

Discussing eating disorders and comorbid diabetes in practice

To understand the complexities of managing eating disorders comorbid with diabetes, the NEDC recently discussed the prevalence, management, treatment and education of this comorbidity with Nicole Walker, Senior Diabetes Dietitian at the Queensland Diabetes and Endocrine Centre (QDEC), Mater Health. On behalf of QDEC, Nicole answered the following questions.

1. What is your experience of eating disorder management when working with individuals living with diabetes?

I have worked as a Dietitian in large Diabetes centres for five years of my career. My Eating Disorders in Diabetes experience, in particular, is within my current role at Mater Hospital, within our large Young Adult cohort here. I have dual experience having also worked with Medical and Mental Health ward Inpatient Eating Disorders without diabetes. Working in this area is challenging and unique; it feels like guidelines for each disease alone contradict the goals of management for the other.

2. What is your understanding of the prevalence of this comorbidity and the most common age of onset?

The prevalence is not well defined, but research suggests anywhere between 20-40% of people with diabetes have some form of Disordered Eating Behaviour (DEB) which is more than the general population (1, 2). Prevalence of diagnosed full syndrome eating disorders is less common, and for Anorexia Nervosa type, there is no difference in the diabetes population compared with the general population (1). More common presentations include Binge Eating Disorders, Eating Disorders NOS and Bulimia Nervosa, especially when insulin omission is considered a compensatory behaviour (1). The most common age of onset is in mid-late adolescence, either soon after diagnosis of diabetes or at the onset of puberty (3).

3. How does the comorbidity of diabetes influence the management of eating disorders?

Insulin is the primary life-saving treatment for Type 1 diabetes (T1DM) and can be restricted or omitted to lose weight rapidly, providing a unique compensatory method for those struggling with body weight, shape or eating concerns (4). Between 4-58% of people with T1DM have omitted or restricted their insulin at times but not always for weight loss, and not all those with eating disorders use insulin omission to manipulate weight. Rates increase to 50-90% in the comorbid condition (4). Therefore, making it a complexity unique to this population but not as a guaranteed symptom of an eating disorder. This dysfunctional "relationship" with insulin is managed both psychologically and with support from the Diabetes care team to individualise or simplify the insulin regimen and educate further for self-management (5).

People with diabetes are more likely to be overweight, have a greater risk of anxiety, depression and poorer wellbeing, have dysregulated appetite hormones and satiety cues and need to have a greater focus on food to manage their diabetes than people without diabetes, all increasing their risk of DEB (1, 2).

Eating Disorders guidelines, as well established as they are, cannot be easily adapted to manage the unique co-morbidity with T1DM predominantly due to these patients requirement for insulin and ability to manipulate this for weight management. What is also difficult is gold standard management of diabetes completely contradicts the ideal management of eating disorders, such as weighing food and counting carbohydrates, recording food, exercise and blood glucose readings and monitoring weight regularly, perhaps encouraging unhelpful scrutiny on these aspects of life (1).

4. What does the care team look like?

Eating Disorder teams are often unfamiliar with and not equipped to manage T1DM, and Diabetes teams are often unfamiliar with and less experienced with managing Eating Disorders; each team can feel lost for how to manage these individuals with a dual diagnosis.

Research suggests the person should be managed by the Diabetes treating team predominantly but with support from their Eating Disorders team colleagues (5). The team may include an Endocrinologist, Diabetes Dietitian, Diabetes Nurse Educator, Psychologist, Psychiatrist, Social Worker, Occupational Therapist, Exercise Physiologist and others ideally an interest or experience in Disordered Eating Behaviours in T1DM (5). In the Eating Disorders arena, a specialist eating disorders team may provide support to the diabetes team and a treatment program depending on the stage of the Eating Disorder.

5. What do you see as barriers to management, treatment, education and support?

Barriers include a lack of sound treatment guidelines due to difficulties in conducting research in this population. It is hard to define what DEB looks like in diabetes and measure the prevalence (1, 2). Each individual with this comorbid condition presents uniquely. Therefore, it is difficult to standardise screening and treatment recommendations, and there is no consensus on the screening tool that is most appropriate for use (1, 6). As Anorexia Nervosa is the least common presentation, it is important to consider DEB at any weight, shape, gender and also in all types of diabetes. For example, males with T2DM are more likely to have DEB than their non-diabetic counterparts (2). Screening and recognition are difficult to standardise to screen for this type of patient. For example, the slim young female that is slowly losing weight, compared with the stable, but overweight female, binge eating and omitting insulin to compensate. Additionally, diabetes teams often work very separate from eating disorders teams, meaning there can be barriers to a joint approach for management.

6. How could we improve this?

By using diabetes-specific Eating Disorder screening tools and ensuring all diabetes and eating disorders treatment teams are aware of the prevalence, signs and risks. Educating the wider community from GPs and people with diabetes, to the pump or Continuous Glucose Monitoring (CGM) reps who provide photos of bodies with CGMs inserted, and potentially a conversation about the bodies into which they assist with inserting these devices. Encouraging early detection and intervention is important to prevent full spectrum eating disorders and the development of guidelines for both diabetes and eating disorders teams on the management of people with T1DM and disordered eating (2).

7. What do you see as important for consideration in best practice treatment and management?

Disturbed eating behaviour in diabetes is common due to a focus on food and counting carbs as gold standard nutritional management (1,) along with the ability to manipulate insulin for weight loss (4).

We must raise community and patient awareness, health care professionals knowledge and do our best to conduct sound research to inform guidelines in this area, to ensure we are not increasing risks as a result of the current methods of diabetes care. At diagnosis, there is an increased risk due to weight loss with initial presentation and subsequently regaining weight with commencement of insulin therapy. Therefore, treating teams should take particular care with education and insulin titration at this time (1). An evidence-based diabetes lifestyle management course such as DAFNE (Dose Adjustment For Normal Eating) is beneficial after one year of diabetes diagnosis for learning self-management principles and developing the knowledge and confidence to self adjust insulin, manage food and exercise, and the risks and management of sick days or ketones (5).

Sound communication within the treating diabetes team and collaboration with other teams involved makes up the foundation for managing these individuals (6). Standardised guidelines would be useful, but as comorbid diabetes and disordered eating patients can be unique in presentation, each individual may need to be treated on a case by case basis depending on the disordered behaviours used (6). If appropriate, the patient might play an important role in the team, setting their own goals and agenda for which the treating teams can support them in achieving patient-centred care.

8. Are there specialist services available that are adapted to support people living with diabetes and disordered eating?

At the Queensland Diabetes and Endocrine Centre at Mater Hospital in Brisbane, we are forming a working party in collaboration with other services. Currently, there is no specialist dual service that I am aware of.

9. As a caregiver, how would you support someone living with diabetes and a comorbid eating disorder?

Being non-judgemental, present for mealtimes and providing a positive and enjoyable environment around food (6). Avoid speaking about body shape, weight or eating habits and dieting behaviours of your own or the person with diabetes. Encourage healthy, well-balanced meals, regular exercise and support the person with their diabetes self-management. Recognise diabetes for the unrelenting and complex disease it is and be understanding of those who live with it and recognise the signs and symptoms of Diabetic Ketoacidosis (6). If you are concerned about someone it is important to ask in a non-judgemental way what might be going on for them and voicing your concern as a caring person in their life maintaining a respectful trusting relationship (6). It is better to voice your concerns than not speak up at all as it is unlikely to encourage a behaviour that wasn't there before but more likely, provide an opportunity for the person to speak about their troubles (2). Encourage the person to speak with and work with their diabetes team and support the person to attend appointments.

10. What resources are available for health professionals working with individuals living with diabetes and disordered eating behaviours?

The NDSS has a great Diabetes and Emotional Health toolkit, which includes information on supporting those with disordered eating behaviour and diabetes. This toolkit includes a process for identifying, referring on and managing patients and an information sheet for the patient or carer (2). The National Institute of Clinical Excellence in the United Kingdom released an update to the NICE guidelines which summarises recommendations for care (5). I am not familiar with all resources, and I am sure there are others out there!

Other non-diabetes specific resources include; The Butterfly Foundation, The Centre for Clinical Interventions and of course, the National Eating Disorders Collaboration. I would encourage health

care professionals working in one of these specialties to upskill in the other as you will likely come across this comorbid condition in your caseload at some point.

References

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