Psychotherapeutic Treatment of T1DE

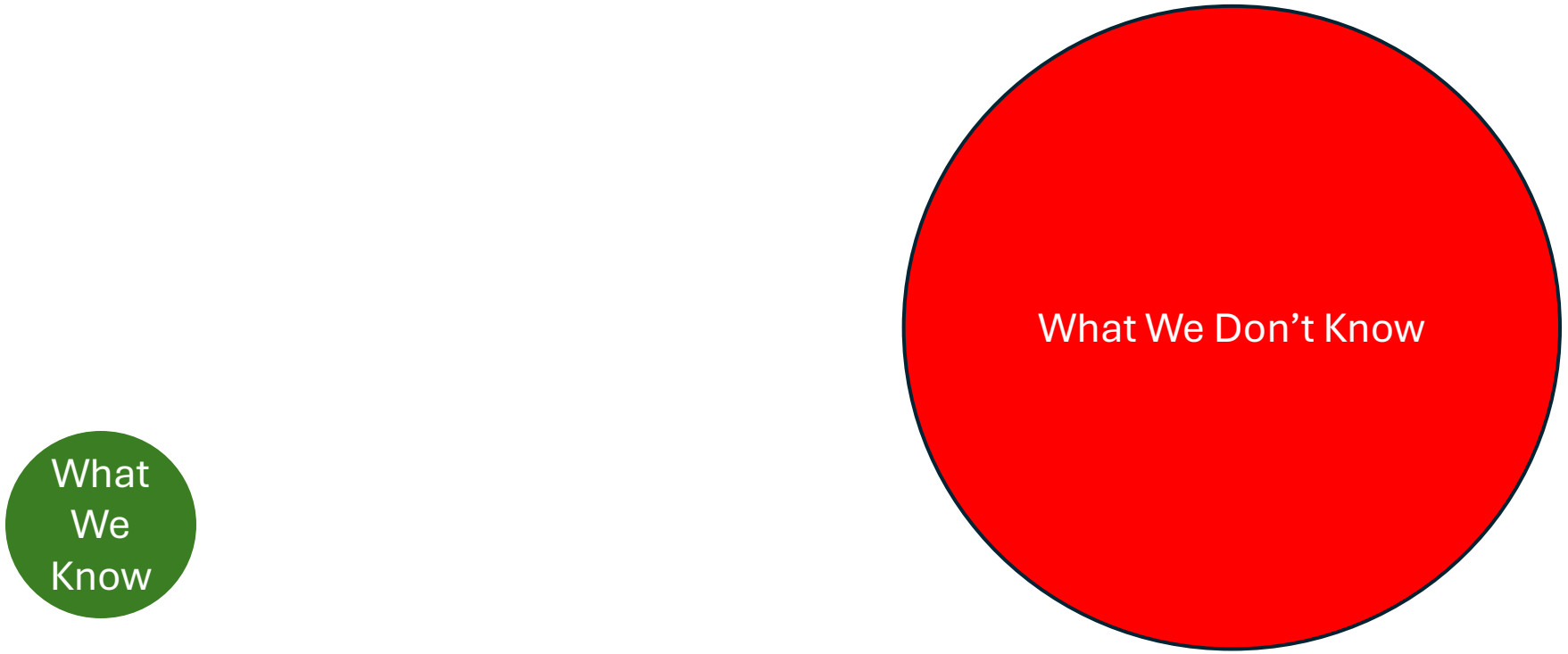
What We Know and What We Don’t Know

- T1DE now firmly established as a clinical entity
- Knowledge increasing
- Uncertainty about how best to treat it

- Variety of approaches in use
  - Educational/supportive
  - CBT
  - Modified CBT
  - Psychodynamic/psychoanalytic
  - Systemic
  - Combinations

- Good time to review what we know and what we don’t know

The Bad News



The Good News

Largely unexplored territory

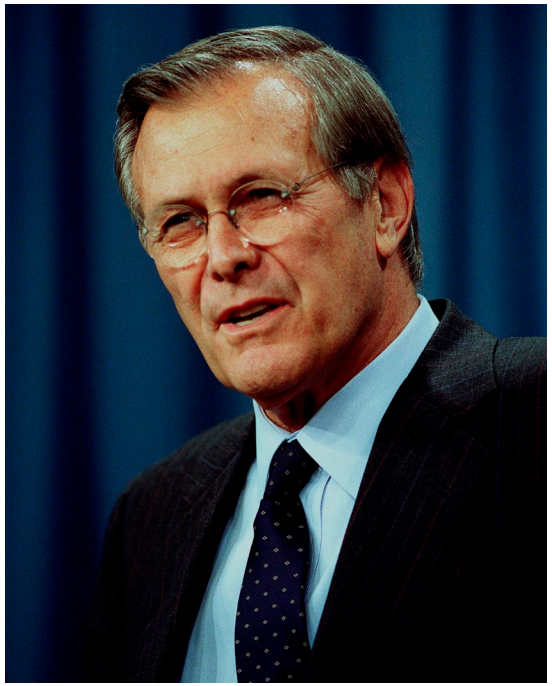
Lots of opportunities to innovate and we might strike gold!

Our Guide

“As we know, there are known knowns; there are things we know we know.

We also know there are known unknowns; that is to say we know there are some things we do not know.

But there are also unknown unknowns – the ones we don't know we don’t know.”



Donald Rumsfeld
US Secretary of Defence
2001-2006

Known Knowns

- General agreement that treatment is best delivered by a multidisciplinary team with expertise in both eating disorders and diabetes

  (UK Parliament, 2024; MacDonald et al, 2018; Zaremba et al, 2020; Ismail et al, 2024)

- Patients value integrated care

  (MacDonald et al, 2018)

- *“Having expert staff who know how to support mental and physical health means the service has given me a holistic approach to my care. I feel listened to, supported and know that the way I feel matters. The staff have taken the time to get to know me on a personal level, and that’s really made a huge difference.”*

- *“I was finally on the path to receiving the help I’d been needing. No judgment, just genuine support where I was seen as a person and not a bunch of individual conditions.”*

Systematic Review and Meta-analysis

- Found limited or no improvement in glycaemic control or eating disorder symptoms with conventional outpatient eating disorder treatments
- Inpatient treatment produced more improvement in HbA1c than outpatient treatment
- Adding a family intervention resulted in greater symptom change in one study

- “People with type 1 diabetes-associated eating disorders require a different form and intensity of intervention”

- Only six articles included in systematic review and three in meta-analysis

(Clery et al, 2017)

Safe Management of People with Type 1 Diabetes and Eating Disorders (STEADY)

- 12 session intervention for mild-moderate T1DE
- Combination of CBT and diabetes education
- Multiple components and can be personalised to the individual

- Most frequently used components:
  - Formulation
  - Behavioural experiments (eg up-titration of insulin dose)
  - Thought records
  - Goal setting
  - Understanding emotions
  - “Riding the wave” of emotions and urges

(Harrison et al, 2025; Stadler et al, 2024)

- Showed statistically significant improvement in anxiety (GAD-5) and diabetes-specific quality of life (DIDP) compared to controls

- Those in active treatment group showed improvements in eating disorders scores (DEPS-R and EDE-QS)

- No difference in HbA1c or other biomedical outcomes but not powered to detect this (*n*=40)

(Stadler et al, 2025)

Known Unknowns

- What should a therapy for T1DE look like?
- What should it consist of?

Essential Elements in a T1DE Therapy

Foundations

"Non-specific" factors common to all therapies

- Therapist's interest and concern
- Instillation of hope
- Making sense of a confusing situation
- Therapist's belief in the therapy

(Wampold, 2015)

Superstructure

Specific elements

- Thought records and cognitive restructuring (CBT)
- Interpretations (Psychodynamic)
- Exploration of individual experience within their relational context (Systemic)
- Etc

What Do We Already Know?

- Weight and shape concerns and fear of weight gain with insulin are core features of T1DE
- Negative feelings about diabetes very common

- T1DE and insulin restriction are associated with:
  - More severe emotional distress and depression

    (Herpertz et al, 2000; Vila et al, 1995)
  - More negative attitudes towards diabetes

    (Biggs et al, 1994)
  - Sense of personal ineffectiveness

    (Khan et al, 1996)

- **Potential "targets" for therapy**

Unknown Unknowns

- What are the key elements of T1DE?
- Which of these are primary (causative) and which are secondary (maintaining)?
- What is its pathophysiology?
- What should be our therapeutic targets?
- **To answer these questions we need an aetiological model**

A Cognitive-Affective Model of T1DE

- “Classical T1DE”
- Insulin restriction to control weight
- May have other functions as well
  - Diabetes denial
  - Expression of anger
  - Means of emotional regulation
  - Care eliciting behaviour
  - Form of self-harm

- Work in progress
- Illustrative not definitive

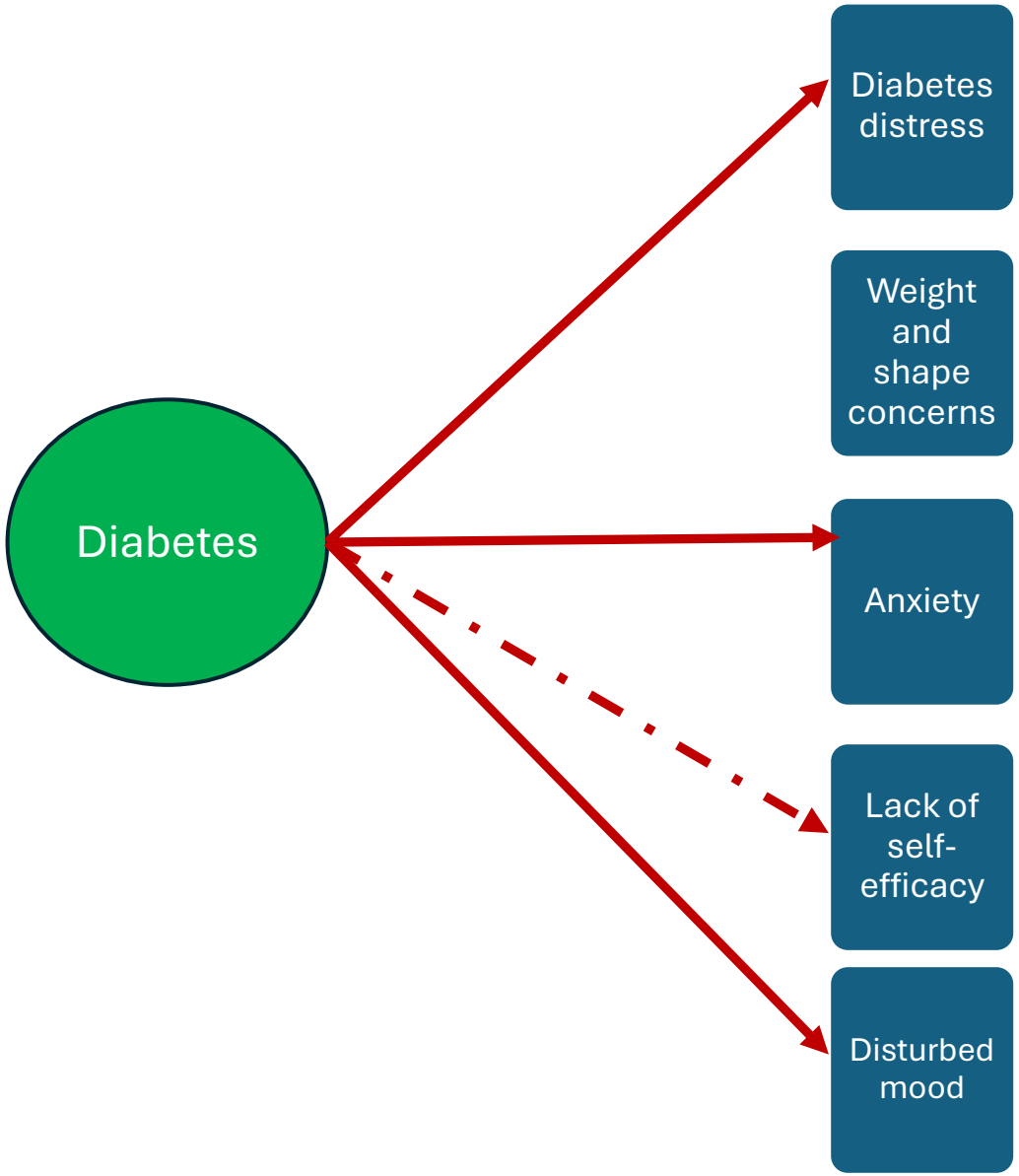
Diabetes distress

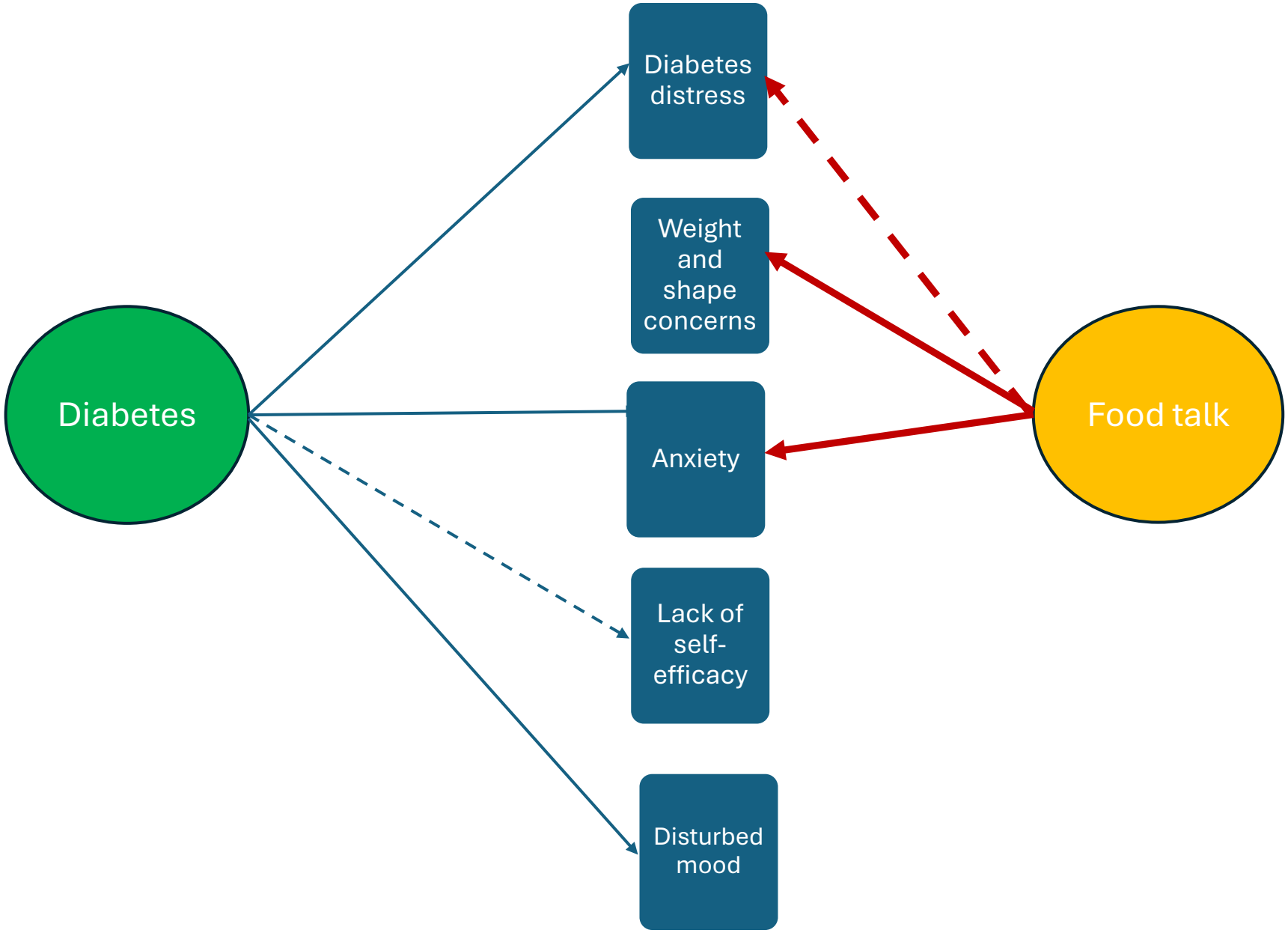
Weight and shape concerns

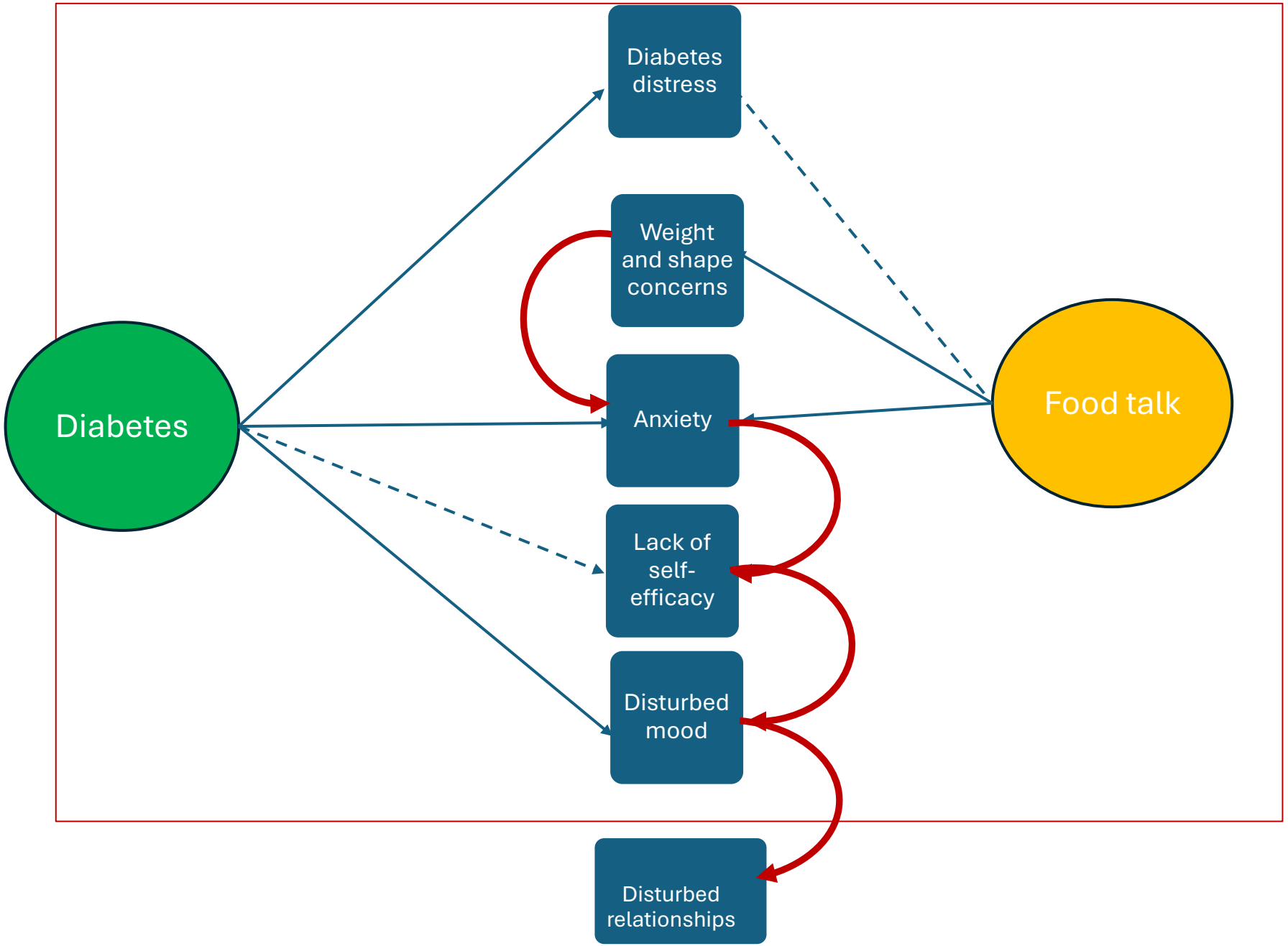
Anxiety

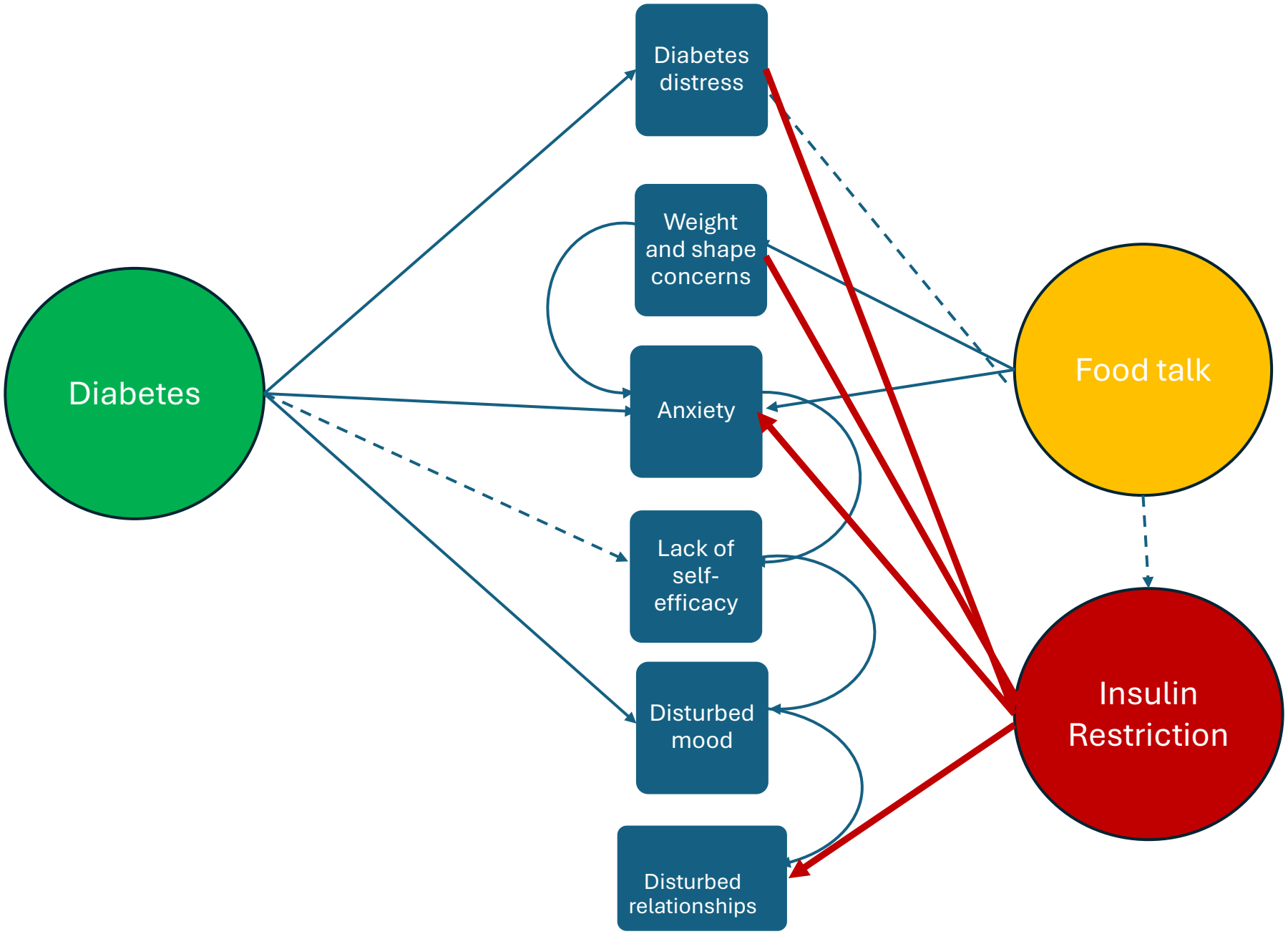
Lack of self-efficacy

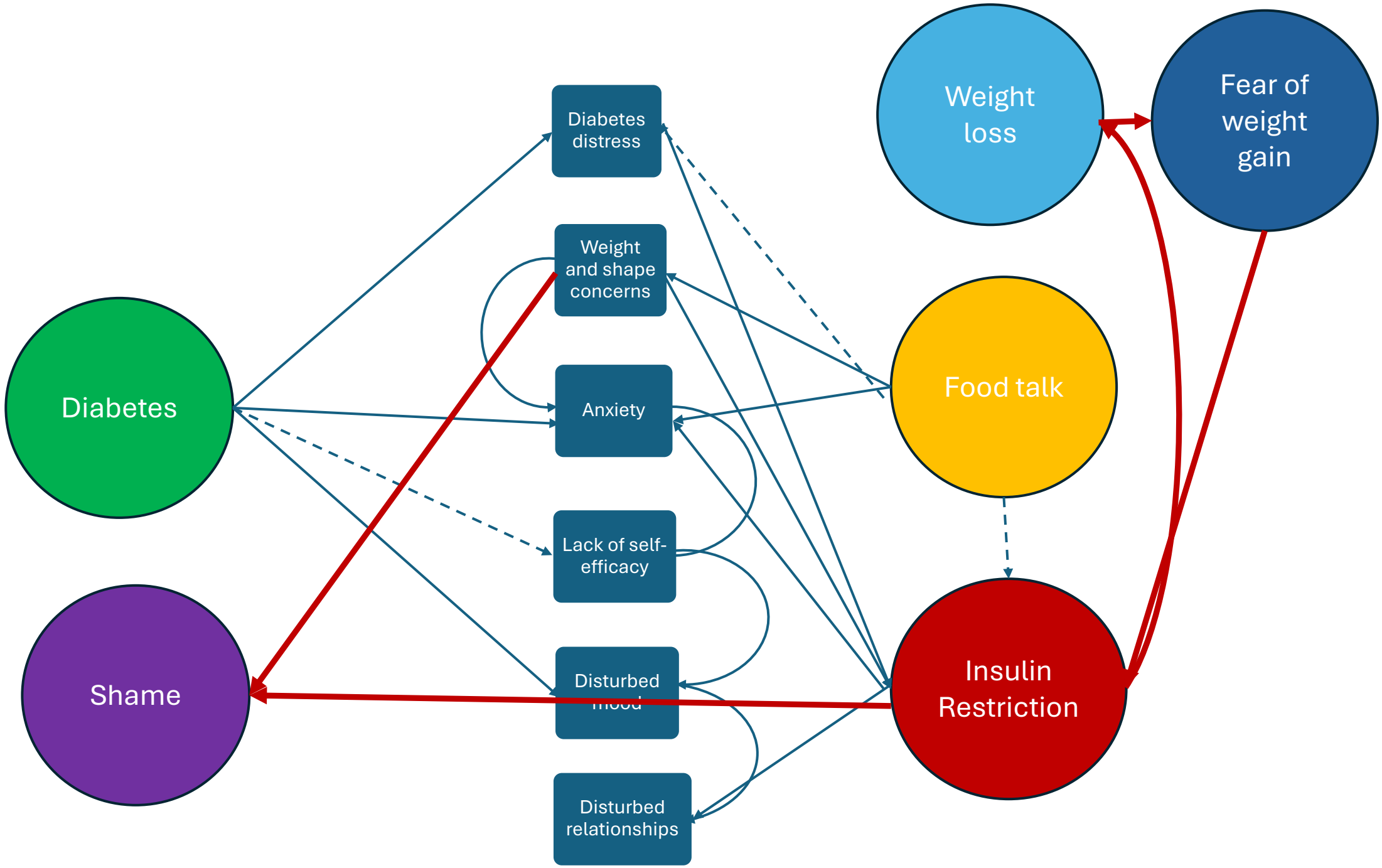
Disturbed mood

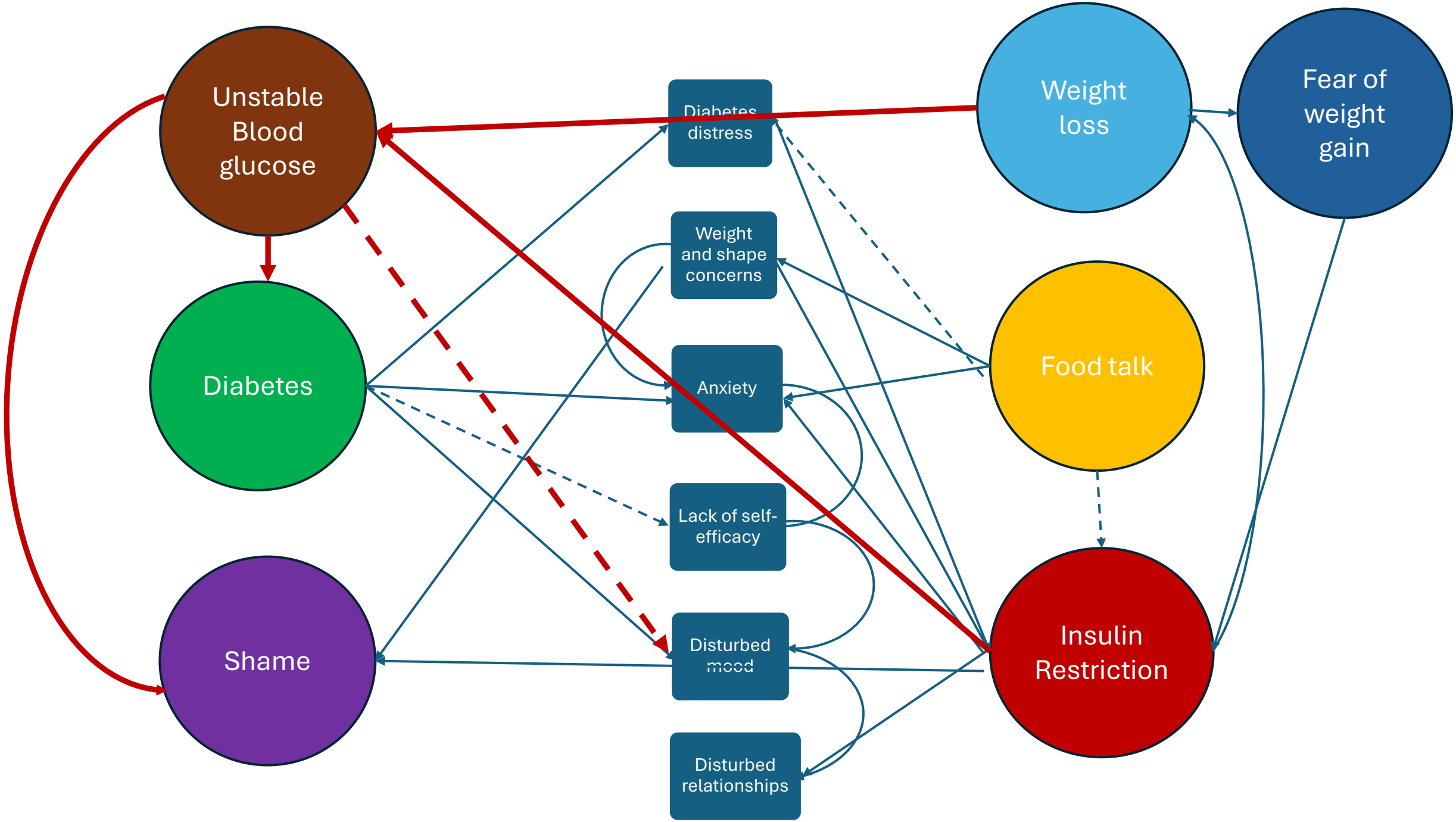

Diabetes
Diabetes distress
Weight and shape concerns
Anxiety
Lack of self-efficacy
Disturbed mood


Diabetes distress
Weight and shape concerns
Diabetes
Anxiety
Food talk
Lack of self-efficacy
Disturbed mood


Diabetes distress
Weight and shape concerns
Diabetes
Anxiety
Food talk
Lack of self-efficacy
Disturbed mood
Disturbed relationships


Diabetes distress
Weight and shape concerns
Diabetes
Anxiety
Food talk
Lack of self-efficacy
Disturbed mood
Insulin Restriction
Disturbed relationships

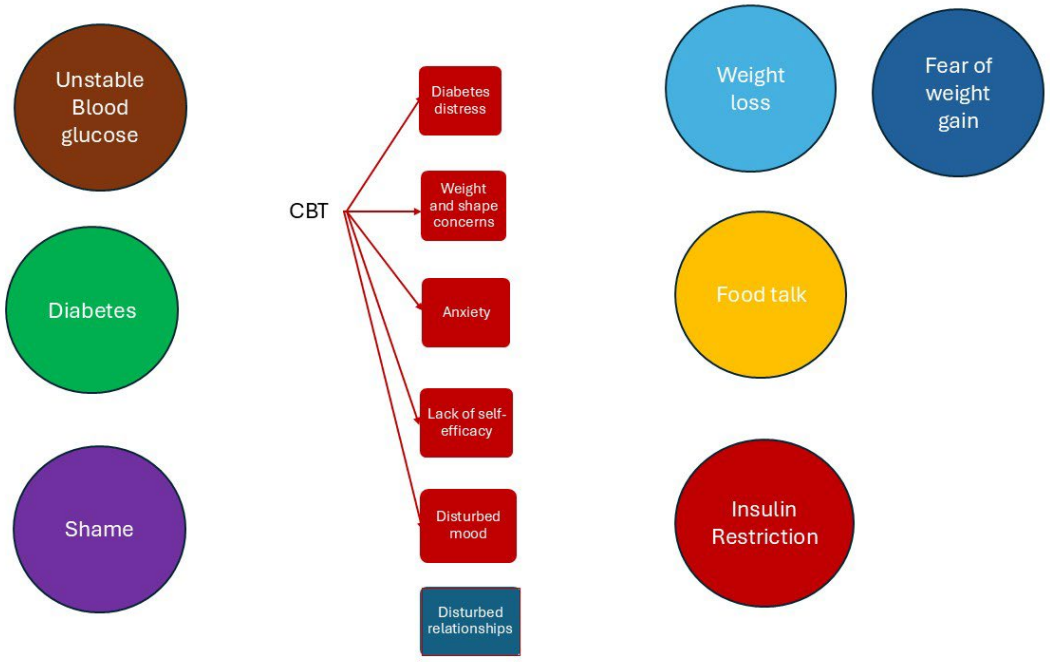

Weight loss
Fear of weight gain
Diabetes distress
Weight and shape concerns
Diabetes
Anxiety
Food talk
Lack of self-efficacy
Shame
Disturbed
Insulin Restriction
Disturbed relationships


Unstable Blood glucose
Diabetes distress
Weight loss
Fear of weight gain
Weight and shape concerns
Diabetes
Anxiety
Food talk
Lack of self-efficacy
Shame
Disturbed mood
Insulin Restriction
Disturbed relationships

Established Therapies

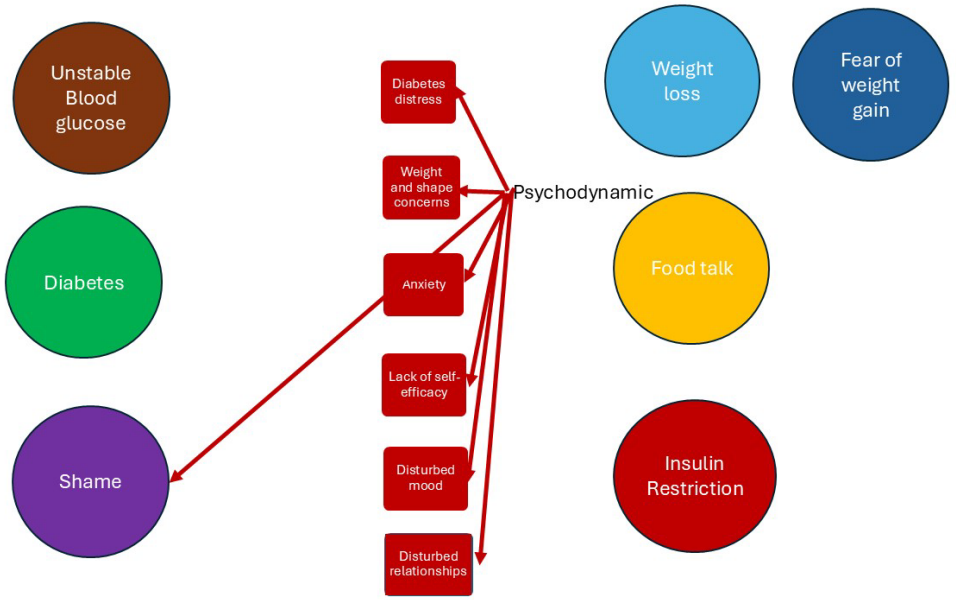
CBT

- Directly addresses weight and shape concerns
- Can also deal with anxiety
- Substantial evidence base in eating disorders
- Can be manualised and easily replicable



Psychodynamic Therapy

- Eating is a fundamental drive
- Closely linked to experiences of being (or not being) cared for and nurtured
- People with diabetes have to care for themselves and (sometimes) be cared for by others
- Sense of loss of autonomy and control
- Able to address interpersonal dimension

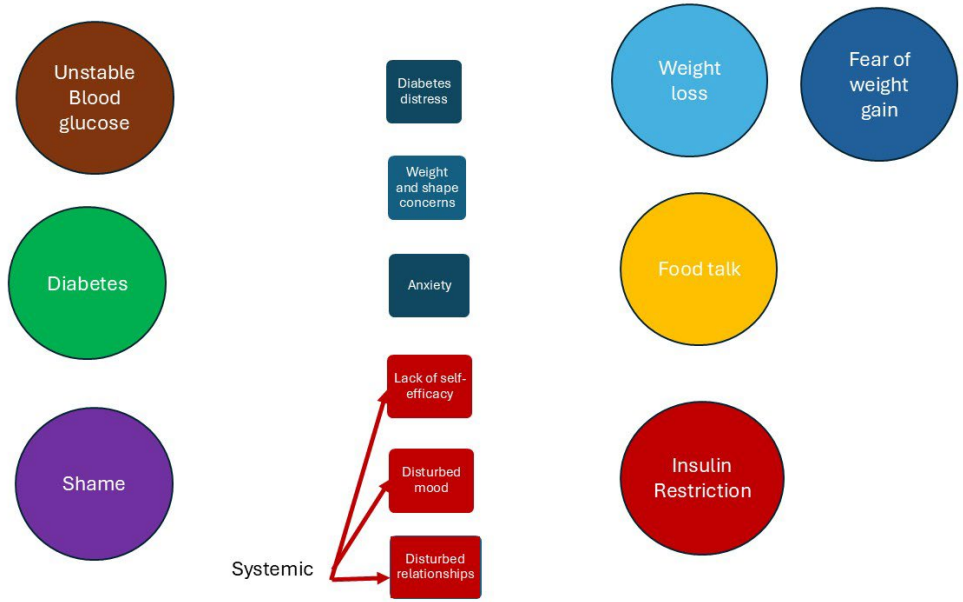


Systemic Therapy

- In younger patients, diabetes is a family issue
  Diabetes ⇄ family dynamics

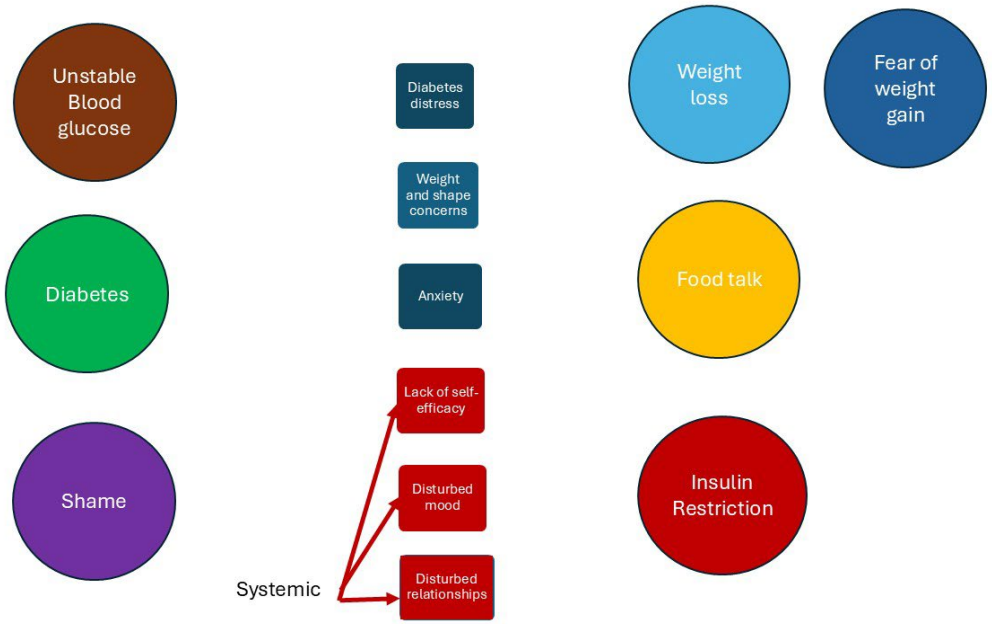
- Who does the injections?
- Who monitors blood sugars?
- Parents can find it hard to let go

- Especially difficult for teenagers who are struggling to assert their individuality and separate from parents
- Diabetes management becomes the battleground between teenager and parents
- Insulin restriction which started as weight control becomes a way of expressing anger and protest



Education

- Central to diabetes self management
- Educate the patient about the effects of insulin restriction and re-insulinisation
- Educate professionals about not using language about food, weight etc that promotes or reinforces eating disordered beliefs



Conclusion

- Multiple therapeutic modalities have potential but need to be modified for T1DE
- Should not discount “non-specific” factors in all therapies
- Integrated, multidisciplinary care essential
- Interventions should probably target a number of areas
  - Weight and shape concerns
  - Autonomy and control
  - Feelings about having diabetes
  - Interpersonal consequences of type 1 diabetes and T1DE
  - Education about T1DE and re-insulinisation
- Family therapy may be useful in children and young people
- Testing of aetiological models may lead to improvements in treatment
- **Lots more to do!**

Thank you

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