

## **Navigating Eating Disorders in your Patients with Type 2 Diabetes**

**Tuesday, March 28, 2023**

la-shell\_johnson@med.unc.edu: Good afternoon, everyone. Welcome to today's webinar, entitled "Navigating Eating Disorders in Patients with Type 2 Diabetes." A few things to note, participants will be muted upon entry and videos turned off. For technical assistance, please use the chat feature located at the bottom of the box. You will also receive an email approximately one month from today, requesting feedback and impact on today's presentation.

la-shell\_johnson@med.unc.edu: After today's presentation, we ask that you visit our training center located at [www.nceedus.org/training](http://www.nceedus.org/training) to view other training opportunities offered by NCEED.

la-shell\_johnson@med.unc.edu: I will now go ahead and introduce today's speaker.

la-shell\_johnson@med.unc.edu: Today's speaker is Dr. Rachel Goode, an Assistant Professor at the School of Social work at the University of North Carolina, at Chapel Hill.

la-shell\_johnson@med.unc.edu: Dr. Goode received her PhD, MPH, and MSW, from the University of Pittsburgh.

la-shell\_johnson@med.unc.edu: Her research focuses on a development, implementation and evaluation of interventions at the intersection of disordered eating and chronic health conditions.

la-shell\_johnson@med.unc.edu: Dr. Goode is also a licensed clinical social worker, and has practice experience with the treatment of eating disorders among clients in university counseling centers and community-based mental health agencies.

la-shell\_johnson@med.unc.edu: Currently, Dr. Goode is the principal investigator of an American Diabetes Association grant, to understand the factors related to binge eating and to improve appetite self-regulation in Black adults with type 2 diabetes.

la-shell\_johnson@med.unc.edu: I also would like to let people know that a recording of this webinar will be available within 2 weeks from today on the NCEED Training Center. Slides will be sent out along with our evaluation, immediately following the webinar.

la-shell\_johnson@med.unc.edu: We will have all unanswered questions sent via email within one week from today by Dr. Goode. We will also have a Q&A segment at the end of this webinar to address any questions posted today. I will now turn things over to Dr. Rachel Goode.

Rachel Goode: Thank you, La-Shell. I am so grateful to be with you all today. I'm really looking forward to just sharing what we know about eating disorders and type 2 diabetes, and I am hopeful that you all will leave today with more knowledge, more confidence, to be able to help our patients who are managing this intersection better. So today we are going to go through a couple of different things. One we're going to just review the definition and types of eating disorders. We're going to explore eating disorders in the context of type 2 diabetes. We're going to examine health outcomes for patients with type 2 diabetes and eating disorders. And then we're going to end with some considerations. We're going to do a case study for working with patients who have type 2 diabetes and an eating disorder.

Rachel Goode: So just to overview, anorexia nervosa, bulimia nervosa, and binge-eating disorder, they are probably the most common eating disorders in the United States. However, when you look at these numbers, don't get scared, because what they represent is that we do not effectively know enough about who has eating disorders. Where there are a lot of stereotypes about who has most commonly had an eating disorder. And often the stereotypes, you know we think of adolescent White women, cisgender women. But we know that anyone can have an eating disorder, and they can affect anyone as we've been hearing more in the media about more individuals coming forward, feeling brave enough to come forward about their struggles with eating. I think it's helping to normalize that we all could be in this situation.

Rachel Goode: And so what particular to what we're doing today? We think about anorexia nervosa, right? That is an eating disorder that has more restriction, right, and patients often have an intense fear of gaining weight. With bulimia nervosa and binge-eating disorder, they share commonalities in that individuals will have binge eating episodes. But the difference is bulimia nervosa is that individuals will also engage in episodes of purging, whether they use the laxatives, whether it's vomiting to get rid of the food, excessive exercise. It can be done in a number of different ways.

Rachel Goode: We also have avoidant restrictive food intake disorder where people have an intense fear of certain food groups, and they might, you know, kind of stray away from eating certain things. And then we have this other category which we're learning more about other things that might fall in to that. Maybe aren't defined, but they still would consist of disordered eating behaviors. So as I show the slide, I you know, as I think, about the landscape, what we know about the intersection of type 2 diabetes and eating disorders.

Rachel Goode: I think what we know is, we know its present. But there's still a lot that we need to learn from those who are experiencing this, the reality of those who are navigating this. And so today, as I go through, I just want to present to you I'm trying to do a good overview of the literature what we know.

Rachel Goode: And just to kind of help you all feel a bit more confident. And so, when I think about this slide, you know. One thing I want to highlight is this is DSM IV diagnosis. But in those who struggle with type 2 diabetes you see binge eating disorder is the most common, the largest, most prevalent eating disorder. Then comes bulimia nervosa, and eating disorder not otherwise specified, so that, that, might look slightly different. But that's still tracking. I think the study was done in the late nineties, but we still see that pattern.

Rachel Goode: And so, when I think about this was a graphic from the American Diabetes Association. They have a mental health workbook, and so this, I thought, presented a great visual. When we think about how common our eating concerns in patients with diabetes. So we look at type 1 diabetes we see, now, you see the top, I will sort of orient you to this, so DSM V diagnosed eating disorder, and then the bottom are disordered eating behaviors, and so that would fall everything else that wouldn't meet DSM V criteria.

Rachel Goode: And so, you see, when it comes to type 2 diabetes, you know about one out of every 10 patients might have a diagnosed eating disorder, but one out of every 4 patients might have disordered eating behavior. So, almost a quarter of all patients. And so, it's actually more common than we would believe. And then, if you look at type 1 diabetes, you see, it's a little bit higher and so these are the most common disorder eating behaviors with type 2 diabetes.

Rachel Goode: One will be binge eating and then compensatory weight control behaviors. As many of you probably already know, when a patient gets a type 2 diabetes diagnosis, they also receive encouragement to try to lose weight. And so, because we, what the research has shown is that weight loss can help participants help improve glycemic control. So that is a very common recommendation, and it's something that patients are commonly, you know, hearing a lot about when they have type 2 diabetes or if they have pre diabetes. You know weight loss is something that is kind of ever before us. And so, when patients are trying to engage in these weight control behaviors. What they may be at risk of is engaging in behaviors where they are, you know, kind of maybe cycling in between dieting and binge eating behaviors to try to manage the weight. And so, we'll talk a little bit more about that.

Rachel Goode: There's also night eating syndrome. And so this is a time where again, this is not a DSM V diagnosed disorder, but this is an eating behavior. I think, when patients just have sounds they might eat a large amount of calories in the evening hours. And so these all really impact glycemic control.

Rachel Goode: There's also other emotional eating behaviors that are related, such as emotional eating, or external or restrained eating; whether you're being prompted by external eating queues, and very susceptible, which I think many are in our country or restrained eating where you are kind of having operating from a frame of restriction. Which again, that can also be challenging when people get their type 2 diabetes diagnosis.

Rachel Goode: So, I wanted to provide a definition of binge eating, since we're going to be referring to it quite often throughout our presentation.

Rachel Goode: So binge eating, is eating in a discreet period of time within any 2 hour period and amount of food that is larger than most people would eat in a similar period of time.

Rachel Goode: But it also comes with this lack of control. So individuals often feel that they aren't able to stop eating, even though they would like to. So I often give the example of like a snowball, and as it's rolling down the hill.

Rachel Goode: People see it rolling, but it kind of takes on a life of its own. And so, sometimes that's how patients have said they felt when they are in the midst of a binge eating episode, kind of just out of control.

Rachel Goode: And so, if a patient is going to get a diagnosis for binge eating disorder, you see some of the criteria. So they have to have, you know, weekly binge eating episodes, for I think about 3 months that the weekly binge eating episodes. The binge eating has to be associated with 3 or more of the following, eating more rapidly than normal, eating until feeling comfortable- uncomfortably full, eating large amount of food when not feeling physically hungry, eating alone because of being embarrassed by how much one is eating, and feeling disgusted with oneself, depressed or very guilty after overeating.

Rachel Goode: Another key marker, is this this marked distress. Right patients are not usually this. They're not happy about this. This is very upsetting to them, and, but there are no compensatory behaviors right? No purging, no excessive exercise. And so you can imagine, when individuals are engaging in recurrent binge eating episodes that some of the consequences might be rapid weight gain, and difficulty managing glycemic control.

Rachel Goode: So what we see there's a lot of different ideas about prevalence, but 8 to 20% of patients with type 2 diabetes might struggle with disordered eating. And so that when I think about the graphic I showed earlier with the 1 in 10, you know, this is just we're trying to pull all the data pieces together. So you might say we said this differently. We're trying to pull everything together to get an idea.

Rachel Goode: And so, as I said, **20 binge eating** disorder is the most common eating disorder in this population.

Rachel Goode: And so, I want to go through some of the research right. Some of the studies that have helped us learn and think about what how type 2 diabetes is, how people are navigating binge eating in the context of type 2 diabetes. This was a study that was in a multi-ethnic population. They had type 2 diabetes and it was in a sample of a 140 patients. So the sample is about 37%, Hispanic 40%, Non-Hispanic White, and 19% Black American. And so, patients were administered the Questionnaire on Eating and Weight Patterns, which is a common questionnaire. Often by research to assess binge eating and other eating behaviors, the Binge Eating Scale, another binge eating measure, and the Beck Depression Inventory.

Rachel Goode: And so, what they notice is that 40% of the sample had disordered eating. So again, I've given you several different numbers now of prevalence, when it comes to disorder eating. And so I think what we can probably say is about 25% to 40% of patients with type 2 diabetes have disordered eating behaviors.

Rachel Goode: What we notice, though some demographic characteristics that were associated with this binge eating, 1) patients were younger, right; they had a greater BMI. They had higher A1C values, and they had higher diastolic blood pressure values.

Rachel Goode: We also noted that when patients were younger and they had African American ethnicity, it was associated with increased odds, like 6 times the odds, for disordered eating behaviors.

Rachel Goode: So this was another study. This was done in black women who were living with tattoo diabetes, and the researchers just wanted to kind of understand some of the experiences with their eating behaviors and they were wanting to know specifically about the role of intuitive eating practices. And if you're not familiar with intuitive eating, it's when individuals are relearning and kind of learn to adhere to their signals of hunger or biological signals of hunger and fullness. There is, you know, less restriction on what they're eating, but more just helping patients kind of be mindful, and enjoy their experiences with food. And so what the women, though when they were there was they were given a semi-structured interview so 60 to 90 min interviews, and they reported that they experience lack of control around food. So, that might sound like some risk for binge eating, regular eating in the absence of hunger they reported that fullness for them felt like sick right? So that indicates, they would probably maybe going over their body, you know threshold of feeling full, and they felt stigma and shame, diabetes related stigma and shame.

Rachel Goode: And so what we know about the health risk for these patients is that each binge

is just in and contributes and really plays a part in insulin sensitivity. And so what we notice is that when patients have increased binge eating episodes, it is often associated with poor glucose control.

Rachel Goode: However, we have seen as a literature mix, because we have seen that there may not be a significant a huge difference between HbA1c levels between those who binge and those who do not. But we noticed that the risk and some of the challenges might be in conjunction with age and BMI.

Rachel Goode: And so one thing, I think, is important to think about what came first. Right? Was it the eating disorder, or was it the type 2 diabetes? And so this study, I thought, gave us a good example. So this was in a sample of adults with type 1 and type 2 diabetes. And so, I want to show you here on the graph.

Rachel Goode: So right here, this is the diagnosis of diabetes. Okay, so 1-5 years earlier, 6-10 years earlier, more than 10 years earlier. And so, what we see here is with the darkest line is type 2 diabetes patients, 57% of these patients in this study reported being diagnosed with their eating disorder more than 10 years before their diagnosis of diabetes. And we see that again, when it comes to type 2 diabetes, 6-10 years, 1-5 years, but more, more of them were diagnosed with the eating disorder before the onset of type 2 diabetes.

Rachel Goode: So that has led us to think that we're wondering if this might be the order. So individuals were engaging in binge eating behaviors which might have led to overweight and obesity. And so then that led to their type 2 diabetes, and then might have come some of their increased challenges with impaired glycemic control.

Rachel Goode: Also, what we recognize is that when you think about I think the factors like, why, right. Why are, what are we seeing in these relationships? Why are we seeing this? And so, when patients get a diagnosis for type 2 diabetes, we have heard them say that they are hearing the guidance as messages about good and bad foods, right? And so participants are really maybe being oriented, maybe for the first time, to recognize in these foods positively impact my blood sugar. These foods do not. And so I, I know our clinicians aren't always telling them these are good and bad foods. But that is maybe how, that what people are hearing and what some are receiving. And so, that can lead to guilt and shame around their food choices. Okay. And so what we've seen in our science is that when people are feeling shame and guilt, then it can precede binge eating, because what can happen is that individuals might just like with dieting right. Individuals are going to try to, you know meet the norm by meeting the standard. But there's, they are gonna probably engage in, maybe restrictive eating practices, because there's good food and bad food. And so, that creates a frame where it kind of makes you feel like you have to just kind of stay on one side.

Rachel Goode: and we know the body does not operate like that, and so that can often lead to individuals having a boomerang effect, and that they can then engage in binge eating, and then people feel guilty, and then they come back. Also, individuals might just distrust their bodies right in their cues.

Rachel Goode: They are learning now that they have to think about less about maybe what they're enjoying, and what food naturally tastes good to them, to those that may more positively impact their blood sugar. And so these experiences can cause patients to maybe turn off listening to themselves and maybe prioritize you know, kind of the outward knowledge and wisdom, which can sometimes be problematic because our bodies are vital, play a vital role in teaming with us to help keep us healthy, and so, without being able to adhere to our queues it can make it challenging for patients to, you know, pay attention to their signals of fullness, feelings of hunger.

Rachel Goode: And it might help them engage in more experiences of restrictive eating behaviors.

Rachel Goode: As I also said, participants might feel pressure to lose weight, right, and so that can lead to dieting, which we have a good literature that lets us know that can also increase the risk of binge eating.

Rachel Goode: So this is just an example of the binge. What we know about the binge and restriction cycle, and so usually when I show this graphic I'm not talking about the context of type 2 diabetes. But I want you to imagine what it might be like for a patient who gets this diagnosis. So over here in the pink, right, they are going to diet and restrict, so maybe they're not dieting and restricting to lose weight, but they are now restricting because they feel like they can't eat certain foods.

Rachel Goode: And so they're trying to follow the plan right. They want to be good. Maybe, you know, ascribing some morality to their behaviors.

Rachel Goode: They also might, you know, just try to just have these actions, these physical actions. You know where they just. They may not always get it right, right? Because we don't as humans. We don't always get it right, and so they might find themselves in places right where they, you know they just can't do it anymore.

Rachel Goode: And so this might lead them to have a binge eating episode. Maybe they go to a cook out, and they have food there that is not quite approved on the plan, right? It does not follow exactly what they were supposed to, you know, might, might, be best for managing their blood sugar. And so patients often then, will engage in their experiences, and they might kind of overdo it, and they might have a binge eating episode often. Often because again, that restriction has been there.

Rachel Goode: And so afterwards that guilt sets in right. People have that fear of gaining weight. Fear it might not maybe be weight gain, but fear their blood sugar values are going to be increased, and they might test their blood sugar and see how high it is. And so then the next step right, they will get into control.

Rachel Goode: So they're gonna kind of swing back on the other side, and they might engage in some more restrictive eating behaviors or try to get back on track with their you know the preferred plan for managing their type 2 diabetes. And, as you see, the cycle just continues, and it and we and I think, as we see with the numbers, you know again, 25 to 40% of our patients are managing this disorder eating. So this just lets us know that more than we think might be engaging in this cycle on a regular basis.

Rachel Goode: So when we think about outcomes right, what do we know about what happens when type 2 diabetes patients have disorder eating behaviors. And so what we see again, that binge eating disorder often it is kind of there first.

Rachel Goode: And so, I don't think we always think about that, but that is usually there first, and then, when patients have binge eating disorder, they have higher rates of acquiring a diabetes diagnosis later in life. In fact, what we've seen is that in about a third of patients with eating disorder diagnoses had developed type 2 diabetes after 16 years of ED treatment and then we saw that in a sample of patients with binge eating disorder, about 12% of those were younger patients who had previous histories of type 2 diabetes, higher weights of BMI, and had higher depressive symptoms. We also see that it's associated with poor quality of life and it, stress, can also exacerbate the relationship, I think, between glycemic control when disordered eating behaviors increase.

Rachel Goode: We see that, however, when patients are engaged in treatment for these symptoms, we can have improved self-care. And, it can help patients kind of understand, and partner with clinicians when they are receiving help for these conditions come conjointly.

Rachel Goode: So now, I want to talk about just some screening tools. Right? So let's say you are treating patients with either type 2 diabetes, or you might be treating patients with binge eating. And so how do we help? How do we identify these behaviors in our patients?

Rachel Goode: I know everyone, does not feel, you know, confident in their ability to identify these behaviors. And so, that's why we have some good screening tools that can take the hardest part out for you.

Rachel Goode: And so, what we think is that in order to identify eating disorders and type 2 diabetes.



Rachel Goode: What they have in common is that there's a screening at, you know their HbA1c fasting glucose, and so same thing with identifying eating disorders right in extensive. So we have brief screenings, and then our extensive screenings are longer interviews that are often used to kind of help us understand a patient's eating disorder behaviors.

Rachel Goode: And so the challenge, though, is that you see these numbers fewer than 50% of persons with binge eating disorder, receive treatment. Now, that should be just like alarming right? Because, and I can think of a number of reasons.

Rachel Goode: One, I think a lot of physicians don't really feel confident about being able to diagnose and treat binge eating disorder. Patients may not understand or even know that it's an eating disorder, and so they may not be able to talk about these behaviors with concern, or be able to let people know that they're struggling.

Rachel Goode: As we see, you know, with binge eating disorder, and their limited medical recognition, you know. Less than 50% report using DSM V criteria to diagnose binge eating disorder. Twenty-seven percent, do not recognize binge eating disorder as a discrete eating disorder, and then greater than 40%, never assess binge eating. So along with our patients, might feel guilty and judged. And so that just leads me to recognize we have more work to do, right. We have more work to do to help our patients be able to talk more freely about whatever concern they're having with their eating behaviors, and to help our primary care physicians feel confident, and feel like they are able to assess and give, and put patients in the right direction to get the help that they need.

Rachel Goode: So this is the Binge Eating Disorder Screener-7. So just look, it has 7 questions. So you also feel encouraged, 7 questions. And so, as we see here, you know, patients are able to fill this out, maybe before the appointment before the session. And, so they can indicate right during the last 3 months, did you have any episodes of excessive overeating? And so then they can see if there's any distress present, and then they can often, you know, use a Likert-like scale to you know assess whether they have loss of control. If they, you know, continue eating when they were hungry, you know, were they embarrassed? Did they feel disgusted with themselves? And did they have any purging behaviors? Okay. And so, then, if the patient answers **yes, right to questions, one or what question one?** Then you continue to questions 2 through 7.

Rachel Goode: Okay. And so if the patient answers yes to question 2 and checks one of the shaded boxes. Okay, so this is not, but these are shaded. They check their boxes. This lets you know that you know you might want to give the patient some additional support to manage their eating disorders, and they might warrant a full diagnostic screening, a DSM V diagnostic screening for binge eating disorder.

Rachel Goode: So another is the SCOFF tool. Okay? And so you see, this is just a few questions, and they're bolded to represent the SCOFF. So do you make yourself sick because you feel uncomfortably full, do you worry you have lost control over how much you eat? Have you recently lost more than one stone, about 15 pounds in a 3 month period? F. Do you believe yourself to be fat when others say you were too thin? And then the other F. Would you say, food dominates your life?

Rachel Goode: Now, one thing I want to make you all aware of is that we just, NCEED, just went through a process where they developed their own screening. So that was based on the SCOFF. And so this is something that you can access right here on the website. It's free and it will give you that, you know very similar. Again, it was based on the SCOFF. And this is a screening tool that you can use, that the center developed to help you, you know, have some more confidence and begin to screen, and it'll give you advice and guidance, depending on how the patient answers.

Rachel Goode: So now I just wanted to spend a little bit of time helping us hear from those who actually have this experience, right? And so my team, we have been doing some research with Black adults who have type 2 diabetes, and we have been doing some interviews with them. And so, and with some providers of diabetes, self-management, education and we have been just, again positioning ourselves to hear what it is like as they're managing this, and what are some of the factors.

Rachel Goode: And I think it's important, you know, as clinicians, as those that serve this population. Often you know we are, we may be doing a lot of the talking, and so we may not get the opportunity to hear as much from patients about, you know just some of what they're managing as they're navigating their eating behaviors.

Rachel Goode: And so in this study, right now we have 14 participants. So we this is hot off the presses, and so we see here. Our participants, on average about 57 years of age. Our participants you know, represent a range of education, but I'd say the about 50% of our sample has at least a master's level of education, and then about 50%. It's. It's kind of interspersed between bachelor's degree, or some college.

Rachel Goode: And then our participants, on average, have been diagnosed about 3 a little over 3 years. They've been diagnosed with type 2 diabetes, and they report at least 2 out of control binge eating episodes in the past month.

Rachel Goode: And so these are just some of the themes that came up, and I'm going to go over them in detail but one type 2 diabetes diagnosis you know, kind of just enhance the perception of restriction. Okay, and so that should already be, you know, making you remember our previous slides about that binge eating restriction path? And then there's some barriers economic barriers to binge eating

treatment. Participants are engaging in eating to manage positive and negative emotions, and they have some coping strategies that they have been using to manage binge eating and type 2 diabetes.

Rachel Goode: And so what we see right that perception of restriction. Participants are working hard right to log their food, to monitor their glucose, and they feel like they have to restrict their carbs and sugar intake. And so what we have noticed that while we know that patients with type 2 diabetes have to have a different relationship with carbohydrates, it seems that when they feel it, they have to restrict that might plant a seed that could lead. And you know, kind of create a pathway that could lead to some later binge eating behaviors.

Rachel Goode: We also see that it's hard, right. Participants are experiencing multiple barriers that get in the way of them, receiving and engage in a treatment to manage their binge eating and their type 2 diabetes financially. That was probably one of the largest barriers that we heard. And so you can imagine, if you are already having financial challenges and getting treatment for your type 2 diabetes, then probably, you know, you're really not going to be able to think about getting treatment for your binge eating.

Rachel Goode: And also, just feeling the need for culturally relevant treatment and not feeling like their voices are, you know it's not really for them, and see that it's maybe catered more towards White clients.

Rachel Goode: We also see a great deal of emotional eating, right. Participants are noting that they are eating to manage positive and negative emotion and binge eating might be a result of a response to either one of those.

Rachel Goode: But they are feeling that shame and guilt that we talked about earlier surrounding their eating decisions. Right feeling like this is not what I'm supposed to be doing, and so patients, to cope, they report using exercise, prayer, you know they really have found benefit from support groups of others who are also managing type 2 diabetes, and they would want therapy, but still feel stigma, right. They still feel like it's, you know that they don't feel confident and comfortable, disclosing that, and going to get the help that they need.

Rachel Goode: And so, this is what a patient said to us. "I have anxiety and depression, and they go up and down. So as I go down, I'm going to eat those till those things go up. Yeah, it just helps me feel good temporarily, then there's the guilt, um, and then I'm back on track again."

Rachel Goode: So this just maps on to exactly what we've heard, and what we've seen in the research.

Rachel Goode: Another patient said, "I'm really scared to eat anything now. Yeah, because I know what's going to happen afterwards and I lose control. You know my sugars will get all whacked out and stuff, and then all day I'm trying to get it under control, and when I get it under control I'm just tired. It's like a job."

Rachel Goode: And so in both of these quotes, what you hear is a weariness, right? Participants are they're thinking, I mean, the type 2 diabetes is a full time job, right? They are focused. They're trying to manage their blood sugar. They're feeling anxiety. They're dealing with restriction. They're managing stress. And so these are things that are kind of centering and, and really impacting their reality.

Rachel Goode: And you know, making it challenging for them to navigate their eating behaviors. So now we're going to talk about. What do we do? Right? What is some guidance? What have we learned about how we can help these patients? I know some of you are going to be primary care physicians. Some of you might be mental health clinicians, you know, just wanting to learn more and so hopefully give everybody a little something that they can use in order to better help these patients navigate this.

Rachel Goode: And so, this was a study where they engaged with patients who had binge eating disorder and type 2 diabetes. And one thing that came out was that patients really wanted these things to be treated together, right. Knowing that their experience, you've been eating wasn't a separate thing to their type 2 diabetes, and often it was siloed, you know. And people were going over here and over there, but wanting it to be in one place. And so, really wanting their primary care physician right to continue to engage in diabetes and binge eating disorder continuing education, to create a person-centered approach, and to have non-judgmental and emotional understanding. You can imagine how embarrassing it is for these patients to talk about their eating behaviors, right? It's already, you know, you see, you know they're probably looking at maybe the A1C or the glucose monitor, and wondering about why some of these values might look the way they do.

Rachel Goode: And so patients again, they're feeling shame, right. And so for those who, you know, might feel confident, it's comfortable to come. But we know some of our patients, probably aren't coming right. If they're experiencing the most severe binge eating, then they might feel so much shame that might keep them from getting the help that they need.

Rachel Goode: And so, we see also that it's helpful to have a multidisciplinary treatment team right? So we have everybody in the same place. Those who again are just part of the team, so that the care can be centered as well as helping individuals with development of coping strategies, right to manage some of the situations that might precede their binge eating episodes.

Rachel Goode: And also help our patients to improve their self-care right, to better, maybe understand some of their thought patterns.

Rachel Goode: I know, often cognitive behavioral therapy has been cited to help participants understand that relationship between their thoughts, their behaviors, and their emotions right, and to be able to help deal with some of the cognition that might also proceed a binge eating episode.

Rachel Goode: And so this is a model that I think, I think, it might map on the best for primary care physicians.

Rachel Goode: And so, we're going to go through it, right. To give you all, walk you all through just what it, what you know kind of your intervention might be like, as you just see here, right. This is these are the 7a's the 7 a's model. Okay. So we're gonna first be aware, right? That people with diabetes may experience eating problems.

Rachel Goode: We're going to ask. We're going to ask about eating problems which I know it seems simple, but it's not. There's a lot of stigma around weight, and I know sometimes I think providers feel like they are walking on eggshells around this issue. And so, thinking about asking about eating behaviors might be even more challenging.

Rachel Goode: So, we're going to ask, though we're going to ask them about eating problems. We're going to assess for eating problems and then based on what we learn, we're going to either provide some guidance. We might make an assignment to another health professional. We might assist with developing a plan, and we might arrange for follow up care.

Rachel Goode: So we're thinking about right, our first a - okay being aware. One thing we might need to remember is, there's certain risk factors that might be present with these patients. Again, that belief about food being good or bad. I know you all hear this a lot in your practices, right? These ideas that patients just hear. It, it may not be being said. Sometimes it is being said, but they're hearing and receiving the guidance as beliefs about foods being good or bad.

Rachel Goode: And so, that can create stress and a dichotomy that sets patients up to. Then, when they're, you know, kind of be in a situation where they can have some more disordered eating behaviors.

Rachel Goode: Patients might be pre-occupied with their body size. Again, hearing guidance that if you're losing weight, this could help you improve your diabetes. That might put a lot of anxiety and pressure on patients to engage in like a weight loss effort, right?

Rachel Goode: Patients might not be able to explain to you recent weight loss, or gain. That can be an indicator. You know that something you know it's sort of eating behavior might be present, and you're looking at what's going on with the diabetes self-management, right.

Rachel Goode: Are they, how are they monitoring their glucose? Is it less frequent? Are they not monitoring their glucose and their outcomes, you know, looking at their A1C values? Are they unexplained? Are they high? These might be things that might cause you to be aware that there may be some disordered eating behaviors that you need to learn more about.

Rachel Goode: So now we're going to go to the ask part of the model. So when we, you know, want to assess these are some ways right. You can say it. I know sometimes.

Rachel Goode: How do I say it right? How do I make these? What do I say? And so these are some examples. You can use these exactly, if it might be helpful for you, so option one. You can ask them open ended questions, right. Individuals with diabetes are often concerned about their weight or shape.

Rachel Goode: How do you feel about their weight or shape? You know one thing I like about that question is that, you know, makes it general first, and normalizes that this is a concern that many individuals might have who are managing a diabetes diagnosis. So it already makes, takes a shame out of it for the patient, because then they can say, oh, yeah, me too. I'm dealing with this, too.

Rachel Goode: Or another way people sometimes feel that food and eating are a difficult part of managing diabetes. Do you find it hard to control what and how much you eat? Can you tell me a little bit more about it? How often does it occur?

Rachel Goode: Again, you're making it general and normalizing the behavior. And then you are going into asking your question about their experiences with their eating behaviors, okay? And so, if you're going to go a little deeper, right, you want to understand any changes in your eating patterns.

Rachel Goode: Anything in your life that might be reasons for your changes in eating patterns, and then you might directly just talk about you know I've noticed that your A1C has been going up over the last

several months, and you've mentioned that you have gained or lost weight. You know, how do you feel about this? Can you share what you think may be affecting this. And so, one thing I note in this is you know the patient you've mentioned that you've gained or lost weight, right? I'm taking the patient's words often that can be an easier way to have the discussion versus we may be assuming, you know, or putting our words on it, because it can maybe cause patients to maybe dismiss what we're saying. But to maybe start with what they've shared first, and use that as a gateway.

Rachel Goode: Then another way. So option one, are the questions, okay, option 2 is to just give them a questionnaire, you know. And so, this is the SCOFF. Remember, we looked at the SCOFF a couple of slides ago. But this is kind of one that's used for diabetes, and so it's that. You see they can check it off very quickly the questions that were similar. And so, and they answer yes to one or more questions.

Rachel Goode: Further assessment is needed. So this is so short. It could be something that patients are doing in the waiting room before they come to see you. It's something that can easily be added on to a treatment protocol, and it is a very unobtrusive way to, I think, learn about some of these eating behaviors, and it might often be a way for you to start the conversation, and then you can maybe go back to some of the open ended questions.

Rachel Goode: So then you think about your part right. You have to provide some guidance. And so you see, acknowledging and eliciting feedback. So an example: "from what you've told me, it sounds like you were having some concerns about [your eating habits, your weight, your body image, insulin use]. These concerns are not uncommon in people with diabetes. And so, if you are okay with this, perhaps we could talk a bit more about what is going on and see what is needed to reduce your concerns.

Rachel Goode: Another way to go about this is, "you know, okay, after listening to you, seeing your lab results, I wonder if you might be struggling with disordered eating, or even an eating disorder." Now, even as I tell you all that you know, those words can, due to stigma in our culture around who has an eating disorder, who has disorder eating those words, depending on who you're talking to. If they don't have a lot of familiarity, you know, this individual might identify, as you know a non-majority racial ethnic minority, you know, they may not be as comfortable with the word eating disorder, because this is not something that again, we don't think anyone culturally. We still think this is a White, predominantly White issue. And so, you just have to be mindful that you might have to think of it in a different way right to think about. Are you? Do you struggle with maybe loss of control, eating episodes? Do you struggle with you know, feeling like you, you know don't have control, or just feeling like you know you're eating you, you know. There might be just some, some, some concerns with your eating behaviors. You might need to think of different pathways and assess and think about the patient you're talking to and then think about your language, because patient patients just might not understand eating disorder. Right? I've seen that in my research, and so and then be able to invite them to share their thoughts.

Rachel Goode: And so we also want to be able to you know, provide information about the eating problem that you identify, you know, and to be able to describe what you've seen right? So you might be able to talk to a patient about what it means to have a binge eating episode.

Rachel Goode: And, and just describe it, and see if that can resonate with their experience and how it's going to impact their diabetes management right? What's the relationship? We also want to, you know see about the support that's there. Here's the part that I think it's the most challenging, is how we're going to get our patients to support that they need right, and so it can. If you're a PCP, right, it'd be great if there was a collaborative care team that you are working with right?

Rachel Goode: A therapist, a clinician that you are aware of, who has expertise. You don't have to have expertise. But if you can think of someone who does and create a relationship where you are referring to one another who can help, you know, just again provide the patient a few supporting elements to get them started.

Rachel Goode: And then you really want to make sure that the patient is comfortable with this approach, right? Because we know our patients will be in our offices, and we, we have this whole plan, and then they don't follow through, and often our patients might have felt like I'm not sure if this is a good fit for me, and so it might take some additional support, because it could be alarming to them to even hear, you know about the fact that this might be disordered eating behaviors. They may just need a little bit more support to understand what exactly you mean.

Rachel Goode: So I thought it'd be helpful for us to go through a case study of a patient who is navigating this. And, and even just to see you know just what some of your thoughts might be. And so this is Sarah.

Rachel Goode: Sarah is a 59-year-old woman living alone, has been diagnosed with type 2 diabetes has currently been managing with diet and exercise and her PCP. She's going into a visit with her PCP.

Rachel Goode: So as she goes to see Dr. Lydia, what she tells her is that a) she's been really trying hard to lose weight, but her efforts aren't paying off. She has gained about 12 pounds over the past few months and she feels down about her weight and embarrassed about her body. Okay, so a couple of different things might be coming into your mind, right, even now, as I said, those things as risk factors.

Rachel Goode: Remember you know, engaging in weight control efforts can be a risk factor for binge eating. You know, feeling that shame and stigma about their body, yet another risk factor, something to that could perk your ears up. So you're like, okay, I'm hearing some of these concerns trying hard to lose



weight. So, that might mean there's a lot of guidance out here, and a lot of it is not evidence based or even evidence informed. And so, patients could be engaging in some behaviors that might be more trendy, but may increase their risk of these disorder eating behaviors. So what are some things that we might consider, right? How could the PCP intervene in this situation?

Rachel Goode: One: Okay, as they're talking, first thing you do is ask some open-ended questions just to learn more about this, right? And even if you're not a PCP, you could begin. If you're maybe a diabetes educator or you're a clinician, you could begin to just assess, you know. Often, I think I remember when I was practicing.

Rachel Goode: I'm good anxious. You know what I would see a certain, you know symptoms, and I would first. But the first step is for me to learn more about it. Right? Learn more about when how often this patient might be experiencing these concerns. And so, so, what we see here in this as we go on, is that after you know, the PCP has asked more questions, gone through some of the examples.

Rachel Goode: You know, she learns that this patient has struggled with her weight, and is currently at the highest weight, ever eats little throughout the day, and then over eats most nights, and then over eats when she's lonely or bored. Okay, and so Lydia then gives the m-SCOFF to her okay. And so Sarah replies, yes, to 2 items. Do you make yourself sick because you feel uncomfortably full?

Rachel Goode: And do you worry because you have lost control over how much you eat?

Rachel Goode: And so, as she reviews Sarah's responses, she sees that you know she might be experiencing some eating concerns, and, as Sarah, you know, again

Rachel Goode: wants to go back reviews the results with her, and you know, and, and Sarah just acknowledges that she feels stressed about her overeating and her weight gain, and has a tendency to restrict her food intake, but then to overeat at the end of the day in response to negative emotions.

Rachel Goode: And so, as Lydia, she, you know, offers her some guidance, you know. She helps Sarah and reassures her, right. This can be fixed. Emotional eating can be addressed, and so she wants to help Sara. A one thing that might be a great beginning step is to help, help regular eating episodes. That's something as a clinician that we often would help our patients who are struggling with binge eating disorder is to help them engage in a pattern of eating at least 3 meals a day and 2 snacks, so to eat regularly throughout the day, to make sure that they are getting their bodies nutrients right, getting what they're eating.

Rachel Goode: And then, also be able to provide her some tools to manage her emotions, because those that emotional eating can be a big factor and help patients be able to define some, you know, to find some new things in their toolbox that they are able to pull out.

Rachel Goode: And so then, Lydia, when we think about assigning right, she can help Sarah understand? Okay, you. We have some people on our care team who might be great for you to meet with, and might make a referral to one of her care team members and to a dietician, you know.

Rachel Goode: And then, is she satisfied, you know, can ask there again. How do you feel about these concerns? And what do you, you know what you want to do next, and keep the patient centered in all of those things. Okay? So, I just wanted to go through again, just an idea of what this might look like as we are navigating this with our patients.

Rachel Goode: So when I think about take home message right? We know that type 2 diabetes and eating disorders exist, and we see binge eating disorder, is night eating syndrome. And those are, you know they are very, that's the disorder eating behavior. That's the most prevalent.

Rachel Goode: And so we need our providers, one to be aware to not be afraid to ask, to not create shame, to be able to help our patients understand what they are experiencing, and then to be able to refer them to professionals who can provide them additional support.

Rachel Goode: And so when you think about again long-term solutions as you're balancing this diagnosis of eating, you know, managing disordered eating and type 2 diabetes. It's so important for patients to have a reliable and a regular eating routine to help them deal with their diabetes related shame and their stigma. You know, really coming up with a process to help them regularly track their blood sugar levels. And then think about, how can we provide some patient-centered education to help patients, a, I think, in addition to nutrition, but also kind of reconnect with their biological signals of hunger and fullness, and to be able to create healthy experiences around eating.

Rachel Goode: So thank you all. And now I will open it up for questions.

la-shell\_johnson@med.unc.edu: Thank you so much Dr. Goode, and thank you all for listening in on today's session. We'll now go ahead and open up for question and answers. Please place your questions in the Q&A box. As a reminder, we will be sending slides from today's presentation out after the

webinar has ended. And for any unanswered questions, we'll be sure to send those responses within one week from today.

la-shell\_johnson@med.unc.edu: The first question reads, are these assessments normed and valid for clients under 18? I work mainly with youth and adolescents, and find that many assessment tools have not been validated for these population.

Rachel Goode: Yeah, this the ones that I showed you were used for adult populations. And I think we are working on creating better assessments for individuals who are adolescents. But that has not really been, I think, a strength. And so, and so I just feel cause it makes it challenging right to be able to assess these behaviors. But yeah, the ones I did present are often, more often used in adult populations.

la-shell\_johnson@med.unc.edu: Thank you for that, Dr. Goode. Do we have any additional questions at this time?

la-shell\_johnson@med.unc.edu: Are there current eating disorder clinics in the US that work to help members with T2 or type 2?

Rachel Goode: You know, I would have to. I hesitate to answer that directly, like work together, because I am not sure of that if there are those who work together. And so, but I can find out and make sure you all have that information.

la-shell\_johnson@med.unc.edu: Thank you so much Dr. Goode. The next question reads, and are these assessments validated across ethnic and racial groups? The assessments that were referred to during a webinar.

Rachel Goode: Yeah, they I would say they have not been validated in every racial and ethnic group. And so that's probably one of the limitations.

Rachel Goode: And so, I would have to do a search of the scientific literature to see if they've been validated in. I'm not sure if there's a particular racial and ethnic group that you're seeing, but I think that is something that we've acknowledged has been one of the challenges in our eating disorder literature, is that these are often aren't validated in other racial and ethnic groups. But it might be a starting place and something that you can use. That may give you an idea. I think one thing I know in my research, I'm often kind of finding them striking that balance. And maybe thinking about how the importance of the

measure to be able to kind of assess some of the disordered eating behaviors. And then, as I gain practice with it, maybe seeing about the ways that it could be made more culturally relevant in order to meet the needs of a population, but almost kind of taking the I know my mom would always say, leave them, take the meat, leave the bones. And so, I find ourselves in those situations sometimes.

Rachel Goode: But, we can still get a lot of important information to help us on identify disordered eating in our clients.

la-shell\_johnson@med.unc.edu: Thank you. The next question asks, what about bulimia and type 2?

Rachel Goode: Yeah, that is something that we have seen, as also it's not as common as binge eating disorder. But we have also seen that, that is a concern we don't have as the most research. I think that's where I see the gaps. We don't have as much research on bulimia nervosa.

Rachel Goode: But one thing I think is important to keep in mind is that both binge eating disorder, and bulimia nervosa share the same common thing, commonality with the with the presence of binge eating episodes. And so the difference again would be the purging. And so some of those same things that might be risk factors for binge eating disorder are probably very similar risk factors for bulimia nervosa. And so I would say, in that case the clinician should just take the extra step, and some of those screening tools provide a question to understand if patients are engaging in purging behavior.

Rachel Goode: Because, that adds an additional complication, I think, onto the treatment, and would really warrant someone getting additional support and referral from a clinician who is skilled in these areas.

la-shell\_johnson@med.unc.edu: Thank you once again, Dr. Goode. The next question asks, what is the incidence of insulin omission for the purposes of weight loss in Type 2 DM.

Rachel Goode: I'll be honest. I'm not sure about that off, off the top of my head, but I can find out what we have. We can pull that information from the literature. I'd have to just do a search and pull that information out.

la-shell\_johnson@med.unc.edu: Okay, thank you.

Rachel Goode: The next question reads: what would you suggest we do to help reduce eating disorders, to help reduce diabetes later in life?

Rachel Goode: Yeah, I think well, one thing I think we've been learning, I'll tell you what I've been learning in my research lab. One thing I think we all again our frame of helping people engage in healthy relationships with food is very minimal, right. We have had a lot of guidance, right? We need to control our weight and a lot of different ways to do that. But we haven't had as much guidance about how do we engage in a healthy relationship with food, paying attention to our signals of hunger and satiety. I also recognize that a lot of our concerns with type 2 diabetes and disordered eating are related to social determinants of health, right? And so we have a system that has created an environment that does not give people equal opportunities to achieve the best health, and so that creates an inequity right?

Rachel Goode: And so people are not having environments where they have maybe safe neighborhoods adequate food. They're not having the economic resources to make the decisions that are best for them. And so, when we're in those situations, and whenever that's present, we're going to continue to see some of these disparities, and some of this increased incidents continue to arise. It's our food environment is also very, very, it's very challenging. It's very challenging. And so, and I think we're going to continue to see increased rates of type 2 diabetes. But I think if you know, again what I'm seeing in my research, when we see patients, and when they're helping, and they're relearning how to work with their body instead of against it or ignoring it. We see that there's improvement in eating behaviors, improvement with weight management, improvement with glycemic control.

Rachel Goode: And so we are just continuing to learn more about how do we contain? How patients kind of incorporate more of these behaviors into their life.

la-shell\_johnson@med.unc.edu: Thank you. Once again, Dr. Goode. We had a statement. **This is: ask people what type one they can abuse their insulin.**

la-shell\_johnson@med.unc.edu: And then the next question reads: how do you recommend talking about weight with patients with BED and type 2 diabetes? I work for a healthy, I work from a health at every size framework, and usually just focus on eating rather than the weight.

Rachel Goode: Yeah, so I would first, I would ask the patient, what they want. Because I think it's important for you to know if the patient is desiring to lose weight. And this is important for you to know for a couple of reasons. Because ideally, I think if you, if the patient has this in their mind and they're working on a weight loss effort they are probably engaging again. It's, it's, a it's a jungle out there, and so they are probably engaging with a lot of things that may or may not be evidence-informed. I really honor and respect. I think that I understand the intention of those who practice at a health at every size,

framework, and I can see the need right to do that, because we know people have experienced challenges.

Rachel Goode: I also, however, see that people still express desires to lose weight and I think from a social work perspective. You know, we often think about the self-determination of the client. And we have some recent science to show that engaging in an evidence-based weight management does not lead to disorder, does not, you know, can be helpful and supportive, and it might even help improve their just, you know eating behaviors, especially if the patient has expressed a desire to lose weight. And so I would let that kind of lead my discussion, because if that patient has expressed that desire, you can probably pretty much bet they're going to someone else to talk about that, and you want to keep that, you know. You want to be able to keep that door open so that you can help that patient make a decision that might be more helpful to them versus something that might lead them to engage in some diet. You know something that might, you know, really harm them.

la-shell\_johnson@med.unc.edu: Thank you so much for that again, Dr. Goode. I'll go ahead and take this last question, and the remaining unanswered questions, we'll get those responses to you within a week.

la-shell\_johnson@med.unc.edu: The last question reads, for diabetes educators do you have any pearls of wisdom on balancing guidance for weight loss, and eating while avoiding putting patients in a position of feeling the need to engage in disordered eating behavior.

Rachel Goode: I really appreciate that question because I recognize the place that the diabetes educators are in? And so I, I don't know if I have any pearls of wisdom, but what I would offer from what we've heard from our patients is to 1) help patients understand this guidance to the shame right somewhere. They're hearing that there are good and bad foods, right? And so and I know one thing we often talk about is creating an environment where patients are scientists and not judges, right? And so, to help them take on any observation, you know, and to examine, like what is the impact of certain foods on our glucose, and then also helping them have skills to deal with, situations where they have were they, you know, may not have us control much control over their eating behaviors. What happens then?

Rachel Goode: Because I think sometimes our patients just don't have the skills to navigate eating experiences that are not always controlled or feel like they don't always have the tools to make decisions in places where I may not be able to eat or how do I make decisions And you know eat things I might, or I might be present and eating things I really, really like, you know. And how do I navigate those in the context of my Type 2 diabetes, and create more conversations so patients can understand. I feel like there's still a lot of misunderstanding about what it means to have a type 2 diabetes diagnosis.

Rachel Goode: Still a lot of stigma and shame, and so I think to also help maybe patients get with each other right to find supportive networks of those who have been to get navigating this for a longer period of time. I know as a clinician we have our opinion, but sometimes the words of someone who has been in these shoes might be more impactful and might be able to help them, you know, examine, and kind of understand what life looks like, living with type 2 diabetes. And how we can't, you know, think of things as good or bad.

Rachel Goode: But we are continuing to learn how to care for our body with this diagnosis and help with the reframing of the language, and hopefully that will help eliminate, will not eliminate, but lesson some of the distress and the shame that for patients are feeling and normalizing right? We're going to also normalize.

la-shell\_johnson@med.unc.edu: Thank you so much again for that, Dr. Goode. I wanted to thank you all once again for joining today's webinar. Dr. Goode, do you have any final words or comments that you'd like to share?

Rachel Goode: No, I'm just saying you all are, you know, continue to do well. Thank you for caring well for our patients who are managing type 2 diabetes and disordered eating.

la-shell\_johnson@med.unc.edu: Thank you once again for your time today Dr. Goode, and thank you all once again for joining. As a reminder, be on the lookout for the slides and our evaluation at the end of the webinar. Thank you all for joining today. Thank you.