

Mallory Tarpley

Often I find that these individuals may say that they once had an eating disorder, but we're starting to see some more public figures who are saying, well, it's still there, or I still have the thoughts, I'm not fully over it. And that for me has been refreshing. We're not hearing those stories nearly enough, but there is this sort of very slow growing acceptance that sometimes these disorders stay with us and they do remain a vulnerability.

LuAnn Heinen

That's Mallory Tenore Tarpley, a journalism and writing professor at the University of Texas Austin. She's the author of *Slip: Life in the Middle of Eating Disorder Recovery*, a book that newly defines the middle place between acute sickness and full recovery. Recognizing that recovery remains a lifelong process for many, Professor Tarpley's book seeks to find strength in progress, not perfection.

I'm LuAnn Heinen, and this is the Business Group on Health Podcast, conversations with experts on the most relevant health and well-being issues facing employers. Today we discuss eating disorders, including risk factors like certain life events, the rise in middle age diagnoses, and best practices for treatment.

Mallory Tenore Tarpley, welcome to the Business Group on Health podcast.

Mallory Tarpley

Thank you so much for having me.

LuAnn Heinen

Your book, *Slip: Life in the Middle of Eating Disorder Recovery*, is just out. Congratulations.

Mallory Tarpley

Thank you.

LuAnn Heinen

I love that it's a very personal story, but not just your story. There's so much additional and helpful content from your own research. What led you to write this book?

Mallory Tarpley

Well, thank you for that. I have wanted to write this book for most of my life. For a long time, I thought I needed to be fully recovered from my eating disorder in order to write it. But I was really intrigued several years ago, probably about five years ago now, around what it would look like to write this book as someone who is in recovery and has been for over 20 years, but someone for whom the disorder remains a vulnerability. I struggled with anorexia as a child and now have been in recovery, but I'm better and not all better. I really wanted to write the book from that perspective, because there's so many books on eating disorders, but they're pretty much all written from the perspective of people who are fully recovered. I was keen on telling a different narrative and looking at how this middle place, this space in between acute sickness and full recovery plays out for other people too. I knew that I didn't just want this to be my own story. I also wanted to include narratives from other people as well as the latest research on eating disorders and recovery.

LuAnn Heinen

Just how common are eating disorders in the U.S. and also globally?

Mallory Tarpley

Eating disorders are quite prevalent. There are an estimated 70 million people worldwide who will have an eating disorder at some point in their lifetime and 30 million Americans will struggle with one. Those numbers are likely lower than they actually are in reality, because we know that many people are never officially diagnosed and never seek treatment in the first place. We also know that eating disorders are on the rise. According to one more recent report, eating disorder related health visits among people of all ages increased by 41% from 2019 to 2022, and among people below age 18, the increase was 93%. So particularly among younger people, we are seeing a greater prevalence of these disorders.

LuAnn Heinen

Do you have a theory as to why?

Mallory Tarpley

I do. This was something that I asked a lot of clinicians about as I was working on the book, and many of them said that they think social media is a big part of this. Now we can't categorically blame social media for the rise in eating disorders, but certainly there is this real pervasive content that we see on social media platforms related to weight loss and diet culture and fat phobia. We often will see this content under the guise of wellness, but sometimes if you look beyond that, you can see that very often these particular posts or accounts or sites are actually promoting weight loss as the sole way of being healthy when in fact we know that there are many other elements that go into one's health.

LuAnn Heinen

Let's at this point, recap what's under the eating disorder umbrella.

Mallory Tarpley

There are several disorders underneath that umbrella. Anorexia nervosa is a common one and that is essentially where people are severely restricting their food intake and are clinically underweight and experiencing physical symptoms as a result of that. There is a newer diagnosis that is lesser known, but not any less common, and it's referred to as atypical anorexia. That is essentially where an individual has all of the same sort of symptoms and meets all of the same diagnostic criteria as someone with anorexia nervosa, but they are not clinically underweight. Oftentimes these patients we find tend to be more stigmatized or overlooked because they don't "look the part" of someone with anorexia and that they are not underweight and for reasons related to genetics or other factors, their bodies just don't get to the point where they are emaciated and have lost a significant amount of weight that puts them into a lower BMI. There is also bulimia nervosa, which is essentially where individuals are often restricting their food intake, but may also engage in binge eating behaviors and then they are releasing that through purging. There is binge eating disorder, which is very prevalent and that is when an individual is eating excessive amounts of food, typically in isolation and with a sense that those behaviors are very much out of control. Lastly, I will say that there is also this disorder that has been gaining a little bit more attention lately, and it is known as avoidant restrictive food intake disorder or ARFID for short. People with ARFID tend to limit their food intake, not so much because of shape or weight concerns, but because of a lack of interest in eating. They may, for instance, have a sensory aversion to the taste, texture, or smell of food. We see that more commonly in children, but certainly it can affect adults as well.

LuAnn Heinen

We've long assumed that eating disorder means underweight and low BMI, but I saw that fewer than 6% of people with eating disorders are medically underweight.

Mallory Tarpley

Yes, this is true, and I actually point to this statistic in my book because it's quite revelatory because there is this misconception that everyone's struggling with an eating disorder, particularly a restrictive one, must be underweight. We know that that's just not the case. This particular study looked at hundreds of individuals, adolescents in particular, who had a range of different eating disorders and only 6% of them were clinically underweight. That is really important as we think about the reality that people in all different body sizes and shapes can and do struggle with eating disorders. But again, sometimes they are not getting the care that they need because their bodies aren't creating these warning signs that they need help and care and attention.

LuAnn Heinen

You said that 30 million Americans will struggle with an eating disorder. I've also read that the U.S. lifetime prevalence is like about 9% and twice as common in women as men and more common in LGBT adults and teens who are more likely to have eating disorders than their heterosexual and cisgender counterparts. I think another point to make is that people of color are half as likely to be diagnosed. So they are very much undercounted and undertreated.

Mallary Tarpley

That is very true. There is this very harmful long held stereotype that eating disorders only affect skinny white affluent girls to the point where there is an acronym SWAG, which describes that descriptor. That has caused many people who don't look the part, who aren't young teenage white girls to think that they can't seek treatment or to feel very isolated in their struggles because they are not fitting that stereotypical mold. We also know that unfortunately doctors receive very little training on eating disorders. Research shows and the interviews that I did confirm this, that doctors typically get about zero to two hours of training on eating disorders in both med school and residency. As a result, there's this real lack of awareness around what eating disorders are, but also who they affect and how they take shape. I interviewed many individuals who believed that they were discriminated against in the medical community because of their gender, because of the size of their body, because of the color of their skin, that is this real reality that we have to contend with and in some ways that has led to this reality that people of color are much less likely than their white counterparts to actually get the treatment that they need.

LuAnn Heinen

It does seem really clear that diagnosing and treating eating disorders is super challenging. We have a mental health condition with damaging physical health consequences, but one that comes with a lot of shame and that breeds secrecy. I'm guessing that people aren't straightforward with their physicians. As you point out, there's little or no training in medical school. Something like 30% of those who seek treatment get it. All of that is before we even get to insurance. What's your take on this?

Mallary Tarpley

We certainly see more treatment programs now than we did in the past. When I was struggling in the late nineties, there were far fewer treatment programs that specialized in eating disorders. So we do see more treatment options available, but there are a lot of barriers to care. Part of this has to do with individuals who don't look the part of someone with an eating disorder sometimes are not seeking help. It may be, for instance, that within their community culturally or otherwise, they may be the only one struggling or it may be that they don't feel like they even know what they're with. Many people struggle with eating disorders, but they minimize what they're going through and think, well, this is just a normal part of being a woman in our society, for instance, or I'm not sick enough to have an eating disorder. So that can compound the issue and create another barrier to care. But, also there are so many other challenges. There are many rural communities where there are just no treatment centers at all. Oftentimes, there are insurance barriers and many of these treatment programs are not able to take insurance. That is a big barrier.

LuAnn Heinen

You've written about the impact of key life stages on eating disorders, on diagnosis, on progression. What happens when in pregnancy, weight gain is a must. Someone who's struggling with eating disorders and trying not to eat or counting calories and overexercising, what happens in pregnancy? How does that play out?

Mallary Tarpley

With pregnancy, it can certainly be a trigger for individuals who have had an eating disorder or who are in recovery from one. We know that anytime there is a transition involving bodily changes, that is going to be a time when individuals really need to consider how they can take care of themselves and be mindful of the possibility of relapse. Sometimes pregnancy can also lead to the onset of an eating disorder, particularly if there are a lot of concerns around gaining weight and then pressure to lose it after the fact. So pregnancy is one of those times when women in particular are more vulnerable and susceptible to relapse or to developing a disorder in the first place.

LuAnn Heinen

What about the postpartum period, which is already a vulnerable time for many women when it comes to mental health?

Mallary Tarpley

Yes, and we don't talk about this as much. I have a chapter in the book where I talk about my own unexpected challenges postpartum, where I had a flare up of obsessive compulsive disorder (OCD), which

is a very common comorbidity for those struggling with eating disorders. I struggled with OCD when I was acutely sick as an adolescent with anorexia, but it had since gone away. But then after I gave birth to my two children, I found myself in this obsessive behavior around pumping and breastfeeding because I knew that that was a way to burn calories. So I felt very isolated in this experience. I felt a lot of shame as a mother, I thought I should have been better and I felt really just fearful of telling anyone about what I was doing. I was often glorified for donating these 10 gallons of breast milk to the local milk bank. If only people knew sort of what was behind that, then it would have been a different narrative. But I talked with a couple of researchers who have looked at the fact that postpartum can be a time when many women actually do struggle with obsessive compulsive disorder, but it's not something that's talked about. And similarly, this discussion around pumping and breastfeeding as a trigger is often not discussed because it runs contrary to the long-held narrative that breast is best. There's very little research done on what this postpartum phase can look like and how it can be triggering for women who've had an eating disorder.

LuAnn Heinen

Then moving on through the lifespan, the *New York Times* just this summer published an article, *Anorexia in Middle Age and Beyond*, about a growing number of older women seeking treatment for eating disorders and you were quoted. Tell us a little bit about that.

Mallary Tarpley

We often think of eating disorders as only affecting young people, but certainly there are people in middle age and beyond who are struggling. I interviewed many individuals for the book who were in their forties, fifties, sixties. I interviewed someone in their seventies. They said that when they were struggling years ago, they never really got the treatment that they needed. We know from research that the sooner someone receives treatment, the better the long-term prognosis. But years ago, if we go back in time to the sixties, seventies, eighties, even the nineties, it was difficult to find specialized eating disorder care. So many of these individuals struggling at the time never really got the care they needed and have always been in this place of either continuing to be sick or just sort of making do with the disorder and not living a very full life. There are times too, when many individuals middle age and beyond may end up relapsing. I talked with women for instance, who felt like their sense of purpose had ended. They had been stay-at-home moms, for instance, and then when their youngest child went off to college, they suddenly were empty nesters. They didn't know what to do with that and ended up relapsing. Other times menopause can also be a trigger. We know that that can be a trigger sometimes even for the onset of eating disorders, but more often than not, it can be a trigger for individuals who have lived experience with an eating disorder and maybe who have been in a period of recovery, but then during menopause experience weight fluctuations, and maybe told by medical providers that they should try to lose weight and get rid of that belly fat. There's all these messages that we hear at different points in our lifetime that carry on into middle age and those are messages we need to be really mindful of in terms of recognizing who's on the receiving end of them and acknowledging that eating disorders affect people of all ages.

LuAnn Heinen

There were sad stories that an older women felt particularly shamed because by whatever age, 60, they were still struggling, and anorexia was considered to be a disease for teens and people in their twenties, and it's almost shameful that you haven't figured it out.

Mallary Tarpley

Yes, exactly. There is this sense of why am I still struggling with this, right? Why can't I get over this? I have so much empathy for older women and men in those situations, because there is that feeling of remorse and feeling of frustration about why can't I get over this, but if an individual has never really gotten proper treatment, it makes sense that they would still be struggling. Sometimes it's the case too, where these older individuals will go into eating disorder treatment programs, but then they're the oldest individuals there and they feel like they almost have to play a paternal or maternal role to the younger individuals there. One woman I talked to had been in a treatment center and she was in her sixties and all of the other people in treatment were in their teens and early twenties, and she said, I felt like I had to mother them. And she ended up leaving far before she was ready just because she was so out of place or so she felt. Treatment programs are trying to address this, so I want to acknowledge that, but we still have a ways to go.

LuAnn Heinen

So the difficult health consequences that can come about when someone has been living with an eating disorder, when do those become felt and what are some of the greatest concerns about long-term health?

Mallary Tarpley

Yes, certainly with long-term health, we have to be really conscious of the fact that there can be sort of longer-term health repercussions. One of them in particular is osteoporosis and so we need to recognize that this can be quite prevalent among people who never received care when they were younger at a time when they should have been developing their bone density. There is a lot of bone density loss that can happen, particularly if someone is struggling with a restrictive eating disorder during their adolescent and teenage years. Now, if someone is struggling during those years and they are able to get help and they're able to restore their weight, then that sort of problem can remedy itself. But if one remains untreated, we know that osteopenia osteoporosis are conditions that we can't really reverse. So later in life, individuals may experience the side effects of these two particular conditions. We also know too, that if someone is continuing to restrict later on in life, then they could have heart complications. They could have a lot more serious issues and we do know that these disorders can be life-threatening. It's really important to seek help and recognize that no matter what age you are, there shouldn't be shame involved in seeking help and acknowledging that you need it.

LuAnn Heinen

Could you summarize what are best practices for treatment today and are there any new treatments on the horizon?

Mallary Tarpley

Yes, treatment has certainly evolved a lot since I was in treatment years ago in the nineties. When I was in treatment, there was this belief that children in particular should be extracted from the home. There was actually this phrase that was used by psychologists and it was called parentectomy, which essentially meant that the child needed to be removed from the home in order to recover. Part of this harkens back to a longstanding belief that mothers in particular were to blame for children's eating disorders. We now know that parents do not categorically cause eating disorders. They can contribute in one way, shape or form, but they do not cause it solely. Now there's a much greater push to not institutionalize children unless they really need it, but rather to say, how can we help empower parents and caregivers to really understand these enigmatic eating disorders better and help their children to restore weight, to start eating, to develop healthier habits at home so that they're not having to be in this cycle and this revolving door of treatment at such a young age. This is referred to as family-based treatment, and it really is considered the gold standard now for treating adolescents with eating disorders. Now, it's not always easy to find a family-based treatment provider. Also, this does require buy-in and time from caregivers, which isn't always possible, but this has been a really important evolution in treatment. There are also really interesting other types of treatment modalities that are starting to emerge. One of the ones I look at in the book, it's called temperament-based treatment. This is one that really appealed to me because it's one that I had not heard of and it's something that essentially looks at the traits of people with eating disorders. So people with anorexia, for instance, tend to share a lot of the same traits like perfectionism, rigidity, persistence, risk aversion. Traits actually develop from brain circuits, which are structured by genes and influenced by the environment. People with anorexia have alterations in the wiring of these circuits, which can lead these traits to be expressed destructively instead of productively. And so with this particular treatment, providers work with individuals to recognize that recovery is not about getting rid of those traits, but learning how to express those traits productively instead of destructively. This is a form of supplemental treatment. It's not the sole treatment that one would undergo with an eating disorder, but they may be engaged in cognitive behavioral therapy, and then also doing this temperament-based treatment as part of that. We see a lot of improvement with treatment. Still today there's no FDA approved drug to treat anorexia and other eating disorders, but with all of this brain-based and genetic research that has been emerging lately, there's hope that maybe we can advance in terms of pharmacological treatments for eating disorders.

LuAnn Heinen

The family-based treatment and temperament-based treatment, those are both outpatient?

Mallary Tarpley

Yes, although there are some treatment centers that are beginning to adopt temperament-based treatment in an inpatient capacity.

LuAnn Heinen

Okay, and no drugs, nothing FDA approved. What about MDMA or any other psychedelics on the horizon, especially I guess, in cases of severe trauma?

Mallary Tarpley

We do know that there is early research into using psychedelics like psilocybin and ketamine, and these do show promise for at least relieving symptoms in people with anorexia. My hope is that there'll be more studies on these drugs and other eating disorders as well. Some eating disorder treatment centers have started using psychedelics to treat patients. It is difficult to know how well these psychedelics work without randomized controlled trials. There are some researchers at the University of California San Diego, who recently conducted the first ever clinical trial evaluating psilocybin among adults with anorexia. Though this study was highly preliminary, the results were really promising. They showed that 70% of participants reported feeling a quality of life improvement and shift in personal identity. 60% reported a reduction in the importance of physical appearance. There is hope that maybe these can be one way of treating these eating disorders.

LuAnn Heinen

Then the personality traits you mentioned, I mean, perfectionism is a big one. I've done a little reading on perfectionism. There's an article recently in the *New Yorker* saying that a lot of people think, oh, I'm a perfectionist when they're trying to give a job interview. What's the weakness? Well, I'm a perfectionist. A lot of people think that perfectionism is about aspiring for excellence and these researchers make the point, it's fear-based. It takes hold in that, you know, you won't be accepted and you won't succeed and you won't be loved unless you're perfect. So I'm guessing that's what temperament-based treatment is trying to resolve.

Mallary Tarpley

Yes, exactly. That's a big part of it. Just looking at how do we think about just the origins of one's perfectionism and the ways in which that perfectionism may have also contributed to one's eating disorder. Because we know that many times people with eating disorders tend to be very perfectionistic about their disorders to the point where they may want to be sort of the perfect anorexic or the perfect bulimic, which sounds quite distorted, but the more someone sort of gets absorbed in their eating disorder, the more that perfectionism really does ramp up. So the eating disorder will often exacerbate that perfectionism, which can be rooted in fear and this desire to please people and to be the best at whatever they're engaging in.

LuAnn Heinen

Well, to that point, there are a lot of athletes, performers, very successful people who have publicly said or stated that they've struggled with eating disorders and maybe are still struggling. I mean, people like Elton John and Jane Fonda and Lady Gaga, Princess Diana. I mean, there's a long, long list of public figures.

Mallary Tarpley

Yes, a lot of people are beginning to talk more about it. It's been interesting because often I find that these individuals may say that they once had an eating disorder, but we're starting to see some more public figures who are saying, well, it's still there, or I still have the thoughts, I'm not fully over it. And that for me has been refreshing. We're not hearing those stories nearly enough, but there is this sort of very slow growing acceptance that sometimes these disorders stay with us and they do remain a vulnerability. The more we can speak truth to that, the more we can have really honest conversations about what recovery looks like.

LuAnn Heinen

Your book is exactly that. You've pretty much coined the term "middle place" and made it okay to say I'm in ongoing recovery.

Mallary Tarpley

Yes, that was so important for me because for the longest time I tried to reach the gold standard of full recovery. In my mind, it was this perfectionistic ideal and I didn't think there was a space in between acute sickness and full recovery. So every time I slipped, I felt like I was failing. With the middle place, it's really about thinking of recovery as this ongoing work in progress where slips happen, but progress is always possible. The idea of being in the middle place is really about normalizing slips as an important part of the recovery process and not seeing them as grounds for failure, but rather opportunities for growth. Because if you think about that word slip, it suggests some sort of forward movement. You can't slip if you're standing still. So living in the middle place is not about settling for stagnancy, but giving yourself more grace when you slip, recognizing that slip, talking to someone about it and asking yourself, how do I get back up now? Not tomorrow, not next week, but now.

LuAnn Heinen

Let's go to body image. In the U.S. a high percentage of women are dissatisfied with their bodies and desire to be a lower weight than they are. Studies show that in preadolescence, roughly 9 to 12. Half of girls and a third of boys dislike their body and nearly 9 in 10 LGBTQ youth are dissatisfied with their body. What is going on with that? Where does that come from and how much does it feed into this small epidemic?

Mallary Tarpley

We see body image issues really playing out early on in life. Part of this has to do with the fact that our society is rooted in diet culture, which essentially tells us that it is better to live in a smaller body. We often hear this messaging that our worth is dependent upon our weight. We can't dismantle diet culture anytime soon, but it strikes me that we are never really taught to identify it in the first place. It's just part of the soundtrack of our lives. Ads for GLP-1s or we see advertisements in magazines for weight loss, and that just becomes the messaging that we are really inundated with. It's important to me as a mother to really talk with my children about what diet culture is knowing that they can't dismantle it, but recognizing that they can try to call it out and defy it individually. This speaks to just this broader concept of something called normative discontent, which is essentially the notion that most people experience some level of discontent with their weight, making that discontent more than norm than the exception. This term was coined by a psychologist named Ruth Striegel Weissman, who I interviewed for the book. She talks about just how prevalent this is. For me, it's important to recognize that as a woman in recovery, because sometimes there's this notion that we have to unconditionally love our bodies. For me, it's been more important to think about how do I accept and respect my body and approach it from more of a place of body neutrality. That can also be important as we think about conversations with children, helping them recognize that they don't necessarily have to love their bodies all the time, because sometimes that can be unrealistic, but nor do we want them to loath their bodies. If we can help them to think more about the fact that their bodies are an instrument and not an ornament and help them recognize it's okay to take up space. That gives me hope for thinking about how we can slowly over time shift the narrative and help to promote more body acceptance.

LuAnn Heinen

Yes, and I'm glad you mentioned GLP-1s. How do they play in to this whole situation? What happens when weight loss is prescribed, for example, for somebody who may have an eating disorder, but their body mass is higher, eating disorders not suspected, what happens?

Mallary Tarpley

We're beginning to have more conversations about this, which is really important. I don't want to demonize GLP-1s because they can be helpful for individuals, but we also need to recognize that they can be triggering for individuals with eating disorders. There's one woman who I heard speak at an eating disorder conference a couple months ago. She was talking about how she was very firmly in her recovery. She'd been recovered from anorexia and binge eating disorder for many years, but she was prescribed a GLP-1 for her diabetes. As she was on this drug, she found herself beginning to have these cognitive distortions where she was really starting to think about weight loss and not wanting to eat and these eating disorder thoughts began to creep back in to the point where she needed to ask for her dosage to be lowered. She would say, I'm not eating my meals, and her doctor had said, well, that's okay if you don't have lunch, and she said, that's not okay for me as someone who has had an eating disorder. So she started to have to set alarms to remind herself to eat so that she wouldn't fall back into dangerous

territory. There's also been a couple of media articles recently that have looked at treatment centers who are finding that they are seeing more patients who are coming to them because they either relapsed once they were put on GLP-1s or they developed an eating disorder once they were on these drugs. We as a society need to recognize this and it also speaks to the need for medical providers to really be screening folks for eating disorders before they're prescribing these drugs.

LuAnn Heinen

Excellent point. What advice or information would you have for family and friends of someone who may be struggling with an eating disorder? What are other signs that might indicate that could be happening?

Mallary Tarpley

One thing to note is that often when people are struggling with an eating disorder, especially in the early stages, there may be a lot of denial. I always mention that because it may be that a family member tries to talk to a teenager, for instance, about their concerns and the teen may very quickly deny it. And that may then shut down the conversation, but it's important to recognize that that denial is often part of the disorder. Part of this is also a lot about secrecy. If you notice that your child or a loved one of any age is engaging in more secretive behaviors around food, or perhaps if they are going to the bathroom every time after they eat, which may indicate that they're purging, those are all signs you need to be looking for. Isolation is another big one. Often people struggling with eating disorders tend to retreat inward in the worst ways possible and that they stop socializing. They won't go out to eat because that is very daunting for them. They really stop engaging with other people. So isolation, secrecy, denial, certainly changes in physical appearance, whether that be weight gain or weight loss, or if you're noticing that the individual is constantly fatigued, for instance, those are all signs that really should raise some flags and that should warrant a conversation around what makes most sense in terms of trying to get this individual help.

LuAnn Heinen

What about only eating certain foods and eating the same few foods over and over and over again? Is that a concern?

Mallary Tarpley

It is very much so and that was a pattern that I fell into when I was sick, where I would only eat a very minimal amount of foods and over time would eat less and less of those foods. Also, you may notice patterns where the individual is cutting up food and very tiny pieces, or they may do that because they want it to look like they have more food on their plate than they actually do. Taking a really long time to eat meals as well is another warning sign. These are signs, particularly if the person's never really engaged in them previously, if they begin to do so, that should be a red flag that something might be going on.

LuAnn Heinen

And maybe compensatory exercising, I've got to do 10 stair flights, or I've got to do this or that every time I put something in my mouth.

Mallary Tarpley

Yes, that compensatory behavior almost always accompanies eating disorders. So if you notice an individual is going for much longer runs or they're going to the gym much more often than they used to, or going for these long walks, that should also be a sign because we know that that could actually be quite harmful for them, particularly if they're not getting enough nutrition.

LuAnn Heinen

Well, let's talk a little bit about the workplace. Many, many employers include various kinds of fitness programming, well-being programs and offerings, incentives, communication strategies, you know, obviously there's a whole food scape at work. Where might there be potential for triggering or unintentional hardship for those coping with eating disorders?

Mallary Tarpley

I'm so glad you brought this up because we don't talk about this nearly enough. Very often there are well-being programs, but those programs often do revolve around weight loss. Again, not demonizing that because there may be some individuals who feel that they want that or need that, or they are in a position

where that's appropriate, but oftentimes that sends the message across that the only way to be well and to be healthy is to lose weight. That is a message that we really need to approach with sensitivity and we need to ask what is our intention behind that messaging and how else can we really be promoting wellness and health beyond just the lens of someone's weight and weight loss. That's important in terms of just making sure that you're taking a more holistic approach and not just offering say a weight loss program, but looking at what are the different components to well-being? We know many people, for instance, with eating disorders have a lot of sleep issues. They're not getting rest. Their mind is racing at night. They may be undernourished and therefore not able to sleep well. So what would that look like to have more programs aimed at thinking about sleep and how we get sleep? What would it mean to have a program that looks at joyful movement? Because a lot of times there is this sense that the only way to exercise, if you have an eating disorder is to do it in a very grueling way, but what would a form of joyful kind of lower impact exercise look like? Also, to just recognizing that sometimes having communal spaces to eat is also really important because many people, again, with eating disorders or with a history of them tend to eat more privately and in the absence of a space where they could eat communally, then they naturally are going to retreat to their office or their cubicle. If we can create more spaces where we try to create a sense of community around food, that can be helpful because it does then encourage this idea that we can recover, we can eat in community with other people.

LuAnn Heinen

Any thought about break room policies, candy dishes on the desk policies, the large stack of brownies sitting in the break room. So that can be a distraction for everybody, but is there anything in particular around that or celebrations at work?

Mallary Tarpley

Yes, I think that's so important because I remember I worked at a place where there was just always food that was available. We would have these big sessions and events and then all the leftover food would be put into the little staff cafeteria. That was quite triggering for me as someone who at the time was struggling with binge eating and restricting. So that was not a very good situation for me. I don't want to say that workplaces shouldn't have food because sometimes it can be celebratory and it can be helpful, but we do want to be careful to just make sure that we are recognizing that that may not be something that we want to be doing day in and day out, where we have just this smorgasbord of food available at all times for everybody, because it could be potentially triggering. I would also say too, that it's important to think about how can we have conversations around comments that might be made in break rooms, for instance, or in staff cafeterias around recognizing that it's not really appropriate to be commenting on what other people are eating or fixating on other people's foods, not nearly enough workplaces even begin to approach how to handle those conversations. That's important, particularly if you have someone who feels like they're being judged about what they're eating, trying to just create policies where we don't really sort of analyze other people's food. We just sort of eat in community and free from judgment. That can be really important.

LuAnn Heinen

I'd like to ask you to read a paragraph from your book. It's on page 185 and it talks about your own story as a very successful reporter when you were working. This is many, many years ago. Then you would come home at night and you were working on deadlines. You've done the reporting work during the day and then you had to do the writing at night and you had a reputation to uphold. Tell us how you prepared for that.

Mallary Tarpley

Sure. I'll read the passage. "Each assignment sparked unbearable anxiety that ended with a frenzied trip to the grocery store. I would report during the workday from the office, then make a pit stop at the neighborhood Publix grocery store on my way home. I would load up on binge foods, ice cream, chocolate chip, granola bars, Swedish fish, trail mix, and fidget at the checkout line, praying I wouldn't run into anyone I knew. I tried going to a different cashier's line each time, fearing I would blow my cover if I went to any one of them too often. I'd rush back into my car and drive home, feeling guilty whenever I inevitably passed people who lived rough on St. Petersburg streets. There they were, begging for something to eat, and here I was with a passenger seat full of binge food. I knew that half the food would wind up in the

trash, where I would pour soap on it to render it inedible, or in the toilet, which became a literal dumping ground for food I wanted to flush away. The waste compounded my shame.”

LuAnn Heinen

I think it's hard for people to understand the suffering that those with eating disorders experience.

Mallory Tarpley

It really is, and that was, I remember, a painful part of my life and a painful passage to write, but there is so much secrecy, so much shame, and part of it is because we just don't talk about eating disorders enough, and we don't talk about the messiness of recovery enough, and that really leaves a lot of people feeling like they need to be silent.

LuAnn Heinen

I just want to say how much I appreciated your book and the courage that you displayed in sharing some really difficult details from your earlier life, and you could have buried those, but you put it out there and others are going to benefit.

Mallory Tarpley

Thank you so much. This was definitely the most courageous piece of writing I've ever put out into the world, but I truly believe that storytelling begets storytelling, so my hope is that in sharing my own story, it will empower others to do the same.

LuAnn Heinen

I've been speaking with Mallory Tenore Tarpley about her new book, *Slip*, that incorporates original reporting and cutting-edge science alongside her personal story of living with anorexia nervosa.

I'm LuAnn Heinen, and this podcast is produced by Business Group on Health, with Connected Social Media. If you liked this episode, rate us and leave a review.