Eating Disorders & Diabetes

T1DE workshop 2

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Aims of the session

- To understand the different types of Eating Disorders seen in Young People with Diabetes, as seen within CEDS
- To understand how to accurately assess the risks
- To understand the complexities and dilemmas involved in working with these Young People
- To understand when and how to refer for support

MFT-CEDS: who are we?

A community-based specialist Eating Disorder Service.

Work across Manchester, Salford and Trafford

Provide a range of NICE concordant treatments

Focus on early intervention and prevention

Support professionals and other agencies via Consultation and Training

MFT-CEDS: how we work

Referrals are screened and triaged daily

Strict timescales in which to offer an assessment (routine, urgent, emergency)

NICE concordant treatment pathways as the primary interventions

We manage a great deal of medical risk: "one-stop shop"

We support young people, families and staff when a hospital admission occurs

What are Eating Disorders?

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- ARFID
- OSFED

Diabetes and the relationship with food

- "From the very first nanosecond of diagnosis, a diabetic is wedded to their food intake. Every time- every single time- a piece of food or drink passes your lips, you have to do a mental calculation of carbohydrate levels and the subsequent insulin intake you'll require via a sharp needle piercing your skin. Food can mean literal pain. Maybe you fancy that extra bit of cake but you don't really want to think about it because perhaps you'll feel guilty about the calorific content. But then, by not thinking about it, you don't inject for it, so forty-five minutes down the line your sugar levels have risen to the point of delirious nausea and you start to wonder at what age it'll be exactly when you prematurely lose your eyesight. "

***Lawrence - JRDF**

Box 1: Proposed diagnostic criteria for T1DE

People with type 1 diabetes who present with all three criteria:

1. Intense fear of gaining weight, or body image concerns, or fear of insulin promoting weight gain.
2. Recurrent inappropriate direct or indirect* restriction of insulin (and/or other compensatory behaviour**) to prevent weight gain.
3. Presenting with a degree of insulin restriction, eating or compensatory behaviours that cause at least one of the following:
   - harm to health
   - clinically significant diabetes distress
   - impairment on daily functioning.

* Indirect restriction of insulin refers to reduced insulin need/use due to significant carbohydrate restriction.

** Dietary restriction, self-induced vomiting, laxative use, excessive exercise, over-use of thyroid hormones, over-use of diabetes medication believed to avoid weight gain or promote weight loss.

T1DE

(MEED – Annexe 3: p5)

Medical Emergencies in Eating Disorders (MEED)

Medical Emergencies in Eating Disorders:
Guidance on Recognition and Management

(Replacing MARSIPAN and Junior MARSIPAN)

May 2022

COLLEGE REPORT CR233

Guidance on Recognising and Managing Medical Emergencies in Eating Disorders

(Replacing MARSIPAN and Junior MARSIPAN)

Annexe 3: Type 1 diabetes and eating disorders (T1DE)

May 2022

MEED – T1DE Red Flags

(MEED – Annexe 3: p6)

Box 2: Red flags for T1DE

Any one of the following:

Biochemical

- Increase in HbA1c above 86mmol/mol or erratic blood glucose levels (e.g. high glycaemic variability, postprandial hyperglycaemia following bolus omission).
- Multiple emergency department or ward admissions with hyperglycaemia, diabetic ketoacidosis (DKA).
- Recurrent ketonaemia (>3mmol/L) – may have compensated metabolic acidosis.
- Recurrent severe hypoglycaemia (two or more episodes over 24 months).

Beliefs, behaviours and functioning

- Over-exercising.
- Impaired awareness of hypoglycaemia.
- Extreme dietary restriction or binge eating.
- Weight loss history (weight loss in line with Medical Emergencies in Eating Disorders guidance criteria) or fear of weight gain.
- Body image concerns.
- History of eating disorder diagnosis.
- Diabetes distress.
- Fear of hypoglycaemia.
- Mental health comorbidity (e.g. depression, generalised anxiety disorder).

Relationships

- Secrecy about diabetes management, failure to request regular prescriptions, disengagement from diabetes services
- Poor school/work performance/attendance
- Conflict at home around meals and eating/diabetes management

CASE STUDY 1

- 16 years old. Diagnosed with T1 when aged 11 years.
- Significant history of poorly controlled diabetes. Concerns have existed about poor attendance for diabetes monitoring. Concerns exist re: weight gain.
- Comorbidities present: anxiety, depression, self-injury and suicidal ideation. Open to core CAMHS.
- Eating concerns at time of referral: 2 month reported history of binge eating and vomiting on a daily basis, body image distress.

CASE STUDY 2

- 17 years old. Diagnosed with T1 when aged 9 years.
- Recent history of poorly controlled diabetes. Marked change in behaviour during clinic appointments. Recent concerns re: rapid weight loss, omitting insulin regularly, repeat recent hospital admissions re: DKA
- Comorbidities present: ASC.
- Eating concerns at time of referral: reports no appetite, restricted food intake, will not eat in front of others, argumentative and confrontational with family members who try to encourage food, body dysmorphia and fear of weight gain. Exercising daily and vomiting.

CASE STUDY 3

- 17 years old. Diagnosed with T1 when aged 11 years.
- History of poorly controlled diabetes and poor attendance at clinic. Marked fluctuations in weight.
- No comorbidities present.
- Eating concerns at time of referral: irregular food intake and small portion sizes at meal-times or replacement shakes, binge eating every evening.

CASE STUDY 4

- 13 years old. Diagnosed with T1 <1 yr.
- Significant history of poorly controlled diabetes. Concerns have existed about poor attendance for diabetes monitoring. Concerns exist re: weight fluctuations, erratic insulin regime, repeat hospital admissions re: DKA.
- Comorbidities present: social anxiety. Open to core CAMHS.
- Eating concerns at time of referral: poor appetite and eating small portions only, argumentative with family members who try to encourage more food, losing weight, worried about vomiting, no body image concerns.

CASE STUDY 5

- 15 years old. Diagnosed with T1 when aged 12 years.
- Significant history of poorly controlled diabetes. Concerns exist re: weight loss, not having insulin regularly and repeat hospital admissions re: DKA, concerns re: complications of diabetes (gastroparesis, neuropathies).
- Comorbidities present: depression. Open to core CAMHS, accessing CBT.
- Eating concerns at time of referral: poor appetite and eating small portions only, frequently missing meals, losing weight, no body image concerns.

Complexities & Dilemmas

- Communication pathways re: multi-agency working: 'shared-care' model to enhance continuity of care and the adoption of a unified response to treatment.
- Recognise the contradictions in how Diabetes and Eating Disorders are both managed: counting carbs and focus on numbers (units of insulin) versus challenging thoughts about food and proactive disengagement from numbers as a priority (weight, clothes sizes etc).
- There may need to be a degree of compromise and negotiation throughout treatment.

Food for Thought (Part 1)

- It was the same during the first few years I started to be seen at an adolescent eating disorder service… Subsequent appointments cantered on my intake, being weighed, my mood, using food diaries and being shown laminated growth charts and recommended portion sizes. They told me about nutrition and the effect of food on blood sugar levels, all the while pretending that my type 1 diabetes did not exist. They'd skim over the topic with maybe one question of how my control was going and assume that my diabetes clinic would be handling it. All this did was make me feel that my insulin manipulation was a tool I could keep safe.

***Claire – Beat / @diabeticswithed**

Food for Thought (Part 2)

- At the diabetic clinic they acknowledged I was being seen elsewhere for an eating disorder, but they made their own ideas up as to what this entailed. Before my issues came to light, I have on many occasions been scolded for high sugar readings and treated like a petulant child that was just being deviant for the sake of it. Or they would wrongly conclude that my erratic charts were linked to the eating disorder for the simple reason that I was not eating enough. Like the eating disorder service, instead of listening to me they just made their own assumptions. They'd tell me I needed to take x dose here and y dose there to improve, without any comprehension over the emotional impact changing my doses would have and of how my fear of extra insulin was a very real and distressing thing.

***Claire – Beat / @diabeticswithed**

Complexities & Dilemmas continued

- Who takes responsibility for weighing a Young Person?
- Who is responsible for arranging blood tests?
- Prescribing dilemmas re: eating disorders and specifically Bulimia Nervosa and Binge Eating Disorder
- Failure to attend appointments (DNAs / 'not brought'): safeguarding considerations.
- What about food diaries?

Further resources

- **Blogs on T1 diabetes and Eating Disorders:**
  - Diabulimia, the mental health equivalent of putting a hat on a hat – Lawrence Smith
  - Amybetic – Type 1 diabetes, mental health and the highs and lows inbetween – Amy Stevens
  - Drifting between services – BEAT / Diabetics With ED
  - Has type 1 diabetes affected your relationship with food? – Beyond Type 1
- **Podcasts**
  - The T1DE podcast is a series all about type 1 diabetes and disordered eating from the ComPASSION Project team.

Further resources

- **Videos on type 1 diabetes and eating disorders**
  - Wessex ComPASSION project (6min 3sec)
  - Recovering from Diabulimia – Diabetes UK (22min 58sec)
  - Supporting Someone with Diabulimia – Diabetes UK (5min 5sec)
  - Living with type 1 diabetes and an eating disorder - Ariella's story – YouTube – JDRF (5min 20sec)
  - Living with type 1 diabetes and an eating disorder - Lawrence's story – YouTube – JDRF (5min 4sec)

Further resources:

Contact us:

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Any questions?