Sick Enough: Dr. Jennifer Gaudiani On Eating Disorders

Sally Vanderwiel, MA, David Puder, MD

None of the presenters have any conflicts of interest.

Summary

In today's episode of the podcast, we talk with Dr. Jennifer Gaudiani (Dr. G), internationally renowned author of the book, *Sick Enough: A Guide to the Medical Complications of Eating Disorders*, and founder of the Gaudiani Clinic in Denver, Colorado. We deconstruct common myths and misconceptions about eating disorders, exercise, metabolic processes and why the term “sick enough” is such an apt title for a text and discussion on this group of complex and life-threatening mental health conditions.

Dr. G speaks with enthusiasm, compassion and such a high level of empathy and positive regard for all of her patients, with an air of humility, acceptance and acknowledgement of past foibles in this field of practice, that one cannot help but to be somewhat altered in thinking more curiously and positively about this group of patients. In addition, one is also inclined to examine their own practices, ideas about concepts like “thin privilege” and the excessive lengths we go to in a society bathed in “fat phobia” to want to change, shame, and construct arbitrary measures of moral success that have little to no bearing on health. These arbitrary measures are discussed in the podcast, along with necessary scientific evidence dispelling myths about eating disorders, along with myths pertaining to normalized but disordered diet practices like intermittent fasting, orthorexia, and exercise for calorie burning.

Empathy gaps and poorly understood topics in the eating disorder treatment milieu

Dr. G discusses the extent to which physicians and therapists come unstuck when conceptualizing and treating patients with eating disorders from the historical perspective that all eating disorder sufferers present in emaciated bodies. This, of course, has historical roots with regards to research bias and knowledge gaps in eating disorders, but also feeds into the moral superiority idea that thinness equates to living the “best kind of life,” so long as that thinness does not become life threatening. Contrary to common perceptions, merely 0.1% of the population actually meets the criteria for anorexia nervosa, which includes having an extremely thin and underweight body. With atypical anorexia, the population is 3%, binge eating disorder 4% and equal across genders, and bulimia nervosa 2%. In actual fact, the majority of eating disorder sufferers present in normal or larger bodies, which adds layers of misunderstanding and often unhelpful, trauma-inducing advice from primary care physicians.

Due to the ego-syntonicity of eating disorders and the deep shame and disgust that accompany an eating disorder sufferer’s internal world, when presenting or being encouraged to present for help for the first time, Dr. G explains this conundrum beautifully in describing her earlier work in

acute care for eating disorders, as well as in her current role at the Gaudiani Clinic. The regularity of seeing patients presenting for help and being told variations of, “You’re fine—you don’t have an eating disorder. In fact, you could probably lose a few pounds,” are so familiar to clinicians working in this field that part of initial work is undoing the damage caused by these experiences.

Perhaps less poorly understood, but certainly a contributing factor in empathy gaps for clinicians, is that the hallmark of eating disorders is denial of disease severity, thus providing the backdrop for common statements from patients like, “I’m fine. I’m good. What are you talking about? I’m not sick enough. Why am I here? I look fine.” This common thread that a sufferer has never gone far enough is also reinforced by the medical professional when assessing whether a patient is “sick enough” to receive treatment. Dr. G outlines the philosophy that just having an eating disorder is enough to receive help, and perhaps in contrast to other service providers’ views, there is deep empathy for the protective purpose that the eating disorder plays in the patient’s life for reasons such as: numbing of emotions for an emotionally unprepared adolescent, dealing with a fat-phobic society, individuating without the requisite skill set, a way to “cool off their brains,” and a myriad other purposes. Dr. G makes the comparison that with cancer sufferers there is a general consensus that one does not want to “keep the cancer”; however, understanding the self-imposed requirement to “hold on” to the eating disorder as part of the patient’s identity is an understandable and necessary component of treatment.

The Broken System

Unfortunately, many medical providers do not want to work with eating disorder patients. While well meaning, due to a lack of knowledge and training in this area it can seem easier to minimize symptoms just as the patients do. The undeniable truth of a medical profession bathed in this fat phobia means so much of eating disorder medical training is unlearning that a “root evil of fatness” exists at the core of most medical problems. While those with cancer are not viewed as morally inferior in today’s modern world, God forbid if a healthy person in a fat body visits their primary care doctor for a medical ailment. Familiar advice given many times over by clinicians of eating disorder patients who present in larger bodies is the lecture on losing weight, counting calories, getting on the scales more often, actively focusing on reducing weight, which is instead only more likely to promote the eating disorder from which they are probably already suffering.

With regards to access to routine and necessary surgeries, a larger-bodied patient would be advised to lose X amount of weight prior to a surgery which would enhance mobility and increase health and happiness. Unfortunately, this patient, who has in all likelihood been on diet cycles since a young age with no result other than increasing weight, is now in a position to go into starvation mode in order to access surgery, thus putting the body at risk of a hugely compromised capacity to heal from said surgery due to malnutrition. In contrast, with risky open abdomen bariatric surgery for weight loss, a green light from surgeons and anesthesiologists is

generally forthcoming because it is the “morally proper” course of action, given the myth that it is medically necessary to cause weight loss in order to be well.

Eating disorder patients do tend to elicit big transference and countertransference reactions in medical and psychological providers, and while many do not want to do this work, Dr. G brings such warmth to the often cold, lonely, and shameful existences of these patients, that one cannot help but feel deep empathy and compassion for their inner experiences.

The assessment of eating disorders and the necessity of a comprehensive narrative

There is no lab test to determine whether one is suffering from an eating disorder and, generally, with the exception of extreme body appearance at either end of the spectrum, one cannot tell by simply looking at a person. Regardless of body weight and symptom prevalence, all lab tests could still glean normal results, despite there being an extremely malnourished and suffering person sitting in front of you. With this in mind, a major indicator of catastrophic medical danger is a low blood sugar reading (hypoglycemia – under 70 mg/dL), meaning that if a body cannot synthesize glucose any longer, the heart is in grave danger. As Dr. G discusses in *Sick Enough*, the starved body has been so preoccupied with breaking down muscle and fat, it begins desperately mining for glucose to keep the brain alive.

While each patient has a unique manifestation of medical complications, markers that can be determined through lab tests include the following:

For malnourishment:

- Low blood glucose can occur as the body's glycogen stores become depleted and the liver's ability to produce new glucose through gluconeogenesis is impaired due to malnutrition.
- A complete blood count (CBC) may show leukopenia, which is a low white blood cell count often resulting from bone marrow suppression or failure, which can be associated with severe malnutrition.
- Elevated levels of aspartate aminotransferase (AST) and alanine aminotransferase (ALT) are commonly observed in malnutrition and may signal liver stress or injury. Such elevations can reflect hepatic autophagy, where the liver cells begin to degrade themselves, a process sometimes seen in starvation.
- If AST and ALT levels are more than three times the upper limit of normal, this can be a predictor of hypoglycemia, regardless of body mass index (BMI). This may be due to severe liver dysfunction, which can compromise the liver's capacity for gluconeogenesis and subsequently increase the risk of hypoglycemia.
- While a low albumin level can indicate malnutrition or chronic illness, it is not specifically indicative of an eating disorder and should not be used in isolation as a diagnostic marker.

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For purging (vomiting, laxative abuse, and diuretic abuse):

A basic metabolic laboratory panel should test for the following abnormalities:

- Electrolyte imbalances: Self-induced vomiting and abuse of laxatives or diuretics can lead to significant shifts in electrolytes. Hypokalemia (low potassium) is one of the most common findings due to vomiting and can be dangerous, leading to cardiac arrhythmias. Hypochloremia (low chloride) can also occur as a result of vomiting.
- Metabolic alkalosis: Chronic vomiting can lead to a loss of stomach acid (hydrochloric acid), resulting in an elevated blood bicarbonate level and a high blood pH, indicating metabolic alkalosis.
- Altered kidney function: Chronic dehydration from fluid loss can lead to hemoconcentration, reflected in elevated BUN and creatinine levels. However, if purging behaviors have led to chronic dehydration and kidney damage, creatinine may be elevated.
- Hypoglycemia or hyperglycemia: Although less common, fluctuations in blood sugar levels can occur due to disordered eating patterns. Hypoglycemia might be seen if there has been a prolonged period of fasting or excessive exercise, while hyperglycemia might occur after a binge eating episode, especially if the individual has a coexisting condition like diabetes.
- Calcium and magnesium: While not part of the standard BMP, individuals with bulimia may also have low levels of calcium and magnesium, especially if they are purging regularly.

Pseudo-Bartter syndrome (severe rebound edema) can occur when purging ceases.
This is related to the cave person brain at work (to be discussed). Diagnosis is made clinically, as there is no blood test; however, a patient with a bicarbonate level of 30 mEq/L and above would be at high risk for this condition.

In *Sick Enough*, Dr. G outlines in detail the medical treatment and management of each physical complication, that may or may not show up in lab results, to ensure that patients are taken seriously and not “fobbed off” in the manner of the “not sick enough” sequelae. She also discusses those unmeasurable elements of suffering during recovery including POTS and associated conditions.

With regard to hands-on physical examinations for eating disorders, best practice advises an administration within a trauma-informed perspective. Embedded within the bodies of eating-disordered patients so often lies years of body policing, bullying, life experience trauma, medical trauma, shame and disgust, etc. For this reason, Dr. G recommends asking for permission from patients, from head to toe and at each step of the way, prior to any physical examinations.

While the majority of patient data is obtained via the spoken word, the following are some physical markers to look for in patients:

- Lanugo hair on the face to preserve warmth in starvation, which reemerges from when body was in the womb
- Puffy and inflamed parotid glands from purging
- Abnormal thyroid appearance
- Dental erosion
- Traumatized and fragile skin
- Edema or water retention
- Coldness in the body extremities

While the above are objective measures of body suffering, narrative markers can be ascertained through developing a warm and non-assumptive dialogue with the patient in the initial consultation. One must always keep in mind that patients' internal mindset that they might not be sick enough to receive help (and to therefore downplay or deny symptoms) are par for the course.

Through a collaborative approach, patients are simply asked to tell their story in order to be known as a whole person, but with an eating disorder acting as the regulator for a range of complex reasons. Questions should inquire about the story of the eating disorder and the patient's unique relationship to food and to their body, as well as to salient life events, interests, and important relationships.

Dr. G gives some recommendations of exploratory topics:

- How the patient copes with stressors (both expected and unexpected)
- The meaning the patient gives to exercise
- The level of impediment regarding activities a patient loves or once loved in life
- How connected the patient is to knowing what they need in life and how to meet those needs
- The patient's sex drive and general energy levels
- Previous treatment trauma
- Other markers of psychological and physical suffering

The synthesizing of assessment of the physical and psychological aspects of eating disorders can also be explained by taking a dive into the world of humankind's supremely clever, well-intentioned, and primitive cave person brain.

The Cave Person Brain

Evolved to protect humans from starvation during times of famine, Dr. G talks about the "cave person brain's" role as identifier and protector of the harms caused by undernourishment. In

simple terms, it is like the part of our brains telling us to breathe, scanning us every day, and communicating in no uncertain terms that it will go to desperate lengths to keep us alive. It does this in several ways, such as slowing metabolism and making us chillier so we can return to homeostasis and maintain body temperature at an appropriate mammalian level. Like the spare room in a house where the heat is shut off to preserve energy, it will expend much less energy on digestion. To preserve calories, it tries to shut down the body and go into metabolic hibernation mode, just like those bears do to pass through the winter without food! This often results in patient symptoms of bloating, nausea, excessive fullness, constipation and a slowing heart rate. While no lab test can definitively tell us when the cave person brain is in charge, there can be lab abnormalities.

Unexpected results were yielded from an important study that compared the physiology of exercise, nutrition, and calories of a nomadic tribe in Northern Africa who, by necessity, walked many miles per day with little food, to regular “couch-potato Americans.” In these results, the collective and protective wisdom of the cave person brain is evident. While the researchers expected to find a result symbolic of the virtue and morality of fasting and increased exercise, the result actually showed that both groups burned the exact number of calories. The laws of thermodynamics imply that if we are not fueling the movement we do, then our metabolisms must slow down in response. In other words, if the tribe had had access to 4000 calories a day, then they would have burned 4000 calories a day due to the ability of the metabolism to increase to match movement. In relation to the idea that virtue and morality are inextricably linked to calorie burning and weight loss, our bodies are actually trying to keep us in homeostasis. For example, burning 500 calories through exercise means a metabolism will work 500 calories slower.

Walking the Talk

One of Dr. G’s major skills as an eating disorder physician lies in her obvious passion for the work, but also in her authenticity and great respect for the patients she encounters. A major struggle for patients with eating disorders is a lack of being in sync with their bodies, emerging from the struggles of an inability to identify needs or to accept that needs exist and, therefore, lack of a skill set to meet those needs in a healthy and nurturing manner. Dr. G highlights the major deficits in eating disorder patients with regards to fundamental tasks of growing up, but even within our current cultural milieu, many struggle with this due to an over management of one’s time and space from parental figures. In addition, there is also the added pressure of the internet and social media influencers micromanaging and hijacking every ounce of individuality in vulnerable individuals.

Dr. G suggests that sharing the “good stuff” with patients, at appropriate times and in an appropriate manner, can be highly beneficial. Identifying one's needs without resisting or judging, and being able to meet those needs without chastisement, guilt and shame, means patients are less likely to engage in self-damage to deal with pressure and problems in life. In fact, eating disorder patients tend to get better more authentically and kindly if the interpersonal

relational aspects of the treating professional exudes warmth, compassion, and the encouragement to explore, with utmost curiosity, their relationship with themselves through the clinician/patient relationship.

Orthorexia, Intermittent Fasting and Diet Drugs

While orthorexia is not an official diagnostic category for eating disorders, it can certainly be a pre or post cursor for anorexia nervosa. The highly detailed rules that do not link to health, but almost become a determining factor for one's morality and superiority, often lead those in this highly rigid system of food rules and regulations to "break" if the rules are broken. Dr. G recommends that real pathways to health, vibrancy, and strength (which are backed by a wealth of scientific data) include body movement and eating consistently and adequately throughout the day (preferably foods that bring joy and are overall well balanced). Of course, there are always mitigating factors that conspire against this ideal, including systemic poverty, which comes with a wealth of factors interfering with eating for pleasure, thus priming the cave person brain towards extreme eating.

Dr. G discusses intermittent fasting in terms of its lack of any solid scientific evidence proving its benefits from a health perspective, deeming it basically "a diet in sheep's clothing." In fact, if the cave person brain is triggered to respond to a body that is in famine for about half the time (discounting sleep as necessary rest), this protective mechanism is required to slow down metabolism in response, thus leading to weight gain. While for some people it can work comfortably without sliding into disordered eating, as they tend to satisfy food requirements despite longer periods of absence, for most it is an invitation to get "weird" about food.

Additionally, diet drugs including GLP-1s like Ozempic, which are used for diabetes and can be helpful for this purpose, are not used in Dr G's eating disorder treatment clinics. Given the rampant misuse of this medicine and the punishing side effects, coming off the medicine often leads to the same results as diet cycling throughout life—a higher weight than prior to commencement.

The Myth of Exercise for Weight Loss

In terms of exercise, Dr. G speaks on the physiology of exercise, nutrition, and calories. In the past, a well-known facet of eating disorder treatment for anorexia included the notion that exercise must cease due to its propensity to burn calories, which, in line with the contradictory nature of the eating disorder, is actually speaking to the eating disorder's desire to exercise in order to burn calories! At times, of course, exercise may need to cease in physical recovery until patients are well enough to identify the type of exercise most congruent with their identity and body capabilities; however, it cannot be overstated that the purpose of exercise is not for weight loss. Increased exercise without an accompanying increase in calories spurs the cave person brain into action to slow metabolism and protect the body.

Many patients, including those who cannot engage in cardio fitness or do not have bodies with a capacity for this, can greatly benefit from strength training (just as good as cardio in reducing risk for diabetes, heart attacks, strokes, hypertension, etc.). Dr. G describes exercise as a way of reengaging the body in movement for vitality and vibrancy, thus reengaging in an identity not dominated by the eating disorder.

Concluding Comments

As clinicians who have the privilege of working with eating disorder patients, we have to ask each and every person we encounter, “What is it like to live in your body?” Questions must be asked with absolute curiosity and interest. Every patient’s experience is unique, and while there may be similarities in symptoms, behaviors, lab results, cave person brain responses, and the denial of illness severity (among other things), to make assumptions of patients’ experiences in the world is to potentially cause further harm.

We can create a space where patients are permitted to tell their stories and be believed, validated, and received with the utmost compassion and respect. If a patient has the experience of feeling like a precious and magnificent part of the clinicians day each and every time they connect, then we are on the right track with eating disorder treatment.

Further reading:

Sick Enough: A Guide to the Medical Complications of Eating Disorders

Connect with Jennifer Gaudiani, MD: here
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