

Eating clean, feeling broken: A qualitative meta-synthesis of the lived experience of orthorexia nervosa

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ABSTRACT

Orthorexia nervosa refers to a pathological obsession with healthy eating, yet its classification, causes, and clinical relevance remain contested. This qualitative meta-synthesis explores the lived experiences of individuals with orthorexic behaviors to better understand the psychological, social, and cultural dynamics that sustain this condition. Drawing on thematic synthesis of 16 peer-reviewed, qualitative studies, three major themes emerged: (1) Origins and Motivations for Orthorexic Behavior, highlighting the role of perfectionism, identity, and socio-cultural ideals; (2) The Orthorexic Experience and Its Consequences, illustrating the emotional, physical, and social costs of rigid dietary practices; and (3) Individual's Perspectives on Orthorexia as a Disorder, revealing ambivalence toward diagnosis, conceptual confusion, and overlaps with other eating disorders. Findings suggest that orthorexia serves both as a personal coping strategy and a moralized performance of health shaped by contemporary wellness culture. The synthesis reveals how orthorexic behaviors are often normalized, socially reinforced, and deeply tied to individual identity—rendering recognition and recovery particularly challenging. Rather than advocating for diagnostic categorization, this study highlights how orthorexic practices are embedded in broader cultural narratives around health, control, and morality.

1. Introduction

In recent years, cultural norms around health and nutrition have increasingly valorized “clean” eating, self-discipline, and physical fitness (Adamidou & Tragantzopoulou, 2025; Simpson & Mazzeo, 2016). As body ideals have evolved (Tragantzopoulou, 2021), so too have the discourses surrounding them. Within online wellness spaces, this idealization has contributed to the normalization of restrictive dietary practices, often framed as moral or virtuous lifestyle choices (Tragantzopoulou, Fixsen, et al., 2024; Tragantzopoulou, Mouratidis, et al., 2024). While restrictive diets such as veganism or vegetarianism are often motivated by ethical or environmental concerns and are not inherently pathological, orthorexia nervosa (ON) has been described as a distressing preoccupation with eating perceived as ‘healthy’, characterized by anxiety, moral self-evaluation, and difficulty tolerating deviation from self-imposed dietary ideals, rather than by restriction per se (Bratman, 2017; Barrada & Roncero, 2018). Importantly, current scholarship does not agree that dietary restriction is a necessary or defining feature of ON, as individuals may experience orthorexic distress

even in the absence of overt restriction or caloric reduction. In ON, eating practices become compulsively monitored and morally charged, interfering with daily functioning and well-being. Whereas “clean eating” often entails avoiding processed or “impure” foods, its pathologization in ON relates less to the behavior itself and more to the psychological meaning attached to it, highlighting how ON differs from non-pathological dietary habits.

Public attention to ON increased in the mid-2010s, partly fueled by media coverage of wellness influencers sharing personal struggles with rigid dietary practices framed as “healthy” (Dunn & Bratman, 2016). These accounts highlighted the potential for an ostensibly health-focused lifestyle to contribute to psychological distress and functional impairment, even in the absence of overtly extreme dietary restriction (Reddy, 2014; Schwartz, 2015). Although orthorexic tendencies had previously been documented in clinical settings (Vandereycken, 2011), empirical research remained sparse (Moroz et al., 2015). The responsibility for recognizing and addressing these behaviors often fell to mental health professionals navigating an ambiguous diagnostic landscape.

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The term “orthorexia” was coined by Bratman in 1997 to describe his personal experience with extreme dietary purity, which, despite being motivated by health, led to social isolation and psychological distress (Lucka et al., 2019; Varga et al., 2013). Although initially anecdotal, Bratman's observations resonated with patients reporting similar anxieties about food quality. He later proposed that ON should be viewed as a clinical condition, emphasizing its potential for physical harm, emotional distress, and compulsive behavioral patterns (Bratman, 2017; Bratman & Knight, 2000). Bratman's evolving conceptualization distinguished ON from other eating disorders (EDs) by its focus on food quality over quantity, complicating traditional diagnostic boundaries. Although ON behaviors may not always lead to dramatic weight loss, their psychological burden can be significant, often concealed under the socially sanctioned guise of health (Strahler et al., 2022; Tragantzopoulou, Fixsen, et al., 2024; Tragantzopoulou, Mouratidis, et al., 2024). Calls for formal recognition of ON (Donini et al., 2022) reflect growing concerns about the thin line between wellness culture and pathology, raising critical questions about how disordered eating is socially constructed, medicalized, and treated. Emerging scholarship has also highlighted the paradox of contemporary health culture, in which behaviors endorsed as responsible, moral, and health-conscious may simultaneously be framed as pathological (Fixsen, Ridge, et al., 2025). Many individuals construct their eating practices as expressions of identity, self-care, and civic responsibility—yet these same practices are increasingly scrutinized and medicalized under the label of ON (Tragantzopoulou, Fixsen, et al., 2024; Tragantzopoulou, Mouratidis, et al., 2024; Fixsen, Cheshire, & Tragantzopoulou, 2025). This complexity underscores the importance of examining ON not merely as a clinical condition, but as a reflection of broader cultural anxieties around purity, control, and the moralization of health.

1.1. Characteristics of ON

ON is marked by an obsessive focus on dietary purity and the rigid avoidance of foods perceived as unhealthy or impure (Varga et al., 2013). This fixation may sometimes extend beyond physical health to encompass moral or personal superiority, with individuals viewing their eating practices as ethically or spiritually elevated (Varga et al., 2013). While some individuals have reported being initially motivated by health concerns or illness prevention (Cheshire et al., 2020), ON can also be driven by anxiety, fear of contamination, a desire for control—especially during periods of uncertainty, such as the COVID-19 pandemic (Tragantzopoulou, 2021; Tragantzopoulou & Giannouli, 2024), and weight control (Depa et al., 2019; Hanras et al., 2024). Although rigidity in eating behavior has often been described as a characteristic feature of ON, recent evidence suggests that its role may be more nuanced. For instance, Roncero et al. (2025) found only a modest association between the overvaluation of healthy eating and ON symptoms, indicating that neither rigidity nor restriction alone can sufficiently define the phenomenon. Rather, it may be the intolerance of deviation from one's perceived dietary ideals, rather than rigid adherence itself, that underlies the distress and functional impairment observed in ON. This distinction highlights the complexity of ON as a spectrum of attitudes and behaviors, ranging from health-motivated discipline to pathological preoccupation.

Importantly, there is still no universally accepted set of diagnostic criteria for ON, and its defining features remain under debate (Cena et al., 2019; Donini et al., 2022). Cena et al. (2019) reviewed the available literature and found broad agreement on three central features: (a) a pathological obsession with healthy nutrition, (b) significant emotional distress when dietary rules are violated, and (c) psychosocial impairment or physical health consequences resulting from restrictive eating practices. Building on this, Donini et al. (2022) proposed a more formalized framework, suggesting that ON involves (a) a preoccupation with eating perceived as pure or healthy, governed by rigid, self-imposed rules; (b) emotional distress, guilt, or anxiety following

deviation from these rules; and (c) functional impairment in social, occupational, or physical domains. The authors also highlighted that ON may be best conceptualized as a feeding and eating disorder, though obsessive-compulsive traits are often present.

Qualitative studies suggest that individuals who identify with orthorexic behaviors may experience social and psychological challenges, although the exact prevalence and severity remain uncertain due to heterogeneity in sample selection and diagnostic criteria. Individuals report experiencing anxiety around unfamiliar foods and social eating situations, resulting in isolation, heightened vigilance, and the adoption of extreme dietary rules (Cheshire et al., 2020; Tragantzopoulou & Giannouli, 2024). These findings suggest that ON is not solely a manifestation of health aspirations, but also a response to deeper fears and compulsions affecting emotional well-being and social functioning. Nonetheless, the classification of ON remains contested. While ON shares certain traits with anorexia nervosa (AN)—such as perfectionism, cognitive rigidity, and a strong need for control—it differs fundamentally in focus. ON centers on the quality or perceived purity of food rather than its quantity or caloric value (Dunn & Bratman, 2016; Koven & Abry, 2015). Unlike AN, ON does not necessarily involve weight loss or a low body mass index (BMI), and current evidence suggests no consistent association between ON symptoms and BMI (Adiningsih et al., 2024). In some cases, ON may emerge during recovery from traditional EDs, offering a socially sanctioned framework for continued restriction (Segura-Garcia et al., 2014). As such, ON may straddle the boundary between wellness culture and pathology—legitimizing disordered eating under the guise of health.

1.2. ON vs. healthy orthorexia

While healthy eating is widely recognized as protective against chronic disease (World Health Organization, 2020), the line between health-conscious behavior and disordered eating is increasingly blurred. Nutrient-rich diets high in fruits and vegetables are associated with improved self-reported health outcomes (El Ansari et al., 2015). The term ‘orthorexia’ derives from the Greek roots *ortho* (‘correct’) and *orexia* (‘appetite’), and does not inherently imply pathology. However, in some individuals, an intense focus on healthful eating can develop into a pattern of behavior that may be considered disordered, leading to social, emotional, or functional difficulties. Scholars caution that much of the literature may prematurely pathologize behaviors that are culturally normative or personally adaptive (Bratman, 2017).

In response to this conceptual rigidity, researchers have proposed a bidimensional model of orthorexic behaviors, distinguishing between pathological ON and non-pathological healthy orthorexia (HeOr) (Barrada & Roncero, 2018; Depa et al., 2019). HeOr refers to a strong, identity-defining interest in healthy eating that is not associated with clinical impairment. Individuals with HeOr invest considerable time and resources in dietary planning but do so in a way that enhances, rather than diminishes, their well-being. In contrast, ON is strongly linked to anxiety, dietary rigidity, and psychological distress, as well as symptoms common to other eating disorders (Zickgraf & Barrada, 2021). However, this distinction warrants critical scrutiny. From a social constructionist perspective, the binary between HeOr and ON is not value-neutral but reflects cultural norms that moralize food, health, and self-discipline. While experiences such as guilt, self-punishment, problems with concentration, or social isolation are real and measurable consequences for individuals, the labeling of these behaviors as “pathological” versus “healthy” is shaped by social expectations rather than purely objective criteria. Distinguishing between HO and ON risks reinforcing normative ideals of proper eating while obscuring the sociocultural forces that define certain eating practices as problematic. This perspective highlights the importance of considering how social, cultural, and moral frameworks influence both the recognition of ON and the interpretation of individual experiences.

Sociocultural research on eating disorders provides a useful parallel.

Allison et al. (2021) observed that recovery from AN often involves a renegotiation of identity and social belonging, as women critically re-evaluate dominant cultural ideals of thinness and beauty. Their work highlights how eating behaviors are deeply intertwined with broader cultural scripts around gender, health, and moral worth. Extending this perspective to ON, Bhattacharya et al. (2022) argued that ON may represent not an entirely new disorder, but rather a cultural evolution of AN—a shift from the pursuit of thinness to the pursuit of health as the dominant moral ideal. As “healthism” and wellness culture increasingly valorize dietary purity, ON can be seen as a contemporary expression of the same underlying cultural anxieties about self-discipline, morality, and bodily control that historically underpinned AN.

Rather than a clear-cut divide, the progression from health-focused eating to pathological obsession may be better understood as complex, context-dependent, and socially mediated. Some conceptual models describe a possible two-stage pattern, in which individuals initially adopt healthy eating for functional or ethical reasons, and in certain circumstances, these behaviors may become more rigid or distressing (Bratman, 2017). Observational studies suggest that psychological factors (e.g., body image, emotional regulation) and sociocultural pressures (e.g., wellness culture, professional environments) can influence how individuals relate to food (Valente, Brenner, et al., 2020; Valente, Syurina, et al., 2020; Cheshire et al., 2020). However, empirical evidence does not establish a linear progression from healthy eating to ON, and factors such as rigidity or moralization of dietary practices are not necessarily core features of ON.

Despite growing theoretical sophistication, existing research on ON has predominantly relied on psychometric assessments or clinician-derived frameworks, which often emphasize diagnostic measurement and classification. While many tools adopt dimensional scoring, such approaches can still risk oversimplifying the complexity of ON by prioritizing quantifiable indicators over personal meaning and sociocultural context. As discussed above, contemporary scholarship increasingly argues for a dimensional and socioculturally grounded understanding of ON—one that recognizes how health-oriented behaviors evolve along a continuum shaped by cultural norms, moral values, and individual meaning-making. However, this shift in conceptualization has not yet been matched by an equivalent focus on the subjective voices of those who live these experiences. To address this gap, the present meta-synthesis systematically integrates qualitative studies that explore the lived experiences of individuals who self-identify as having ON. The research question that is examined is the following: How do individuals who self-identify as having ON experience and make sense of their condition, particularly in relation to personal, emotional, and sociocultural factors? By synthesizing first-person accounts across diverse contexts, this study aims to illuminate how people understand, negotiate, and give meaning to their eating practices in relation to personal, emotional, and sociocultural forces. This approach moves beyond diagnostic categorization to examine the lived aetiology of ON—how restrictive or health-focused eating patterns develop, are maintained, and are rationalized within everyday life. Rather than seeking to refine diagnostic boundaries, this meta-synthesis foregrounds the richness of lived experience as an essential dimension of understanding ON. It contributes to the field by offering a more experientially grounded account of how individuals navigate the tensions between wellness culture, moral identity, and psychological distress. In doing so, it bridges theoretical and empirical divides, advancing a more integrated and human-centered understanding of ON as a phenomenon situated at the intersection of health, culture, and selfhood.

2. Method

This review was conducted in accordance with the ENTREQ (Enhancing Transparency in Reporting the Synthesis of Qualitative Research) guidelines (Tong et al., 2012) to ensure transparency and rigor in reporting (Appendix A). A qualitative meta-synthesis is a

methodological approach that allows for the integration, reinterpretation, and contextualization of findings from primary qualitative studies. Rather than aggregating data, meta-synthesis seeks to generate new, interpretive insights that transcend individual studies (Thorne et al., 2004). This synthesis aimed to explore how individuals who self-identify with orthorexic tendencies make sense of their eating practices, values, and challenges. Recognizing the socially constructed and contested nature of ON, this study sought to highlight first-person narratives that may otherwise be subsumed under clinical or psychometric categories. The synthesis was conducted using the structured framework developed by Sandelowski (2007), which comprises: formulating a clear research question, performing a comprehensive literature search, critically appraising included studies, systematically extracting data, and conducting interpretive thematic analysis.

2.1. Search strategy

The literature search was designed to identify peer-reviewed qualitative studies that focused on the lived experiences of individuals who self-identify with ON or orthorexic behaviors. A preliminary scoping search was conducted to refine search terms and inclusion criteria. The final search strategy included terms such as (“orthorexia” OR “extreme healthy eating” OR “orthorexia nervosa”) AND (“qualitative” OR “interview” OR “focus group”) and was applied across six electronic databases: PubMed, PsycINFO, Embase, Web of Science, Medline, and CINAHL. Only studies published in English between 2000 and 2024 were considered, given the relatively recent conceptual emergence of ON. Additional studies were identified through backward citation tracking and lateral searches of reference lists.

Inclusion criteria required that studies: (1) used qualitative methods for data collection and analysis; (2) explored participants' subjective experiences related to ON or health-obsessed eating practices; (3) involved individuals who explicitly self-identified with orthorexic behaviors or discussed such behaviors in depth; (4) were in English; and (5) were published in peer-reviewed academic journals. Mixed-methods studies were included only if qualitative data were reported separately and in sufficient detail. Studies that focused solely on psychometric validation, clinical perspectives, or secondary data sources were excluded.

2.2. Study selection

The database search yielded a total of 184 unique records, with an additional 21 identified through hand-searching reference lists. After duplicate removal, 162 titles and abstracts were screened for relevance. This initial screening excluded reviews, opinion pieces, conference abstracts, and studies lacking a qualitative focus. The remaining 41 full-text articles were assessed for eligibility, resulting in the exclusion of 25 studies due to lack of self-identified ON participants or insufficient qualitative data. Ultimately, 16 studies met all inclusion criteria and were included in the synthesis, as illustrated in Fig. 1. Screening was conducted independently by two authors, who applied the eligibility criteria to titles, abstracts, and full texts. Discrepancies in study selection were discussed, and consensus was reached through joint review. Throughout the process, a reference management tool (Mendeley) was used to organize sources and ensure systematic tracking of each study. Transparency and reflexivity were maintained during screening, with decisions documented at each stage.

2.3. Quality appraisal

All included studies underwent formal appraisal using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (CASP, 2018), which evaluates aspects such as research design, data collection, ethical considerations, and the clarity of findings (see Table 1). To facilitate comparison across studies, we applied a modified scoring framework:

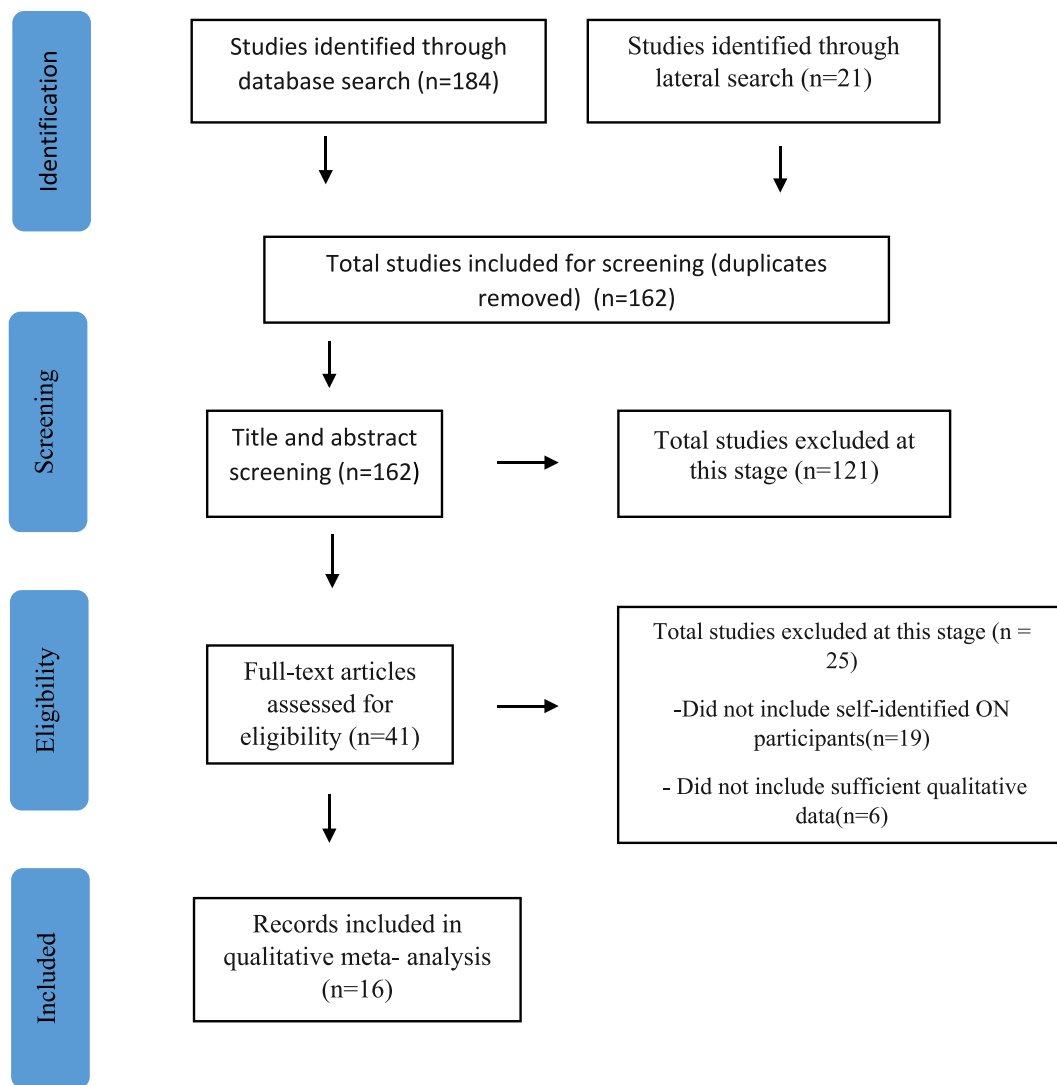


Fig. 1. Overview of the selection process (PRISMA flow diagram, adapted from Moher et al., 2009).

studies scoring 8–10 were classified as high quality (Grade A), 5–7.5 as moderate quality (Grade B), and below 5 as lower quality (Grade C). This adaptation provided a pragmatic means of distinguishing levels of rigor, while acknowledging that CASP itself is not inherently designed as a quantitative scale. Quality appraisal was conducted independently by two authors. To ensure inter-rater reliability, agreement was calculated for all ratings (Cohen's $\kappa = 0.82$, indicating strong agreement). Discrepancies were resolved through discussion until consensus was reached, and approximately 50% of the studies were additionally reviewed by a third author for verification.

In line with recommendations for qualitative evidence synthesis, no studies were excluded solely on the basis of appraisal outcome. Instead, methodological limitations identified through the CASP process were considered during the interpretation of findings. Table 1 provides a summary of the CASP assessment for each study, identified by first author and year of publication to enable traceability.

2.4. Data extraction and synthesis

Data extraction focused primarily on the findings sections of each study, including both participant quotes (first-order constructs) and interpretive commentary from study authors (second-order constructs). This approach allowed for a layered analysis of how orthorexic

behaviors are experienced, interpreted, and narrated. Extracted data were managed using NVivo 12 software (Dhakal, 2022), which facilitated the organization of codes, categories, and emerging themes. The synthesis followed an interpretive thematic approach consistent with qualitative meta-synthesis principles (Sandelowski & Barroso, 2006). The process was iterative and collaborative: the lead author conducted initial coding, with themes refined through team discussions and repeated data immersion. Emphasis was placed on identifying tensions, contradictions, and complexities in how ON is lived and understood across different contexts, rather than seeking convergence or diagnostic consistency. Conceptual saturation was reached when no new themes emerged across studies. Descriptive information such as sample characteristics, geographical context, methodological approach, and focus of each study was extracted and presented in a summary table (see Table 2).

Effect sizes were calculated for each theme by dividing the number of primary studies in which the theme appeared by the total number of studies included in the synthesis. This method highlights the relative prominence of each theme within the body of literature, offering a transparent way to indicate their prevalence. In qualitative synthesis, effect sizes do not serve as statistical measures but rather as indicators of how consistently particular experiences or perspectives were represented across studies. This approach enhances interpretive depth by

Table 1
Quality assessment using the Critical Appraisal Skills Programme (CASP) for qualitative research.

Study	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?	Overall Score	Grade
Valente, Brenner, et al., 2020	1	1	1	1	1	0	1	1	1	1	9	A
White et al., 2021	1	1	1	1	1	0	0.5	1	0.5	1	8	A
Lewthwaite & LaMarre, 2022	1	1	1	1	1	0	0.5	1	1	1	8.5	A
Opitz et al., 2022	1	1	1	1	1	0	1	1	1	1	9	A
Fixsen et al., 2020	1	1	1	1	1	0	0	1	1	1	8	A
Mitrofanova et al., 2021	1	1	1	1	1	0	0	1	1	1	8	A
Tragantzopoulou & Giannouli, 2024	1	1	1	1	1	0	1	1	1	1	9	A
Valente, Syurina, et al., 2020	1	1	1	1	1	0	1	1	0.5	1	8.5	A
DeBois & Chatfield, 2021	1	1	1	1	1	0	0	1	1	1	8	A
Mateo-Martínez et al., 2025	1	1	1	1	1	0	1	1	1	1	9	A
Greville-Harris et al., 2020	1	1	1	1	1	0	0.5	1	1	1	8.5	A
Greville-Harris et al., 2022	1	1	1	1	1	0	0	1	1	1	8	A
Talbot et al., 2023	1	1	1	1	1	0	1	1	1	1	9	A
McGovern et al., 2020	1	1	1	1	1	0	0.5	1	1	1	8.5	A
Cinquegrani & Brown, 2018	1	1	1	1	1	0	0	1	0.5	1	7.5	B
Cheshire et al., 2020	1	1	1	1	1	0.5	0.5	1	1	1	9	A

Table 2
Summary of included papers.

Study	Source of data	Aim	Data collection	Data analysis
(Valente, Brenner, et al., 2020)	10 participants	Explore how and why individuals who self-diagnose with ON feel that certain experiences have shaped their development of ON.	Semi-structured interviews	Thematic analysis
(White et al., 2021)	21 participants	Examine ON-related attitudes and behaviors among U.S. college students, with a particular focus on exploring concerns related to healthy eating and diet quality as defined by proposed diagnostic criteria, body image concerns and disordered eating, and sociocultural influences	Semi-structured interviews	Thematic analysis
(Lewthwaite & LaMarre, 2022)	15 participants	Explore what do individuals articulate as their motivations for adopting and engaging in daily health practices which have become highly significant and/or problematic in their lives.	Semi-structured interviews	Thematic analysis
(Opitz et al., 2022)	246 online comments	Explore individual experiences and conceptualizations of ON regarding characteristic and underlying causes	Text mining	Thematic analysis
(Fixsen et al., 2020)	9 participants	Explore how different actors (laypersons and professionals) position themselves around debates concerning health and eating on and offline, and what their accounts tell us about tensions around the labeling of healthy eaters as “troubled persons”.	Semi-structured interviews	Thematic analysis
(Mitrofanova et al., 2021)	10 participants	Examine the experiences of those following a diet indicative of ON in the United Kingdom.	Semi-structured interviews	Thematic analysis
(Tragantzopoulou & Giannouli, 2024)	13 participants	Explore the triggers and situations that precipitate stressful beliefs and emotions among individuals who self-identify as preoccupied with healthy eating, as well as the coping mechanisms developed to manage these feelings.	Semi-structured interviews	Thematic analysis
(Valente, Syurina, et al., 2020)	12 participants	Understand the factors that influence people choosing to follow a diet they perceive as being healthy	Semi-structured interviews	Thematic analysis
(DeBois & Chatfield, 2021)	18 participants	Clarify the development and progression of ON	Semi-structured interviews	Interpretive phenomenological analysis
(Mateo-Martínez et al., 2025)	4 participants	Explore the experiences of individuals with ON	Semi-structured interviews	Discourse analysis
(Greville-Harris et al., 2020)	40 Blog entries	Explore individuals' personal experiences of ON, as described in online blogs.	Online Blogs	Thematic analysis
(Greville-Harris et al., 2022)	141 participants	Explore conceptualizations of ‘health’ and ‘healthy eating’ in individuals scoring high on orthorexic symptomatology.	Open-ended Questions/Online Qualitative Survey	Thematic analysis
(Talbot et al., 2023)	500 textual posts containing #OrthorexiaRecovery	Examine how people who self-identify with ON use the hashtag #OrthorexiaRecovery and how recovery is represented within this online space.	Instagram Posts	Thematic analysis
(McGovern et al., 2020)	8 participants	Explore the experiences of orthorexia from the perspective of recovered persons	Semi-structured interviews	Thematic analysis
(Cinquegrani & Brown, 2018)	Stories and online communications of 30 online users	Understand the fixation with ‘clean eating’	Online communities	Thematic narrative analysis
(Cheshire et al., 2020)	9 participants	Understanding the key, defining ON features and what factors might influence its development.	Semi-structured interviews	Thematic analysis

situating themes not only in terms of richness but also in terms of their relative recurrence across contexts.

3. Results

The analysis of the findings resulted in three main themes, each with sub-themes. Table 3 below presents the themes and sub-themes.

Table 3
Summary of themes and sub-themes.

Themes	Sub-themes
Origins and Motivations for Orthorexic Behavior	Sociocultural Pressures and Conflicting Messages Personal Traits and Identity Drivers Health and Ethical Motivations
The Orthorexic Experience and Its Consequences	Cognitive Rigidity and Control Social Withdrawal and Lifestyle Disruption Paradoxical Health and Emotional Consequences
Perspectives on Orthorexia as a Disorder	Retrospective Recognition and Resistance Orthorexia as a Safer Alternative and the Ambiguities of Recovery

3.1. Origins and motivations for orthorexic behavior

This theme explores the underlying drivers behind orthorexic behaviors, highlighting the interplay between sociocultural, psychological, and moral influences. Across studies, participants described how Western ideals of health, body image, and success—intensified by digital media—shaped their perceptions of “healthy” eating. Personal traits like perfectionism and anxiety contributed to a sense of control and identity tied to food practices, while motivations rooted in physical health and ethical values further reinforced rigid dietary habits. Together, these sub-themes reveal how ON often emerges not from a singular cause but from a complex combination of internal dispositions and external pressures.

3.1.1. Sociocultural pressures and conflicting messages

Across multiple accounts, individuals described growing up exposed to Western sociocultural ideals that equated health with thinness, discipline, and ultimately, happiness and success (Valente, Brenner, et al., 2020; Greville et al., 2019). These ideals were deeply internalized and often intensified by social media, where exposure to wellness influencers, restrictive diets, and “clean eating” narratives normalized disordered patterns under the guise of health. Beyond normalizing restrictive patterns, social media also fostered confusion and self-doubt, as participants struggled to navigate the overwhelming and

contradictory health advice online. One participant reflected, “*Nobody really knows what diet is best... so really social media plays a big part. Like me who was confused really about diet... it plays upon the mental aspect*” (Valente, Brenner, et al., 2020).

In many cases, social media did not just reflect but actively shaped perceptions of health, promoting both unattainable ideals and contradictory guidance. This flood of information became a source of growing anxiety and obsessive research. Camille (Valente, Brenner, et al., 2020) noted, “*The more I learned, the more confusing it got... I got a lot more restrictive.*” Similarly, Brad (Lewthwaite & LaMarre, 2022) acknowledged the psychological toll of contradictory advice: “*There’s almost too much information and conflicting information out there that it makes you paranoid... maybe that can lead down an unhealthy track.*” The abundance of advice, often conflicting or fear-based, blurred the lines between healthy intention and pathological behavior, leaving individuals feeling increasingly unsure and unsafe in their choices. This confusion was exacerbated by the role of health blogs, online forums, and media messages that moralized food and created hierarchies of “good” and “bad” eating (Greville-Harris et al., 2022; Martinez et al., 2025). One blogger described “*scouring every women’s magazine, cycling through all of the 1,200–1,500 cal-per-day meal plans*” (Greville-Harris et al., 2022), while another explained how “*detoxing, restricting and eliminating foods was healthy*” in the eyes of online wellness communities (Greville-Harris et al., 2020).

Participants also described how sociocultural pressures linked health with body image ideals. While thinness remained a standard, newer ideals celebrated muscularity, tone, and physical performance — often fueled by the fitness industry and influencer culture. As one Reddit commenter noted, “*Wanting to be stronger simply replaces wanting to be skinny... muscular is the new desirable body type*” (Opitz et al., 2022). Others, such as Jake and Liam (Fixsen et al., 2020), engaged in body-building and dietary restriction to meet these expectations, supported by motivational media and the aesthetic demands of online visibility. Sociocultural and digital contexts did not merely influence ideas of health — they created a climate of confusion, comparison, and moral obligation, within which orthorexic behaviors could be justified, encouraged, and even praised. As one participant stated, “*People often compliment my diet... it looks very healthy... but the behavior itself is not*” (Opitz et al., 2022).

3.1.2. Personal traits and identity drivers

ON often developed within a psychological framework shaped by pre-existing traits like perfectionism, anxiety, and black-and-white thinking. These traits were described as long-standing and often intensified during periods of instability, serving as precursors to disordered eating. For many, the pursuit of healthy eating was not simply about food, but about regaining control: “*Because my life felt so out of control, I decided to try to control food and eat healthier. And it snowballed from there*” (Valente, Brenner, et al., 2020). This “snowballing” reflected how high standards in one area of life extended into health behaviors, creating cycles of control and rigidity. Participants also linked these internal pressures to identity formation. Eating “clean” or exercising excessively became markers of discipline, virtue, and even superiority. “*I like choosing the healthiest options just to prove to myself over and over again that I have a lot of self-control. My orthorexia won’t permit junk food*” (Opitz et al., 2022). In this way, ON operated as both a coping strategy and a moralized identity project.

Achievement and optimization were central to how participants rationalized their routines. Health practices were often framed as accomplishments: “*It makes me feel good, like yay on track I’m achieving what I want to achieve*” (Lewthwaite & LaMarre, 2022). Male participants in particular emphasized strength and utility, though underlying appearance ideals were still present (Fixsen et al., 2020). For some, orthorexic behaviors took on spiritual or moral weight. Clean eating became a source of pride, even judgment. “*I felt elated, holy almost, because of how virtuously I was eating*” (Cinquegrani & Brown, 2018). This sense of moral

superiority appeared in subtle comparisons with others: “*My roommate was eating Doritos on the couch and I couldn’t help but judge*” (Cinquegrani & Brown, 2018). Ultimately, ON was not only a response to inner distress but also a way of constructing self-worth and meaning. As one participant reflected, “*I don’t believe my orthorexia is something to struggle against... it gives it a sense of purpose, beauty, and virtue*” (Cinquegrani & Brown, 2018).

3.1.3. Health and ethical motivations

For many participants, health concerns were the initial driver of dietary change. Conditions like lactose intolerance, Crohn’s disease, coeliac disease, or high cholesterol prompted strict dietary vigilance (Fixsen et al., 2020; Tragantzopoulou & Giannouli, 2024). Clean eating was seen as a way to manage symptoms and prevent future illness: “*Now that I’m getting older you have to start worrying about things like cancer... and a part of why you eat healthy is to try and avoid that*” (Fixsen et al., 2020). Food was widely viewed as preventative medicine, with one participant stating: “*I’ve always thought of food as medicine... a preventative measure to eat well and to eat good produce now*” (Cheshire et al., 2020). Even after the resolution of physical issues, restrictive habits often persisted, driven by a deeper psychological need to “fix” or control the body. As one participant put it, she was “*on an endless search to heal various physical ailments through food elimination and diets*” (Greville-Harris et al., 2020). For others, health rationales overlapped with enduring concerns around weight, appearance, and former eating disorders. Tracking food intake through journaling reinforced control: “*You can check what you have eaten and make sure that you have consumed all the right food for your body and health*” (Tragantzopoulou & Giannouli, 2024).

Ethical beliefs also played a powerful role. Participants adopted vegetarian, vegan, or halal diets out of concern for animal welfare, environmental sustainability, or religious practice. As one shared: “*Not eating meat is not a dietary thing per se, it’s animals*” (Fixsen et al., 2020), while another added, “*Killing animals is like selling your soul*” (Mitrofanova et al., 2021). These convictions were often shaped by exposure to food documentaries or social media. Rafaela expressed a desire for full food transparency: “*Everything needs to be organic... I can source it and have the insurance that my food has not been tampered with*” (Mitrofanova et al., 2021). Across these narratives, health and ethical motivations frequently overlapped. Clean eating emerged not only as a means of achieving physical well-being but also as a way to live in alignment with personal values. As one participant reflected: “*This course was an introduction into how food can be used as medicine... and how to nourish themselves from different perspectives*” (Cheshire et al., 2020). Food, in this context, became more than sustenance—it was a philosophy and a form of self-definition.

3.2. The orthorexic experience and its consequences

This theme explores how orthorexic behaviors manifest in individuals’ daily lives and the profound toll they take on psychological, social, and physical well-being. Participants described the cognitive rigidity that governed their eating, the emotional distress that accompanied perceived dietary failures, and the isolating impact on relationships and routines. Although often motivated by a desire for health, these behaviors frequently resulted in paradoxical harm—both bodily and emotional—highlighting the complex and often contradictory nature of the orthorexic experience.

3.2.1. Cognitive rigidity and control

Many individuals described rigid food rules and black-and-white thinking that governed their eating behaviors, often resulting in significant psychological distress. Foods were classified as strictly “safe” or “unsafe,” with deviations triggering intense guilt, fear, and compensatory behaviors. As one Reddit user reflected, “*If I have safe foods, that means I have an infinite number of unsafe foods... I would feel like I binged*

and would want to purge” (Opitz et al., 2022). This moralization of food created a fragile system of control, where any dietary “transgression” was experienced as a personal failure. Participants frequently described the mental toll of this rigidity. Stella explained how a simple indulgence spiraled into distress: “I can’t go get an ice cream... then it starts up mental monkeys... I’m going to feel bad, I’m going to hurt, I’m going to get out of control” (Fixsen et al., 2020). Others believed certain foods were harmful or toxic, with one blogger recalling, “I genuinely believed that those foods would cause me physical and mental harm” (Greville-Harris et al., 2022). This anxiety often manifested physically, through symptoms like digestive issues and immune dysfunction. Participants frequently described a cyclical relationship between anxiety and bodily symptoms, suggesting that fear of “unhealthy” foods intensified physiological reactions. As one participant reflected, “... I have a theory ... that when we consistently think negative and fearful thoughts about food, our body begins to see it as a threat. Literally. Our immune system encodes it, our digestive tract rejects it and our brains see it as a source of anxiety. What was once necessary is now the enemy - physically and psychologically.” (Greville-Harris et al., 2020). This pattern created a self-perpetuating cycle: anxieties around eating specific foods heightened physical symptoms, which in turn confirmed and strengthened the belief that these foods were dangerous. Rather than alleviating health concerns, dietary restriction often led to greater emotional burden, preoccupation, and a sense of bodily fragility. These accounts suggest that the relationship between anxiety and physical symptoms was largely participant-perceived rather than clinically established, yet it played a crucial role in maintaining orthorexic behaviors.

A pattern of obsessive preoccupation also emerged. While some participants thought about food only at mealtimes, others reported intrusive, all-consuming thoughts. As one participant noted, “All the time,” when asked how often they thought about food (White et al., 2021). These thoughts were often negative, linked to guilt or anticipated punishment: “If I eat a large quantity... I’ll definitely have like a negative backlash afterwards” (White et al., 2021). Ultimately, cognitive rigidity served as a coping strategy for managing anxiety and asserting control—but paradoxically led to greater emotional burden, physical symptoms, and disordered eating patterns.

3.2.2. Social withdrawal and lifestyle disruption

Across studies and online accounts, one of the most distressing consequences of orthorexic behaviors was social isolation. While some individuals found community within clean-eating or fitness circles, the broader social impact was often marked by avoidance, loneliness, and conflict (Valente, Brenner, et al., 2020; Tragantzopoulou & Giannouli, 2024). Many withdrew from social events involving food due to anxiety about eating “impure” or “unsafe” meals. “I would hide away a lot of the time [...] always wanna eat on my own,” one participant shared, highlighting the protective yet isolating nature of these routines. Family dynamics were frequently strained. Participants described how holidays or gatherings became stressful due to their restrictive rules, sometimes requiring separate meals or specific accommodations (Lewthwaite & LaMarre, 2022). For some, these tensions escalated into severe conflict. Mary recalled, “I had troubled relationships and almost got divorced. And then my daughter stopped talking to me for a year because I was so obsessed”.

Romantic and platonic relationships were similarly affected. When others could not understand the rigidity, feelings of being “difficult” emerged: “You make a fuss all the time about what you can’t eat [...] people start getting annoyed,” one participant admitted (Mitrofanova et al., 2021). Friendships often faded due to repeated meal refusals or perceived inflexibility. As Tragantzopoulou and Giannouli (2024) also noted, social gatherings like office parties or dining out triggered significant anxiety, leading many to opt out entirely. Daily life became dominated by food-related logistics—meal prep, ingredient checks, and rigid schedules shaped work choices, living arrangements, and even travel plans (Lewthwaite & LaMarre, 2022). Social plans were commonly avoided to maintain control, with one participant

summarizing, “I probably naturally tend to eat by myself and alone” (Lewthwaite & LaMarre, 2022). When routines were disrupted, compensatory behaviors like restricting, purging, or over-exercising followed (Cheshire et al., 2020). While social withdrawal was common during active orthorexia, some found healing through connection with others in recovery. Online communities and shared experiences offered much-needed understanding—contrasting with earlier immersion in “cultish” wellness spaces that had once deepened their isolation.

3.2.3. Paradoxical health and emotional consequences

Although ON is often rooted in the pursuit of optimal health, participants across studies described serious physical and emotional consequences that undermined their well-being. Restrictive diets commonly led to malnourishment, hair loss, fatigue, amenorrhea, gastrointestinal distress, and even long-term conditions such as osteoporosis and IBS (Valente, Brenner, et al., 2020; DeBois & Chatfield, 2021; Greville-Harris et al., 2022). As one participant reflected: “They[extreme vegan subreddit communities] intentionally make food taste bland, so you won’t want to eat it and simultaneously give yourself low sodium and possibly an iodine deficiency” (Opitz et al., 2022). This irony—where health-driven behaviors resulted in physical harm—was a recurring theme. Individuals often eliminated entire food groups, prioritizing discipline over nourishment, and subsisted on highly limited diets. For example, one person described eating only ‘lettuce, vegetables, hummus, and occasional avocado,’ avoiding even whole grains or tofu (DeBois & Chatfield, 2021). Such extreme restriction often resulted in fatigue, hair loss, and other signs of malnutrition.

Emotional distress was equally pervasive. Participants reported intense guilt, anxiety, and self-disgust after eating foods perceived as “unhealthy.” One said, “I would freak out, likely to be disgusted with myself and feel strong anxiety about the effects” (Talbot et al., 2023). Attempts to regain control often triggered more restriction, compensatory fasting, or binge-restrict cycles. “I had this constant pendulum swinging... and then I would binge on things that were quite the opposite”. Many described punishing their bodies through excessive exercise and harsh self-talk. “Sweaty, extensive exercise... every day, without fail,” recalled one (Greville-Harris et al., 2022). Another admitted: “I had abused [my body] ... Worked her past her limits. Starved her. Punished her” (Greville-Harris et al., 2022). Ultimately, control became illusory. Dietary rules dictated not just food, but daily life. “It will dictate how I should cook my food... or whether or not something has to be organic” (DeBois & Chatfield, 2021). Many participants later recognized the psychological toll, marked by depression, emotional numbness, and social isolation. As Karen summarized: “I had little energy to go and do things and meet people, so I was very, very sad”.

3.3. Perspectives on orthorexia as a disorder

This theme explores how individuals interpret, question, and make sense of their orthorexic behaviors—both during the experience and in hindsight. It highlights the fluid and often contested nature of ON as a diagnostic category. While some participants later recognized their behaviors as disordered, others resisted this label, viewing their practices as rational responses to personal, cultural, or ethical concerns. Additionally, the theme examines how ON can be perceived as a “less harmful” alternative to other EDs, complicating both recognition and recovery. These perspectives reveal the blurred boundaries between health and pathology, and the cultural forces that shape how orthorexia is named, understood, and treated.

3.3.1. Retrospective recognition and resistance

For many participants, orthorexic behaviors were only recognized as problematic in hindsight. At the time, their strict food and exercise routines were seen as virtuous—rooted in discipline, health, or moral values rather than disorder (Lewthwaite & LaMarre, 2022). This perception was bolstered by cultural norms that valorize clean eating

and self-control. “I would have just kind of adamantly rejected any kind of labels,” one participant admitted (Lewthwaite & LaMarre, 2022). Only later, often through relationships or personal upheaval, did they begin to reflect on the rigidity and anxiety underlying these habits. As one recalled, “He wanted to go out for dinner... I’d sit there with like a miso soup... but at the time it was so serious” (Lewthwaite & LaMarre, 2022). Retrospective insight allowed participants to distinguish between health-promoting practices—marked by flexibility and ease—and orthorexic ones, characterized by guilt, compulsion, and moral inflexibility. While some acknowledged overlaps with AN or bulimia nervosa (BN), they identified ON’s unique focus on purity and healthfulness as distinct. Yet this distinction was often blurry. For some, ON felt even more restrictive in terms of food variety than their past AN behaviors. Persistent fatphobic beliefs and fear of weight gain remained central: “I think I’d rather be dead than be fat” (DeBois & Chatfield, 2021).

However, not all participants accepted ON as a disorder. A subset rejected the label outright, expressing frustration with what they saw as the pathologizing of healthy living. “There are eating disorders, but eating healthy isn’t one of them,” argued one respondent. “This quackery is a disservice to those who lead a healthy lifestyle” (Cinquegrani & Brown, 2018). These responses reflected a form of narrative resistance, framing rigid food practices as rational, empowering, or ethically driven. “This cr*p is just one more way in which the industrial food system tries to make people who eat real food feel marginalized” (Cinquegrani & Brown, 2018). For some, orthorexic behaviors served as a coping mechanism during periods of instability. As one participant explained, “There was nothing I could do about any of those things. But, I sure could control my calories” (Cinquegrani & Brown, 2018). Such accounts highlight how ON sits on a contested boundary between wellness and pathology—shaped not only by individual psychology, but also by cultural ideals, power structures, and personal meaning-making.

3.3.2. ON as a safer alternative and the ambiguities of recovery

Many participants described ON as a “safer” alternative to previous eating disorders like anorexia or bulimia. Though still highly controlled, their current food practices were framed as healthier and more socially acceptable. As Gal reflected, eating healthily felt like “a nicer way than having to starve yourself” (Lewthwaite & LaMarre, 2022), offering a sense of control without overtly extreme behaviors. Some participants saw ON as a form of self-care or even personal success. “This to me feels like a blessing,” one stated, contrasting it with past disordered patterns (DeBois & Chatfield, 2021). However, this perception often masked the disorder’s harm.

Recovery narratives were complex and often conflicted. While some recognized the need for change, others resisted it due to fears around losing control or abandoning perfection. Some criticized treatment programs for reinforcing orthorexic thinking by overemphasizing nutritional value: “They preach that you have to value the nutritious value of food, and I feel like that pushes the orthorexic ideals” (DeBois & Chatfield, 2021). The process of recovery was described as deeply personal and emotionally taxing. “Truthfully, recovery is not easy... there are days when I feel guilty for eating” (Talbot et al., 2023). For many, the turning point came with realizing their disorder had been hidden behind a culturally celebrated obsession with health. “I did eat food—just as long as it met my ‘healthy’ standards” (Cinquegrani & Brown, 2018). A recurring frustration was the invisibility of orthorexia and the struggle to be taken seriously. “It hurts when people say my orthorexia is not serious because I don’t have anorexia... when I am ‘so healthy’” (Talbot et al., 2023). This lack of recognition delayed help-seeking and reinforced feelings of isolation. Still, some found relief in letting go. Reflections on reclaiming joy and connection underscored the costs of an orthorexic lifestyle: “Lost in endless rules and regulations that left me neurotic, unhappy and exhausted” (Cinquegrani & Brown, 2018). As Lesley expressed, “Eating with friends and family and sharing those little indulgences... is more important for our relationships than we sometimes realize” (Cinquegrani & Brown, 2018).

4. Discussion

This review explored the lived experiences of individuals engaging in orthorexic behaviors, generating three interrelated themes: (1) Origins and Motivations for Orthorexic Behavior, (2) The Orthorexic Experience and Its Consequences, and (3) Perspectives on Orthorexia as a Disorder. Taken together, these themes illuminate ON not simply as a dietary fixation, but as a complex psychosocial phenomenon shaped by personal, cultural, and moral dynamics. The findings echo and extend prior scholarship by foregrounding the blurred boundaries between health and pathology, the moralization of food, and the underexplored role of identity and social belonging in sustaining orthorexic practices.

4.1. Sociocultural ideals and the moralization of health

ON emerges against a backdrop of longstanding sociocultural pressures around body shape and eating. Historically, disordered eating has been linked to ideals of thinness and self-discipline, particularly among women (Hesse-Biber et al., 2006). In contemporary societies, these pressures have shifted toward a broader focus on health, wellness, and moralized eating—what has been described as “healthism”—where dietary practices are imbued with ethical, aesthetic, and social significance (Crawford, 2006). In the modern context, these historical and cultural pressures are reinforced and amplified through digital media and wellness discourses. One of the most salient findings across studies was the role of sociocultural pressure—particularly digital and media discourses—in shaping and reinforcing orthorexic behaviors. Participants internalized Western ideals of thinness, productivity, and self-discipline, often mediated through “clean eating” trends, influencer culture, and wellness marketing. These ideals were not only pervasive but often contradictory, generating anxiety and confusion (Opitz et al., 2022; Valente, Brenner, et al., 2020). These findings are further supported by research highlighting the influence of online spaces—such as healthy eating blogs, wellness websites, and social media platforms—in promoting orthorexic tendencies. Mitrofanova et al. (2021) suggest that time spent engaging with such content can catalyze rigid food practices, as users are often exposed to advice from self-proclaimed experts who position dietary control as a moral and aesthetic virtue. These platforms frequently recycle dominant discourses around food, health, and the body, reinforcing binary distinctions between “good” and “bad” foods and valorizing thinness (Boepple & Thompson, 2014; Donghi & Wenerholm, 2014; Tragantzopoulou, Fixsen, et al., 2024; Tragantzopoulou, Mouratidis, et al., 2024). Moreover, many of these spaces are underpinned by entrepreneurial motives—promoting products, brands, or lifestyles—that further entrench neoliberal ideals of self-optimization (Tragantzopoulou, Fixsen, et al., 2024; Tragantzopoulou, Mouratidis, et al., 2024). This aligns with research suggesting that the healthiest ethos of neoliberal societies positions health as a moral imperative and personal responsibility (Crawford, 1980; Lupton, 2013). Within this framework, ON becomes a culturally sanctioned pursuit: socially rewarded, yet privately distressing.

Importantly, the findings also challenge simplistic narratives that frame ON purely as a dietary concern. Participants’ narratives were infused with moral, aesthetic, and even spiritual overtones—healthy eating became a marker of virtue, superiority, and self-worth (Cinquegrani & Brown, 2018). The moralization of food choices contributed to rigid thinking, social isolation, and a fragile sense of identity bound to dietary purity. Current consensus definitions, such as that proposed by Donini et al. (2022), conceptualize ON as primarily motivated by health, aesthetic, and healing concerns rather than by ethical or animal welfare motives. While the present findings broadly align with this framework—given that health and self-purification were dominant themes—they also suggest that moral and ethical rationales can merge with health-focused beliefs in ways that reinforce orthorexic patterns. In this sense, ethical eating may not cause ON per se but can provide a socially acceptable avenue through which health-related

moralization intensifies, blurring the boundary between value-based eating and pathology.

At the same time, several participants referenced calorie counting, weight monitoring, and body control—behaviors typically associated with AN. This overlap underscores the complex relationship between health and weight ideals, as these constructs are often conflated in contemporary wellness culture. While participants frequently articulated their behaviors as health-motivated, their narratives also revealed implicit desires for thinness, bodily control, and aesthetic validation. Acknowledging this tension is critical: orthorexic and anorexic tendencies may coexist or shift fluidly along a continuum, reflecting how societal ideals of health are frequently intertwined with normative pressures toward slenderness and self-discipline (Cena et al., 2019; Depa et al., 2019).

Within a neoliberal context, where health is framed as a personal obligation and success is equated with self-control, orthorexic practices become symbolic acts of moral responsibility (Bergman et al., 2019; Håman et al., 2015; Madden & Chamberlain, 2010). Individuals are encouraged to view dietary discipline as a form of self-governance, and deviations from these standards are often internalized as personal failure (Cohen, 2022; Fixsen, Cheshire, & Tragantzopoulou, 2025; Tragantzopoulou, Fixsen, et al., 2024; Tragantzopoulou, Mouratidis, et al., 2024). Thus, ON may reflect not simply individual pathology but a cultural logic in which food becomes a battleground for performing moral worth, social distinction, and personal accountability.

4.2. Identity, perfectionism, and emotional regulation

The theme of Personal Traits and Identity Drivers highlighted the psychological mechanisms that sustain ON. Perfectionism, black-and-white thinking, and a need for control frequently preceded or co-occurred with disordered eating behaviors. These traits were not merely personality traits, but appeared as coping mechanisms in response to life instability or emotional distress (Valente, Syurina, et al., 2020). This supports previous findings that ON may serve as a form of emotional regulation, providing individuals with a structured way to manage uncertainty, anxiety, and low self-esteem (Koven & Abry, 2015). Moreover, participants often derived a sense of identity, meaning, and moral superiority from their eating habits. Clean eating became not only a routine but a philosophy and a source of self-definition (Greville-Harris et al., 2022). The performative nature of this identity—especially in online spaces—suggests ON may serve both intrapsychic and social functions. Previous research has highlighted that online communities are a source of connection and validation, offering individuals not only a platform to display their commitment but also a space where their practices are affirmed and celebrated (Tragantzopoulou & Giannouli, 2025; Yeshua-Katz, 2015). Within these communities, dietary behaviors become tied to collective values, fostering a sense of belonging, identity, and purpose (Gale et al., 2016; Yeshua-Katz, 2015; Yeshua-Katz & Martins, 2013). It is perhaps for this reason that participants described resistance to change and ambivalence toward recovery: giving up ON would also mean relinquishing a source of pride, belonging, and moral clarity. These insights underscore the importance of addressing the identity-reinforcing function of ON in both research and treatment.

4.3. Paradoxical outcomes: health pursuits that harm

The second theme illuminated the paradoxical consequences of ON. Despite being motivated by health, participants often experienced physical deterioration, psychological distress, and social disruption. From nutrient deficiencies to emotional numbing and loneliness, the costs of orthorexic behaviors were substantial and wide-ranging (DeBois & Chatfield, 2021). These findings mirror previous work that conceptualizes ON as a health paradox—where the pursuit of wellness results in ill-health (Bratman & Knight, 2000; Dunn & Bratman, 2016). Notably,

the rigidity of orthorexic routines often extended into broader life domains, dictating social interactions, travel, work, and relationships. While this level of impairment aligns with diagnostic criteria for other EDs (APA, 2013), ON remains under-recognized and difficult to classify. Participants' experiences of guilt, preoccupation, and intrusive food-related thoughts suggest that orthorexia is deeply distressing—but to frame this solely as psychopathology risks oversimplifying its roots. Rather than being reducible to individual pathology, ON appears to emerge at the intersection of personal histories and powerful sociocultural forces that valorize self-optimization, moral purity, and bodily control. The appearance of “healthy living” may obscure the extent to which these behaviors are driven by societal expectations and identity-based pressures, often exacerbated by wellness culture and digital media. A more critical understanding of ON is therefore essential—one that moves beyond clinical categorization to interrogate the wider cultural conditions that make such patterns both possible and desirable (Fixsen, Cheshire, & Tragantzopoulou, 2025; Fixsen, Ridge, et al., 2025).

4.4. Ambiguity, legitimacy, and diagnostic tensions

The third theme—Perspectives on Orthorexia as a Disorder—captured the conceptual ambiguity surrounding ON and the difficulties participants faced in recognizing or naming their behaviors as disordered. Many participants initially rejected diagnostic labels, viewing their habits as rational, ethical, or superior. Only in hindsight, often after significant social or emotional fallout, did some acknowledge the dysfunction underlying their routines. This retrospective realization supports literature suggesting that ON often masquerades as wellness, eluding early detection (Cena et al., 2019). Interestingly, a number of participants viewed ON as a “safer” or more acceptable version of previous EDs, particularly AN or BN. While seemingly healthier, these behaviors often preserved core features such as control, restriction, and body-based anxiety (Lewthwaite & LaMarre, 2022). At the same time, we are acutely aware that contemporary pressures to attain an ideal body and eat ‘clean’ have left many individuals oscillating between extreme practices and the ongoing desire to finally accept or love their bodies (Adamidou & Tragantzopoulou, 2025; Tragantzopoulou, 2025)—against a backdrop where even treatment for EDs can carry its own psychological and physical tolls (Tragantzopoulou, Fixsen, et al., 2024; Tragantzopoulou & Giannouli, 2020, 2023; Tragantzopoulou, Mouratidis, et al., 2024). For instance, participants in these studies highlighted how treatment environments sometimes reinforced body surveillance, triggered weight-related anxiety, or imposed rigid recovery expectations that could feel disempowering. In some cases, medical monitoring and dietary prescriptions, while well-intentioned, risked reproducing dynamics of control and restriction, complicating the path toward genuine self-acceptance. These insights suggest that recovery itself is not always a linear or unproblematic process, but can introduce new challenges to embodied well-being. Thus, while distinctions between pathological and non-pathological ON have been proposed (Barrada & Roncero, 2018; Depa et al., 2019), we must critically reflect on where the threshold is drawn, who is pathologized by such classifications, and who ultimately benefits from their institutionalization. Rather than simply asking whether ON is a form of harm reduction or a repackaged disorder, it may be more fruitful to explore how individuals use “healthy” practices to navigate deeper psychological needs in a cultural context that moralizes self-discipline. The ambivalence expressed in participants' narratives—between empowerment and entrapment, health and harm—highlights the need to view ON not only through a clinical lens, but as a cultural response to contemporary anxieties around identity, worth, and bodily control.

4.5. Limitations and future directions

This meta-synthesis draws on 16 qualitative studies, offering rich

insight into the lived experiences of individuals with orthorexic tendencies. However, the body of literature remains limited in both scope and diversity. Most included studies were conducted in Western, predominantly white, and relatively affluent contexts such as the United States, the United Kingdom, and Northern Europe. This narrows the cultural lens through which ON is understood and limits transferability of findings to other sociocultural settings. Given the global proliferation of wellness ideologies, future research must examine how ON is experienced and expressed across different racial, cultural, and socioeconomic groups.

A further limitation arises from the nature of meta-synthesis. The analysis was based on data already interpreted and reported by the original study authors, rather than on raw transcripts. This may restrict nuance, as important contextual detail or participant meaning-making might not have been fully captured. Moreover, the studies included in this synthesis used different criteria for identifying participants with orthorexic behaviors, ranging from self-identification with the ON label to high scores on ON, related questionnaires. Such heterogeneity in operationalization may influence the comparability of findings and introduces ambiguity about whether participants' experiences reflect the same underlying phenomenon. In a few cases (e.g., [Cheshire et al., 2020](#); [Fixsen et al., 2020](#); [Valente, Brenner, et al., 2020](#); [Valente, Syurina, et al., 2020](#)), inclusion criteria and sample overlap warrant cautious interpretation. Cheshire et al. and Fixsen et al. drew on the same participant pool but reported distinct analytical foci, while Valente et al.'s sample included individuals below the diagnostic threshold for ON. In addition, the included studies were published between 2020 and 2024, a period when social norms and cultural discourses around “clean eating,” wellness, and body image may have shifted. This temporal framing may affect the transferability of findings to other cultural moments.

Finally, while the quality appraisal indicated that most studies were of high methodological rigor, some exhibited limitations in areas such as reflexivity and consideration of researcher–participant dynamics, which should be borne in mind when interpreting findings. The fluidity of orthorexic behaviors- from socially sanctioned health practices to clinically impairing obsessions- underscores the urgency of developing more flexible and context-sensitive frameworks. These should avoid over-pathologization while remaining attuned to the real harm experienced by those navigating this blurred terrain.

Appendix A. The ENTREQ Checklist

Item	Guide and description	Reported on page #
Aim	State the research question the synthesis addresses	10–11
Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	12
Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until theoretical saturation is achieved).	13–14
Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	13–14
Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psychINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organizational websites, experts, information specialists, generic web searches (Google Scholar), hand searching, reference lists) and when the searches were conducted; provide the rationale for using the data sources.	13–14
Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research and search limits).	13–14
Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies)	13–14
Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	21–24
Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications the research question and/or contribution to theory development).	13–14

4.6. Conclusion

ON emerges as a complex and culturally situated phenomenon, shaped not only by individual traits such as perfectionism and identity-seeking, but also by broader moral discourses and societal ideals around health, body, and self-discipline. Though often masked by a wellness narrative, orthorexic behaviors can lead to significant psychological, physical, and relational harm. The blurred boundary between health and disorder—and between socially sanctioned self-care and compulsive control—reveals deeper cultural anxieties about morality, productivity, and bodily perfection. Recognizing ON as both a personal struggle and a sociocultural symptom is crucial, not to pathologize health-consciousness, but to interrogate the values that render certain behaviors virtuous and others disordered. These findings urge a more critical and compassionate approach to health—one that resists reductive categorization and acknowledges the lived realities behind diagnostic boundaries. In doing so, we can better support individuals without reinforcing harmful ideals of control, restriction, or moralized eating.

CRediT authorship contribution statement

Panagiota Tragantzopoulou: Writing – review & editing, Writing – original draft, Visualization, Supervision, Software, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Vaitsa Giannouli:** Writing – review & editing, Formal analysis. **Sophia Zachariadou:** Writing – review & editing, Formal analysis.

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Declaration of competing interest

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Data availability

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