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Chapter 7

Orthorexia Nervosa: the Medicalization of Extreme Healthy Eating Practices

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Introduction

In this chapter we examine the construction of the proposed eating disorder orthorexia nervosa (ON), the politics around its potential inclusion in the DSM, the polemic between desirable healthy eating versus pathological or deviant eating, and market interests underpinning the identification of new eating disorders. So far orthorexia has been studied largely from an individual ontological perspective (Musolino, Warin, Wade, & Gilchrist, 2015) neglecting symbolic and normative factors and the role played by psycho-politics in the framing of eating disorders. Our study explores three different perspectives on extreme healthy eating; those who self-identify as highly preoccupied with healthy eating, professionals with expertise in eating disorders including ON, and posters on an eating disorder social media site. By focusing on and comparing the narratives of individuals who differentially position themselves around debates concerning health and eating, we can begin to understand the tensions around labelling Extreme Healthy Eaters as 'troubled persons' (Gusfield, 1989) and explain how healthy eating gets transformed into a medical/ psychiatric condition as constructed/acknowledged first by professionals and subsequently by members of the public. We begin with a constructionist critique of psychiatric diagnosis (Horwitz, 2012; Jutel, 2014) and the expansion of disordered eating categories within its diagnostic armory.

The medicalization of eating

The social construction of medicine concerns the processes by which certain behaviors and experiences come to be defined as medical conditions (Conrad & Barker, 2010). From the conventional medical perspective, diagnoses are useful classification tools which allow for shared understanding and aid practitioners in identifying treatment options and predicting treatment outcomes. They can also be useful for patients to help them understand what is happening to them and to gain acknowledgment and support. From a constructionist perspective, a diagnosis represents a 'focal point at which numerous interests, anxieties, values, knowledges, practices and other factors merge and converge' (Jutel & Nettleton, 2011, p.794). Within our network society this includes, not just the creation and use of medical diagnoses by experts, but the adoption of labels by those in allied institutions. Delivering a diagnosis is therefore far more than a clinical act; it is a moral indictment which for the individual themselves alters their self-definition, and ensures that 'the individual now inhabits an illness' (Klinkenborg, 1994), be this in their own mind or as a life-long part of the individual's medical history.

Of the aspects of medicalization most critiqued by constructionists, those concerned with the construction of mental illness are arguably the most controversial. Historically, the labelling of mental illness was reserved for those whose behavior was extremely bizarre and disruptive, while Freudian psychotherapy paid little attention to diagnosis altogether. Throughout history, what DellOsso et al. (2016) describe as the 'psychopathology of eating disorders' has been a moving feast, with the extensive categorization of disordered eating a relatively recent development which needs to be considered as part of the wide move toward the labelling of 'deviant' behaviors according to the language and principles of modern psychiatry. Self-restricted food intake for example, as recorded in the Middle Ages as *anorexia mirabilis,* was associated with holiness and extraordinary penitential practices (DellOsso,

2016), whereas its contemporary version Anorexia Nervosa is regarded as a serious pathological disorder[1] that sits within a spectrum of psychiatric eating and feeding disorders.

The 2013 *Diagnostic and Statistical Manual for Mental Disorders* (*DSM-5)* defines an eating disorder (ED) as 'a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs health or psychosocial functioning' (APA, 2020). Since its inception, the American Psychological Association (APA) have repeatedly altered and extended their classification of eating disorders, with the 2013 version differing from *DSM-IV-TR* on several counts. Three disorders - avoidant/restrictive food intake disorder, rumination disorder, and pica - have been moved from 'Feeding and Eating Disorders of Infancy or Early Childhood' to the general section; modifications have been made to anorexia nervosa and bulimia nervosa;[2] and binge eating disorder (BED)[3] has gained the status of a formal diagnosis (APA, 2013). The APA's assertion that these changes, 'better represent the symptoms and behaviors of patients dealing with these conditions across the lifespan' (APA, 2020), has failed to allay the spate of criticisms and allegations that have followed from the ranks of psychiatrists, psychologists and scholars (Welch, Kalssen, Borsova, & Clotheir, 2013). Allegations include secrecy, conflict of interest, lack of empirical substance and medicalization of normality (Horwitz, 2012). Many of these criticisms are detailed in an open letter initiated by the Society for Humanistic Psychology in 2013, which represented over 15,000 individuals who sought major reforms to the DSM (Robbins, Kamens, & Elkins, 2017).

There are a number of pertinent issues to consider concerning the psychiatric labelling of disordered eating practices. Firstly, the over-appropriation of psychiatric labels to unusual

[1] A DSM defined disorder characterised by distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat.
[2] A DSM defined disorder characterized by frequent episodes of binge eating followed by inappropriate behaviors such as self-induced vomiting to avoid weight gain.
[3] A DSM defined as recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control (APA, 2020).

eating choices and behaviors can lead to an over-problematizing and stigmatizing of EDs such that the media and others portray them as norm-violating behaviors, with obesity associated with greed, binge eating with lack of self-control etc., resulting in widespread social censure and prejudice (Guthman & DuPuis, 2006). Our second point is posed as a query: should these emerging categories be viewed as psychiatry responding to new clinical information that has emerged from individual 'pathological' cases, or do they represent a deeper dyscrasia founded on a widespread dissatisfaction with, and pathologizing of, the contemporary body? A social constructionist perspective would suggest the last option. In order to understand more about these issues we turn to the empirical literature concerning lay and professional attitudes to dysfunctional eating.

Perspectives on dysfunctional eating

A great deal of research has documented the prevalence and negative health implications of stigma attached to having a mental health diagnosis (Corrigan, 2004); less has been written about the stigma associated with particular EDs (Puhl & Suh, 2015). Obesity for example would appear to be a highly ubiquitous source of social and self-directed censorship and stigma (Sikorski et al., 2011), with institutions profiting from a 'cult of thinness,' which in turn has spawned multiple industries designed to treat the psycho-pathology of over-eating (Hesse-Biber et al., 2006). Social attitudes to other EDs appear more complex. One study found attitudes toward individuals with EDs to be more stigmatizing than those toward individuals with depression, with the former rated as more fragile, more responsible for their disorder and more likely to use their disorder to gain attention than people with depression (Roehrig & McLean, 2010). However the study found attitudes to be ambiguous; some participants believed aspects of EDs could be beneficial (e.g. attention to weight loss) but also thought others would be motivated to imitate these behaviors with negative consequences (Roehrig &

McLean, 2010). A moral and aesthetic hierarchy of EDs also appears to exist among certain groups, with a diagnosis of anorexia viewed as morally superior to being labelled with bulimia nervosa or binge eating disorder, such that a cross-over to the latter could be viewed as shameful or morally weak (Mortimer, 2019).

At the same time, a growing on- and off-line resistance to the stigmatizing and medicalization of EDs has also been documented. This resistance has been aided and supported by feminist literature e.g., Malson's 2003 paper critiquing the medicalization of anorexia and Saguy's 2012 paper arguing how fat as an issue relates to gender, social class and race/ethnicity. Both authors call for weight issues to be explored as socially, discursively produced problems (Malson, 2003; Saguy, 2012). On-line *Pro-Ana and Pro-Mia* eating disorder support forums have become increasingly popular, despite strong criticism by those in research and medical communities for promoting serious eating disorders as a lifestyle choice and thereby normalizing them (Borzekowski, Schenk, Wilson, & Peebles, 2010; Christodoulou, 2012). Some researchers suggest their appeal may be related to the social support they offer, along with mechanisms for coping with a stigmatized illness and self-expression enabled through these sites (Tong, Heinemann-LaFave, Jeon, Kolodziej-Smith, & Warshay, 2013; Yeshua-katz, 2015). Others refute the utility of these sites for much more than promoting graphic material to endorse and support eating disorders (Borzekowski et al., 2010).

The views and perceptions of clinicians to the people whom they treat is a generally underexplored area (Currin, Waller, & Schmidt, 2009; Vandereycken, 2011). Some clinicians may refute the need for psychiatric labelling of eating (Vanheule, 2012), however others may find the use of a label with which to identify aberrant ideas and responses around food and eating in patients/clients helpful for reassurance that their course of action is correct and as a means of convincing the patient/client that they have a medically recognized problem. Existing studies indicate that clinicians find people presenting with EDs particularly challenging

(Geller, Williams, & Srikameswaran, 2001) as patients or clients with EDs such as anorexia frequently exhibit either a strong ambivalence to reducing their symptoms, or a complete lack of interest in change. In one study of clinicians' responses to the adolescent female patients they were treating for an ED, patterns of reactions included a sense of competence and empathy, but also feelings of anger and frustration, feeling worried about clients or angry toward the parents (Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009).

Orthorexia nervosa- a new eating disorder?

One relatively new eating disorder which has yet to be officially unclassified is that of Orthorexia Nervosa (ON), a dependence or fixation on healthy food, where the desire to consume quality food plays the main role in the symptomatology (Varga et al., 2013). This alleged disorder represents one of a range of new maladaptive eating and 'health-promoting' behaviors which have been identified by non-psychiatric clinicians (in this case alternative medical practitioner in the 1990's, Dr Steve Bratman) that has gained prominence through a mixture of academic research and media hype. First described in 1997 by Bratman in association with health food junkies (Bratman, 1997) the problem usually begins 'as an innocent habit' used to overcome physical diseases or to improve one's health. To quote Bratman:

> "Many of the most unbalanced people I have ever met are those have devoted themselves to healthy eating. In fact, I believe many of them have contracted a novel eating disorder, for which I have coined the name 'orthorexia nervosa.' (Bratman, 1997 quoted 2017)."

Despite its unofficial diagnosis, ON has spawned a vast body of statistical studies and the development of multiple orthorexia scales, including the Bratman Orthorexia Test (Bundros, Clifford, Silliman, & Neyman Morris, 2016) and ORTO-15 (Dunn & Bratman, 2016), all attempting to define and assess risk factors for ON in different population groups. The status of ON as a clinically unique disorder, rather than a variant of other disorders, has become a hot topic of debate among clinicians and health researchers across the globe (Gramaglia, Brytek-Matera, Rogoza, & Zeppegno, 2017). 'Established' characteristics of ON now include a growing concern about consuming only healthy food, the presence of high levels of self-discipline and a sense of moral superiority over people who consume junk food (Bratman, Steven, 2000; Varga et al., 2013). Widely regarded as sharing traits with anorexia nervosa and bulimia nervosa (Varga et al., 2013), studies have also linked ON to personality traits including perfectionism and narcissism (Oberle, Samaghabadi, & Hughes, 2017), psychological disorders such as a body dysmorphia (Bo et al., 2014) and obsessive compulsive disorder. The vast majority of ON studies are correlational, very few explore the experiences of those with ON traits (Nevin & Vartanian, 2017) or professionals working in areas in which extreme healthy eating practices are observed among clients (Håman, Lindgren, & Prell, 2017).

A growing number of scales used to 'detect' ON have emerged in recent years, even so debates still wage around whether or not ON as a disorder really exists (Brytek-Matera, 2012). 'Orthorexic' practices can appear to have much in common with 'pro-health' eating behaviors, such as vegetarianism, veganism, raw food diets and more recently clean eating, which are increasingly popular with those aiming at physical, mental or spiritual purification. With its links to slimming, sport and exercise, orthorexia has been variously called 'healthy anorexia' (Musolino et al., 2015) and a 'life-style syndrome' (Haman, Barker-Ruchti, Patriksson, & Lindgren, 2015). In the media it has been alternatively criticized and glamorized (Haman et al., 2015; Vogue, 2019).

Nicolosi (2006) adopts a wider philosophical perspective of the orthorexia phenomenon to suggest that we now inhabit an 'orthorexic society', in which people's relationship with food is plagued with alimentary fears and obsessions. Three main factors- a weakening of the restraining power of traditional institutions (religion, ethnicity, community) on food intake and dietary practices, the ever-increasing distance between the food producer and consumer and the framing of the body as an individual project- all underly the orthorexic disposition that characterizes western modernity (Nicolosi, 2006). Twenty-first century society has witnessed unprecedented attempts to atomize and marketize self-care in the form of body aesthetics, as achieved through such things as fitness regimes, low carbohydrate diets and body building (Koven & Wabry, 2015). The result has been a medical and public U-turn in thinking concerning eating practices considered at one time part of marginal subcultures, such as veganism, but also the emergence of more extreme healthy eating norms and behaviors especially among young females, the population group most heavily targeted for health and beauty products and media messages (McRobbie, 2008). The constant search for accurate information, along with the instability of advice in these messages further contributes to anxieties around food choices (Rangel et al., 2012). A kind of moral panic has ensued over the so-called 'epidemic' of obesity (Guthman & DuPuis, 2006) which, in an individualistic society, has largely been blamed on lack of self-control rather than neoliberal market forces demanding over consumption.

In addition to psychiatry, there are lots of other institutions and social actors who are interested in labeling problems and in the emergence of a 'kind-of-diagnoses.' Media and industries, such as the food, beauty and fitness industries, have outstanding potency in both creating an obsession with healthy eating among the citizens (Koven & Abry, 2015), and the marketing of products which align with this trend. Numerous other institutions - 'troubled person industries' (Gusfield, 1989) - have subsequently come forward to offer their support to

individuals with eating problems. Some such as counselling, clinical psychology and dieticians have existed for decades, others such as online eating forums and various social media sites have emerged more recently with the network society (Manuel Castells, 2011). Following the latter is vast crowd of consumer who, for various reasons such as health status, age and gender, are vulnerable to both the messages conveyed about diet, health and fitness and their treatments, including those concerning extreme eating practices (Fixsen et al., 2020).

In summary, moral debates and vested interests surrounding the labelling of extreme healthy eating as pathological are complex and nuanced (Dell'Osso et al., 2016). While the formal categorizing of psychiatric illnesses remains the privilege of psychiatry and its diagnostic 'experts', other groups share interests in these labels. It is the adoption and contestation by allied professions and wider society concerning extreme healthy eating practices that forms the main topic of our chapter. For this we now turn to our empirical study of three different cohorts - laypersons and professionals- who have different interests in, and perspectives around, extreme healthy eating.

Methods

We chose triangulation (investigator, method and data triangulation) to gather as many different perspectives on orthorexia nervosa, and the meanings ascribed to extreme 'healthy' eating practices, as possible. Our data set consisted of three sets of on and offline data, gathered over a six-month period by three different researchers working under the direction of the second author. Our final data sets were: nine interviews with people who self-identified as highly preoccupied with healthy eating (cohort A: 'Extreme Healthy Eaters'); 'ortho' threads from an eating disorder social networking site (cohort B: 'Posters'); and seven interviews with clinical psychologists, dieticians and a family therapist who have long term experience of

working with eating disorders (cohort C: 'Professionals'). All parts of the study were approved by the University Psychology Ethics Committee.

'Extreme Healthy Eaters' were recruited through poster advertising and social media, and later via snowball sampling. As there is no formal orthorexia diagnosis, the purpose of the study and its inclusion criteria (age 18 years or above and self-reported healthy eating that had taken over their lives) were described in lay terms to prospective participants. Those with a diagnosed psychiatric disorder or who were having inpatient treatment for an eating disorders were excluded from the study. The final cohort (A) consisted of 6 female and 3 male participants. Seven Extreme Healthy Eaters were based in the UK, and two were based in the United States. Recruitment of professionals was purposive and aimed at those with diverse and in-depth expertise in eating disorders, and specifically ON. All professionals identified as female, as attempts to recruit male participants were ultimately unsuccessful. Three professionals were based in the UK, two in USA, and one worked in both the UK and USA. (See table one: study participants)

Once initial contact was made, participants were emailed a copy of the participant information sheet and consent form and given an opportunity to ask questions about the study. Interviews were arranged face-to-face or via telephone/skype according to the following participant preferences: Extreme Healthy Eaters face-to-face (n=6), telephone (n=3); Professionals face-to-face (n=3), telephone/skype (n=3). Interviews lasted between 23 and 46 minutes for people with ON and between 37 and 69 minutes for professionals. Interview guides included set topics but were sufficiently flexible to allow participants to raise other topics of importance to them. Participants were assured that the interview was private, and that any data used from the interview would be anonymized and would form part of a larger data set.

Interview process

Semi-structured interviews with lay people ('Extreme Healthy Eaters') explored the whole context of individuals' eating choices, including healthy eating choices, reasons for eating healthy and impact of the diet including impact on daily activities, physical and psychological well-being, and social/educational/work life. Questions also explored the influences on participants' diet. Semi-structured interviews with 'professionals' focused on their perception of and experience of fixations with healthy-eating, what they regarded as the key features of ON, how fixations with healthy-eating manifested in clients, factors influencing their development and, professional treatment strategies and their limitations. In addition to analyzing face-to-face and Skype interviews, we analyzed data from threads selected from an 'orthorexia' forum on an eating disorder website collected over a 2-month period between 2017 and 2018. For maximum variability, the data focused on threads that contained multiple responses from a variety of posters. Each thread contained between 10 and 68 comments. This site is accessible within the public domain, and the majority of forums and thread topics can be read without creating an account. All posts on the site are anonymous (the site does not allow users to use their real name as a username).

Data analysis

In the first stages of analysis, data from different interviews and stakeholder discussions were considered as separate elements. By repeatedly reading transcripts of interviews, the first author familiarized herself with all the data covering the full range of themes. NVivo was then used to extract more codes and analyse different sections of the data in various ways. Finally, maps and diagrams were used to creatively synthesize ideas. As ideas were generated, they were discussed with the research team and with different stakeholders. Data was coded using a modified constant comparison approach (Strauss & Corbin, 2015), inspecting and comparing all data and fragments arising in a given case and moving from a larger to more compact data

set (Silverman, 2014). At different stages of data analysis, emerging codes and themes were discussed with the team. As final codes emerged, data was repeatedly rescanned manually to check for any missing or hidden codes or concepts.

Results

Cohort A: Extreme Healthy Eaters

Extreme Healthy Eaters in our study ascribed to a variety of dietary practices for different reasons, however all emphasized the significant health benefits of eating healthily and avoiding 'junk food.' The idea of food as form of medicine aligned with what they had learned concerning the benefits of eating in a biologically pure way. As Tim explained, refraining from low quality foods could go a long way toward prevent future illness:

> Now that I'm getting older you have to start worrying about things like cancer . . . Parkinson's, Alzheimer's, all that type of stuff, and a part of why you eat healthy is to try and avoid that in a lot of ways. I think there's a lot of evidence that cancer can be linked to an unhealthy diet and eating high fat fried foods- who knows what that does in terms of the risk of getting cancer? *Tim*

Several of the cohort had chosen to abstain from meat for ethical reasons: "Not eating meat is not a dietary thing per se, it's animals"; "I started cooking for myself and meat grossed me out, the blood and bones." Jane was convinced that 'going' vegan had been the right choice: "'Cowspiracy'. . . It's mainly about how the general meat and dairy industry is bad for the environment." Healthy eating with also part of a chosen lifestyle in which food was used to promote fitness levels and a particular body shape, for recreational or business purposes. Three of the cohort trained in body building and used dietary manipulation and supplements as a way of achieving their ideal body shape and muscle tone goals:

> It's a good time we're speaking, to be fair, because I'm about to do a competition in the next seven weeks. So… I'm on like a, a strict diet, and right now it'll be more like six meals a day, spread out between maybe two and a half to three hours. And then meals will be just kind of intake a high protein, a low carb, but healthy standard fats. *Jake*

Body builder Liam had "done a lot of research into nutrition from the body building, power-lifting side." Initially he had been "heavily influenced" by names "in the industry" who post on Twitter and YouTube, "but then you start to develop more of your own understanding" of nutrition. Now working to establish his own online business, Liam believed that his good physical shape would work in his favor; "The [online] visuals draw you in…. probably the biggest element is physical appearance."

Another factor underpinning healthy eating choices was the influence of the family. Stella had a mum who had bulimia, while her grandmother (a "yo-yo dieter") had been on numerous slimming pills and dieting programs: "I look at my mum and grandma and I say, 'I don't want to be like them.'" Despite her attempts to rationalize such behaviors, for Stella, overeating continued to provoke feelings of disgust within herself and towards others:

> "I don't know if it's because when, when I quit swimming, I went from 60 kg to 82 fucking kilos, right, I was disgusted in myself. So now I have an even more skewed opinion of fat people, I think it's disgusting." *Stella*

For other Extreme Healthy Eaters, childhood evoked very different food memories. Edi, one of the older members of the cohort, described herself as a little over-weight but "rather obsessive about healthy eating." Having grown up in an Italian family, good dietary habits had been instilled into her at an early age; "there was always a delicious meal on the table, we all sat down at the table together as a family." Liam also cited his mother as being the biggest influence on his dietary interest and choices; "All her meals are very, very good in the traditional healthy eating landscape."

Participants in this study were requested to talk at length about their dietary preferences and eating schedules and most described them in detail. While the planning and monitoring of a 'healthy' diet regime was undoubtedly preoccupying, even sometimes stressful, it provided "reference points to work from." Extreme Healthy Eaters experienced feelings of disappointment or guilt after having deviated from their diet; Liam admitted that he felt worse "mentally" if he didn't eat healthily for some time, "because I feel like I am not developing toward my goals." Most Extreme Healthy Eaters could recall social scenarios in which adhering to their usual dietary choices had proved awkward or impossible, nevertheless social isolation (a frequently cited negative consequence of ON) failed to emerge as a major issue for the full cohort. On the contrary, personal contacts with people who followed or advocated similar dietary practices (partners, trainers, therapists, friends), along with information they had gathered from nutritional literature and media could help to reinforce personal beliefs and regimes. In summary, while Extreme Healthy Eaters were aware of the personal and social costs of following a relatively strict diet, all were convinced that of its benefits and most said they felt much better for it. As Clare explained:

> I like the way I eat. I think it's a healthy way to eat, I think, I feel comfortable . . . and ultimately, I don't see myself changing my diet . . . And I think health wise I'm doing

> well. I'm 61 years old, I'm going, almost 62, my last checkup was great, I feel good, I don't have to take a lot of medications and ultimately, proof's in the pudding. *Clare*

Cohort B: Posters

Posters, like Extreme Healthy Eaters, had strict rules around food and eating, but were more self-berating and more concerned about their ability to maintain these rules and the consequences of deviating from them; "I have so many rules and fears"; "Kept making them [rules] stricter and stricter." Following their restrictive regimes did not, however, rid Posters of anxieties around the effects of eating forbidden foods; "I can't let go of my anxiety . . . I live a sad and pathetic existence." Online users adopted their own argot to describe their common experiences; what was known as "cycling" (alternating between orthorexia eating and a former eating disorder) was also commonly discussed on the site. Posters on the site wrote of how orthorexia eating had replaced a past ED, e.g., "I suffered from anorexia before it developed into ortho [orthorexia]…I guess now I'd be called a restrictive anorexic." For some, this was seen as a sign of recovery; "I developed ON [to] counteract all the damage I've done." The cycle of eating and purging (self-induced vomiting and/or laxative use) was a frequently discussed topic, with which many battled:

> I didn't realize it but as i started to add more healthy calories into my diet, i added more unhealthy ones too & i began to binge at night. now i have put on 20ish pounds & even though i look healthy, i miss that control of only eating cleanly. And now when i have those binges of unhealthy things, i have resorted to purging.

Breaking one's resolve was a source of distress, but to keep "clean" and healthy, purging was seen as sometimes necessary; "If I don't eat clean, I will get sick." Warnings were issued about

the dangers of falling back into old patterns while attempting to clean up or lose weight, and advice offered to those who might feel inclined to purge after "messing up", e.g., "Purging sets a person up to binge and purge. How do I know this? Been there, done that. It's hell." A dilemma for Posters was that, while "ortho" in the sense of "healthy eating" had to be a good thing, being obsessed to the point of complete irrationality was very distressing, e.g., "i pretty much just want to die whenever i feel somewhat pressured to eat 'normally.'" Harsh language was used to describe the sense of personal disgust Posters felt when they transgressed from their self-imposed regime (e.g., "failure"; "pathetic"; "fucked up"). Like Extreme Healthy Eaters, some Posters blamed their families for their extreme attitudes to food, e.g., "Mother and sister would guilt me for like eating a bag of chips or something ridiculous"; "eating decisions are governed by a single rule, ruthlessly drilled into my head by my retired gymnast parents." In contrast, the website was portrayed as a safe place to express one's fears and emotions. Sharing their transgressions and concerns was, for some Posters, a huge relief, "Realizing that I'm not alone. That it isn't just a failure on my part but a biological response." Messages of support and reassurance were offered to others who had broken rules; e.g., "The holidays is *so* rough to eat through with disordered food stuffs, I commend you for doing it." There was also a celebratory tone in some threads concerning a shared adherence to food purity; "I must be really demented because I don't see how this is sad. I mean, it's fabulous. Our binges are all about healthy foods. That's a win."

Cohort C: Professionals

Professionals in our study voiced strident opinions concerning attitudes to food, health and appearance in society, and their effects on young females in particular. Sue, who had worked with eating disorders for over three decades, spoke of "witnessing the emergence of idiosyncratic, irrational ideas about the power of food to affect health and wellbeing." Our

environment had, Anna considered, "provided us with lots of rules about how to get it right, and certainly for a woman body image, food and eating, is the kind of big, dominant story." There were feminist issues here; when Nina moved to Los Angeles (LA) she was struck by how objectified women there were, "so much was about body size, and also a sense of inferiority." Until recently it was her higher income clients that leaned towards orthorexia, however she had noted a restricted, elitist type of eating emerging within the US Latino community, as part of an ethos of "finding a better life." Wendy spoke of a growing panic over the health crisis in the States, with major food companies competing with each other over this; "Let's make sugar look bad, let's make dairy look bad." These messages were prominent everywhere in LA, "There's billboards with, 'oh let's freeze off your fat', or 'try this juice cleanse.'" While LA might be seen as the "home of orthorexia" Pippa, who had worked with sports people from around the world, believed the high prevalence of orthorexia in her male clients had a lot to do with the pressures of that particular work environment, but also the influence of social media on attitudes toward food and body image:

> "[ON] almost seems more of an acceptable illness for a male to have- whereas there's a lot of stigmas, I think, with anorexia in males generally, so people don't always admit it. And I think a lot of that [pressure] comes from the bodybuilding community . . . and Instagram . . . food blogs. *Pippa*

Trying to get a client to move out of their "orthorexic pattern" was described as "absolute murder," because it was "a safety behaviour" of a similar kind to people with OCD washing their hands compulsively. Speaking from her experiences in California, Anna described a "very interesting trend" in which the entire family could hold these core beliefs about food and health, although most of the professionals regarded the mother's role as central, "Majority wise it's

the women or the mother, the matriarch figure, running the ideology and running the thought process of the orthorexic tendencies." Sue blamed the parents for setting these eating trends and sending out unhelpful messages to their children; "Parents think it's smart and cool, 'oh I'm not eating carbs, oh I'm not eating meat, our family is becoming vegetarian', they're not wise." Family therapist Harriet felt this went right to the root of parenting in modern society:

> Homelife, it's something about not being nurtured . . . you know, mums and dads aren't available, either they're working long hours. . . there's some very strict families, and that's the only thing they've [the young person has] got in control of themselves- how much they put inside their bodies. *Harriet*

Professionals as a body considered ON to be associated with other EDs, primarily anorexia and bulimia nervosa. Many of their clients shared the obsessive, perfectionist traits of anorexics; "Neat and tidy. Conscientious. High achievers in sports. They've got healthy eating and they go to the local grammar school, that's another flag." (Harriet). Unlike anorexia nervosa and bulimia however, "healthy eating"/restrictive eating was problematic because it is "so validated . . . rewarded in our society." In addition, many clients whom dietician Wendy would consider as "orthorexic" had started out with digestive problems or food intolerances, then progressed to a deeper pathology.

Although most freely used the term orthorexia, professionals were divided in their opinions about the its usefulness for treatment purposes. Pippa was part of an ON working group who were keen to get it included in the DSM. Nina, on the other hand, was concerned that, were it to become an official diagnosis, it could be used in schools to single out picky eaters such as her child with Asperger's syndrome. Sue saw no virtue in pathologizing healthy eating unless

it was causing gross nutritional deficiencies or creating excessive paranoia about food. Having recovered from a short-lived eating disorder herself, Sue considered the expanding the DSM to include clinically non-significant symptoms and behaviours to be a dangerous trend. Where treatment had improved could be seen in "how we understand such patterns, and how we think of them in terms of a person's ability to function."

Discussion

Our findings focused on extreme healthy eating from three perspectives; participants who self-identified as "extreme" healthy eaters, posters on an eating disorder ('*pro-ana'*) Internet forum and non-psychiatric professionals with experience in treating eating disorders. For Extreme Healthy Eaters, adherence to healthy eating was seen as part of a lifestyle choice, the alternative being framed as moral compromise or impending ill health. Aware of the personal and social costs of following a more or less strict diet, members of this cohort critiqued "junk food" eating, framing their healthy eating practices as an act of self-care with positive moral, social and ecological consequences. Posters on the *pro-ana* site expressed similar sentiments concerning the benefits of adherence to healthy eating practices and the hazards of poor-quality foods, however they were more troubled over the extent to which preoccupations with weight and eating dominated their lives. They wrote of their various psychological and physical struggles, including alternating between healthy 'ortho' eating and binging and purging ('b/p'), otherwise known as 'cycling'. As described in other studies of on-line eating forums, the anonymous nature of posts may have allowed for more frank discussion of stigmatized topic areas (Tong et al., 2013; Yeshua-katz, 2015), while sense of community was furthered through expressions of mutual support and the use of an in-group argot (Fixsen & Ridge, 2017).

Professionals, while intrinsically supporting healthy balanced diets, saw their role as challenging extreme eating beliefs and behaviors which might become pathological. They

regarded orthorexia nervosa as multi-factorial, citing exposure during childhood and adolescence to extreme attitudes and behaviors related to exercise and diet as part of the problem. In general, professionals' criticism was levelled at 'colluding' agents such as media, communities and parents, rather than sufferers themselves, who were largely viewed as victims of a wider social dyscrasia. By and large, members of cohorts shared a common feature: while castigating modern society for its poor food choices, they sought for explanations and conclusions concerning their own and others' eating practices within a framework of self-optimization and popular psychology.

The consequences of labelling

Most of the vast body of clinical literature on EDs has failed to consider the symbolic and normative factors concerned with the labelling of disordered eating or the agents and industries making and staking their various claims in this field. The social constructionist approach on the other hand, takes a broad perspective of a dynamic society, regarding both the labels and meanings that individuals and institutions use for all phenomena including 'deviant' eating practices as subject to constant reconstitution (Gergen, 1985). As our study illustrates, those who self- identify as Extreme Healthy Eaters may take a different perspective to those tasked with diagnosing or treating their problems. Thus, while those with ON may be viewed as vulnerable persons seeking to cope with the constant barrage of health and fitness advice circulating through a society obsessed with the pursuit of a perfect body, our study suggests a diverse set of rationales to exist among health food advocates, who may choose food as their remedy for personal health reasons, ethical issues or other psychosocial ills plaguing modern society. In this sense, our Extreme Health Eaters reflect a growing viewpoint concerning the importance of self-care within the political and medical community, even while some take some of these messages to an extreme.

As a social problem (such as 'disordered' eating) becomes a recognized social fact it demands solutions and interventions from individuals and institutions in society, including those representing new professions that have emerged in a symbiotic relationship with that problem. Our study serves as an illustration of how extreme healthy eating has spawned a whole set of 'psy-professional' actors (Cohen, 2016) - dieticians, clinical psychologists, sports therapists and others- who stake claims in this field and repurpose psychiatric labels in the course of their work. The multiplication of 'troubled persons' (Gusfield, 1989) agencies (such as 'pro-ana' forums) on the Internet is a further indication of the need to reconsider both the institutions influencing psychiatric diagnoses and the processes leading to the medicalization of 'issues' in the first instance. Yet, the power to definitively validate mental illness, including that relating to eating and feeding, remains the prerogative of psychiatry (APA, 2013). Hence, while psy-professionals may disagree among each other about particular categorizations, practitioners and their clients have found themselves under increasing pressure to adopt the language and labels of psychiatry for financial, credibility and insurance reasons (Jutel, 2014).

The construction of new EDs has other implications, such as in the monitoring of new forms of human behavior, the re-categorization of existing behaviors previously defined as 'eccentric' and an acceptance by society that "Troubled Persons professions" (Gusfield, 1989) are necessary to intercede on behalf of lay persons and to correct these psychosocial problems. Eating is also a highly lucrative industry, and one that thrives on the creation of new opportunities to problematize fundamentals of human life. Once in the public domain, labels such as orthorexia become ever more fashionable and profitable, with markets potentially 'feeding' the eating problems they purport to address. What is labelled as ON is therefore the creation of a society in which hyper-reflexivity around food choices, conflicting information concerning correctness of diet, preoccupation with bodily shape and appearance and emphasis on individual rather than societal responsibility- each propelled by market forces- combine

with individual susceptibilities and ecological/moral concerns, to predispose individuals toward extreme 'healthy' eating beliefs and behaviors. The construct that is orthorexia nervosa is thus an excellent example of the way in which a phenomenon (healthy eating) gets gradually transformed into a psychiatric illness that over time is acted upon and capitalized by more and more sectors of society and notably 'Troubled Persons Industries.'

Study strengths and limitations

Our consideration of extreme healthy eating from three sets of perspectives outside of psychiatry and our highlighting of the normative and practical complexities around the framing of extreme healthy eating as orthorexia nervosa or otherwise is, we suggest, highly novel. In addition, our findings illustrate how the construction of a new psychiatric category such as ON is highly complex, and how neoteric meanings and labels can come to be attached to phenomena which are not in themselves entirely new (such as extreme forms of eating). For logistical reasons however, our sample was small, and thus our conclusions tentative. We therefore welcome further studies in this area.

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