Orthorexia Nervosa (ON) is a term defined as a “fixation on righteous eating” coined in 1997 by Steven Bratman, MD. ON is characterized by obsessive thoughts about food, self-punishment with fasts or overexercise, restrictive eating behaviors, and a belief that one’s self-esteem is based on dietary choices. Individuals who develop ON may initiate a quest for a healthier lifestyle, but then dysfunctional, compulsive beliefs about food emerge that then impair health, work, and social functioning. Because ON is not yet an established psychiatric diagnosis, the specific constellation of psychiatric symptoms necessary to separate lifestyle choices related to eating healthfully (not ON) from pathologic behaviors and obsessions surrounding eating healthfully (potential for ON) are not fully established.

In contrast to ON, eating disorders (EDs) have established diagnostic criteria that include dysfunctional feeding behaviors, cognitive problems related to self-esteem and body image, and body weight is significantly low (for anorexia nervosa only). Individuals with ON appear to share traits for both EDs as well as obsessive-compulsive disorder. Dunn and Bratman proposed diagnostic criteria for ON as an obsessional preoccupation with healthy foods paired...
with impairment of physical or mental health because of the obsession, and the lack of a different mental illness, an established medical problem, or religious belief leading to the behaviors. Based on those proposed criteria, individuals with ON deny a desire for and lack the weight loss characteristic of anorexia nervosa. However, the relationship between ON and EDs have not been determined. Our study sought to address this gap in the literature by examining whether symptoms of ON were related to symptoms of EDs in a population of registered dietitian nutritionists (RDNs).

A better understanding of the relationship between ON and EDs may help to reduce risk of EDs and to improve treatments for ON. EDs have substantial medical complications, with anorexia nervosa showing the highest mortality rate of any psychiatric illness. If risk for ON is related to risk for EDs, use of interventions that reduce the development of EDs among individuals at high risk for ON may reduce incidence of EDs. In addition, effective treatments for EDs exist, with evidence supporting medications, family therapy, and cognitive behavioral therapy. Currently, there is little evidence to support specific treatments or interventions for ON.

Thinking about food choices is a large part of both the work of RDNs as well as part of the pathology of ON and EDs. An increased prevalence of EDs has been reported among RDNs. More recently, ON has also been observed to be more common in RDNs than the general population, although there have been no studies of this in the United States. Because both ON and EDs are common in RDNs, this population was selected to consider whether these problems are related.

There were two major study goals. First, determination of the prevalence of risk for ON and EDs among a sample of RDNs was motivated by a desire to consider how work as an RDN might influence food behaviors and cognitions in the United States. Using the same population, a second objective was to determine whether the different types of symptoms common in EDs, including restraint, eating concerns, shape concerns, and weight concerns, were also present in ON. Clarification of the relationship between these illnesses may help in the treatment and prevention of both ON and EDs. Together, these questions construct a framework connecting professional work as an RDN with the individual mental health of these clinicians.

**METHODS**

**Participants**

The Institutional Review Board at University of Texas Southwestern Medical Center approved this study. The Commission on Dietetic Registration provided a random sample of 2,500 e-mail addresses of RDNs from throughout the United States. Each RDN received an e-mailed invitation to participate through Mail Chimp (www.mailchimp.com), which provided a de-identified link to a survey in Google Forms (www.google.com/forms). Participation demonstrated consent; identifying information was not collected. RDNs currently pregnant, breastfeeding, or unable to read English were excluded. Participation was voluntary, and participants were not compensated for their participation.

**Instruments**

Participants reported whether they had obtained any type of treatment for a current or previous ED (selecting from anorexia nervosa, bulimia nervosa, binge-eating disorder, and eating disorder not otherwise specified), how long they had been an RDN, provided self-reports for both current height and weight as well as their low and high weights as adults, age, and dietary constraints (selecting from no dietary restrictions, low fat, low carbohydrate, gluten-free, vegetarian, vegan, paleo, or Mediterranean).

The Orthorexia Nervosa Questionnaire (ORTO-15) is a validated, 15-item questionnaire designed to determine risk of ON. A high risk of ON is seen as a score below 40 with higher scores (maximum of 60 points) indicative of normal eating behavior. Questions included on the ORTO-15 consider the influence of eating beliefs in terms of health (eg, “Are you willing to spend more money to have healthier food?”), ruminative behaviors (“Does the thought of food worry you for more than three hours a day?”), and self-esteem (“Do you think that the conviction to eat only healthy food increases self-esteem?”). The Eating Disorder Examination Questionnaire (EDE-Q) includes 28 items that measure eating disordered cognitions and behaviors occurring over the past 28 days, providing a global score and 4 subscales (Eating Concern [“Has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in?”], Shape Concern [“Has your shape influenced how you think about yourself as a person?”], Weight Concern [“Have you had a strong desire to lose weight?”], and Dietary Restraint [“Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?”]). Increased ED behavior is indicated with higher scores, with a score above 2.5 considered a sensitive and specific threshold to identify clinically relevant symptoms of an ED among nonclinical samples.

**Analysis**

The percentage of participants scoring below 40 on the ORTO-15 were reported as at high risk for ON and the percentage of participants scoring above 2.5 on the EDE-Q were reported as at high risk for an ED. The participants were then divided into three groups: RDNs reporting current or past treatment for an ED (D-ED), RDNs with a score <40 on the ORTO-15 (D-ON), and RDNs in healthy comparison group, with a score ≥40 on the ORTO-15 and no self-report of ED treatment (D-CH). Analysis of variance, followed by Bonferroni-corrected pairwise comparisons, and χ² analyses comparing the groups were completed in SPSS version 23. A Mann-Whitney U test was conducted when Levene test assumption of equal variances of the populations were not equal. Results of parametric comparisons among the study groups were reported as no differences were observed with the nonparametric test. Weight or height was missing for five participants; these subjects were excluded for the body mass index analyses. Because there were only 21 male participants (9 in the D-CH, 12 in the D-ON, and 0 in the D-ED groups), all analyses were repeated without the men, but there were no significant differences.
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