Orthorexia Comes of Age: Perspectives on the “Healthy” Eating Disorder
Learning Outcomes

• Describe proposed criteria for a new diagnosis of orthorexia.

• Differentiate between orthorexia and anorexia nervosa.

• Guide a patient exhibiting signs of orthorexia to improved nutritional intake.
Disclosures

Steven Bratman, MD

Nothing to disclose
Origin of the term
What Foods Should I Cut Out?

• Practicing alternative medicine in 1990s

• Patients: “Doc, what foods should I cut out?”

• Primarily related to theories of improving health via diet

• Began to recognize that for some patients more important to relax about eating than to improve diet
Side Effects of “Healthy” Diet

• In alternative medicine, “healthy” diet touted as side-effect alternative to medications

• Recognized numerous side effects:
  • Cannot share food with other people
  • Cannot eat things one enjoys
  • Must pay intense attention to food
  • Identity wrapped up in food
  • Guilt, shame fear when err
Disease Disguised as a Virtue

• From holistic perspective, more important to relax about food rather than restrict further

• Had personally gone through something very similar in 1970s while living on organic farm

• Recognized would be difficult to explain: Patients thought they were being virtuous.

• To recommend loosening up would be like saying, “Drive drunk a little. Commit a little larceny.”
Invented Term

- Ortho = right

- Orexia = hunger

- Nervosa = fixation / obsession

- Analogy to anorexia nervosa

- Orthorexia nervosa: Obsession with eating the right food
Early Publications

• Published term in 1997 Yoga Journal article

• Reprinted in Utne reader

• Immediately taken up by popular magazines

• Book Health Food Junkies, 2000
“Tease Therapy” to Eating Disorder

• Intended term as “tease therapy” to help people loosen up

• Only later recognized as eating disorder

• Kate Finn, person who had contributed to book, died of orthorexia in 2003

• Cause of death was protein-calorie malnutrition, but was not trying to lose weight.

• (Detailed story on orthorexia.com, “Fatal Orthorexia”)
Disconnect

• Patients (like Kate Finn) would present for help, and would be told “you want to be thin”

• Patient with orthorexia would say they don’t want to be thin; want to be pure, healthy, clean

• Created disconnect and possible treatment failure

• Suggests benefit for distinct diagnosis
Published Case Histories

• 28 y.o. female raw vegan 12 years, severe malnutrition. No desire to be thin; no typical anorexic behaviors. Zamora et al. (2005)

• 30 y.o. male restricted diet to brown rice and unsalted vegetables leading to hospitalization. No concern about weight. Park, et al. (2011)
  • Macrobiotics?

• 33 y.o. female 8 year history of raw fruits, raw vegetables and raw eggs; social isolation and undesired weight loss. BMI 14.5 Saddichha et al. (2012)

• 28 y.o. male, eating protein shakes and supplements. “My body is my temple, and these are the pure building blocks I need to be healthy.” BMI 12.3 Moroze, et al. (2014)
Research

• Health Food Junkies proposed a self help quiz.

• Misinterpreted as formal “test,” and referenced in the literature as the Bratman Orthorexia Test (BOT)

• Inadequate for research

• BOT converted to the ORTO-15, used for research in Turkey, Italy, Eastern Europe, Portuguese speaking countries
Problems with ORTO-15

• Extraordinarily high “prevalence” rates
  • 81.9% Brazilian dietitians (Alvarenga, et al 2012)
  • 86% Spanish Yoga practitioners (Valera et al, 2014)
  • 40% Turkish medical students (Fidan et al, 2010)

• Can reduce rates by adjusting cutoff

• Nonetheless, ORTO-15 pathologizes interest in healthy eating rather than identifying an eating disorder related to healthy eating

• Lacks other standard requirements of test construction

• Was developed without the logically prior step of proposing formal criteria
Historical context
Ancient Theories of Healthy Eating

• Pre-modern medicine used diet as primary method of healing

• Complex theories of healthy eating in ancient China, India, Greece

• Theories contradict one another

• In 16th century, French writer Montaigne satirized contradictory nature of diet theories in essay
Healthy Eating in 19th Century Europe

• Medicine continued to have numerous dietary theories of health. Low diet. Cooling diet. Warming diet
• Back to Nature (Rousseau)
• Early 19th century in spas of Germany: Avoid canned food, eat raw vegetables, vegetarianism, walk barefoot in nature (Sebastian Kniepp)
• In mid and late 19th century US, theories involving fiber and whole grains. (Kellogg, Post and Graham) Muesli
• In Japan, reaction against western diet led to “macrobiotic diet”
  • Traditional Japanese diet plus theories of acid/base, sodium/potassium, yin/yang balance
Early 20th Century US

• 1918 Benedict Lust (disciple of Sebastian Kniepp) created First Health Food store, and founded Naturopathy (Natural Medicine)

• 1920s: Gaylord Hauser in Hollywood emphasized wheat germ, blackstrap molasses, yogurt, brewers yeast (Disciples: Greta Garbo, Paulette Goddard, Marlene Dietrich, Ingrid Bergmann)

• 1935 Jack LaLanne founded first fitness gym, San Francisco Bay Area

• (My grandmother was a follower of Gaylord Hauser, my mother of Jack LaLanne)
1950 – 1970 United States

• Chemical dietary supplements (vitamins)
• Large increase in popularity of “natural medicine” concepts
  • Eliminate pesticides, preservatives, food coloring, coffee, tea, sugar, spicy foods, wheat, dairy, red meat
  • Food combination theory
  • Acid/alkaline
  • Food sensitivity

• Asian dietary ideas (macrobiotics)
• Beginning of inventive period: Single diet guru invents theory out of nowhere
• Kale becomes magical food
1980 to 2000 United States

- Numerous dietary theories flourish
- Low carb becomes new dogma
- Older idea that wheat is bad becomes “gluten is bad”
- Idea of going back to Eden (the name of a 1920 diet book) gives birth to Paleo. Initially involved raw meat (Cave Man)
- Candida
- Zone
- Blood Type
- Supplements-only
- Kale remains magical
Post 2000 United States

- Mainstreaming of some basic naturopathic diet ideas as “Clean Eating”
- Dietary theories becoming less alternative and more mainstream
- Low calorie often equated to “healthy”
- Currently dominated by Clean Eating, Paleo (v.2), Veganism, Raw Foods
- Exercise now included
- Kale is still magical!
ORTHOREXIA: Proposed Criteria
External Initiating Forces

• Large, overt social support for “the healthier you eat the better.”
  • Educational programs in schools
  • Healthfoodist parents
  • Governmental programs (“Ministry of Orthorexia”)
  • Numerous books
  • Buy-in from professionals (both alternative and conventional)
  • Evangelizing friends, social media
  • Treatment for another eating disorder
  • “It’s just true!”
Transformation

• Begins as exuberant interest in healthy food

• This is NOT an ED
  • No matter how irrational the theory, adoption of a dietary theory is NOT in itself a disorder!
  • Should not pathologize disagreement

• In susceptible individuals, transforms into an ED
Individual Risk Factors

• Adoption of a highly restrictive dietary theory
• Health-foodism in parent (undue importance assigned to food)
• Childhood illness involving diet and/or digestive issues
• Medical problems that can’t be addressed by medical science
• Traits of perfectionism, OCD, extremism
• Fear of disease
Movement Toward Excess

• Certain foods are idealized as semi-magical superfoods (kale!)

• Other foods demonized as evil

• Subjective benefits initially experienced with restrictions fade; progressively stricter diets needed to produce same effect

• Escalating restrictions, decreased food variety
Movement Toward Excess, continued

- Entire food groups may be cut out; progressively more severe cleanses may be utilized

- Violation of dietary rules causes fear of disease and sense of impurity accompanied by anxiety and shame

- Food becomes primary source of self-worth, happiness, meaning
Characteristics

• Obsessive focus on food choice, planning, purchase, preparation, and consumption

• Food regarded primarily as source of health rather than pleasure

• Distress or disgust when in proximity to prohibited foods

• Exaggerated faith that inclusion or elimination of particular kinds of food can prevent or cure disease or affect daily well-being
Characteristics, continued

• Periodic shifts in dietary beliefs while other processes persist unchanged

• Moral judgment of others based on dietary choices

• Body image distortion around sense of physical "impurity" (can never become pure enough)

• Persistent belief that dietary practices are health-promoting despite evidence of malnutrition
Characteristics, continued

• May include marked or excessive focus on exercise as part of health seeking behaviors, and/or utilize exercise capacity as a means to self-evaluate health

• May use body appearance and maintenance of ideal weight as indicator of optimum health (looking fit)
Becomes a Compulsion

• What was initially a choice becomes a compulsive behavior

• Individual may attempt to relax rules, but cannot

• May experience health problems such as malnutrition

• More commonly, psychological problems such as social isolation and inability to focus attention on anything other than food

• At this point help may be sought, either by the individual or by others around them
Not ARFID

• ARFID Characteristics do not match typical orthorexia

• Apparent lack of interest in eating or food, often called “selective eating” or “picky eating.”
  • Aversion based on the sensory characteristics of food, often color, shape or texture.
  • Conditioned negative response to food, such as due to an anticipatory anxiety about aversive experience while eating, usually a choking phobia or fear of vomiting.
First PUBLISHED Sample Criteria

• Jessica Setnick proposed sample criteria in her self-published Eating Disorders Clinical Pocket guide

• Thom Dunn proposed related criteria in 2014 paper: Microthinking about Micronutrients: A Case of Transition From Obsessions About Healthy Eating to Near-Fatal “Orthorexia Nervosa” and Proposed Diagnostic Criteria. (Moroze et al, 2014)

• After reading these, I decided to jump in:
  • Need somewhere to start, and if I author the criteria, they will have greater chance of being used
  • Main concern: criteria not seen as demonizing specific dietary theories. Those most in need would perceive such as attack on favorite theory rather than description of eating disorder
Proposed Formal Definition of Orthorexia Nervosa

Two Criteria

• Must satisfy ALL of Criteria A
• Must satisfy ONE of Criteria B

Proposed Formal Definition of ON

Criteria A - All of the following:

1. Compulsive behavior and/or mental preoccupation regarding affirmative and restrictive dietary practices* believed by the individual to promote optimum health**

2. Violation of self-imposed dietary rules causes exaggerated fear of disease, sense of personal impurity and/or negative physical sensations, accompanied by anxiety and shame.

3. Dietary restrictions escalate over time, and may come to include elimination of entire food groups and involve progressively more frequent and/or severe "cleanses" (partial fasts) regarded as purifying or detoxifying. This escalation commonly leads to weight loss, but the desire to lose weight is absent, hidden or subordinated to ideation about healthy food.

*Dietary practices may include use of concentrated "food supplements."

**Exercise performance and/or fit body image may be regarded as an aspect or indicator of health.
Proposed Formal Definition of ON

Criteria B- Any one of the following:

1. Malnutrition, severe weight loss or other medical complications from restricted diet

2. Intrapersonal distress or impairment of social, academic or vocational functioning secondary to beliefs or behaviors about healthy diet.

3. Positive body image, self-worth, identity and/or satisfaction excessively dependent on compliance with self-defined "healthy" eating behavior
Recent Trends
Evolution of “Healthy”

• The concept of “healthy” and “low calorie” have begun to merge in popular conception
  • Not in initial cases, nor through multi-century history of healthfood-ism.
  • Dietary theories are now most often presented as a means of losing weight AND becoming healthier
  • Has led to convergence of weight loss and “eating healthy”

• Similar transformation of exercise: previously separate concepts of exercise for health, weight loss and appearance have merged
Other Evolving Characteristics

• Elements of ON often present along with those of other eating disorders

• May develop after treatment of standard EDs

• Exercise dependence more frequently present even in cases of “pure” orthorexia

• Orthorexia merging with concepts of life extension; biohacking.
Future Steps in Process

• In development (Thom Dunn): 100 question survey tool to identify Orthorexia Nervosa (ON)

• Use of that tool in research

• Discover whether there is value in defining ON as a separate syndrome
Disclosures

Marci Evans MS, CEDRD(S), LDN, cPT

Nothing to disclose
Case Study: Amy
Getting to Know Amy

• 29 year old female

• Lives with long-term boyfriend

• Clinical Psychology PhD Student

• History of trauma, illicit drug abuse, anxiety/depression, disordered eating

• Current: PCOS, dairy allergy

• Referred by her therapist
Getting to Know Amy

Her goals:
1. Determine nutritional needs & “make a plan”

2. Learn skills to decrease obsessive, perfectionist thinking and planning

3. “Health” has become opportunistic- change that!

4. Balance, freedom, support, confidence
Assessments: Nutrition

- Meal/Snack Pattern
- Food prep, groceries, eating out, location, with whom, etc.
- Food: love, dislike, fear, safe, binge, cravings, avoided
- Detoxes/Fasting, Cheat day
- Social eating

Marci’s Mental Notes:
- Calorically adequate
- Very low carbohydrate
- Repetitive
- Low satiety
Assessments: Nutrition

- Time spent thinking about food & nutrition
- Emotions connected to food & eating
- Degree of deprivation, flexibility, spontaneity
- Impact on social interactions & relationships
- Beliefs

Marci’s Mental Notes:

- Significant strain on relationships & social interactions
- Hours each day reading about health and fitness
- Consuming, stress, anxiety, guilt, shame, self-loathing
- Psychological & emotional deprivation
- Major “carb” hang-up/clean eating/good/allowed
Assessments: Body Image

- Likert Scale
  
  Strongly Dislike → Dislike → Slightly Satisfied → Satisfied → Very Satisfied

- Body parts, body composition
- Weight history
- Body checking
- Factors that alter perception

Marci’s Mental Notes:

- Highly influenced by social media, social situations, and body checking
- Preoccupation with circumference, body composition measurements
Assessments: Exercise

- Frequency, Type, Intensity, Time
- Attitudes & beliefs about exercise
- Relationship between food, exercise, and body image
- Degree of flexibility
- Relationship between exercise & mental health
- Motivation to exercise
- Where & with whom

Marci’s Mental Notes

- Positive mixed with problematic
- Untangle from food
- Feelings vs. appearance
Amy’s Catch Phrases

- BIOHACKING
- MAXIMIZE BRAIN & LIFE SPAN
- BODY COMPOSITION
- OPTIMAL/IDEAL
- CLEAN
- PURE
- CALCULATING
- BETTER
- FUNCTIONAL FITNESS
- “AMY FRIENDLY”
Counseling Strategies

• Take time to build rapport
  • Let her tell her story
  • If the work is voluntary & she is not medically compromised, let her lead
  • She is the expert in her experience

• Use Motivational Interviewing.....like a lot
  • Open-ended questions: what about your eating isn’t working for you, if you could change one thing what would it be, what’s it like for you when..., tell me more about that
  • Pros/Cons but drop YOUR agenda
Counseling Strategies

• Acceptance & Commitment Therapy (ACT)
  • Highlight discrepancy between values & actions to create cognitive dissonance

• Mindfulness & Self-Compassion
  • Your job is to mirror the voice you hope “she” generates
  • Journaling & cognitive strategies
Counseling Strategies

• Behavioral Interventions
  • Media intervention: Instagram, online reading, picture archives
    • Small experiments $\rightarrow$ BIG results
  • Changing gyms: no numbers focus
  • “The exercise routine that was right for my mind became right for my body.”
  • Reducing body checking
  • Food exposures: tortilla chips
  • Increasing total carbohydrate intake sloooooowly
  • Social eating strategies: plate food
  • “Reinforcing Environments”
Counseling Strategies

• Body Image - Education
  • Perception
  • Emotional Awareness: YOU are the bridge to her therapy!

• Building Outside Supports - boyfriend & safe friends
In Amy’s Words

I feel Free

I have more self-compassion

I feel more genuine

This work has had a ripple effect, it’s changed my relationship with myself
Disclosures

Jessica Setnick, MS, RDN, CEDRD

Nothing to disclose
Future Paths for Orthorexia
Research Is Needed To:

A. Refine the Diagnosis

B. Create & Evaluate Treatment

C. Determine the Actual Disease

D. Determine Risk Factors

E. Create Prevention Programs

F. Guide Professionals on Ethical Issues
Unanswered Questions

1. How is Orthorexia different from:
   - Anorexia Nervosa?
   - Other Eating Disorders?
   - Obsessive-Compulsive Disorder?
   - Other Anxiety Disorders?

2. Where is the line between Orthorexia and:
   - Non-standard dietary theory?
   - Ethical/environmentally-driven food choices?
   - Strict adherence to medical nutrition therapy?
   - Culturally-sanctioned restrictive eating?
   - Religious practice?

3. Are there multiple diseases of orthorexia or just multiple pathways to orthorexia?
Ethical Issues

1. What makes orthorexia a mental illness vs. a personal choice?

2. Can a person with orthorexia be compelled to receive treatment?

3. Is it ethical to compel a person with orthorexia to violate his or her personal beliefs in the interest of treatment?
The only way to help individuals with orthorexia is to individualize treatment.
The best professional to identify orthorexia is the Registered Dietitian.
Dietitians need to assess for anxiety around eating and self-esteem connected to food rules.
Dietitians need to be very comfortable working with mental health professionals. This includes making referrals and frequent communication.
Practice Applications

• Start asking patients and clients:
  • Do you experience guilt and shame around eating?
  • Do you eat differently when you are alone?
  • How much of your day do you spend on food planning and preparation?
  • Is the way you eat supportive to your lifestyle or has it taken over your life?

• Make connections with mental health professionals
  • Do they have expertise with anxiety disorders?
  • Are they willing to see a patient with an eating disorder?
  • Will they be open to communicating frequently to provide the best patient care?
  • Will they feel comfortable leaving food and nutrition recommendations to you?
Contact Information

• Dr. Steven Bratman
  • stevenbratman@googlemail.com

• Marci Evans MS, CEDRD, LDN, cPT
  • marci@marcird.com
  • www.marciRD.com
  • @marciRD // www.facebook.com/marciRD

• Jessica Setnick, MS, RD, CEDRD
  • Jessica@UnderstandingNutrition.com or Jessica.Setnick@RemudaRanch.com
  • www.UnderstandingNutrition.com
  • @JessicaSetnick
  • www.IFEDD.com