OVERVIEW OF EATING DISORDERS WITH TYPE 1 DIABETES

- An eating disorder is a brain based disorder characterized by abnormal food and nutrition related behaviors. Types of eating disorders.
  - Anorexia – restricting nutrition, often to avoid taking insulin, resulting in very low body weight.
  - Bulimia – recurrent episodes of binge eating followed by compensatory behavior including insulin omission.
  - Purging Disorder (diagnosed under OSFED) - normal eating patterns with recurrent compensatory behavior including insulin omission.
  - Orthorexia – obsession with eating healthy or pure foods leading to extreme restriction of certain foods, e.g. carbohydrates, leading to malnutrition.

- There are complex biopsychosocial factors contributing to an eating disorder.
  - Biology - genetics, neurochemical imbalance, irregular functional MRI.
  - Psychology – depression, anxiety, low self-esteem, lack of control, perfectionism, anger at diabetes, co-morbid mental health disorders.
  - Social – trauma, social pressure, troubled relationships, media.

- People with insulin dependent diabetes constitute a high risk population.
  - Puberty is peak diagnosis time for both T1D and ED.
  - Weight restoration post diagnosis equates to “insulin makes me fat.”
  - Diabetes management triggers a biological predisposition.

- What triggers the eating disorder may not be the same thing that maintains the eating disorder. For example,
  - Begins with body image issues then becomes a coping mechanism.
  - Begins with diabetes burn out then becomes about weight maintenance.

- Insulin omission is different than other forms of purging such as vomiting, taking laxatives or excessive exercising.
  - Omission is passive, the person simply does nothing.
  - To not test, inject or bolus makes a person more “normal”.

- As a person works to recover from their eating disorder, they must contend with this chronic illness that will persist post recovery.

- Insulin reintroduction requires close communication between the eating disorder therapist and endocrinologist to ensure it’s done at a safe and appropriate rate.
  - Begin with minimum amount of insulin necessary to prevent diabetic ketoacidosis.
  - Blood glucose goals and testing should be realistic.
  - Anticipate common side effects; gradual lowering of A1c reduces these risks