ORTHOREXIA NERVOSA - CURRENT INSIGHTS INTO THE CLASSIFICATION OF AN EMERGING PSYCHIATRIC CONDITION

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BACKGROUND

The phenomenon of Orthorexia Nervosa (ON) was first described by Bratman in 1997 as an obsessive behavior motivated by great concern for following a healthy diet. Although a growing number of researchers have focused on this condition in the last years, it remains poorly understood as there is no universally shared definition, the diagnostic criteria are under debate and most assessment tools used in the literature revealed some flaws. Thus, ON is not formally recognized as a psychiatric diagnosis neither in DSM-5 nor in ICD-10 due to the lack of consistent empirical data on this field. Discussion on whether ON is a distinct disorder, a culturally influenced attitude or if it might be included in the spectrum of eating disorders (ED) or obsessive-compulsive disorders (OCD) has been at the forefront research in this issue mostly because, as far as the diagnostic boundaries are concerned, it is of note that this condition shows important symptom overlap with both anorexia nervosa (AN) and OCD. Some researchers claim that ON may be a variant of avoidant/restrictive food intake disorder (ARFID).

OBJECTIVES

The present work aims to assess and present the state of the art regarding the overlapping features of ON with other psychiatric conditions, systematizing the most recent knowledge on this emerging condition.

MATERIALS AND METHODS

The authors collected the latest available literature published between 2016 and 2019 through a search into Pubmed/Medline databases using the key terms “orthorexia”, “eating disorders” and “OCD”.

RESULTS

- Focus on quality and purity of food, unrealistic food beliefs
- Absence of body image disturbance and concerns about weight loss (?)
- Pursuit to maintain health rather than low self-esteem
- Normal weight or mild
- Strive for pure body, motivated to reach optimum health
- Open and rationalized rules, flaunt behaviors
- Avoid bad foods but embrace healthy foods, usually do not skip meals
- Healthy eating/food-related obsessive-compulsive symptoms

- ❖ Over-concern about eating dominates one's life
- ❖ Adaptation of behavior and lifestyle to eating, diet becomes intertwined with identity
- ❖ Potential for weight loss (direct *versus* indirect)
- ❖ Poor insight on condition and its consequences
- ❖ Guilt over food transgression
- ❖ Ego-syntonic thoughts
- ❖ Lack of pleasure and detailed preoccupation about eating
- ❖ Goal-orientation, dietary restrictions as markers of self-discipline
- ❖ Obsessive and ritualistic focus on eating
- ❖ Potential to malnourishment and other medical complications
- ❖ Bio-psycho-social etiology
- ❖ Egocentric nature

- ❖ Obsessive-compulsive features (intrusive recurrent thoughts, ritualized behaviors in order to reduce anxiety caused by the first)
- ❖ Preoccupation with contamination
- ❖ Time consuming

- Obsessive-compulsive personality traits (cognitive and behavioral rigidity, perfectionism)
- High anxiety levels
- Strong need for control
- Impaired functioning, social isolation and poor quality of life
- Preoccupation with details and perceived rules
- Poor external monitoring
- Impaired working memory

- Focus on quantity of food, extreme calorie restriction
- Disturbed body image
- Concerns about weight loss motivated by the need for perfect figure
- Low self-esteem, depends on weight loss
- Must be underweight, fear of gaining weight
- Strive for extreme thinness, thin-ideal standard of beauty
- Focus only on avoiding foods, skip meals
- Excessive exercise

- ❖ Ashamed/secretive about behaviour, hidden rules
- ❖ Depressed mood

- Non-specific, different types of obsessive-compulsive symptoms (obsessions and compulsions may extend beyond food)
- Ego-dystonic thoughts and compulsions
- Preserved insight into condition
- Lack of perceived quality of life

Some studies refer to limited symptom overlap with other mental disorders (bulimia nervosa, somatoform and autism spectrum disorders,...) At present, and based on DSM-5 criteria, ON would be most appropriately categorized as a distinct subtype of ARFID.

CONCLUSIONS

In the last years, researchers have mostly reported similarities, differences and possible comorbidity between ON and AN and OCD. Symptoms that showed to be exclusive to ON also raised the hypothesis of facing ON as a unique disorder. The increasing effort to better understand the features of ON is currently insufficient to categorize this condition. An “Orthorexia Nervosa Task-Force” was recently created to answer the remaining questions. In conclusion, although the evident overlap among these three disorders outlines a promising framework, the current literature is not unequivocal about where ON would best fit in the actual classification systems. ON is still rarely observed in clinical practice and more qualitative studies are needed for it to gain inclusion on the next version of DSM or other classifications.