Disentangling orthorexia nervosa from healthy eating and other eating disorder symptoms: Relationships with clinical impairment, comorbidity, and self-reported food choices

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Orthorexia nervosa (ON), while not an official diagnosis in the DSM-V, is increasingly recognized by eating disorder clinicians and it is a condition that poses serious risk for our clients. Research into orthorexic behaviors is still new and exploring what separates orthorexia from “healthy eating” is an integral question for the field, especially as our culture continues to moralize wellness-based behaviors.

Researchers Zickgraf, Ellis, and Essayli (2019) designed a study with the goal to define orthorexia more specifically and disentangle it from the related concepts of healthy eating, DSM-V eating disorder diagnoses, and comorbid mental health conditions often seen alongside eating disorder diagnoses (specifically OCD). Their sample included 449 adults recruited on Amazon's Mechanical Turk. The final sample was 49% female and 50.6% male; one participant reported a gender of “other” and one did not report gender. The sample was 74.7% White, 10.3% African American/Black, 8.9% Asian, 2.0% Native American, 4.8% Hispanic/Latinx, and 8.6% multiracial, and had a mean age of 33.6 (9.5), ranging from 20 to 69 years.

Participants were asked to self-report on the Eating Habits Questionnaire (EHQ), with items scored on a 1-4 likert scale. Participants also filled out the Clinical Impairment Assessment—Eating only (CIA-E), which measures how much an eating disorder interferes with someone’s daily life, the Eating Attitudes Test-Severe Restricting for Thinness/Bingeing and Purging (EAT-26-SRT/BP), which measures behaviors associated with anorexia and bulimia, the Obsessive Compulsive Inventory-Revised (OCI-R), which measures OCD behaviors, and the Nine-Item ARFID Screen (NIAS), which measures behaviors associated with ARFID. Participants were also asked to report their dietary intake, and their BMI was determined based on their self-reported weight and height.

Statistical analysis supported a three-factor solution for the EHQ, with factors representing normative healthy eating behaviors (“behaviors”), positive feelings associated with healthy eating (“feelings”), and life interference from rigid healthy eating (“problems”). Overall, orthorexia symptoms were more strongly related to anorexia and bulimia than to ARFID. Of the three subscales mentioned above, only the interference from rigid healthy eating (“problems”) was related to other eating disorder behaviors. When controlling for other eating disorder symptoms, orthorexia behavior was not
related to eating that would qualify as clinically impaired or OCD, although it was related to higher intake of fruits/vegetables and lower intake of discretionary foods. When other eating disorder symptoms and orthorexia symptoms were statistically controlled for, the subscale of “problems” was related to clinical eating impairment, OCD symptoms, and higher intake of both fruits/vegetables and discretionary foods.

The researchers concluded that the “problems” scale of the EHQ does in fact capture disordered eating symptomatology that is distinct from other eating disorders and from normative healthy eating behaviors, consistent with descriptions of orthorexia. Though this seems but a small step towards quantifying orthorexia, this article continues to build upon the work that is being done to isolate what exactly orthorexia symptomatology looks like, benefiting future research studies and brings us one step closer to including it in future DSM publications.