to each meaningful unit. Researchers then discussed the codes in order to reach consensus on a codebook that would be used going forward. Codes were further categorized and themes identified based on the transcripts. Saturation of themes was noted after the fourth and final focus group.

RESULTS

Twenty-five men with T2DM, with a mean age of 50 ± 10.7 years participated in the study. Men were AA with a mean hemoglobin A1c of 10% ± 2.5 % and BMI of 33 ± 5.4 kg/m2. Most men were unmarried (60%) and unemployed (88%)

Why we eat (personal)

The men identified physiological needs as an integral component of maintaining overall health and discussed cues for eating. Among these men, some eating practices are consistent with IE principles (e.g., physiologic cues). "I eat when I am hungry." Others expressed eating practices that are not aligned with principles of IE. One participant discussed eating as a coping strategy for stress reduction, while other men discussed loneliness and external stimuli as cues for eating, "I'm in the house alone." "If I see it on TV and I got it in my house I'm gonna probably eat it." The participants' comments denote cues for eating that could be a response to internal (e.g., habits, emotions) or external cues such as environmental stimuli (e.g., TV commercials).

Ways to manage diabetes (behavioral)

Two themes were identified under this category: 1) healthy eating practices and 2) self-discipline.

Healthy eating practices—When participants were asked to discuss the sorts of strategies they use to help control diabetes, there was a general consensus in all four focus groups that compliance with prescribed diet is crucial. One participant expressed, “I can eat the proper thing, but if I go back and eat too much of the thing, say like fruits, I eat two or three apples, oranges or something like that, boom…even if I take my medicine like I’m supposed to.” Another participant stated, “To manage it is to eat the proper food while you’re on diabetes, to eat vegetables, to eat—corn’s not good for you.” The participants’ comments suggest that these men with diabetes can identify and understand the importance of healthy eating strategies to control their blood glucose. Conversely, comments reflect that sometimes their eating strategies are not aligned with healthful practices.

Self-discipline—Self-discipline was another major theme discussed as one of the ways to manage diabetes among the study participants. The men expressed the importance of believing in their ability to control their diet to manage diabetes. For example, one participant said, “But at the end of the day, you just got to have a made up mind [laughter] if you’re gonna do it or not. You don’t have to have self-control, 100% self-control. You can have some off days.” Another participant also stated, “I basically think even though you may have a old lady, whatever, but it’s basically up to you.”

Barriers to and strategies for diabetes health (environmental and behavioral)

Closely linked to the men’s efforts for managing their diabetes health was their discussion of barriers to and strategies for healthy living. Many expressed desire for increased diabetes health knowledge and education. One participant expressed, “The problem is when you ain’t got knowledge of diabetes. That’s when you run to sickness, don’t know how to control your sugar, sugar out of control, what foods to eat, what heals your body, what don’t heal your body.” Another participant voiced concern about ambiguous healthcare provider instructions related to optimal glucose level. “I have heard so many different levels even from doctors telling you that 120 is the normal or 130 is the normal. I really don’t know exactly what the normal is cuz I have heard different doctors tell you different levels.”

There was general consensus among all four focus groups that social support, specifically from spouses/significant other is important for all people living with chronic disease. One man expressed, “It feels good to have someone help you.” Two other participants complained of lack of spousal support. “My wife don’t help me, I get more support from my dog.” Another expressed, “Show me that you care just a smidge and–just a smidge. Just show me that you care.”

Some men expressed concerns about environmental and internal factors that are attributable to their poor eating habits. During each focus group, participants reported barriers to healthy eating such as habits, food availability in the home, cost, and dietary planning. Several men expressed frustration about financial constraints, and the taste of foods perceived as healthy. When asked by researcher 1, “What kinds of things make it difficult for you to select the right foods and amounts that are healthy for you to eat,” responses varied among these participants, “My habit. My habit. I just like to eat and don’t want to miss no meals cuz I love to eat.” Two participants responded, “I think economics have a lot to do with the way—

how you eat cuz if you're not getting enough income coming in, what you have to eat the proper way, cuz lots of fruits, lots of vegetables, it's very expensive to eat that way seven days a week." "It's like you be trying to plan hours and hours on how you're gonna eat something healthy." There was a general consensus among these men on dissatisfaction with taste of "diabetic foods" or diabetic healthy diets, "It just don't seem like it taste right." "Momma used to put that lard in it__man."

In contrast to barriers discussed during each focus group, participants expressed personal strategies used to improve their overall diabetes health. Some men emphasized self-efficacy related to their chronic disease and diet. The following quotations suggest that the participants feel some level of comfort managing their diet. "I found out a lot of stuff about how a diabetic is supposed to eat---, I went on the Internet and a lot of time I try to follow you know the meal plans on the Internet." "It's hard but I try to eat at the same time every day. That keep me from getting too hungry." "I just keep telling myself I can do it and I can't depend on nobody else." There was general consensus that glucose control, seeing a healthcare provider as scheduled, and medication adherence are strategies that promote good diabetes health. "Oh yes you gotta take your medicine and go to the doctor when you supposed to."

DISCUSSION

NPs provide care to patients with diabetes in a variety of settings and environments, and study has shown that nurse-managed interventions help to improve health outcomes among patients with moderately severe diabetes.[10] The substantial need for providers in outpatient settings who are equipped to manage chronic diseases provides new impetus to educate NPs on barriers to and strategies for diabetes self-care, especially for minority populations such as AA men. An important finding of this study was the extent to which participants discussed ways to manage diabetes but voiced numerous barriers that prevent their successful self-management.

While confirming previous findings, our results also provide further insight, showing that participants struggle with traditional dietary habits that are not aligned with a healthful diet. Some participants in this study discussed psychological cues for eating including stress. The discordance between psychological wellbeing and healthy eating habits could explain the increased mean BMI (33 ± 5.4 kg/m2) and hemoglobin A1c (10 ± 2.5%) in this sample of AA men. Lee et al. (2016) found a similar result in a sample of AA men with T2DM who also cited stress as a cue for eating.[6] Similarly, in a qualitative study conducted by Willig and colleagues, AA women with T2DM reported eating as a coping mechanism when they felt stressed about external factors.[11] Some men in the current study explained that they missed traditional food seasoning and cooking methods from childhood and expressed discontent with the taste of perceived healthy foods. The literature points out that dietary-related behaviors are determined by external factors (e.g., cultural) and that individuals may unconsciously engage in eating practices deemed as preserving traditions.[12] Culturally-tailored interventions that focus on cooking preparation and promoting foods that can be part of a healthy diet, as opposed to foods to avoid, may provide an opportunity to improve

healthy eating behaviors. Previous study has reported that positive compared to negative messages about healthful practices are more associated with behavioral modification.[13]

Healthy eating, specifically IE, is a dietary strategy that offers promise as an effective approach for glycemic control. In this study among men with poorly controlled diabetes (mean hemoglobin A1c 10 ± 2.5%), the results revealed self-reported eating practices that are not consistent with principles of IE practices. Miller and colleagues conducted a prospective randomized controlled trial among adults age 35 to 65 years old with T2DM to examine the impact of mindful eating strategies relative to group diabetes self-management education (DSME) based intervention on dietary intake, weight loss, and glycemic control. Their findings revealed that dietary training in mindful eating strategies and diabetes self-management education (DSME) were both associated with better dietary intake, weight loss, and reduced hemoglobin A1c by 0.67 ± 0.2%.[14] Given that previous study has revealed an association between mindful eating practices and DSME, and hemoglobin A1c levels it is necessary to further investigate these specific associations in AA men with diabetes.

Most patients with diabetes receive education at least once that includes how to manage food portion size and count carbohydrates and overall healthy eating strategies, yet several men in this study still struggle, citing need for more education. Study findings from Huxley et al. (2015) revealed that knowledge alone does not improve diabetes outcomes.[15]

For the men in our focus groups, regardless of their eating practices, financial constraints were a key factor that emerged as a significant barrier. In a recent meta-analysis Cooper et al. (2013) found that green leafy vegetable intake was inversely associated with diabetes.[16] However, in our current study men felt that higher costs of healthy foods (e.g., fresh fruits and vegetables) compared to lower costs of unhealthy foods (e.g., fast foods) in their neighborhoods were barriers to healthful eating practices. According to some participants, unhealthy foods were selected and purchased by family members (e.g., spouse or meal preparer) and available in their home because of financial constraints. Other study findings revealed that higher food prices in low-income neighborhoods are barriers to healthy eating and contribute to some chronic diseases such as obesity.[17] The perceived lack of availability of healthy foods could be an indicator for food insecurity for the AA men in this current study. According to the American Diabetes Association (ADA), among individuals with food insecurity (FI) (i.e., inconsistent availability of healthful food and the inability to regularly obtain food by socially acceptable means) some may intentionally purchase less expensive energy and carbohydrate-rich processed foods, increasing their risks for obesity and diabetes. Healthcare provider recommendations from the ADA include developing interventions designed to mitigate the increased risk for poorly controlled diabetes and related complications for individuals with higher rates of FI (e.g., minorities). Therefore healthcare providers/systems could develop tailored interventions that include providing income-based vouchers for farmers markets, neighborhood gardens, affordable whole food grocery stores, and mobile healthy food delivery services as strategies that could improve eating practices and diabetes outcomes in AA men with FI.[18]

Social support was discussed as both a barrier to and potential facilitator for healthy eating and diabetes-health. While many individuals with diabetes often find formal social support

to be helpful, the married men in this study overwhelmingly expressed a need for family social support, especially from their spouse. Spousal support has been identified as an important psychosocial factor that can improve self-management practices and subsequently diabetes-health.[19] In 2013 32% of AA men compared to 50% of men across all other races had a spouse/significant other.[20] In the current study the majority (60%) of participants were single. This finding suggests that participants in the current study may have difficulty finding social support from informal sources (e.g., spouse) to assist them with diabetes management practices. NPs could facilitate the organization of a network of unique Community Health Workers/Advisors (CHAs) or mentors who share similar characteristics with AA men with diabetes. Male CHAs of similar racial/ethnic heritage living with diabetes could provide an opportunity to address a gap in uniquely designed interventions that target AA men in the Deep South. In the absence of informal social support from spouse or family members, interventions that maximize support from NPs and the health care team could provide AA men with psychosocial support regarding diabetes management.

Limitations

Although findings from these focus group sessions may provide important insight into the needs of this population of men, this study is not without limitations. First, our sample was largely homogeneous (e.g., similar socioeconomic backgrounds, all living in the same region of the US). Second, the sample size was small (N= 25), which is consistent with qualitative design so our findings cannot be generalized to other populations. Finally we did not assess effects of other factors such as masculine beliefs and values that have been reported in the literature to affect men's health behaviors. Despite these limitations, this study fills a gap in the literature regarding perceived needs for healthy eating and diabetes-health in Deep South AA men with T2DM.

CONCLUSIONS

The results of this study highlight the need for health care providers, specifically NPs to be aware of psychosocial, physiological and environmental barriers of diabetes self-management in AA men with diabetes. Additionally, some AA men with diabetes may benefit from extra emotional support from their health care team in the absence of informal support from family members. With increased knowledge of these men's daily struggles with diabetes management, NPs should enhance their treatment plans to include conversations about barriers to and strategies for diabetes self-management and available community programs uniquely designed for AA men. Future interventions aimed at tailored diabetes treatment plans, with an emphasis on healthy eating behaviors and social support, may be effective in reducing racial inequities related to diabetes and its complications among AA men.

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Highlights

1. Diabetes is more prevalent in men compared to women.
2. Most diabetes-care is provided in outpatient setting.
3. Nurse practitioners are needed to provide high-quality diabetes-care.
4. Social Cognitive Theory can be used to promote healthy eating practices.

Table 1.

Selected quotes by categories.

Categories	Men's Illustrative Comment/s
Why we eat?	
"What are some of the reasons why people eat"	"You got to eat to stay healthy and if you on insulin……"
"Why do you think you may eat unhealthy foods?"	"Then again the person that's sitting there eating the good food, they basically tempt you."
Ways to manage diabetes.	
"What are some things you can do to manag your diabetes?"	"I basically just regularly started going to see a doctor and taking my medicine like I'm supposed to. I'm saying annual checkups, stuff like that, as I got older, but when I was young, I thought I was invincible." [Laughter]
"What are somethings your wife or family can do to help you with your diabetes?"	"If you got somebody they got to be interested in you diabetes too. You supposed to be married."
Barriers of and strategies for healthy eating. (behavioral and environmental):	
Strategies	
"What are some of the things you do to mak sure you are eating healthy?"	"Three things, stay away from the fried chicken. Stay away from the sodas. And then you just gotta feel like you can do it on your own, don't' depend on somebody else to tell you how to eat……."
	"You got to make sure you season it (food) right…and then you got to try not to buy that bad stuff from the store."
Barriers	
"What are some of the things that make it hard for you to eat healthy?"	"It ain't nothing like that way how we were raised up. It ain't nothing like my Mama put that grease in them collard greens."
	"When I open the refrigerator, everything in there to me is bad, unless it's cabbage. If it's not cabbage, everything that's in there is – Bologna, hot dogs, sausage, bacon. "