

Conference over coffee: Menopause, mental health, disordered eating and trauma

The 2026 London Conference of the Primary Care Diabetes & Obesity Society took place on Wednesday 1 July at the Royal College of General Practitioners. Aligned with the newly updated NICE NG28 guidance, the programme focused on early intervention, multidisciplinary collaboration with the Integrated Neighbourhood Team, and practical strategies that empower individuals to self-manage their conditions and achieve better long-term health. In this short report, Pam Brown summarises the key take-home points from two more sessions of the conference.

Diabetes and obesity management in menopause

Itunu Johnson-Sogbetun, GP with experience in women's health, sexual and reproductive health and menopause care. GP tutor and examiner, Queen Mary University of London

- Menopause affects the whole body: energy, mood, sleep, weight, bones, heart and brain function. Experiences vary.
- Menopause is stigmatised and taboo in many Black, Asian and minority ethnic communities – women are expected to endure silently.
 - Beliefs and attitudes impact health-seeking behaviour.
- Decreases in oestrogen, testosterone, progesterone and insulin sensitivity, and increases in cortisol, occur.
- Cardiovascular protection is reduced with declining oestrogen:
 - Promotes visceral fat accumulation.
 - Vascular dysfunction raises blood pressure.
 - Adverse lipid profile develops, increasing risk of atherosclerotic cardiovascular disease (ASCVD).
- Menopause is a critical window for risk stratification and prevention:
 - Screen early, intervene proactively for all of these risk factors, not just symptoms.
 - Multidisciplinary approach improves long-term outcomes.
- Menopause impact varies by diabetes type:
 - Type 1: increased basal insulin needs and complicates insulin dosage.
 - Type 2: insulin resistance worsens, risking disease progression.
 - Prediabetes: menopause may increase risk of transition to type 2 diabetes.
- Risk of type 2 diabetes increases by 24% with early menopause (Yazdkhasti et al, 2024).
- Hormone replacement therapy (HRT) in women aged <60 years or within 10 years of menopause may:
 - Improve endothelial function.
 - Improve lipid profile.
 - Reduce ASCVD progression.
 - Improve insulin sensitivity.
- Non-hormonal options for symptoms:
 - SSRIs, SNRIs, gabapentin and clonidine for hot flushes and mood disturbance.
 - NK3 receptor antagonist fezolinetant for vasomotor symptoms (MHRA warning: risk of liver injury). NK1/NK3 antagonist elinzanetant for vasomotor symptoms and sleep disturbance.
 - Lifestyle changes and cognitive behavioural therapy may also be helpful.
- Ethnicity:
 - Aim for an individualised, culturally competent approach to assessment, risk stratification and management.
 - Use ethnicity-adjusted BMI and waist circumference thresholds.
 - Incorporate traditional foods in culturally tailored dietary advice.
- Address hormone hesitancy:
 - HRT is safe for many women when carefully prescribed and monitored; help women make confident, empowered decisions.
- Practice culturally responsive care:
 - Clinical curiosity: Take interest in people's lives, not just their symptoms.
 - Open communication: foster a safe, judgement-free space.
 - Education and awareness: provide clear, culturally sensitive information.
 - Trauma-informed care: respect cultural factors and understand minority trauma in healthcare settings.
 - Symptom recognition: actively listen and acknowledge symptoms.
 - Shared decision-making: treat women as equal partners in care decisions.
- Clinical pathway:
 - Consider HRT first.
 - Review diabetes medication.
 - Consider weight loss medication.
 - Assess and monitor key cardiometabolic and renal markers.

Further reading

- Yazdkhasti M et al (2024) [The association between age of menopause and type 2 diabetes: A systematic review and meta-analysis](#)

- Forde R et al (2024) [Type 1 diabetes and menopause, what women would like to know: A public and patient involvement exercise](#)
- Partridge C (2023) [At a glance factsheet: Diabetes and menopause](#)

Diabetes and obesity management in complexity: Mental health

Disordered eating, substance misuse and GLP-1 RA therapy

Zoe Kolokotroni, Senior Lecturer in Behavioural Pharmacology, Leeds Beckett University Obesity Institute

- Eating behaviour assessment should be central to metabolic care:
 - Obesity, type 2 diabetes, eating disorders and mental health share biological and psychological pathways, and frequently coexist.
 - People with type 2 diabetes:
 - Around 25% have disordered eating (not an eating disorder – subthreshold patterns that harm glycaemic control and wellbeing).
 - 7–20% have binge-eating patterns. Night-eating syndrome also common.
 - Increased alcohol and nicotine use compared with the general population.
 - People with obesity:
 - 20–30% have disordered eating (binge, restrictive, emotional and night eating).
 - Around 14% have binge eating disorder (BED).
 - Increased alcohol and nicotine, especially in those with BED.
 - Screening for eating disorders, disordered eating and substance use should be routine, not exceptional.
 - People want non-judgemental, practical and psychologically informed support.
- Assess eating behaviour routinely when considering GLP-1 RA therapy:
 - Assess binge eating, restrictive eating,

compensatory behaviours, eating disorder history and, where relevant, substance use.

- Think beyond weight and HbA_{1c}:
 - Explore the “why” behind eating behaviours; monitor psychological wellbeing alongside metabolic outcomes.
- Work across services:
 - Integrated diabetes, obesity, dietetic and psychological care are essential for people with complex eating behaviours.
- Prescribe GLP-1 RAs carefully – evidence of benefit and potential harm:
 - May help with satiety regulation, modulation of reward pathways, improve impulsivity and inhibitory control.
 - However, potential to harm:
 - May reactivate or entrench restrictive pathology in those with history of anorexia or avoidant/restrictive food intake disorder (ARFID).
 - Profound appetite suppression.
 - Rapid weight loss can be misused.
 - Gastrointestinal effects may mask, mimic or enable purging, with rebound when stopped.
 - May benefit binge-type pathology but require caution in restrictive eating disorders.
 - Emerging evidence in BED:
 - Reduction in binge eating severity, Binge Eating Scale scores, binge frequency, cravings and emotional eating.
 - GLP-1 RAs are one component of care, not a treatment for eating disorders.
 - Signals of risk and misuse:
 - Population data largely reassuring, but screen for individual risk.
 - Absence of evidence is not the same as safety.
 - FAERS US pharmacovigilance confirmed intentional overuse and use without prescription.

- EMA review of suicidal ideation and self harm – no causal link established.
- Promotion for aesthetic weight loss in adolescents raises exposure in vulnerable groups.

Key conclusions

- **Metabolic health and eating behaviours cannot be considered in isolation.**
- **Effective metabolic care is not just about prescribing the right medication; it is about understanding the person behind the condition and the drivers of eating behaviour.**

Further reading

- Whatnall M et al (2026) [The relationship between weight, eating behaviours and mental health over time in the YOUTH longitudinal cohort study](#)

Depression, stress and trauma

Professor Jason Halford, School of Psychology, University of Leeds

- Eating behaviours associated with obesity include:
 - Emotional eating.
 - External eating (driven by environmental cues).
 - Mindless eating – while distracted, ignoring appetite cues.
 - Reward-driven eating – high-fat, high-sugar, energy-dense, ultra-processed foods; large portions.
 - Eating patterns – eating away from home, skipping breakfast, fast food, sweetened drinks.
- Mental health issues associated with obesity:
 - Anxiety, depression.
 - Eating disorders.
 - Neurodivergence.
 - Psychotic disorders – bipolar disorder, schizophrenia.
 - Substance use disorders.
 - Personality disorders.
 - Psychological factors.
 - Biological factors.
 - Side-effects of medications (antidepressants, antipsychotics).

- If onset of obesity <20 years:
 - Associated with higher current BMI, more weight loss attempts, greater feelings of helplessness.
 - Impact more severe and harder to manage.
 - Healthcare professionals should consider depression screening in adolescents living with obesity.
 - High proportion have poor mental wellbeing and low self-esteem (especially in females, older adolescents, and those with obesity class II and III).
- Bariatric surgery candidates:
 - 37–72% have a psychiatric disorder.
 - Up to 33% have a substance misuse disorder.
 - Up to half may have an eating disorder.

Stress, mood and weight

- Repeated stressful life events are associated with emotional eating and preference for energy-dense foods rich in sugar and fat (Torres and Nowson, 2007).
 - Mechanisms include elevated cortisol, hormonal and metabolic changes, and inflammation.
- Perceived stress (global and job-specific) correlates with waist circumference and visceral obesity.
- Psychological approaches include:
 - Cognitive behavioural therapy.
 - Behavioural therapy.
 - Motivational interviewing.
 - Acceptance and commitment therapy.
 - Mindfulness-based cognitive therapy.
 - Compassion-focused therapy.
 - Trauma-based therapy.
- Compassion-focused therapy for obesity:
 - Aims to reduce shame, self-criticism and emotional distress.
 - Helps develop self-compassion, understanding that weight-related

- struggles are not due to personal failure.
- Includes soothing-rhythm breathing, compassionate imagery and reframing negative self-talk.
- Supports emotional regulation, reduces binge or comfort eating, improves motivation for health behaviours.
- Kinder self-relationship may enhance engagement with therapy and sustainable lifestyle change.

Practising trauma-informed care

- Consider:
 - Current events.
 - Past trauma, including post-traumatic stress disorder (PTSD).
 - Childhood maltreatment, including neglect; bullying; physical, emotional, verbal and sexual abuse (severity more important than type of trauma).
- Drawing a life events weight graph (see [Kushner, 2020](#)) can be helpful in understanding when and why weight gain occurred.
- Obesity and trauma (Mason et al, 2016):
 - Multiple adverse childhood experiences (ACEs) associated with a 46% increased likelihood of adult obesity. Two in three adults have had at least one ACE.
 - 69% of bariatric surgery patients have a history of child abuse or neglect.
 - 39% of people with PTSD are obese.
 - Possible mechanisms include maladaptive coping, defence mechanisms, changes in emotional regulation.
- Healthcare settings may reinforce trauma due to weight stigma and discrimination, resulting in reduced clinician trust, healthcare avoidance and less engagement with treatment.
- Effective obesity care requires addressing underlying trauma, not just weight.

- Aim to improve engagement, reduce re-traumatisation and support sustainable health rather than focusing solely on weight loss.
- Trauma-informed care for obesity:
 - Recognises that past trauma can shape eating behaviours, metabolism and engagement with healthcare professionals.
 - Creates safe, respectful, non-judgemental environments, avoids weight stigma and builds trust.
 - Focuses on understanding the “why” behind behaviours; aims to improve engagement and reduce harm.
 - Includes collaboration, empowerment and choice. May include trauma screening, supporting emotional regulation and tailoring treatment to individual needs.

Resources

- West Yorkshire Health and Care Partnership. [More than weight: Exploring the human, social and economic cost of obesity](#)
- Gilbert P (2010) [Compassion Focused Therapy](#). Routledge, London

References

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- Mason SM, Bryn Austin S, Bakalar JL et al (2016) Child maltreatment's heavy toll: The need for trauma-informed obesity prevention. *Am J Prev Med* **50**: 646–9
- Torres SJ, Nowson CA (2007) Relationship between stress, eating behavior, and obesity. *Nutrition* **23**: 887–94
- Yazdkhasti M, Jafarabady K, Shafiee A et al (2024) The association between age of menopause and type 2 diabetes: A systematic review and meta-analysis. *Nutr Metab (Lond)* **21**: 87

Author: Pam Brown, GP, Swansea.

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