Rebecca Eyre:
It's a very secretive illness and so there's also ruptures and trust and ruptures in relationship. A lot of people with eating disorders isolate a lot in order to hide their behaviors from people and hide their struggles from people. That really ends up casting a really long shadow on these relationships that might have once been very close.

LuAnn Heinen:
That's Rebecca Eyre, Chief Executive Officer of Project Heal, a non-profit whose mission is to break down systemic, health care, and financial barriers to recovery from eating disorders. A licensed therapist, Rebecca has treated eating disorders and trauma, a common precursor, for over a decade. She's been the CEO of Project Heal since 2020, living a personal passion to ensure that treatment and healing are possible for everyone.

I'm LuAnn Heinen and this is the Business Group on Health Podcast, conversations with experts on the most important health and well-being issues facing employers. Today Rebecca Eyre and I will discuss the growing prevalence of eating disorders, their potentially devastating consequences, and the misconceptions that most of us have about them. We'll also talk about equity and diagnosis and treatment, and how employers can create a workplace that's eating disorder informed.

Rebecca, welcome to the podcast today.

Rebecca Eyre:
Thank you so much for having me. I'm excited to be here.

LuAnn Heinen:
We have a lot to talk about, but let's start with the basics. What is an eating disorder?

Rebecca Eyre:
An eating disorder is essentially a disrupted relationship with food and it can look a lot of different ways. I don't know that there's a very good definition of what “normal eating” is, but when a person's relationship with food is negatively affecting their health or their quality of life, it might fall under the category of an eating disorder. The Diagnostic and Statistical Manual, otherwise known as the DSM, outlines a handful of umbrellas under which those eating disorders might fall.

LuAnn Heinen:
In the past you've made a distinction between an eating disorder that's diagnosable and disordered eating that I think many of us struggle with.

Rebecca Eyre:
Yes, absolutely. I would argue that most people in the United States have some kind of disordered eating, mostly because we have such a prevalent diet culture in this country and a lot of people have felt pressure to change their bodies for so many reasons. Also, food is such an everyday part of our lives and it has such emotional meaning and it's very normal and natural for someone to turn to food and to use food in a way to cope with distress. So disordered eating technically does fall under an eating disorder diagnosis. There's something called otherwise specified feeding or eating disorder, and it's essentially kind of a subclinical eating disorder. I would argue that disordered eating is on a spectrum and then there's a point at which frequency of behaviors or degree of life interruption tips it over into proper eating disorder diagnosis status. Disordered eating is common. Skipping meals because you're trying to lose weight or because you're stressed, preoccupation with body image, eating well past the point of fullness, feeling like you need to exercise or

compensate after you've eaten more than you wish that you had, aversion to certain textures. All of those things can be considered disordered eating.

LuAnn Heinen:
What are the major types of eating disorder?

Rebecca Eyre:
Well, the most commonly understood one is anorexia nervosa, which is characterized by severe caloric restriction and malnutrition, typically anchored by a fear of gaining weight and some body dysmorphia or like an inaccurate sense of your own body size, so someone who's very underweight, really believing that they're a lot larger than they are. Binge eating disorder was added in 2015, and that is not what we think of as overeating, it's a lot more like a significantly larger volume of food in a single setting that is often characterized by feeling like you've lost control. Then there's bulimia nervosa, which includes those binge eating episodes, but they're always followed by compensatory behavior like purging by vomiting or laxative abuse or exercise or even fasting is considered a compensatory behavior. Then there's something called avoidant restrictive food intake disorder, which is quite similar to anorexia nervosa, except it's not anchored by body image distress. It's a lot more commonly anchored in sensory processing issues, aversion to certain textures or temperatures, and a lot of rigidity around what types of food will be eaten. It's really common in folks with autism spectrum disorder or with sensory processing issues. Then there's a beautiful umbrella called otherwise specified feeding or eating disorder. I think it's worth mentioning underneath that umbrella is what we call “atypical” anorexia and I put atypical in quotes because it's actually a lot more common than anorexia nervosa and the only difference between atypical anorexia and anorexia nervosa is weight. There are a lot of people in the eating disorder space, clinicians, researchers, etc., who would argue that there is no meaningful difference between them and the weight criteria for anorexia nervosa should be removed and atypical anorexia should be taken just as seriously as anorexia.

LuAnn Heinen:
Let's talk about the statistics, which are a little bit alarming. How common are eating disorders and what happened to the trend line during Covid?

Rebecca Eyre:
Yes, well the most recent data that we have says that nearly 30 million people in the United States will be diagnosed with an eating disorder in their lifetime, which means that around 5 million people are living with an eating disorder today. That is only including people who have been diagnosed and we also know that people do not have ready access to diagnosis. Most people in the field believe that that number is a lot higher, but assuming it's that 30 million number, that's 10% of people in the United States. Those numbers went up significantly during Covid, partly because I think access to diagnosis and awareness went up, but also Covid created a perfect storm for people with eating disorders - people lost their structure, they lost community, they had an overwhelming sense of anxiety and eating is a really common way for people to manage distress. So people who might have had a predisposition to an eating disorder found themselves struggling with one. Someone who already had an eating disorder, their eating disorder was intensified. Even people who had been in long-term recovery from eating disorders found themselves relapsing with their eating disorder in the pandemic. What we found is, especially with adolescents, that hospitalization doubled during the first year of Covid 19. That was really difficult, especially against the backdrop of so many people losing their jobs and losing their insurance, so the problem intensified and the access to resources also was negatively impacted pretty dramatically and so created absolutely an eating disorder crisis in this country.

LuAnn Heinen:
That brings me to the burden on caregivers, especially for adolescents, you mentioned. What is the impact on family members of someone living with an eating disorder?

Rebecca Eyre:
I think much like substance use, eating disorders affect the whole family. I think one of the most difficult things about eating disorders is that it's very, very personal because at the end of the day, no one can make you eat

or not eat anything. It's a place where people ultimately have quite a lot of autonomy and control, and so especially for adolescents, parents feel helpless in the face of this eating disorder, which is being bolstered by really distorted and untrue thoughts and they can't ultimately do much about it. So there's a certain degree of helplessness and a lot of people with eating disorders also can be pretty deceptive, the behaviors thrive in the shadows, it's a very secretive illness. There's also ruptures in trust and ruptures in relationship, and a lot of people with eating disorders isolate a lot in order to hide their behaviors from people and hide their struggles from people, and that really ends up casting a really long shadow on these relationships that might have once been very close. For loved ones watching someone that you care about and maybe even someone who's well-being you're technically in charge of as a parent, you have such a sense of like, what is going on, what happened to my child, where did they go? There's a sort of disappearing that happens and sometimes that's literal, but very often it's relational. Because there's such a lack of education about eating disorders in our general culture, a lot of parents have no idea where to start. They have oftentimes their own unaddressed issues with food. So oftentimes when they see some of those same behaviors in their kids, it can be hard to recognize how serious the issue is until it takes on a life of its own. What's really devastating about this is also that eating disorders are such a fatal mental illness. It's the second most fatal mental illness after opioid use disorder. One person dies of an eating disorder every 52 minutes in this country. When you think about how genuinely devastating eating disorders are, it can be really terrifying to watch a loved one go through that and have no idea where to start.

LuAnn Heinen:
It does seem that they're dramatically underdiagnosed and undertreated from some of the statistics that you've shared. Is that partly because this is squarely both a physical and a mental condition? We know we should have a holistic approach, but you've got to choose what practitioner to go to, who knows how to spot this, who knows how to make the treatment referral?

Rebecca Eyre:
I think it's really tricky. I think one of the most important things that people don't realize is that most, if not the majority of mental health programs, master's level programs and doctoral programs, don't include robust eating disorder training. That means that most mental health practitioners and medical doctors are practicing without any training and screening for eating disorders, let alone treatment in eating disorders. The treatment landscape for eating disorders is really sparse. There are less than 6,000 providers in the country that can effectively treat eating disorders. With 5 million people, you can see how those numbers simply don't add up, so a lot of people go underdiagnosed. There are some really troubling statistics, especially around biases and discrimination. If you are a person who matches the stereotype of an eating disorder, which most people have a mental image of a white, very underweight, presumably cisgender teenage girl, that is going to be someone who's a lot more likely to be accurately screened and diagnosed because they sort of fit this cultural and most typical image that we have of someone with an eating disorder. But less than 6% of people with eating disorders are underweight and there are a lot of diagnoses that are actually a lot more common in black and brown communities. Eating disorders are eight times more common in trans and non-binary communities. We have actually really high incidence rates in other communities that are totally missed.

LuAnn Heinen:
If someone would like to find treatment, what is the evidence-based standard?

Rebecca Eyre:
That's a really good question and unfortunately there isn't one. There are certain types of treatment that have been proven to be effective with certain types of eating disorders in certain populations. We have a better sense of what to do with an underweight adolescent female. That is something that I think there's a lot more evidence-based care around, but unfortunately, eating disorder research is one of the most underfunded categories of medical and mental health research. When we talk about evidence-based care, we really simply do not have a lot of data to say what kinds of treatment works with all kinds of diagnoses, with all kinds of identities, with all kinds of body types. Unfortunately, I think a lot of treatment is ineffective because it's not designed for the wide variety of people who actually have eating disorders.

LuAnn Heinen:
There's hospitalization, as I understand it, partial hospitalization, and family-based therapy. Are those the major treatment options?

Rebecca Eyre:
No, there's more. There's inpatient, which you're right, is basically equivalent to hospitalization. Then there's residential, which is essentially just below the acuity level of inpatient, but it's still 24-hour care and it's very similar to kind of rehabilitation for substance use disorder. You don't need to be in medical crisis or have medical instability, but you do need 24-hour supervision and containment. Then partial hospitalization is basically day treatment. Then intensive outpatient is bundled care, therapy, nutrition, group support, and that's typically happening around your job or your school, but it's still pretty intensive. Then regular outpatient is just a therapist, a dietician, a doctor, just typical doctor's office visits. Family-based therapy is a certain kind of outpatient care that is evidence-based for adolescents and young adults with anorexia nervosa and bulimia, and it's very effective and it really heavily leans on the family. That's something that we're seeing more and more is an essential component.

LuAnn Heinen:
What is the average cost of treatment? I would presume that the less intensive treatments are much less costly.

Rebecca Eyre:
It's estimated that a full course of treatment at all the levels of care a person with a severe eating disorder might recover, would run someone around a quarter of a million dollars. That would include a month in in-patient, a few months in residential, a few months in partial hospitalization, a few months in intensive outpatient, and a good year of outpatient care. That is, of course, only one version of this scenario and doesn't account for any changes in acuity or relapses along the way. The University of California San Diego estimates that the average individual eating disorder treatment episode is $80,000. We're really looking at massive, massive costs here. Even when you're an outpatient, that's supposed to be the lowest cost version of this and certainly relies on you to do most of the work yourself at home, you're still looking at $750 a week between all of these providers to make sure you're medically stable, to work with you on your meal plan, and to address the underlying issues.

LuAnn Heinen:
Those are some serious costs and some serious challenges. One of the reasons there aren't enough treatment providers, do you think the demand would be there?

Rebecca Eyre:
I really think that if we could get serious about helping people fully recover from eating disorders, that there would be more than enough resources. I think also if we expanded our idea of who is worthy of and who has a right to quality, affordable care, I think that we would have a really dramatically different eating disorder field. Right now, the vast majority of the eating disorder field is focused on people with medically unstable anorexia nervosa or bulimia nervosa. Obviously, that makes sense, right? A lot of resources being poured towards the most medically complicated and the most medically dangerous eating disorders does make some sense. Unfortunately, like I said, the vast majority of people with eating disorders aren't necessarily going to get to that level of medical acuity and they're going to not have access to the resources that they need. What's really wild to me as a provider myself, is this is the only diagnosis in the DSM that has a medical metric to determine whether you meet criteria for it. All of the rest of these diagnoses are understood to be mental health conditions that are measured by behavioral and psychological symptoms. With anorexia, we have this weight criteria and it's very confusing and it doesn't really match the data that we have about what anorexia actually looks like and how it affects people. The last thing I want to say about this is that we wouldn't wait for someone who was struggling with alcohol use disorder to be in liver failure before we provided them with the care that they needed in order to get sober and to rebuild their life. Unfortunately, with eating disorders, we really are waiting until someone is medically unstable, where the eating disorder is negatively affecting their organs, where they simply are in serious medical danger, before we get them access to the care that they

deserve. The volume of people who are denied authorization for non-medical care, because they don't meet medical necessity requirements, is staggering.

LuAnn Heinen:
One of the things I learned from speaking with an alcohol use disorder expert is that at the mild to moderate end of alcohol use disorder spectrum, there is a lot of self-care. They use fellowship models that work extremely well and are evidence-based. Is there a parallel for eating disorders where you can reach people in that more primary and secondary prevention stage?

Rebecca Eyre:
I really love that question and I like this idea a lot. I do believe that a lot of more mild eating disorders are absolutely treatable with community interventions, with mentorship, with just being around peers who understand. I think there's absolutely data to suggest this. Project Heal also did some research on the value of peer mentorship and basically shared lived experience as being a really important key to eating disorder recovery. I think what's really hard is that with alcohol, you have an abstinence solution and those community fellowship-based models are all gathered around the same pretty black and white goal of abstinence. With eating disorders, there is no such thing as abstinence. It's not a black and white solution. You have to eat multiple times a day in order to maintain your life.

LuAnn Heinen:
I'm speaking with Rebecca Eyre who leads the non-profit Project Heal, whose vision is for every person with an eating disorder to have the resources and opportunities they need to heal. We'll be back in a moment.

LuAnn Heinen:
Let's move on to why have you said that America has an eating disorder?

Rebecca Eyre:
For the majority of the time that most of the people who are alive today have been on the planet, there has been a huge emphasis on body size as, not only a metric of health, but also a metric of kind of moral quality, that there's something that is ideal about this. It's built into our popular media. It's built into our New Year's resolutions. It's built into our concept of health. This preoccupation with thinness as the ultimate ideal, the way to secure love, the way to get belonging, the way to have status, there's something very baked into our society that highly, highly values thinness above all else. The length that a lot of people are willing to go in order to maintain that or to achieve that is really scary and there's a multi-billion dollar diet industry that demonstrates how important this is to our society.

What's really wild about that is that the data also shows that 97% of people who diet or who intentionally attempt to lose weight will not only gain it back, but gain even more back. We understand that dieting doesn't work and yet we have a very strong value on it as something that we congratulate people on. When people lose weight, we praise them. We don't even stop to ask why they've lost weight. Maybe they lost weight because they have cancer. Maybe they lost weight because they're grieving. Maybe they lost weight because they have an eating disorder. It's just universally considered positive. I think people have assigned a lot of moral value to different foods and they have a lot of very black and white ideas about why a person should eat, why a person should not eat, what someone who's healthy looks like.

All of these things disrupt our ability to listen to our bodies. There's a huge movement towards intuitive eating in this country and it's certainly a huge part of what eating disorder recovery looks like. It's this idea of trusting that your body knows when it's hungry, knows when it's full, knows what it's craving and why, and believing that maybe the body contains some wisdom. More and more we're learning that the mind-gut connection and we have so much data to suggest that food is cultural, it's spiritual, it's emotional, it's very relational, it's built into so many layers of our existence on this planet, but we keep trying to treat it like our bodies are machines, and if we could just crack the code of this machine, then we could achieve our greatest happiness. That is simply not how food works and not how bodies work, but it's truly one of the most universal experiences of being.

LuAnn Heinen:
I agree to your point that a lot happens in sort of in the early family years that's just buried deep and then there's judgment everywhere, not just the physician's office. There's a lot of that. Where we used to have, like maybe the *Vogue* magazine, you'd have to go out and buy it, to see that now it's everywhere in social media, so many influencers making a living, pushing information out to young people and to everyone.

Rebecca Eyre:
The interesting thing about influencer culture is that in a lot of ways it's changed our brains. Historically, we only had visual access to people who were in our direct communities, whether it's our town or our village, this is for millennia. Now we have instead of one or two extremely beautiful people in our town or village, we have access to like literally all of the most extremely beautiful people on the planet at the same time, and it can really distort our sense of what most people look like. It's like a psychological farce. There's something very, very strange about having visual access to not only the celebrities anymore, we're talking about really hundreds of thousands, maybe even millions, of the people who are closest to that beauty ideal. I think it really has, especially for young brains, an overwhelming impact of creating the illusion that this is a lot more people than it is. There is a statistical truth that less than, I don't know, 5% of people are this close to the beauty ideal and unfortunately all of them are online wearing very little clothes and making it seem like they're the norm, and that's not reality. That's not what our neighborhoods and our towns look like.

LuAnn Heinen:
At the same time, obesity in America and globally is on the rise at the highest levels of our lifetime and trending up. And we know, I know that as you call it the O word, isn't your favorite, but obesity is associated with dangerous health impacts, high blood pressure, type 2 diabetes, stroke, sleep apnea, osteoarthritis, and so on. We, in our work at the Business Group, have supported obesity as a medical condition. People with obesity who want treatment should receive insurance coverage for bariatric surgery, counseling, there are new and very seemingly effective drugs on the market. That's something that's happening on the coverage side. Then at the workplace there's also a well-being culture, but it is about holistic well-being, physical, emotional, social connectedness, financial security, and community. What's your reaction to that or your cautions to that?

Rebecca Eyre:
I think that in my world, and again working with people with eating disorders for 12 years, I would argue that we're tackling the same problem with very different definitions and a very different kind of set of truths. I think there's a huge gap between the eating disorder space and everything you just described. There's a lot of research to suggest that some of those negative health outcomes that are associated with obesity, to use your language, are actually associated with rapid weight fluctuations, yo-yo dieting, and some of those ways that people are trying to treat that “weight problem.” I would argue, personally, that I believe that a lot of the “solutions” for this weight problem in America are actually causing the weight problem in America. As diet culture has increased, so has people's weight and that's very easily understood in the context of the data I provided about 97% of diets not only failing to lead to sustained weight loss, but leading to weight gain.

I think if we could start working on body acceptance in this country and removing some weight stigma, we would actually see a lot less rapid weight fluctuation, a lot lower incidents of some of those negative consequences associated with rapid weight fluctuation. I think we would see overall those numbers starting to

go down. I think that the world has always had people of size in it, it always will, and I think treating it like it's *the* problem is problematic. Personally, I think that it is a symptom of a different problem, of a disordered relationship with food in America, and with I think warped values about what health means. There are a lot of people who would be categorized as obese in this country who are a lot healthier than me and I'm a thin person, and we're not, I think, measuring some of the more important metrics. I don't think we're teaching people how to eat when they're young. Instead they grew up, especially my generation, with overwhelming pressure to lose weight. I think if you actually sat down and spoke with people who would identify as either fat or overweight, you would probably hear that they have been trying to lose weight their entire lives, that they wish that they could lose weight, that they would do anything to lose weight, that they have tried having an eating disorder even, that they maybe even have an eating disorder. If that's true, maybe the problem isn't on the individual. I think there's a lot of social determinants of health and I think when you add in the layer of food deserts and food access, you get a much more nuanced picture of where the problems lie than one that is strictly focused on, if only we could help these fat people lose weight. We need to stop stigmatizing weight because it's actually not a valid or helpful measure of health.

LuAnn Heinen:
You would be not in favor of the BMI as a key health indicator?

Rebecca Eyre:
No and I think there's a pretty growing consensus about that based on the history of the BMI and the inaccuracy of it as measuring health. There's a lot of folks, even in the traditional medical system, that are moving more towards different measurements, whether it's ideal body weight calculations. A lot of different people have tried to come up with different calculations, but it really varies. It varies based on bone density, it varies based on muscle mass, it varies based on so many factors. I just don't think that a simple division of height versus weight is a helpful way to say whether someone is doing a good job at taking care of themselves.

LuAnn Heinen:
Let's talk about some of the equity issues that relate to both diagnosis and treatment. Who's being left behind and why?

Rebecca Eyre:
Well, if you visit a treatment center in this country, the odds of seeing anyone who is not white are fairly slim. The vast majority of people in eating disorder treatment are white. A lot of folks are cisgender. A lot of folks are able-bodied. A lot of folks are neurotypical. I think those are some of the ways that we have prioritized certain types of people and certain bodies over others in our culture. It's also intersectional with if you have a family that has neurotypical tendencies or is able bodied, they're a lot more likely to be gainfully employed and to have really good insurance and therefore they're a lot more likely to be able to afford that. So there's also proven racial bias in eating disorder diagnosis. There was a study that demonstrated that an eating disorder case was presented to doctors and 43% of the time, if the person was white, they were accurately diagnosed as having an eating disorder. 41% of the time they were accurately diagnosed if they were Latina or Hispanic. Then only 17% of the time they were accurately diagnosed if they were black. I think it's important to note, obviously, the huge gap between white and black people in this study, but it's also important to note that even among the white people with eating disorders, 57% of those folks were missed. Then you move to that number of black folks and it's 83% of people are missed. So you have racial discrimination and then it's being added on top of simply missing eating disorders, ad hoc. I think it's really important to pay attention to all of the ways in which we're taking certain types of people's health concerns seriously. I think there's a lot of data to suggest that black people experience a lot of harm in medical spaces, a lot of dismissal for symptoms that are taken a lot more seriously in their white counterparts, and that's definitely bleeding over into eating disorders.

The last thing I will say is that the BMI was absolutely built around a white cisgender man. That was the basis of the BMI. There are totally different trends among body mass and body type and body size and communities of color. Applying this very standard BMI metric to different kinds of communities is problematic for that reason as well. Someone who might be at the absolute peak of their health, what might be considered obese if

they come from a certain background. I think then you can even look at the inverse of that. Applying the BMI to someone from Japan might also make it seem like they're underweight or maybe like absolutely so healthy, but they might not at all be at their ideal health weight, but they're being just blanketly dismissed as fine because they have genetically typically smaller bodies. I think we need to be a lot more individualized in trying to understand how a person's health actually is beyond just looking at them or having them get on a scale.

LuAnn Heinen:
Can you spend just a few minutes speaking about the LGBTQ+ community and eating disorders?

Rebecca Eyre:
Yes, it's definitely known that eating disorders have higher incidence rates in LGBTQ+ spaces, and there's a lot of ideas about why that is. Obviously, that umbrella includes both categories of sexuality and categories of gender, which are totally different experiences. The incidence rates, like I mentioned in trans and gender nonconforming folks, are eight times higher than in cisgender people. I think that has a lot to do with the body dysmorphia and gender dysphoria that people experience and the overlap between those and the ways in which we have ideas about what people of certain genders look like and the ways in which someone might try to manipulate that through their eating. But with LGBTQ+ people, there's some interesting data across different categories. In a lot of studies they show that actually lesbians experience lower body image distress than their straight female counterparts, but gay men have extremely vicious body image ideals for each other in their community, and that's actually one of the most common places to see either anorexia or bulimia nervosa in this country. It kind of varies based on the community that you're in. In a lot of ways, it depends on who you're in that community with and what your relationship is with it, and also when you add in the layer of religion. If a queer person is growing up in a very religious environment where their sexuality is considered wrong, then they're going to have a lot higher likelihood of having an eating disorder because they're going to have a deep sense that there's something wrong with their body, that there's something wrong with them.

LuAnn Heinen:
Wow. Let's just spend a minute, I've got to ask you what it is that brought you to this level of depth of understanding, passion for this work. I know you were named CEO about a year after arriving at Project Heal. How did this happen?

Rebecca Eyre:
Yes, well, I stepped into the CEO role in April of 2020, which is why I know so much about eating disorders in Covid in particular, because we received thousands of applications of people expressing and describing some of the most devastating experiences of lack of access to eating disorder care in the pandemic. I have been an eating disorder therapist since 2011 and I got into this field because my mom had anorexia my entire life, and both my sisters struggled with bulimia, and I was really surrounded by eating disorders my entire life. So I have a really deep understanding of what they are actually about. I have first-hand experience watching these things play out over the course of years, but frankly I got into this field quite reluctantly because I was surrounded by them. It wasn't until I started treating them that I realized how healing it would be for me to realize that healing was possible. At the time when I got into this field, I hadn't known anyone who had ever recovered from an eating disorder. I really thought it was a life sentence and sometimes even a death sentence. I have come to realize that eating disorder healing is entirely possible. A full recovery from an eating disorder is possible. I know many people who have done that and became really passionate about making sure that anyone who was willing to do the hard work of recovery had access to that.

LuAnn Heinen:
Well, thank you for that. You really are making great strides and it can look like a Sisyphean task and it's a really big mountain and a big heavy boulder you're pushing up. I've seen you out and about, you're doing really awesome work.

Rebecca Eyre:
Thank you.

LuAnn Heinen:
What advice would you have for employers? Right now there's a big focus on rethinking onsite facilities, that includes dining, that includes whatever exercise and fitness facilities there might be. What thoughts do you have about culture, messaging, facilities?

Rebecca Eyre:
I think it's safe for most employers to assume that there's someone on their team or someones that have an eating disorder, that have a history of an eating disorder, and so I think creating eating disorder informed workplaces is just a good practice. One of the ways to do that is to have weight neutral spaces where people are not commenting on body sizes and where people are not weighing themselves in public or having weight loss contests or commenting on weight loss or weight gain or basically trying to erase the value that is placed on one's body as an indicator that they're successful or doing the right things. I think that the most important thing is to understand that eating disorders might not be visible, that you don't know what an eating disorder looks like, that you might not be able to tell who has an eating disorder by looking at them, and understanding that most people have a fraud relationship with food. As an employer trying to provide those resources, make sure that you're understanding the complexity or at least creating space for the complexity, that this is not just a body's issue, this is not just a medical issue, this is a mental health issue as well, and these things are all connected and mental health is a really big part of health. I think the most important thing I would add is that employers have a huge opportunity to build health care plans for their employees that adequately cover mental health and eating disorder treatment is a big part of that, and that accommodations can be made for doctor's appointments and things like that. Understanding that this isn't a six-week solve and that this is a long-term issue that is going to take a little bit of time.

LuAnn Heinen:
Rebecca, thank you so much for your time today. I learned a lot.

Rebecca Eyre:
Thank you for having me. This was really helpful to me and I hope helpful to the people listening.

LuAnn Heinen:
I've been speaking with Rebecca Eyre of Project Heal, an organization that helps break down systemic health care and financial barriers to eating disorder healing. Go to the https://www.theprojectheal.org/ to learn more about eating disorder diagnoses, statistics, and red flags, causes and impacts, and common misconceptions about eating disorders and the people who have them.

I’m LuAnn Heinen. This podcast is produced by Business Group on Health, with Connected Social Media. We hope you liked the conversation and feel inspired to rate us and leave a review.