Orthorexia Nervosa: Medicine, Media, and the Co-Production of a Diagnosis

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Amy A. Ross Arguedas

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Abstract

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Amy A. Ross Arguedas

This dissertation examines the birth and rise of orthorexia nervosa, a proposed psychiatric diagnosis described as a pathological fixation with healthy eating. Orthorexia made its first public appearance in the pages of a popular magazine for yoga practitioners in 1997, and later in a self-help book on the subject. Despite its origins outside of the medical establishment, orthorexia began to circulate in the popular media, and then made its way into the academic literature. More than two decades later, tens of thousands of posts on the social media platform Instagram carry orthorexia hashtags and an official task force is studying its inclusion into the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) of the American Psychiatric Association. This poses the question of how a diagnosis born in the popular media has come to circulate so widely in spaces both inside and outside the medical institution.

To understand the process through which knowledge about orthorexia has been constructed and legitimized, I examine its co-production across four separate but interacting knowledge production assemblages: news media, scientific research, clinical practice, and social media. I show how distinct arrangements of knowledges and actors have come together in each assemblage, putting the term to use in somewhat distinct ways, but with sufficient overlap to enable a shared project in favor of its legitimation. I also document the emergence of specific diagnostic entrepreneurs, and their contributions to the process, including the doctor who first proposed the term, a vegan blogger, and multiple dietitians.
More significantly, however, I argue that orthorexia’s legitimation and circulation has been inextricably tied to media and their logics. Media have not been simple mirrors of medical debates or even mere sites for claims-making to take place. Instead, as increasingly pervasive socio-technical assemblages in themselves, they have come to constitute relevant actors in knowledge production in their own right. Furthermore, media logics exert a hybridizing force that contribute to blurring the boundaries between science/non-science and lay/expert categories, while also straining professional jurisdictions.

Finally, I posit that orthorexia sheds light on the growing anxieties around eating, as multiple valuation frameworks enter into conflict. Taking seriously the idea of entrepreneurship, I suggest orthorexia can be understood as a product of “creative friction” between alternate evaluations of what constitutes “good” eating and “health.” In the context of healthist imperatives surrounding nutrition and risk-avoidance, we can appreciate how orthorexia discourse asserts alternate values that re-center ideas like pleasure, moderation, and social connection, as central to “healthy eating.”
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Chapter One: Introduction

It’s hard to go far nowadays without encountering health advice concerning food or weight. Labels on packages and menus invite vigilance of caloric and nutritional content, headlines and documentaries warn us about the dangers of food items on our plates, and advertisements of low-fat, high-protein, organic, gluten-free foodstuffs reinforce beliefs about “good” and “bad” diet choices. The message has not gone unnoticed. According to a Pew report, in the United States, 97% of adults believe healthy eating habits are either very important (72%) or somewhat important (25%) for living a long and healthy life (Funk & Kennedy, 2016, p. 22). In the United Kingdom, nine in 10 adults believe what you eat makes a big difference in how healthy you are (G. Prior, Hall, Morris, & Draper, 2011, p. 79). At the same time, surveys among US and UK adults suggest nearly half of the population is fed up with experts telling them what to eat (G. Prior et al., 2011, p. 77; Quarles, 1996). Among those who have the ability to choose, never has food choice been such a fraught endeavor.

It is in this context that the term “orthorexia nervosa” began to circulate in the late 1990s. This diagnostic sounding label is used to describe a purported new mental disorder, a pathological obsession with healthy eating. Orthorexia is not currently in the Diagnostic and Statistical Manual for Mental Disorders (DSM), but is currently under review by a DSM task force for possible inclusion in a future update to the manual. This dissertation examines the peculiar trajectory of orthorexia nervosa through the news media, academic scholarship, clinical practice, and social media. I demonstrate how orthorexia has taken different shapes in different knowledge production assemblages, and argue that orthorexia’s legitimation has been inextricably tied to media and their logics in different ways. Moreover, I set out to show how
media logics contribute to blurring the boundaries separating science and expertise from outsiders, while also straining professional jurisdictions. Finally, orthorexia can inform our understandings of the frictions and tension that arise around modern conceptions of health as it relates to human behaviors.

**The Birth of Orthorexia: An Inception in Popular Media**

Orthorexia nervosa made its first appearance not in a psychiatric conference or journal article, but in the pages of the 1997 fall issue of *Yoga Journal*, a magazine founded in 1975 for followers of the “yoga lifestyle” (Yoga Journal, 2015). The article, titled “Health Food Junkie,” was written by holistic physician Steven Bratman, who at the time lived in Colorado and specialized in alternative medicine (Bratman, 1997). In his text, Bratman advanced a simple, yet unconventional argument: that when taken to the extreme, healthy eating could paradoxically become unhealthy—pathological, in fact.

The idea was one Bratman had toyed with for some time, upon reflecting on his own personal history as a cook and organic farmer at a commune during the seventies, and more recently, his professional experience as a holistic physician prescribing nutritional medicine to his patients. In the article, Bratman (1997) related his experience at the commune, where his increasingly stringent food habits progressed from total vegetarianism to the point where he “disdained any vegetable that had been plucked from the ground for more than 15 minutes” (p. 44). Unable to share food with others and plagued by intrusive thoughts, Bratman recalled, he found himself lonely and obsessed. He was eventually able to escape his “righteous eating” (Bratman, 1997, p. 45), and went on to study medicine. However, he came to recognize similar patterns in some of the patients for whom he prescribed dietary therapies, as they fixated over
achieving dietary perfection, which he believed resulted in “in a rigid, fearful and self-punishing lifestyle that caused more harm than good” (Bratman, 2017, p. 381).

In 1996, Bratman consulted a Greek scholar, who helped him devise the term “orthorexia nervosa,” a spin-off of the formally recognized eating disorder anorexia nervosa (from the Greek “ano-” signifying “without,” “-orexis” meaning “appetite”), but substituting “ano” with “ortho,” which means “right” or “correct,” in allusion to the concept of dietary perfection (Bratman, 2017). Bratman, cognizant of the “therapeutic trick of naming” (Bratman, 2017, p. 381), started to use the term in his practice to help his patients identify and break with rigidity in their eating. He also decided to publish the piece in *Yoga Journal*,1 which resonated with and produced such an enthusiastic response from readers, that he decided to publish a full-length self-help book in 2000, *Health Food Junkies*. The following year, he launched the website [www.orthorexia.com](http://www.orthorexia.com), which has gone through multiple make-overs of form and content but remains active almost two decades later.

Bratman’s word choice for labelling extreme health seeking behaviors did more than endow orthorexia with the rhetorical legitimacy of a medical sounding name, it effectively framed these behaviors as a mental disorder, and more specifically, as a form of disordered eating. Healthy eating had not previously been within the eating disorder jurisdiction, although other eating extremes certainly were, such as eating too little or too much. Broadening the scope to include extremely health-focused eating required him to extend the boundaries of the eating disorder framework, in what, drawing from the social movements literature, we might call a “frame extension” (Snow, Rochford, Worden, & Benford, 1986). Of course, even within the

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1 The same article was later reprinted in another American magazine called the *Utne Reader*. 
mental illness realm, eating disorders constituted only one of multiple options available for framing orthorexic behaviors. And while he did nod at some of these other diagnostic categories in his book, the eating disorder frame ultimately prevailed. He underscored this framing in his description of orthorexia vis-à-vis formally institutionalized eating disorders: “Whereas the bulimic and anorexic focus on the quantity of food, the orthorexic fixates on its quality” (Bratman & Knight, 2000, p. 10).

In contrast to his choice of a technical sounding label, Bratman’s language throughout his early texts is very casual and down-to-earth, with an abundance of metaphors and humor. Perhaps most striking is the prevalence of moralistic evaluations of orthorexic individuals and behaviors, alongside medical arguments about malnutrition or physical debilitation. While resonant with ideals many hold dear, the extent to which these aspects constitute a mental dysfunction are not always clear. One suspect claim relates to priorities. In a section called “Priorities Upside Down,” he suggests that the “most usual harm” of orthorexia is “the cost of lost opportunities” (Bratman & Knight, 2000, p. 30) and recalls a time in his life when he would not consider dating non-vegetarians, a criterion he now saw as “insane.” “How can dietary preference rank as an important consideration, as compared to character, kindness, interests, emotional maturity, sense of values?” (Bratman & Knight, 2000, p. 33). Later on, in analyzing the case of a patient who had collected a series of food rules from various wellness promoters, Bratman lamented that none of the authors “she trusted so much had included a note of balance, a recommendation to consider other values than length of life” (Bratman & Knight, 2000, p. 61).

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2 In his book, Bratman draws explicit connections between orthorexia and addiction (even referring to it as an addiction in the book, and alluding to this idea in the very title) and obsessive compulsive disorder.
These examples, addressing matters of priorities, time allocation, and personal investment, all suggest that Bratman’s claims were invoking something more than medical rationales.

Despite his initial enthusiasm for the term, Bratman’s position on the need to officialize orthorexia, for instance, via inclusion in the DSM has waxed and waned over time. His original text explicitly referred to orthorexia as “pathological” and presented the condition as analogous to anorexia and bulimia, and was cited by news outlets as suggesting the obsession could take on “the dimensions of a true eating disorder” (Brook, 2008). Similarly, in a 2004 version of his website—where he designated himself the “inventor” of orthorexia, he stated that the condition is “not yet a DSM IV diagnosis (though I think it should become one).” However, at other times, he referred to orthorexia in a more casual tone, for instance, calling it “a tongue-in-cheek way of sympathetically teasing the problem out of people” (Huget, 2001). Bratman’s vacillation on the matter grew more tangible later on. In a 2014 post on his website, he externalized his ambivalence: “Orthorexia is not yet a DSM diagnosis, and I am not sure that it should be. There is a tendency in the modern world to pathologize an increasing number of human behaviors and I have no desire to contribute to this trend” (Bratman, 2014). Nonetheless, in 2016 Bratman co-authored his first-ever academic publication on orthorexia with researcher and neuropsychologist Thomas Dunn, in which they advocated for orthorexia’s formal recognition (see Chapter Three).

3 Unfortunately, Bratman declined the request my request to interview him. In an email response dated June 8th, 2019, he claimed to be “terminally bored with this subject,” adding, “I don’t have anything to say on it at all!” Nonetheless, copious interviews with news media, in addition to written records through his book, his website, (current and past versions were consulted via the Internet archive, with records dating back to February 2001), two articles published in academic journals in 2016 and 2017, and his now dormant Twitter account, provide ample insight into his shifting positions and concerns with regards to the diagnosis and his desire to be involved in the conversation.
Bratman’s desire to participate in the popular conversation about orthorexia also appears to have evolved, from eager to reluctant and even unwilling, perhaps a reflection of his fatigue on the subject or disenchantment with the quality of the news coverage. A 2017 article depicts a jaded Bratman who “sighed at certain questions” and told the reporter he was receiving “at least one request a day for an interview. I’m a little tired. Plus, what I read in the news is often muddled and depressing” (Pousaz, 2017). Moreover, in a 2017 editorial, Bratman criticized what he considered to be a common misunderstanding in the popular media: the reduction of mere veganism or the desire to avoid processed foods with orthorexia the pathology. However, by this point in time, Bratman’s name had proliferated in news articles around the world attached to the diagnosis, attributed with “coining” or “discovering” it.

Orthorexia in Context

From a sociological perspective, the emergence of orthorexia as a medical diagnosis constitutes both an epidemiological phenomenon and a social process (Packard, Brown, Berkelmen, & Frumkin, 2004). Thus, an examination of orthorexia’s origins can take two different approaches: on the one hand, one can focus on the emergence of the behaviors that are now understood as orthorexia; on the other hand, one can focus on how those behaviors came to be collectively understood in diagnostic terms, as a mental illness. While this dissertation is predominantly about the latter, understanding the former is also crucial to making sense of knowledge production and the different actors involved. I review both vantage points below.

Secular moralities. The first approach is to examine the origins of the anxieties and behaviors we might call orthorexia. Of course, nobody wants to feel unwell or ill. But what is it that makes people become obsessed, so to say, with pursuing healthy eating? Here, a large body
of literature examining the relationship between health and morality provides a useful entry point for understanding how seemly neutral and unbiased biomedical knowledges are embedded in and productive of a broad moral order (Brandt, 1997; Metzl, 2010; Rozin, 1997). First proposed by Crawford (1980), “healthism” refers to the expansive moralization of health pervading culture—initially in the US, but increasingly, worldwide—since the 1970s. Healthism describes a “preoccupation with personal health as a primary—often the primary—focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of lifestyles” (Crawford, 1980, p. 368). Healthism is theoretically helpful for understanding our contemporary “cult of the body,” encompassed by a fascination with diet, fitness, and lifestyle (S. Brown, 2015; Smith Maguire, 2008), and the celebration of “health” as a reflection self-discipline and control.

Healthism permeates public health discourses, especially relating to food and exercise, which enforce ideas about proper behaviors concerning health, including its imperatives of prevention, risk avoidance, and physical optimization—the “duty to be well” (Greco, 1993). A primary concern with healthist ideology is the attribution of health outcomes to personal responsibility. In healthist societies, proper health becomes central to establishing moral worth, and adherence to health-enhancing or risk-reducing behaviors defines “good” and “bad” citizens (Lupton, 1995; Polzer & Power, 2016). As Lupton (1995) points out, moral judgements are central to the logic of public health, the constitution of the contemporary body, and the regulation of society. In line with a Foucauldian approach to power, these judgments operate largely from within, through self-disciplinary practices, and thus remain largely invisible:
In the interest of health, one is largely self-policed and no force is necessary. Individuals are rarely incarcerated or fined for their failure to conform; however, they are punished through the mechanisms of self-surveillance, evoking feelings of guilt, anxiety and repulsion towards the self, as well as the admonitions of their nearest and dearest for ‘letting themselves go’ or inviting illness. (Lupton, 1995, p. 11)

Among other things, healthism is criticized for individualizing health to a single dimension—the super-value of health, which provides a secular moral code requiring adherence to various prescriptive and proscriptive norms (Crawford, 2006; Katz, 1997). Public health discourses deriving from healthist ideologies have also been criticized for their reductionism, individualization, and decontextualization of health and illness (Arribas-Ayllon, 2016; Rangel & Barry, 2014; Yates-Doerr, 2015).

Food, the central object of concern in orthorexia, is amenable to moralization for many reasons. Eating is a necessary, ongoing, and highly social practice in which some choice is usually possible, and it tends to be associated with pleasure, a realm particularly susceptible to social control (Mintz, 1997; Rozin, 1997). Diet constitutes a crucial site for the construction of morality, as beliefs previously grounded in religious doctrine shifted toward secularized knowledge about the biochemical constitution of food, while retaining concerns with worldly desires and weakness of the flesh (Coveney, 2006). Binary categorizations of foods as “good” and “bad”—which have historically pervaded food discourses—now map onto categories of healthfulness and create a narrative in which eating “healthy” food is also morally correct (Lupton, 1996). We can think of contemporary nutritional discourse focused on physical optimization and risk-reduction as analogous to and largely embedded in healthism, something
we might refer to as nutritionism. I draw from Scrinis’ (2013, p. 2) concept of nutritionism as an ideology “characterized by a reductive focus on the nutrient composition of foods as the means for understanding their healthfulness, as well as by a reductive interpretation of the role of these nutrients in bodily health.” In speaking of nutritionism, I am also emphasizing the moralization, individualization, and decontextualization of food choice.

Despite the far-reaching influence of healthism and nutritionism, expressions of resistance can be found in media. Phillipov (2013) demonstrates how cooking shows like MasterChef counter public health promotion, not by overtly contesting nutritionism, but by engaging with food on a register that renders it irrelevant. Such programs speak to a “foodies” culture that celebrates luxury and enjoyment (J. e. Johnston & Baumann, 2010), and recognizes that lay people often negotiate with health imperatives (Backett, 1992; Backett, Davison, & Mullen, 1994). Thus, while healthist discourses are expansive, they do not escape opposition.

Nonetheless, these ideologies shape the human psyche and social relations in tangible ways. We see glimpses of it in labels advertising “guilt-free” versions of foods in grocery store aisles. We see it in media discourses celebrating fitness and deriding fatness (Boero, 2012; Roy, 2008; Smith Maguire, 2008). Moreover, empirical research demonstrates people judge themselves and others based on food choice, favoring those who consume items perceived as “healthy” and “unfattening” (Lupton & Chapman, 1995; Stein & Nemeroff, 1995). At the same time, good/bad categories have become increasingly complex and unstable because nutritional knowledge remains in constant flux (Askegaard et al., 2014; Lupton, 2003) and intersects with moral evaluations of food as it relates to issues like production ethics (e.g., animal welfare, environmental sustainability) and taste as a marker of social status (Askegaard et al., 2014).
Thus, the calculous of what constitutes morally “good” and “bad” food involves a constant reevaluation of what food is actually “healthy” based on nutritional parameters, but also their alignment with or potential opposition to other evaluative frameworks. These various overlapping considerations help provide a contextual backdrop for current anxieties and obsessions about how to best achieve—and publicly “perform”—healthy eating.

**The medicalization of deviance.** The second vantage point from which to examine the rise of orthorexia—and the emphasis of this dissertation—is to focus not on the origins of orthorexic behaviors, but on the emergence and dispersion of a medical diagnosis to describe them. The proposal of orthorexia as a diagnosis constitutes an example of what Kroll-Smith (2003) calls redescription, the painting of a qualitatively different picture of something by describing it in a new way. “Redescription becomes sociologically interesting when it changes the way people routinely see, think and behave towards themselves, others and the world” (Kroll-Smith, 2003, p. 630). Through the orthorexia label, certain behaviors and emotions associated with healthy eating are clustered together, differentiated from others, identified as problematic, and reinterpreted as disordered or pathological. That is, behaviors that may otherwise be celebrated as epitomizing self-discipline and healthfulness are transformed into a pathological state.

Medical sociologists use the concept of medicalization to theorize the application of medical logics to a growing number of human experiences, situating them within the purview of the medical institution (Conrad & Schneider, 1980; Zola, 1972). Through medicalization,

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4 Here vegetarianism and veganism stand out for their particularly strategic and effective efforts to align multiple evaluative frameworks in their claims-making activities. Thus, discourses promoting veganism often target not only health and fitness concerns, but also animal rights, environmental issues, and aesthetic ideals.
medicine becomes the defining framework through which physical and emotional experiences are understood; in doing so, it shapes our perceptions of illness and healing. Medicalization is used both to describe the transformation of individual conditions into medical problems (i.e., the medicalization of healthy eating), and to conceptualize the broad cultural shift in which human experiences and distress are framed through a medical lens (i.e., the medicalization of society). More recently, scholars have acknowledged the increasingly complex, multi-sited, and multi-directional character of biomedicalization, including the participation of diverse actors ranging from corporations and activists to lay people, who may promote bottom-up or “sideways” medicalization (A. E. Clarke, Shim, Mamo, Fosket, & Fishman, 2003a; Conrad, 2006).

Psychiatry has been a key site for medicalization, visible in the expansion of therapeutic culture, which recasts social problems as individual ones to be addressed through therapeutic encounters (Furedi, 2004), and redefines an ever-growing number of psychological conditions or “abnormal” behaviors—those on the extremes of what is considered the norm—as pathologies (Cohen, 1993; Horwitz, 2002). Over time, scholars have documented and analyzed the social processes through which a broad array of behaviors become medicalized, including drinking (Schneider, 1978), sexual passions (Irvine, 1993), hyperactivity (Conrad & Potter, 2000), buying (S. Lee & Mysyk, 2004), trauma (W. J. Scott, 1990), and shyness (S. Scott, 2006). Since the publication of DSM-I in 1952, the number of diagnoses has more than tripled, exceeding 300 in DSM-5, published in 2013 (Grohol & Tartakovsky, 2016). A burgeoning subfield of medical sociology has directed its attention to diagnosis as a focal point of medicalization (P. Brown, 1995). Among other things, diagnoses legitimize and normalize illness, direct medical treatment,

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5 Medicalization is not a one-way process. While much less common, conditions can be de-medicalized, as in the case of homosexuality.
provide boundaries for what is acceptable, and invite compliance or resistance to medical intervention (Bryant, 2011; Jutel, 2011a). As “ways of knowing,” diagnoses continually interact with technologies, values, and politics.

As the concept of medicalization suggests, medical control has not always been the predominant approach to deviant behavior. Conrad and Schneider (1980) demonstrate that in the not too distant past, religious, moral, and criminal definitions were much more prevalent for interpreting and managing deviance. The adoption of a medical model of deviance represents a general shift from a model of deviance as badness to one of sickness. This is not to say that medical problems now lack a moral dimension, but that they are primarily interpreted, legitimized, and treated through medical frameworks. I draw from labelling theory and its interactionist approach to deviance as resulting from their social condemnation in society, rather than intrinsic to behaviors themselves (Horwitz, 1990); they are thus contextual and relational. The concept of deviance has to do with the violation of social norms: “Those categories of condemnation and negative judgment which are constructed and applied successfully to some members of a social community by others” (Conrad & Schneider, 1980, p. 5). This “makes the study of the imputer or definer as important as the study of those defined as deviant” (Conrad & Schneider, 1980, p. 19). Thus, examining how orthorexia came to be understood as a pathology and who participated in the endeavor is as important as understanding the origins of the behaviors themselves (for more on this issue, see Håman, Barker-Ruchti, Patriksson, & Lindgren, 2016; Hanganu-Bresch, 2019).

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6 This approach is in direct conversation with sociological inquiry that analyzes the role of the medical institution—in this case, psychiatry and psychology—as an organ of social control (Gremillion, 1992; Horwitz, 1982; Kirk & Kutchins, 1992).
Understanding Contemporary Psychiatry

Orthorexia was not born in a vacuum; it emerged in a very particular professional context that not only enabled its uptake, but shaped its development. Having a basic grasp of that context is necessary for making sense of how and why knowledge production about orthorexia has emerged and proliferated, and who has participated in the process. As a purported mental disorder, orthorexia exists within the jurisdiction of what N. Rose (1998) refers to as the “psy disciplines.” Yet, psychiatry as profession has been plagued by ignorance since its origins. Whooley (2019) argues that the profession’s inability to pin down “the essence” and the “appropriate way of knowing its object” has led, over time, to a vacillation “between drastically different visions of knowledge or ‘styles of reasoning’” (p. 4–5), resulting in several paradigm shifts over time. Each paradigm has left a legacy that in some way shapes how mental illnesses are conceptualized and addressed today.

The idea that extreme anxieties about eating healthy food might comprise a mental pathology is unique to contemporary culture. Prior to the twentieth century, mental illness labels were reserved for individuals engaging in behaviors considered extremely strange, incomprehensible, and disruptive (Horwitz, 2002). The psychiatric discipline resided in the asylum. However, this changed in the early 1900s, in large part thanks to Freud and his psychoanalytic theory, which transformed psychiatric practice and ushered in the era of dynamic psychiatry. A prime contribution of this shift was the blurring of boundaries between normal and pathological conditions by attributing both neurotic and normal traits to the same internal sources. Dynamic theories deriving from Freud advanced the idea that mental symptoms were “intelligible but distorted results of struggles with internal impulses,” repressed into the
“unconscious” (Conrad & Schneider, 1980, pp. 52–53). This perspective placed neuroses and normal behaviors on the same continuum, rather than defining them as categorically different (Horwitz, 2002). By doing so, dynamic psychiatry broadened the range of experiences and individuals treated by mental health professionals, while also moving psychiatrists out of the mental hospital setting and into private, office-based therapy (Whooley, 2019, p. 116).

A second important change in psychiatric care involves the weakening hold of psychiatrists over the mental health jurisdiction. Abbott (1988) posits that the professions make up an interacting ecology where they compete with each other over different jurisdictions. Psychiatry’s weakened legitimacy, deriving from its ongoing ignorance problem, contributed to its weakening monopoly over mental illness, and the subsequent usurpation of other professional jurisdictions with their own claims to stake (Whooley, 2019). This derived in large part from the efforts, in the sixties and seventies, to reinvent the profession along the lines of community psychiatry, which emphasized a team-based approach to care, involving other professionals. While this project ultimately failed, it effectively opened up the field to other disciplines and “psychiatrists found themselves ‘under heavy assault from clinical psychologists, psychiatric nurses, social workers, and psychiatric technicians…clamoring for equal authority, equal status, and equal recompense’” (Whooley, 2019, p. 153). Coupled with other shifts in healthcare, this unsuccessful reform contributed to psychiatry’s loss of control over mental illness, thus the notion of “psy disciplines” in the plural.

A third transformation has been the biomedicalization of mental illness, resulting from the most recent paradigm shift toward diagnostic psychiatry, which reconceptualized the expanding experiences and anxieties treated by dynamic psychiatry as distinct diseases with
specific boundaries. Although touted as a scientific victory, many scholars argue the shift was actually rooted in professional politics geared toward appeasing a potent anti-psychiatry movement in the sixties (Kirk, Gomory, & Cohen, 2017; Kirk & Kutchins, 1992; Whooley, 2019). To confront these attacks, the psychiatric institution aligned itself with the biomedical establishment—by that point in time, prestigious and dominant—which had been revolutionized and professionalized under the rubric of disease specificity (Whooley, 2019, p. 120). Biomedical logic posits that symptoms are reflective of physical pathologies, which in turn correspond to specific underlying entities; thus, diseases can be classified into clear-cut categories (Rosenberg, 2006). To realize the transformation, psychiatric reformers developed a systematic scheme to organize psychiatric knowledge in the image and likeness of biomedicine (Kirk & Kutchins, 1992, p. 23).

The efforts crystalized with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980, which in adherence to biomedical conventions, developed standardized descriptions of psychiatric disease entities (i.e., diagnostic criteria) and a classification system. Through the paradigm shift, the DSM was centered as an organizing force within psychiatry, and is now embedded in a broad range of healthcare practices, from therapeutic methods and insurance, to scholarly knowledge production in the US, and increasingly, worldwide. As an “information infrastructure” (Bowker & Star, 1999), the DSM actively shapes how psychiatric knowledge is produced, including what diagnostic categories can exist and how they presumably relate to each other. Creating a new diagnosis, such as orthorexia, requires situating it within the broader classification system, determining what “family” of disorders it belongs to, and providing sufficient distinctions to separate it from
already existing diagnoses. This discrete characterization is then used to measure prevalence, generate prognoses, and determine treatment, all of which are central to the biomedical enterprise.

**The diagnostic turn and its limitations.** The shift toward diagnostic psychiatry, implemented with DSM-III and subsequently DSM-IV and DSM-5, persuasively detached the profession from a depreciated Freudian theory and infused it with a scientific demeanor. While the diagnostic paradigm of psychiatry disavowed the dynamic system it replaced, Horwitz (2002) argues that the range of conditions it includes in its classification system have much in common with dynamic psychiatry as it “reclassified as specific diseases the huge realm of human behavior” previously claimed by its predecessors (p. 2). Thus, while representing a theoretical departure from dynamic psychiatry—which did not conceptualize mental distress in terms of discrete entities—diagnostic psychiatry maintained the prerogative to address the large spectrum of symptoms Freud had defined as treatable through psychoanalysis, while reasserting them as biological conditions.

Unlike dynamic psychiatry, which focused on identifying the underlying causes of neuroses, the descriptive approach of diagnostic psychiatry averted issues of causation altogether and made the symptoms themselves the primary foci for classification. This descriptive nature of the DSM results in a tautological approach to mental disorder (Brinkmann, 2016), as the DSM “offers behavioral diagnostic criteria as if they confirm the existence of a valid disorder, when the criteria merely describe what is claimed a priori to be an illness” (Kirk et al., 2017, pp. 165–166). Moreover, the DSM implicitly suggests that each diagnosis it consecrates represents a discrete mental condition with biological origins. Thus the tendency to talk about mental health
diagnoses as natural entities that are discovered, rather than categories that are created. This rhetorical move facilitates the erasure of the work that goes into deciding what behaviors to include and cluster together for a single diagnosis, and which sets of diagnoses are grouped together. And while advances in genetics and neuroscience were expected to clarify the boundaries between disorder and non-disorder, and among the discrete conditions, research has failed to yield the anticipated results (Poland, 2015).

Among other faults, skeptics criticize the DSM’s inability to produce a consistent definition of mental disorder or address concerns about the validity of its core constructs (i.e., the extent to which diagnostic categories describe actual diseases) (Cooper, 2015; Kirk et al., 2017; Whooley, 2019). Construct validity involves an understanding of the causes and underlying nature of mental disorders and thus corresponds to the philosophical matter of whether or not something is pathological, and in this sense, concerns basic questions about the nature of reality (Kirk & Kutchins, 1992, p. 29; Whooley, 2019, p. 181). DSM-III reformers bypassed validity issues by focusing their efforts on improving reliability, which refers to the probability that two observers will apply the same diagnosis when presented with the same case (Hyman, 2010; Kirk & Kutchins, 1992). The reliability of the categories was asserted through the development of the “kappa statistic,” a formula that was problematic but unintelligible to lay people (Kirk et al., 2017, p. 142; Kutchins & Kirk, 1986). This technical and rhetorical strategy effectively produced what science and technology scholars call a “black box,” which mystifies the complexity and controversy behind knowledge production (Latour, 1987) and helps keep critics at bay, while creating an image of scientism.
While a valid classification system requires reliable categories, reliability does not guarantee validity, and “in absence of a valid definition of mental disorder, there is no limit to the number of discrete conditions researchers and clinicians can develop” (Horwitz, 2002, p. 74).

The number of diagnoses in the DSM has consistently increased with every single edition. At 265 diagnostic categories, the DSM-III, released in 1980, more than doubled the 106 “reactions” in DSM-I, published less than three decades earlier (Grohol & Tartakovsky, 2016). The manual grew to 300 categories with DSM-IV in 1994, and had a similar 10% increase with DSM-5 in 2013 (Grohol & Tartakovsky, 2016). Each DSM version also altered a considerable number of existing categories; whereas anorexia was the only eating disorder recognized a few decades ago, today eight distinct diagnostic codes exist. Among other changes, DSM-5 relabeled its eating disorder section as “feeding and eating disorders” and included modifications to anorexia and bulimia, in addition to including new diagnoses like binge eating disorder (Call, Walsh, & Attia, 2013). In 2016, an Orthorexia Nervosa Task Force (ON-TF) was established to study the diagnosis’ inclusion in the DSM (Cena et al., 2018).

**The eating disorder field.** The eating disorder field is unique, even within the psy disciplines. Feminist theory and activism have played a key role in shaping how eating disorders have come to be conceptualized, studied, and addressed. Eating disorders, which are believed to be the mental illnesses (alongside addiction) with the highest mortality rates (Harris & Barraclough, 1998), disproportionately affect women with female to male ratios ranging between 3:1 and 10:1, depending on the study (Gordon, 2000; Hoek & van Hoeken, 2003; Hudson, Hiripi, Pope, & Kessler, 2007). Since the eighties, feminist scholars and activists have advocated for reading anorexia nervosa as symptomatic of the deeply fraught beauty ideals imposed on women,
including the idealization of unrealistic thinness (Bordo, 1988, 2003; Gremillion, 2005; Orbach, 1986; Wray & Deery, 2008). Bordo (2003) developed one of the most influential critiques in this sense, lamenting the medicalization of eating disorders as it obscures “an adequate understanding of the ubiquitous and thoroughly routine grip that culture has had and continues to have on the female body, and how commonplace experiences of depreciations, shame, and self-hatred are, and why this situation has gotten worse” (p. 66).

While the medical model of eating disorders has maintained its dominance, many of these feminist-inspired ideas have been translated into psychological research examining, for example, the relationship between exposure to media images of thinness and body dissatisfaction or eating disorder symptoms, and resulting in sociocultural models of eating disorders (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999; Tiggemann, 2011), and micro-level approaches like objectification theory (Fredrickson & Roberts, 1997; Fredrickson, Roberts, Noll, Quinn, & Twenge, 1998). In the midst of the individualizing and biologizing approach to mental illness, these contributions have secured a widespread acceptance of social factors—often read as expressions of patriarchal oppression (Bartky, 1988)—as fundamental contributors to eating disorders, although certainly not the sole cause. To be clear, it is not that these biomedicalizing trends are lacking in eating disorder scholarship—quite to the contrary, genetic and neuroimaging research on eating disorders has proliferated in recent years—but that they coexist, sometimes in harmony and other times in tension, with sociocultural understandings.

**Knowledge Production in a Mediatized World**

In making sense of the medicalization of orthorexia—specifically, how knowledge about it has been produced and circulated, and who has participated in the process—this dissertation
foregrounds the role of media. By media, I am referring to the interplay between symbolic content and meaning with material artifacts, practices, and the social arrangements or organizational forms associated with them (Boczkowski & Lievrouw, 2008; Lievrouw & Livingstone, 2006). Thus, I approach media as sociotechnical assemblages where diverse knowledges and actors intersect. Throughout this dissertation, I show how media have been consequential to the constitution and configuration of orthorexia knowledges in diverse ways. This is, in large part, because of the increasingly central role of media in social life and their disruption of traditional production and consumption patterns.

Analogous to the concept of medicalization, mediatization refers to the process whereby more and more media emerge and become increasingly relevant to the construction of society and culture (Hjarvard, 2008; Krotz, 2009; Livingstone, 2009; Lundby, 2009). Mediatization does not imply that all people or contexts are equally embedded in media, nor that there is a single media with a uniform logic. It simply acknowledges the deep, consistent and self-reinforcing role of media in contemporary life, as social interactions increasingly take place via media, and that results in actual changes to the dynamics and structure of the social world (Couldry & Hepp, 2017, p. 15). From this perspective, media do not provide a second-class form of communication, but a profoundly consequential reconfiguration of interactions and ultimately the building blocks through which we construct our shared reality. In acknowledging the role of media, I also consider the importance of media logics, which refer to “the institutional and technological modus operandi of the media, including the ways in which media distribute material and symbolic resources and operate with the help of formal and informal rules” (Hjarvard, 2008, p. 113). The concept of media logics is not intended in a deterministic way;
rather, it is meant to capture and account for the fairly consistent patterning of practices and behaviors associated with particular media, which are shaped by diverse factors, including technological affordances and social norms.

The importance of media in biomedicalization processes has been acknowledged by other scholars. A. E. Clarke, Shim, Mamo, Fosket, and Fishman (2003b) mention media in their discussion of the “transformations of the production, distribution, and consumption of biomedical knowledges,” one of five central processes co-constituting biomedicalization. Indeed, news interest in medical topics has dramatically grown in the past several decades with health stories now dominating science coverage (Bauer, 1998; Bucchi & Mazzolini, 2008). Briggs and Hallin argue for taking health journalism more seriously, overcoming perceptions of journalists as mere disseminators or translators of information, and considering them mediators among contending interests, values, and registers of knowledge (Briggs & Hallin, 2016; Hallin & Briggs, 2015).

Indeed, an important string of scholarship in science and technology studies (STS) has argued that because the construction of social problems depends on successful claims-making, mass media constitute key arenas where definitions and claims compete for legitimacy (A. Anderson, Petersen, & David, 2005; Hansen, 2000; Zehr, 2000). Foundational to this work is Hilgartner’s (1990) critique of the popularization model of science, which presupposes the existence of “pure” or “uncontaminated” scientific knowledges that are corrupted through their popularization in media. He points out that there is no concrete boundary separating genuine knowledge from popularized representations of it, as knowledge is presented in many different contexts, ranging from journal articles to mass media. Moreover, simplification is an important
part of both popular accounts and scientific work; thus, popularization can be viewed as an extension of knowledge production, where differences are a matter of degree rather than constitution entirely different phenomena.

Drawing from STS, Briggs and Hallin (2016, p. 5) advocate for the need to examine the role of news media in the co-production of modern epidemics, including how they “might form a part of the production of medical and scientific objects and subjects.” The STS concept of co-production reflects the notion that scientific knowledge is not a transcendent mirror of an objective reality; rather it embeds and is embedded in social practices, identities, norms, discourses, instruments, and institutions (Jasanoff, 2006, p. 3). Thus, understanding the role of the media in the co-production of biomedicine demands a clearer articulation of their contribution, one that transcends a top-down model. Here it is fundamental to understand mediation as an active and consequential role (Briggs & Hallin, 2016, p. 15). At the same time, Briggs & Hallin’s (2016) attention to news overlooks other media forms that may be equally consequential for knowledge production and claims-making in the increasingly mediatized environment (see Miah & Rich, 2008 for more on the medicalization of cyberspace). Thus, my analysis includes chapters corresponding to both news and social media.

**Expertise and Knowledges in Hybrid Spaces**

A second key theme running throughout this dissertation relates to matters of knowledge sources or claims-makers, that is, who is producing the knowledge, and their relationship to expertise—legitimized through professionalization—and other kinds of knowledge. As orthorexia’s origin story in the Yoga Journal foreshadows, orthorexia did not emerge in a scientific venue or from scientific procedures, nor was its proponent an eating disorder or even a
mental health expert. We shall see in forthcoming chapters the participation of diverse and somewhat unexpected actors, which requires a greater elaboration on lay and expert categories.

**Lay versus expert?** L. Prior (2003) points out that the world of professional dominance has waned in recent decades, leading to a legitimation crisis during the late twentieth century. In medical sociology and STS, this democratizing trend has expressed itself in two primary ways:

The first has been an increased interest in what lay people have to offer by way of knowledge of health and illness. The second has been a tendency to argue that lay knowledge can be every bit as valuable as professional knowledge. The two trends often come together in discussions of that 1990s hybrid, the ‘lay expert.’ (L. Prior, 2003, p. 43)

Central to this body of work is Epstein’s (1995, 1996) research examining how AIDS activists positioned themselves as credible participants in the production of knowledge, in large part by learning the language and culture of medical science. The concept of lay expertise has also been used to refer to not to the lay acquisition of technical knowledge, but to the embodied knowledges acquired through personal experience, used to counter medical knowledges or fill in the gaps of medical expertise (Busby, Williams, & Rogers, 1997; Conrad & Stults, 2010; Morello-Frosch et al., 2006; Raz, Amano, & Timmermans, 2018). These are two different kinds of lay knowledges and contributions. At the same time, expertise is not an all-encompassing status; that is, individuals are experts in specific areas. Even in the medical field, a specialist in dermatology will be limited in their technical knowledge of cardiology or psychiatry.

**Knowledges come together.** In practice, disparate kinds of knowledges and knowers often encounter each other in what Callon, Lascoumes, and Barthe (2009) term “hybrid forums,” open spaces where diverse and heterogenous actors (e.g., experts, politicians, laypersons, etc.)
come together to discuss matters implicating the collective. Particularly illuminating for the case at hand is their emphasis on the relationship between hybrid forums and controversy. Callon et al. (2009, pp. 24–25) posit that hybrid forums are typically sites of socio-technical controversies; thus, a central activity in these spaces is the establishment of a clear and shared border between the technical (and thus cordoned off from public debate) and the social—a line that typically fluctuates throughout the controversy. As a result, they provide ideal sites to examine the “overflows” of science and its techniques, which are typically identified by groups who believe to be affected by them: “Overflows are inseparably technical and social, and they give rise to unexpected problems by giving prominence to unforeseen effects” (Callon et al., 2009). Media, I will show throughout the dissertation, not only constitute increasingly prevalent and pervasive hybrid forums in and of themselves, they also tend to contribute to the hybridization—in terms of actors and knowledges—of other spaces, including those that are in the professional realm.

Yet, the concept of hybrid forums fails to capture the remarkable “discursive promiscuity” and blurring of knowledges or lay/expert categories that often characterize hybrid spaces, as knowledges intermingle and claims “weave in and out of expert and lay domains” (Irwin & Michael, 2003, p. 112). Here, the admittedly cumbersome concept of “ethno-epistemic assemblages” helps illuminate the dynamic in which these heterogenous knowledges and actors are brought together, related, and patterned; “how such ‘odd’ mixtures come together, cohere and ‘work’ as, perhaps, unitary or singular actors” (Irwin & Michael, 2003, p. 113). Moreover, the concept is intended to accommodate concerns about how coordination among disparate actors is accomplished, including the heterogeneity of actors that participate, the variety of practices
involved, the role of discursive complexity, and of course, the impact of media through which discourses and practices circulate (Irwin & Michael, 2003, p. 116).

As we move through the following chapters, we will see how different “ethno-epistemic assemblages” emerge in orthorexia knowledge production. I am especially interested in how media, as socio-technical assemblages with their own logics, contribute to shaping the orthorexia knowledges and actors that come together. I, thus, center on four kinds of assemblages, two of which are media-centered: news media, scientific scholarship, clinical practice, and social media. By zooming in on these four key, patterned sites, we can better appreciate how unique mixtures of orthorexia knowledges and actors differentially come together in various spaces, creating different kinds of hybrids.

**Claims-Making as Entrepreneurship**

A final overlapping theme that will appear throughout the chapters is the importance of certain entrepreneurs in orthorexia claims-making. From a symbolic interactionist perspective, social problems, including the definition of pathological behaviors, are products of processes of collective definition, which exist in relation to other social problems (Hilgartner & Bosk, 1988). Innovative definitions are advanced by specific actors through claims-making activities (Spector & Kitsuse, 1987). We can think of the actors who confront the challenge of legitimating new knowledges as entrepreneurs (Turcan, 2018, p. 437). Becker (1963) outlined the relationship between entrepreneurship and deviance in his discussion of moral entrepreneurs, actors who make the rules that define an act as deviant—or in this, case, pathological: “Without the enterprise required to get rules made, the deviance which consists of breaking the rule could not exist” (Becker, 1963, p. 162). Even if a practice is objectively harmful to a group, the harm must
be discovered, pointed out, and framed. Entrepreneurs are the actors who fulfill these tasks and “supply the push necessary” to get the rules (here, the diagnosis) created.

The concept of entrepreneurship has been applied to medicalization in previous scholarship. In her account of fibromyalgia, Barker (2009) discusses the roles of diagnostic entrepreneurs, in her study women sufferers and rheumatologists, who contributed to the expansion of the biomedical jurisdiction through the creation of a diagnosis. Despite his own internal turmoil on the matter, Bratman constitutes a diagnostic entrepreneur, par excellence, responsible for resignifying extreme health-seeking behaviors, creating a diagnostic label, and publicly staking his claim in magazines and a book. However, entrepreneurship is rarely a solo endeavor and we shall see that he was quickly joined by other relevant actors, some individual and some collective. We shall also see how some orthorexia entrepreneurs recur across different assemblages, while others are more confined to specific ones.

Chapter Overview

The empirical chapters begin where the orthorexia story takes off: in the news media. Chapter Two explores how orthorexia news coverage has spread and circulated over time, how articles have depicted the diagnosis, and who they have relied on as sources. Examining close to two decades of orthorexia news coverage, I argue that the logics of journalism have significantly shaped orthorexia knowledge production and source selection in ways that reverberate in popular and scientific discourse alike. Furthermore, by articulating the patterned institutional, professional, and individual factors shaping orthorexia coverage, I argue that news media constitute not only key sites for other actors to make claims, but actors in and of themselves. In producing and circulating particular narratives about orthorexia, determining who has the
authority to speak on the subject, and more broadly asserting orthorexia’s legitimacy as a new eating disorder, they contribute consequentially to the entrepreneurial work pushing for orthorexia’s legitimation.

Chapter Three examines orthorexia’s trajectory in the academic literature, focusing on certain key junctures and entrepreneurs throughout this process. I analyze how orthorexia science has been shaped by professional conventions and the increasingly porous boundaries of the psy jurisdiction, which enable outside disciplines to play a decisive role in knowledge production—especially in the realm of eating disorders. I show how the proliferation of orthorexia scholarship was initially spearheaded by researchers with expertise in nutrition, and has relied heavily on the development of a problematic measurement instrument, which has nonetheless transformed orthorexia into an object more or less amenable to conventions in psychological science. Furthermore, I demonstrate that while the academic literature quickly erased the visibility of media contributions, media were in fact fundamental to the establishment of the earliest orthorexia literature and the persistent media interest in the subject has not gone unnoticed.

In Chapter Four, I follow orthorexia into clinical practice. Based on interviews with 35 clinicians, I examine how healthcare providers from different disciplines learn about, make sense of, address, and utilize orthorexia in their everyday work. I show that orthorexia’s uptake among clinicians cannot be understood in abstraction from the widespread theoretical dissonance in the field and shared ambivalence about the DSM’s validity. Yet, clinicians overwhelming support orthorexia’s inclusion in to the manual grounded in a very practical, shared concern with helping people in distress live more fulfilling and satisfying lives. Thus, in spite of its unofficial status, clinicians already use the diagnosis for a variety purposes with colleagues and patients alike.
Finally, I show how eating disorder treatment centers and patients emerge, alongside dietitians and media, as primary contributors to orthorexia entrepreneurship in a highly hybridized professional context that is ripe for diagnostic expansion.

In Chapters Five and Six I examine the circulation of orthorexia on Instagram, based on over 350 hours of ethnographic fieldwork online and on interviews with 34 users of the platform, who regularly engage the subject on their accounts. Chapter Five provides a general overview of the kinds of users who maintain orthorexia-related accounts, what drives them to use the platform to address the subject, and how the logics of Instagram (i.e., the technological and social affordances) shape the kinds of practices and interactions that take place. In Chapter Six, I approach the online orthorexia community as a subculture of sorts to show how users deploy the medicalization of their food obsessions to create a shared identity through which they actively subvert dominant health discourses.

Finally, in the conclusion I discuss how this case contributes to our understanding of scientific knowledge production in the context of mediatization. I argue that media constitute increasingly prevalent and pervasive hybrid forums for knowledge production in and of themselves, while also contributing to the hybridization—in terms of actors and knowledges—of other spaces. Furthermore, I draw on the sociology of professions to make sense of the jurisdictional expansion taking place in the eating disorder field. I also foreground embodied knowledges as central to orthorexia legitimation project. Finally, I draw from literature on entrepreneurship in organizations and institutions to examine orthorexia as a product of creative friction. These insights can contribute to future work on knowledge production.
Chapter Two. Orthorexia in the News: Journalism as Knowledge Production

On August 23rd, 1998, an article with the headline “Teenage Girls Face New Food Hazard” appeared in the British tabloid Sunday Mercury. The article lead asserted teen girls were “falling victim to a new eating disorder” as they “falsely convince themselves” they have food allergies and cut out vital parts of their diet. The text goes on: “The condition has yet to be officially recognised in this country, but an American doctor has already coined the term Orthorexia.” This news article was one of the first to address orthorexia and would be succeeded by hundreds more. Like many that followed, the story takes Bratman’s claims of a new eating disorder at face value, and relies on only one other source—a dietitian—to validate the legitimacy of a diagnosis that, at the time, had not been seriously examined by mental health experts or scholars. In this chapter, I argue that these news stories, in the aggregate, played a key role in shaping the future of orthorexia as a diagnosis and they did so based not on scientific or medical norms, but on journalistic ones.

Studies of health and medical journalism are commonly based on “popularization” or “dissemination” models that examine news as a reflection of ongoing scholarly debates or as gatekeepers who moderate and simplify the passage of pre-existing information from a knowledgeable scientific or medical community to the public (Bucchi, 2014; Hallin & Briggs, 2015). These assumptions conceptualize news media as a mirror, distorted as it may be, that reproduces or amplifies the agendas of others. However, orthorexia news coverage troubles these dominant models of health news in two glaring ways: not only was orthorexia’s first appearance

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7 Portions of this chapter were previously published in Journalism (Ross Arguedas, 2019a), Journalism Practice (Ross Arguedas, 2019b), and Social Science & Medicine (Ross Arguedas, 2020).
in a popular—rather than a scientific—venue, but media interest actually preceded formal scientific conversations on the subject.

Sociological and STS critiques of popularization models that overlook the value of media as relevant sites where claims-makers “do science,” offer a helpful entry point for conceptualizing orthorexia coverage. Not only is science presented in many different contexts from academic journals to newspapers without a true boundary separating them, but these claims can flow in many different directions. Hilgartner (1990, p. 522) underscores the idea that “popularized knowledge feeds back into the research process” as scientists “learn about fields outside their immediate research areas from popular account.” Bucchi (2014) makes a similar point arguing that the “communication of science at the popular level may influence core scientific practice in many more different and subtle ways than simple support and reinforcement” (p. 21). Moreover, it is not just the production of claims, but also of claims-makers that is at stake. In determining whose voices get heard and on what terms, popular media assign authority to certain sources (Kitzinger & Williams, 2005). I suggest that to understand the role of media in the co-production of “medical and scientific objects and subjects” (Briggs & Hallin, 2016, p. 5) we must remain attentive to how media logics shape news coverage.

In this chapter, I explore how orthorexia news coverage has spread and circulated over time and space, how articles have depicted the diagnosis, and who they have used as sources. For the analysis, I draw primarily on two sets of data: 492 English-language news articles published worldwide between 1998 and 2016, and interviews with journalists who wrote and published articles about orthorexia between 2013 and 2018 (see more about the methods in Appendix A).
I argue that the logics of journalism have shaped orthorexia coverage, both qualitatively and quantitatively, in ways that reverberate in popular and scientific discourse—that is, they consequentially shape how knowledge and knowledge producers are constituted within the news centered ethno-epistemic assemblage. By articulating the patterned institutional, professional, and individual factors shaping orthorexia coverage, I argue that news media constitute not only key sites for other actors to make claims, but actors in and of themselves. In producing and circulating particular narratives about orthorexia, determining who has the authority to speak on the subject, and more broadly asserting orthorexia’s legitimacy as a new eating disorder, they contribute consequentially to the production of medical knowledges.

**Pegs and Waves: Patterns in the Spread of Orthorexia Coverage**

The first two decades of orthorexia news publications have been unevenly distributed among 15 countries, mostly in the Global North. The UK took a distant first place, responsible for about 40% of the total \((n=197)\) publications, followed by Australia with 18% \((n=87)\), the US with 13%, \((n=64)\), and Canada with 13% \((n=62)\). India \((5%; \ n=24)\), New Zealand \((5%; \ n=23)\), and South Africa \((4%; \ n=19)\) formed a cluster with intermediate coverage of orthorexia. Countries like China, Singapore, and Lebanon constituted the remaining 2% of articles. In terms of orthorexia’s salience as a topic, 47% of the stories were primarily about orthorexia \((n=233)\), while the diagnosis acquired a secondary role in 19% of the articles \((n=92)\), and was only briefly mentioned in the remaining 34% \((n=167)\). Nearly half of the articles were features \((47%; \ n=232)\), characterized by longer extensions, a preponderance of personal stories, and a more narrative writing style. Close to one in five publications were traditional news stories \((21%; \ n=64)\). 
n=105), another fifth were opinion articles (19%=93), while a smaller percentage belonged to other genres, including vignettes and book reviews (14%; n=70).

Orthorexia coverage has not been not constant; instead it has come in waves that grew over time (Table 2.1). Journalistic interest in scientific and medical topics tends to mirror other kinds of news where “the primary drivers of coverage patterns are not the content areas on which stories are focused but, instead, the production infrastructure through which that content must pass” (Dunwoody, 2014, p. 32). When it comes to ongoing issues, coverage “waxes and wanes with the presence/absence of [news] pegs” (Dunwoody, 2014, p. 32). As a result, media interest follows a cyclical pattern, referred to as the issue-attention cycle (Cacciatore et al., 2012). Fishman (1980) refers to spikes in coverage as “news waves,” produced by news organizations when they report heavily on a subject.

Several newsworthy occurrences, providing unique “news pegs,” explain the primary surges in orthorexia media interest. The first came in 2001 (33 articles), following the publication of Bratman’s book, Health Food Junkies. A second surge, in 2008 and 2009 (36 and 37 articles), succeeded the release of journalist Michael Pollan’s book, In Defense of Food, which briefly mentions orthorexia. The third, most notable, spike occurred after a popular blogger and Instagrammer, Jordan Younger, made her struggle with orthorexia public in 2014 (41 articles), and published a memoir in 2015 (102 articles). Younger’s announcement did more than peak interest in the subject, her association with Instagram profoundly shaped explanations of orthorexia’s causes: from 2014 onward, articles began to depict orthorexia as a problem caused by technologies like social media, an explanation inexistent in narratives before then when the diagnosis was associated mainly with diet trends like veganism. All but one of the 62
articles implicating technologies as contributors to orthorexia were published after Younger’s announcement, and many discussed her case.

Between 1998 and 2016, news interest preceded and remained mostly independent of research or scholarship on the topic. The first empirical study on orthorexia was not published until 2004, three years after the first surge in news), and academic interest was fairly slow to catch on (Table 2.1). The growth of academic publications on orthorexia also came in waves with a general upward trend, similar to the news waves but trailing temporally behind them. The growth spurts in academic publications, small in 2003 and 2012, didn’t amass much force until 2015 when the total of 17 publications almost tripled the previous year’s six articles, and most notably in 2017 and 2018, when the volume grew to exceed 30 articles per year. These academic waves succeeded the 2001, 2008–2009, and 2014–2015 news waves. The record year for academic publications was 2017, two to three years after the Younger story went viral in 2014 and 2015.

Table 2.1: Comparison of Academic and News Articles Per Year (1998–2018)

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<thead>
<tr>
<th>Year</th>
<th>Academic</th>
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</tr>
<tr>
<td>2007</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>2008</td>
<td>4</td>
<td>36*</td>
</tr>
<tr>
<td>2009</td>
<td>1</td>
<td>37*</td>
</tr>
<tr>
<td>2010</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Year</td>
<td>Academic Articles</td>
<td>News Articles</td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>2011</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>2012</td>
<td>5</td>
<td>24</td>
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<td>2013</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>2014</td>
<td>6</td>
<td>41*</td>
</tr>
<tr>
<td>2015</td>
<td>17</td>
<td>102*</td>
</tr>
<tr>
<td>2016</td>
<td>13</td>
<td>79*</td>
</tr>
<tr>
<td>2017</td>
<td>32</td>
<td>--</td>
</tr>
<tr>
<td>2018</td>
<td>30</td>
<td>--</td>
</tr>
<tr>
<td>Total</td>
<td>132</td>
<td>492</td>
</tr>
</tbody>
</table>

Note: This table compares the number of peer-reviewed academic articles containing the word in their title or abstract (including commentaries, literature reviews, and empirical studies) with the number of news articles containing the word “orthorexia” in their title or text. Only English-language texts were considered for this analysis. I did not collect data on news articles in 2017 and 2018. Asterisks denote years in which the number of news publications broke the previous record of total publications per year.

Orthorexia news publications have come in bursts, initiated by one article and replicated by two or three others shortly after, followed by periods of silence. A regional-historic logic appears to have driven the imitation: the enthusiastic interest spearheaded by UK newspapers reverberated most significantly within the British Commonwealth, in countries like Australia, Canada, and India. Meanwhile, imitation among US outlets has tended to be more confined within American borders. In addition, the simultaneous appearance of articles with identical content across news outlets suggests content sharing was taking place. While outlets sharing texts usually make some modifications, altering the title, adapting the extension, or adding local sources, the core content usually remains identical. This was documented among regional newspapers, but also across borders, in line with the geographic logic previously mentioned.

Imitation and content sharing have operated in conjunction, resulting in pockets of heightened news interest. Take the following example: On November 1st, 2004, after two months of silence on orthorexia in the news media, The Daily Telegraph (UK) published a column about orthorexia titled, “Fussy Can Be Dangerous.” The following day, the Daily Mail published an
article by journalist Robin Yapp, with the headline, “Why food fads can turn into a deadly obsession,” in which she drew on the column but included other sources. On November 3rd, *The Daily Telegraph* in Sydney and *The Courier Mail* in Queensland, both in Australia, published shortened versions of Yapp’s article with different titles. On November 7th, reporter Mary Papadakis published the article “Fears of ‘pure’ eating” in the *Sunday Herald Sun* (Australia). Shortened versions of her text were also published the same day without a byline in two other outlets in South Africa and Australia. Thus, a single column spurred publications on the subject in at least six other news outlets in three different countries.

**Orthorexia narratives.** News waves often result in the development of consistent “media templates” that serve as a rhetorical shorthand to make sense of information across news organizations (Kitzinger, 2000). As templates spread, they contribute to shaping narratives around certain issues. In the case of orthorexia news, a consistent biomedical framework has undergirded most of the coverage, which taking Bratman’s cue, effectively reinterpreted extreme healthy eating as a novel and increasingly prevalent pathology. In addition to this overarching template, articles typically drew from four recurring narratives that presented orthorexia as absurd, obnoxious, paradoxical, or dangerous. I briefly explain the four, below.

Articles employing the absurd narrative highlighted the eccentric and unusual behaviors attributed to orthorexic people, often in a humorous tone. Autobiographical anecdotes—present in 56 articles—were not the exception, with some writers ridiculing their own secret food rituals or those of people they knew. This narrative was most prevalent in feature articles, which used a broad range of literary devices from metaphors to hyperboles to highlight the purported absurdity of orthorexia, as in a 2005 article explaining, “Orthorexics start small… Giving up caffeine here,
a bit of tofu there”; however, “before you know it, they’ve got a picture of nutritionist Dr. Gillian McKeith in their wallet and they’re up a mountain, living off sunlight.” (Bleakley, 2005). Also modelling Bratman, these articles drew on metaphors likening orthorexia to religion, suggesting orthorexics were overcome with “a frightening amount of moral zeal” (Garner, 2001) in their quests for spiritual “purity.” Detailed exemplars of purported orthorexics drinking 12-banana smoothies, travelling with blenders, or having panic attacks in grocery stores also pervaded many feature articles.

Publications adopting the obnoxious narrative were inclined to depict orthorexic behaviors as annoying or detestable. While present in some features, this theme came up most often in opinion articles where writers vented their frustrations with dieting practices of friends and acquaintances. Orthorexic behaviors were rendered obnoxious on three primary dimensions. The first of these underscored their pretentiousness, for instance, qualifying orthorexics as “righteous-eating zealots” (Squires, 2015) or “annoying and smug” (Skenazy, 2001). Second, orthorexics were accused of imposing their habits on others. In addition to religious metaphors of evangelization, military metaphors also came to the fore in this narrative, with phrases like “food fascism” (Johnson, 2014) or “militant food fundamentalism” (“Too Much of a Good Thing,” 2002). A third annoying facet of orthorexia involved how strict eating requirements inconvenienced others, as difficult guests, frustrating dinner companions, and exasperating customers. While these two narratives persisted, they were most frequent during the first decade of coverage, giving way to the latter two narratives in the second decade of coverage.

The third prevalent theme depicted orthorexia as fundamentally paradoxical, underscoring the apparent contradiction intrinsic to orthorexia: that healthy eating, widely
encouraged for physical wellbeing, can actually make you sick. Countless titles repurposed this idea and embraced the literary possibilities of the irony with headlines like, “Can naughty be healthy?” or “Clean Eating Can Become a Dirty Prospect.” These publications tended to be less critical and focused on the negative health outcomes or experiences of suffering. They also examined the behaviors with a more empathic light, as well-intended rather than fundamentally absurd or obnoxious. Articles adopting this approach were more often traditional news articles than features, and addressed orthorexics with greater compassion than the first two narratives as well-intended individuals who had lost control of their health endeavors. Furthermore, they often framed orthorexia as a problem of extremes, prescribing moderation or balance as the remedy. Thus, enjoyment became central to assessing of wellbeing:

My heart went out to these people [orthorexics]. What kind of fat-free, fructose-free, joy-free lives were they leading? They would never know the creamy comfort of a glob of butter on their morning toast ... Or the satiated smile after downing a chilled Coke on a hot day. Sure they’d outlive us by a couple, but at what cost? (Bachchan Nanda, 2014)

The paradoxical narrative sometimes overlapped with a fourth approach depicting orthorexia as dangerous. While most articles referred to orthorexia’s negative consequences, articles in this category made dire outcomes the primary focus. The most extreme version of this narrative appeared mostly in British and Australian tabloids, which published the highest volume of articles describing orthorexia as a “Dieting horror” or explaining how healthy eating could become “a deadly obsession” ("Dieting Horror," 2004; Yapp, 2004). One article titled “Death by Broccoli” warned “vegie-obsessed Gold Coasters are making themselves sick through healthy
eating” (Laughlin, 2016). Contrary to the humor in the absurd and obnoxious approaches, these articles adopted an alarmist tone, warning people of the impending danger.

These narratives tell us a lot about the kinds of claims being made about orthorexia in the news media. They also point us to some of the tensions arising between distinct perspectives on what constitutes desirable eating. In particular, they shine light on the discord that emerges as health-oriented restrictive eating (basing food choice entirely on beliefs about their nutritional value) collides with other widespread functions of eating, such as social connection or pleasure, and broader social norms dictating social interactions. In these news narratives, orthorexia extends the eating disorder framework to encompass a new set of behaviors, and in doing so, aligns with these alternate principles, while transforming the most stringent dieters from models of self-discipline to absurd, arrogant health fanatics who are compromising their health. At the same time, it reconstitutes pleasure and joy as valuable for their contributions to a person’s quality of life. It is impossible to ignore a sense of delectation in many of these articles as they put the “sanctimonious,” “wheat germ breath[ing],” tofu-loving individuals (Huget, 2001) in their place. This in no way negates the idea that orthorexia may be distressing and impairing; it simply suggest that there was an audience eager to embrace claims about orthorexia.

Orthorexia strikes a chord. Consistent with my findings on content imitation, the 13 journalists I spoke to alluded to monitoring other news outlets. Eight claimed to have first heard about orthorexia in another news article; others learned about it through social media, sources, and friends. Moreover, nine reporters believed they had personally encountered orthorexia or orthorexic behaviors. One Chinese reporter said she learned “that ‘clean eating’ had become a way of life for many friends and felt compelled to investigate its link to orthorexia” (ONJ-09).
Several identified on a more personal level, such as an Indian journalist who said that prior to writing the article, she had “started wondering whether I had it”; a British reporter who said orthorexia “did strike a chord” (ONJ-06); and an American journalist who said she saw herself in the story, adding, “I knew that if it had been such a problem in my own life then it probably was a problem in other people’s lives” (ONJ-05). The identification with orthorexia led reporters to assume the topic would be applicable and relevant to the lives of readers.

Not only did journalists find orthorexia relatable, it ticked multiple newsworthiness boxes as a topic both important and interesting to cover. For example, the notion of potential danger made orthorexia a matter of public health. One journalist explained: “I thought it was important to talk about how our obsessions as a culture with dieting and weight loss could become dangerous.” Moreover, many associated orthorexia with popular dieting trends that were on the rise, making the coverage even more timely and applicable. As one journalist suggested, “The growing popularity of ‘clean’ eating” prompted her to write the article, because “if more people were eating this way then surely there were more people at risk of developing orthorexia” (ONJ-09). Another news value associated with orthorexia was novelty, as one journalist put it: “Well I suppose I hadn’t heard of it before, so that was interesting to me to start with” (ONJ-08). An additional aspect that piqued interest was the element of surprise associated with label, as it brought into question the burgeoning “wellness” culture in a counterintuitive and “clever” way (ONJ-03). Two other characteristics mentioned were the association with celebrities and the perceived controversy surrounding orthorexia’s status.

**Constructing a Legitimate Diagnosis**
While news interest in orthorexia is in itself relevant, it only tells part of the story. How articles depicted the proposed diagnosis’ legitimacy is equally important. To understand how orthorexia’s status was publicly constructed, I categorized all the articles as “unsettled,” “settled,” or “undeclared,” based on whether they acknowledged orthorexia’s uncertain or unofficial status in some way, whether they depicted it as an established mental disorder, or whether their treatment of the label was unclear or non-medical. I found that despite its unofficial state, publications predominantly treated orthorexia as legitimate: 58.3% of articles (n=287) presented orthorexia as a settled diagnosis, double the 25.6% (n=126) that acknowledged its unofficial status in some way, and more than triple the 16% (n=79) of articles unclear about what kind of problem orthorexia was. While the proportion of articles presenting orthorexia as settled grew slightly over time, the difference was not statistically significant, indicating its legitimacy was taken for granted from the very beginning.

Some variations regarding the state of the diagnosis were apparent depending on the type of publication (Table 2.2). News articles (72.4%) and other genres like lists and vignettes (64.5%) were significantly more likely to address orthorexia as settled than features (52.2%) and opinion articles (53.8%). At the same time, features (32.8%) and news stories (25.7%) acknowledged orthorexia’s unsettled status at statistically higher rates than opinion articles (16.1%) and other genres (12.9%). Opinion articles (30.1%) and other genres (22.6%) were more likely to use orthorexia ambiguously, while news stories were the least likely to do so (1.9%).

**Rhetorics of Certainty.** Writers relied on various narrative strategies to construct orthorexia as a legitimate diagnosis, to present and manage uncertainty when they did
acknowledge it, and on some occasions, remained agnostic about the nature of the problem or provided unclear information. I synthesize these rhetorics below.

**Producing legitimacy.** Most articles, even those acknowledging orthorexia’s unofficial status, employed language that contributed to creating an aura of legitimacy around the diagnosis. The first and most common mechanism to achieve this was taking orthorexia for granted by presenting a definitive image of it as a new, de facto illness. The language of discovery enforced the idea of orthorexia as a pre-existing entity that had been “more recently discovered” (Oaten, 2013). Associating the label with official diagnoses was another common approach that bolstered its legitimacy. Orthorexia was usually couched in the well-established framework of eating disorders, like a 2016 article about a woman who had “been through almost the entire spectrum of eating disorders, starting with binge eating, moving on to bulimia, and anorexia, with occasional bouts of orthorexia—an obsession with healthy foods” (Borg, 2016). Orthorexia was woven into narratives about people’s struggles around food, providing a name for compulsions deemed problematic.
Table 2.2: State of Diagnosis * Article Type Crosstabulation

<table>
<thead>
<tr>
<th>Type</th>
<th>Settled</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feature</td>
<td>121</td>
<td>52.2⁺ 6.4</td>
<td>35 15.1⁺ 4.6</td>
<td>76 32.8⁺ 6.0</td>
<td>232 100</td>
<td></td>
</tr>
<tr>
<td>News</td>
<td>76</td>
<td>72.4⁰ 8.4</td>
<td>2 1.9 3.1</td>
<td>27 25.7⁺ 8.3</td>
<td>105 100</td>
<td></td>
</tr>
<tr>
<td>Opinion</td>
<td>50</td>
<td>53.8⁺ 9.9</td>
<td>28 30.1⁰ 9.2</td>
<td>15 16.1⁰ 7.4</td>
<td>93 100</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>48</td>
<td>64.5⁺ 11.6</td>
<td>14 22.6⁺ 10.2</td>
<td>8 12.9⁰ 8.4</td>
<td>35 100</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Table includes frequency, row percentages, and standard error of means by column. The⁺ and ⁰ symbols group together and denote categories in each column in which the differences were not statistically different at the p<0.05 level. The standard errors were calculated using the Wilson score interval, which is appropriate for small sample sizes. The statistical significance was calculated using Fisher’s exact test.
In addition, the provision of Bratman’s self-test in over 50 articles and referrals to eating disorder charities and clinics further contributed to the construction of orthorexia as a mental pathology.

**Managing uncertainty.** The quarter of articles that included some acknowledgement of orthorexia’s unsettled state in the medical institution, used a variety of strategies to manage the uncertainty. Most frequently, writers included it as a minor caveat, explained as a natural consequence of its newness. Occasionally, the justification was an overt defense of the diagnosis, like one feature story that reasoned: “But wasn’t the term anorexia poo-pooed for many years by the medical establishment?” (L. Jones, 2001a). Furthermore, many stories anticipated orthorexia’s formal acceptance, implying that while “not yet recognized by the medical world” (Charke, 2006), it was just a matter of time. About 30 articles included opposing points of view about orthorexia’s status, relying on the journalistic balance norm. Most did not center on the controversy; instead, they included the counterpoint toward the end, as a secondary issue. Less than a dozen articles foregrounded uncertainty, adopting a skeptical approach that centered on controversy rather than novelty, for instance, characterizing orthorexia as an “obsession with healthy eating as defined by the Internet” (Kaplan, 2015) or interpreting the label as an attempt to the pathologize everyday behaviors.

**Undeclared and unclear uses.** While there was almost unanimous consensus that orthorexic behaviors were troublesome, a portion of articles did not explicitly qualify orthorexia as a medical concern or diagnosis. Some of these articles were about orthorexia’s inclusion in dictionaries and limited themselves to defining the word without declaring it a mental illness, although arguably invoking the notion with concepts like “obsession.” Other writers talked about orthorexia as a symptom of an eating disorder or a precursor rather than a disorder in itself, or
circumvented clear labelling of orthorexia as a mental disorder. A handful of articles made the point that orthorexia was not a diagnosis, explaining it was “not a medical term” but rather “an apt word-play to pinpoint the fixation we now seem to have on eating the ‘right’ food” (Carrigan, 2002). Other times yet, orthorexia was discussed in terms of character flaws, as a “fad,” a “food fashion” (Williams, 2008), or a form of “extreme fussiness” (L. Jones, 2001b). The juxtaposition of assertions legitimizing orthorexia as a diagnosis alongside others questioning its validity or using moralistic language, often led to an unclear mishmash of ideas about the nature of the problem, despite being embedded within a biomedical framework.

**Perceptions of uncertainty.** Most reporters interviewed believed orthorexia was a valid diagnosis, based the opinions of their sources, their own knowledge, or a combination of the two. Half of the interviewees deferred to their sources, who they interpreted as enforcing the validity of the diagnosis. In the words of a British reporter, “The fact that so many experts I spoke to seemed to believe that it was a real thing, made me feel convinced” (ONJ-04). Another explained that as “a 20-something-year-old who has mostly lived in cities, and I do things like go to yoga and cook my own food… it makes sense to me. I feel like I’ve either interacted with or noticed things that are along the line of orthorexia” (ONJ-12). Two interviewees were lukewarm in their responses, maintaining they did not have “enough experience in the area to be able to make a value judgment on whether it’s a useful term in that [medical] sense” (ONJ-08). However, all seemed to agree that regardless off the medical status, orthorexic behaviors were a problem.

The fact that orthorexia was not an official diagnosis did not seem to interfere with the decision to cover the story—for some it even added appeal. “I think it made it a bit more interesting if anything,” stated one British reporter (ONJ-03). Another journalist said she had not
dwelled on the issue: “To be honest, I didn’t actually think too much about whether the term orthorexia was problematic... Because it seems to be quite a prevalent issue for many people, I think it does help to have a title” (ONJ-13). A few interviewees reasoned that since their articles were human interest stories focusing on experiences, the legitimacy “wasn’t as much of an issue” (ONJ-07). One British journalist recalled her editors inquiring about how medically endorsed the diagnosis was, and allowed the story “so long as we looked at it from a human-interest angle as opposed to…the medical side of it” (ONJ-08).

Some reporters did reflect on the validity of the diagnosis and grappled with it in various ways. Four people discussed their own reasoning on the topic—mostly off-paper—for example, arguing the DSM is only updated occasionally and other conditions took years to be included. The need to “get the word out that it’s happening” took precedence over waiting for the DSM to “maybe or maybe not pick it up” (ONJ-02). “It’s a living document, right? It gets updated all the time...that is sort of the nature of the DSM,” suggested another reporter (ONJ-12). Several writers anticipated its inclusion in the future. Another approach was to include a caveat in the story (five people) or include a counterpoint of a skeptic (one person).

**Choosing a Source, Making an Expert: Predominant Voices in Orthorexia Coverage**

Journalistic norms prescribe reliance on facts, attribution of information to external sources, and presentation of different sides of a story. By attributing knowledge to others, reporters can more easily claim the role of objective observers of reality (Franklin & Carlson, 2010). The interaction between journalists and sources exerts a crucial influence on society by giving them the ability to shape ongoing meanings in culture (Berkowitz, 2009, p. 102). Thus, journalists exercise power by determining whose voices get heard and on what terms, enforcing
beliefs about who are authorized knowers about issues (Ericson, Baranek, & Chan, 1989, p. 3).

But who gets to claim expertise over an unofficial diagnosis? In this section, I examine the use of sources in orthorexia coverage including what kinds of claims-makers have been granted authority by the media and what contributions they have made. I begin with some general descriptive data to give a general overview of sourcing patterns.

On average, each story attributed information to 1.63 sources (SD=1.87). The number dropped to .99 (SD=1.31) when considering only sources with professional credentials. Table 2.3 shows the distribution of articles based on the number of total and credentialed sources attributed information about orthorexia. Most striking is the fact that over one in four articles (27%) did not attribute information about orthorexia to any sources at all, and 39.2% used a single source. The remaining 35% attributed information to two or more sources. Again, when considering only credentialed sources, the percentages drop: almost half of the articles (49%) used no credentialed experts at all, while a quarter of articles (26%) used a single credentialed source, and the remaining 25% used two or more credentialed sources.

<table>
<thead>
<tr>
<th>Total</th>
<th>Total sources</th>
<th>Credentialed sources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>0</td>
<td>133</td>
<td>27.0%</td>
</tr>
<tr>
<td>1</td>
<td>193</td>
<td>39.2%</td>
</tr>
<tr>
<td>2</td>
<td>54</td>
<td>11.0%</td>
</tr>
<tr>
<td>3</td>
<td>47</td>
<td>9.6%</td>
</tr>
<tr>
<td>4</td>
<td>20</td>
<td>4.1%</td>
</tr>
<tr>
<td>5+</td>
<td>45</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

*Note: Frequency and column percentages.*
As one might expect, the number of sources varied depending on the salience of orthorexia within the article (Table 2.4), with the number of sources generally increasing the more central orthorexia was to a story. Thus, over half of the articles where orthorexia was the main subject attributed information to two or more sources, whereas only 19% percent of those where orthorexia was secondary, and 8% where orthorexia was just mentioned, used two or more sources. Differences in sourcing also emerged by article genre (Table 2.5). News stories had the smallest percentage of articles with no experts (11%) but a large percentage with a single source (44%), while one in five features used zero sources and 37% used a single source. Almost 45% of news and feature articles relied on two or more sources. These numbers were much lower among “other” genres like lists and vignettes, where information was often synthesized into short texts and not attributed. Opinion articles contained the largest proportion of articles using no sources. Almost 40% of these texts were written by healthcare providers: 18 nutrition experts, 13 mental health professionals, and four physicians, none of whom were researchers on the topic.

Table 2.4: Number of Sources * Topic Salience Crosstabulation

<table>
<thead>
<tr>
<th>Total sources</th>
<th>Primary</th>
<th>Secondary</th>
<th>Mention</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>29 (12.4%)</td>
<td>37 (40.2%)</td>
<td>67 (40.1%)</td>
</tr>
<tr>
<td>1</td>
<td>70 (30%)</td>
<td>38 (41.3%)</td>
<td>85 (50.9%)</td>
</tr>
<tr>
<td>2</td>
<td>38 (16.3%)</td>
<td>9 (9.8%)</td>
<td>7 (4.2%)</td>
</tr>
<tr>
<td>3</td>
<td>37 (15.9%)</td>
<td>4 (4.3%)</td>
<td>6 (3.6%)</td>
</tr>
<tr>
<td>4</td>
<td>17 (7.3%)</td>
<td>2 (2.2%)</td>
<td>1 (0.6%)</td>
</tr>
<tr>
<td>5+</td>
<td>42 (18.0%)</td>
<td>2 (2.2%)</td>
<td>1 (0.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>233</td>
<td>92</td>
<td>167</td>
</tr>
</tbody>
</table>

*Note: Table includes frequency and column percentages.*
Table 2.5: Number of Sources * Article Type Crosstabulation

<table>
<thead>
<tr>
<th>Total sources</th>
<th>Feature</th>
<th>News</th>
<th>Opinion</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>44 (19.0%)</td>
<td>12 (11.4%)</td>
<td>48 (51.6%)</td>
<td>29 (46.8%)</td>
</tr>
<tr>
<td>1</td>
<td>85 (36.6%)</td>
<td>46 (43.8%)</td>
<td>32 (34.4%)</td>
<td>30 (48.4%)</td>
</tr>
<tr>
<td>2</td>
<td>27 (11.6%)</td>
<td>19 (18.1%)</td>
<td>6 (6.5%)</td>
<td>2 (3.2%)</td>
</tr>
<tr>
<td>3</td>
<td>26 (11.2%)</td>
<td>14 (13.3%)</td>
<td>6 (6.5%)</td>
<td>1 (1.6%)</td>
</tr>
<tr>
<td>4</td>
<td>13 (5.6%)</td>
<td>7 (6.7%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>5+</td>
<td>37 (16.0%)</td>
<td>7 (6.7%)</td>
<td>1 (1.1%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Total</td>
<td>232</td>
<td>105</td>
<td>93</td>
<td>62</td>
</tr>
</tbody>
</table>

*Note: Table includes frequency and column percentages.*

**Source types and their contributions.** Different kinds of sources appeared in articles in varying proportions. Table 2.6 shows the number and percentage of articles citing at least one source of each category. Healthcare providers were the most common source type, in nearly half of the articles. Bratman stood out as the single most prevalent source, mentioned in nearly one-third of publications. While multiple articles misunderstood his credentials, suggesting he was a “specialist in eating disorders” (Durack, 2001) or a psychologist (Symons, 2003), for the most part, his qualification as a physician sufficed to position him as a “health expert” (Wells, 2002) appropriate to comment on medical matters. Throughout the articles, Bratman’s quotes and information attributed to him fulfilled a variety of functions, including legitimizing orthorexia, describing it, explaining its consequences, and helping identify it. Bratman was also referenced as a person who had suffered from the disorder, an experience he detailed vividly in his book:

> Bratman knows because he used to be one. Running an organic farm near Albany, he got to the point where he would eat only food that had been picked less than 15 minutes before. He chewed each bite 50 times and left his stomach deliberately half empty.

(Skenazy, 2001).
Bratman thus fulfilled dual roles as expert and exemplar. Over time, as other experts took up the baton of orthorexia claims-making, Bratman lost prominence within the articles.

Table 2.6: Articles With at Least One Source of Each Category

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare providers</td>
<td>247</td>
</tr>
<tr>
<td>Bratman</td>
<td>154</td>
</tr>
<tr>
<td>Dietitian/Nutritionist</td>
<td>117</td>
</tr>
<tr>
<td>Mental health professional</td>
<td>76</td>
</tr>
<tr>
<td>MD/Doctor</td>
<td>35</td>
</tr>
<tr>
<td>Clinic representative</td>
<td>58</td>
</tr>
<tr>
<td><strong>Academic</strong></td>
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</tr>
<tr>
<td><strong>Eating Disorder non-profit/advocate</strong></td>
<td><strong>72</strong></td>
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<tr>
<td>Affected individuals</td>
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</tr>
<tr>
<td>Non-public figure</td>
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</tr>
<tr>
<td>Public figure</td>
<td>38</td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td><strong>118</strong></td>
</tr>
</tbody>
</table>

*Note: Credentials were based on information provided in the text. Often, experts were identified with two credentials—these were counted in both categories. In total, 359 articles attributed information to at least one source.*

Bratman aside, dietitians and nutritionists appeared most often as designated experts, in 24% of articles—almost 50% more often than mental health experts like psychiatrists and psychologists (in 15% of articles). Administrators and clinic representatives were cited in 12% of the sample, usually in association with eating disorder treatment programs. About 7% used sources they described as physicians, general practitioners, or simply doctors. Some of these professionals held dual credentials as clinic directors or members of professional associations. The contributions of different healthcare providers overlapped significantly. They usually
supported the perception of orthorexia as a legitimate mental pathology and suggested it was on the rise. One dietician at the British Dietetic Association referred to orthorexia as an “emerging” eating disorder (Ings-Chambers, 2011).

Information attributed to healthcare providers included descriptions of orthorexia and symptoms to help identify or distinguish it from unproblematic healthy eating. In addition, they discussed a variety of consequences attributed to orthorexia, from emotional distress to physical complications. They also assured to have seen orthorexia among clients and occasionally provided exemplars. For example, one psychologist interpreted the case of a client she deemed obsessed with health food:

“Wilson panicked for she would need an extra couple of hours every day, just to soak and wash the fruits and vegetables in potassium permanganate…” says Dr. Sharita Shah, consultant psychologist, Bombay Hospital. Wilson, she adds, exhibited classic symptoms of Orthorexia Nervosa, which experts have dubbed “the new health eating disorder.”” (E. Malik, 2015)

However, some differences emerged among healthcare providers. While dietitians regularly discussed psychological topics, they were also more prone to emphasize nutritional matters, including misunderstandings about food allergies and rigid diets. Mental health professionals were most inclined to address psychological causes and underscore the importance of treating underlying problems, like low self-esteem, a need to feel in control, or trauma (Mansworth, 2002; Proctor, 2012). Psychologists and doctors more often qualified orthorexia as unofficial, clarifying they did not “know too much about orthorexia as it’s relatively new” (Doel, 2005), or advocated for more research. They were also cited more frequently than dietitians with
counterpoints questioning orthorexia’s validity as a distinct diagnosis (in 30 articles), like one psychologist, who argued, “I don’t think the symptoms are significantly different enough from bulimia or anorexia that it deserves a special diagnostic category” (Ellin, 2009).

Much less often, articles relied on researchers or scholarship as information sources (6%). In fact, despite the fact that by the end of 2016 (the sample cut-off) over 50 articles had been published in academic venues, only two researchers—Thomas Dunn, who published an article on orthorexia at the time of his interview, and Simon Knowles, who had research underway—were interviewed for news stories. Both were trained in psychology and seemed to believe in orthorexia’s validity.

Another category, present in 15% of articles, were individuals affiliated with eating disorder charities and advocacy groups like Beat and the Butterfly Foundation. Most were spokespersons, including administrators and press officers, without expert credentials. These sources contributed to legitimizing the condition via awareness-raising and more often the cultural factors they believed contributed to orthorexia (E. Jones, 2014). For instance, one article acknowledged orthorexia was not an official disorder, but “The Butterfly Foundation chief executive Christine Morgan believes it is one. ‘It’s where somebody is totally fixated on what is so-called healthy food,’ she said. ‘It’s hidden because as a society we admire people who get into healthy eating’” (Trieste, 2014). Furthermore, readers were urged to seek support if they identified with the symptoms; 75 articles provided contact information, which typically belonged to non-profits. Multiple articles also cited orthorexia’s definition from the website of the National Eating Disorders Association (NEDA).
One in five articles included personal stories of purported orthorexics. Writers used these exemplars to fulfill two main functions: to illustrate what orthorexia looks like in real-life and to elicit emotional reaction in readers, such as disdain, surprise, or empathy. For example, one account described a woman whose “‘pure’ diet had become so distorted that she found herself crying in the produce section of a grocery store because she could not decide whether the kale or the chard was ‘better’” (Quinlan, 2014). Almost one-third of the articles contained examples of public-figures. The most prominent was the Instagrammer, Jordan Younger, who recalled that she became “‘more and more limited in what I was comfortable eating. I even joked about it with friends, calling certain foods, like eggs, fear foods’” (Norton, 2015). TV hosts Mika Brzezinski and Carrie Armstrong also shared their experiences with orthorexia in ten articles. Not all individuals presented as exemplars agreed with the diagnosis. In these instances, reporters often interpreted their response as an inability to admit their problem. A related trend emerged regarding the use of personal stories: close to 20 percent of articles included alleged exemplars of orthorexia without their perspectives. Over half of these cases were celebrities like Victoria Beckham and Beyoncé. An assortment of other sources also appeared throughout the articles, including chefs, other media, dictionaries, and a life coach.

Aside from Bratman, Younger was the most common single source, appearing in close to 30 different articles. Deanne Jade, the founder of the NCFED, was in third place, appearing in 22 articles. Jade, whose credential as a psychologist was often absent from the stories, made increasingly enthusiastic statements defending the distinctiveness of orthorexia and claiming it was on the rise. By 2009, she was offering prevalence estimates, printed in multiple outlets, claiming, “‘one in 10 women and around one in 20 men have orthorexia in the UK’” (Titchener,
The fourth most common source was writer and journalist Michael Pollan, referenced in 19 articles, followed by Ursula Philpot, chair of the British Dietetic Association’s mental health group, who also reaffirmed orthorexia was spreading (15 articles). Other recurring sources include Christine Morgan, CEO of the Butterfly Foundation (9 articles); psychiatrist Angela Guarda and spokesman for the Eating Disorders Association, Steve Bloomfield, (8); celebrity chef Nigella Lawson and TV host Carrie Armstrong (7); and Mary George from Beat (6).

Finding and choosing sources. Overall, reporters’ source selection was based on beliefs about who possessed knowledge relevant to orthorexia, such as clinicians who “seemed…well-versed in this type of thing” (ONJ-05). Journalists conceptualized their sources in terms of experts versus non-experts, lumping diverse professionals together. One reporter explained: “I was looking for registered dieticians, psychologists, people of that nature. Anyone with a relevant degree who had said…or written something [about orthorexia]” (ONJ-11). Private clinics were mentioned among US reporters, who sought interviewees at “the local eating disorder clinic” (ONJ-12), or asked treatment centers “if that was a diagnosis they worked with” (ONJ-02). Furthermore, several reporters listed non-profits under the umbrella of eating disorder authorities. A UK journalist interviewed a representative from British charity, Beat, who she considered an “authority” that could give orthorexia “gravitas.” She elaborate that they are “the first port of call to know what’s happening on the ground” (ONJ-06). An Australian reporter spoke to a representative from the Butterfly Foundation, explaining: “She’s amazing and super knowledgeable and she was really helpful for all of those stories” (ONJ-13). Whether they were press officers or recovered advocates, charity representatives were viewed as experts in their own right, regardless of their professional credentials.
The proclivity toward dietitians as experts reflects an association of orthorexia with diets, and more significantly, an understanding that since it relates to “healthy eating,” experts in nutrition are ideal to discuss it. For example, an Indian reporter explained that she only sought nutrition experts “because it [orthorexia] has to do with food and clean eating” (ONJ-01). Orthorexic behaviors were often interpreted as indicative of nutritional misinformation, thus making dietitians ideal experts to set the record straight. Moreover, reporters recalled that some dietitians were publicly discussing orthorexia at events or on their websites, which positioned them as credible sources. Several dietitians also identified publicly as having suffered from orthorexia, which stood out to one journalist: “Usually you don’t have cancer researchers who are studying cancer because they had cancer… So, it was unusual, definitely” (ONJ-12).

While Bratman’s name was mentioned by over half of the reporters I interviewed, most quoted him from his book or website. The only journalist in the sample who interviewed him recalled that after her article was published in 2015, *The Washington Post* picked it up. She remembered Bratman “called me back and was like, ‘I don’t know why this article hit such a nerve but I’ve been talking about this for 15 years and suddenly every one’s calling me’” (ONJ-05). Indeed, 2015 that was the year of the largest news wave. Another journalist distinctly remembered trying to interview Bratman in 2018, but he was “not interested in speaking to me,” claiming he no longer addressed the subject and was even “rude” about it (ONJ-11).

Journalists acknowledged they used other outlets as information sources. Some “read a bunch of stories” (ONJ-01) for background information, while others cited “various magazine and newspaper articles” (ONJ-09) in their texts. Prior coverage not only reaffirmed the newsworthiness of the topic and offered easily replicable “media templates,” but also shaped
further source selection. One interviewee, for instance, began her reporting by “contacting people who had already spoken to other media outlets [about orthorexia]” (ONJ-08).

While perceived relevance and reputation were crucial to source selection, other factors were also significant in choosing interviewees or source repertoires. For instance, professional norms like balance shaped the expectations journalists set for themselves. Only one reporter alluded to the most traditional version of the balance norm, involving the inclusion of different sides of a debate. More often, balance manifested in the form of including both experts and non-experts, or perceived insiders and outsiders. The American journalist who had interviewed Bratman and people with personal experiences, elaborated on her decision to also contact a dietitian she perceived as neutral: “I thought…. ‘I can’t just have personal experiences and the guy who made it up; like, I need something else.’ I wanted someone from the outside” (ONJ-05). Thus, balance had more than one meaning in the medical context.

The beat of the reporter and their perception of the kind of story at stake also proved relevant. Only two of the 13 journalists covered medicine or science—the rest were generalists, freelancers, feature writers, or covered beats like lifestyle and technology. Journalists who perceived their articles to be human interest stories were most inclined to interview a single source. One such journalist justified, “The focus of my piece wasn’t going to be about medical history of the term and what it meant…I wanted to focus on somebody who understood that they were suffering from it and how that affected them” (ONJ-08). Another reporter justified her reliance on a single source “because it was only about her story, it wasn’t about the issue in general” (ONJ-07). She then admitted, “Actually, we had a space in the paper we had to fill, and a public relations person had emailed me about the event the nutritionist was speaking at.”
This last quote points to pragmatic considerations shaping source selection in news coverage, which must be understood in the context of highly demanding workloads and time constraints. The first is mere accessibility of sources. Some journalists interviewed friends or relied on clinicians and non-profits to provide exemplars. Public relations professionals also figured in the equation for journalists from the UK: two were prompted to write their stories through press releases, while another found a charity representative via a Gorkana (media) request. A freelancer recalled that she “had no contacts” so she started Googling and emailing people that seemed appropriate: “I was just throwing stuff against a wall and hoping that something would stick” (ONJ-05).

 Indeed, the internet emerged as a crucial tool to find information and sources. Emblematic of the Internet era at large, journalistic research about orthorexia relied heavily on online searches (mentioned by nine journalists). As a result, source selection was tied to sources’ ability to optimize their online visibility and association with orthorexia through blog posts, podcasts, websites, and social media platforms. One journalist related, “As soon as I Googled orthorexia, I found Jordan Younger, who was a big advocate for that at the time” (ONJ-05). As a popular blogger and Instagrammer, Younger was particularly visible. Another journalist recalled writing her story after reading a post by a nutritionist/influencer she “followed for a while [on Instagram].” At least three other journalists found sources on social media, as well.

Orthorexia Coverage in the Context of Journalism

In the aggregate, these findings point to various systemic, professional, and personal factors shaping orthorexia news as they converge in to patterned media logics. We can best appreciate the substance of news media logics by situating the findings vis-à-vis journalism
scholarship. At the broadest level, the spread of media interest in orthorexia illustrates how widespread institutional logics affecting the contemporary media ecosystem inform coverage of specific topics, including orthorexia. The growing tendency for journalists to monitor their competition, alongside the convergence of ownership and recycling of news content, have been linked to greater homogenization of content across outlets (Boczkowski, 2010; Boczkowski & De Santos, 2007; Saridou, Spyridou, & Veglis, 2017). The periods of silence followed by concentrated spurts of coverage in multiple outlets suggest media interest in orthorexia was driven, at least partially, by these trends. Also consistent with the monitoring and imitation explanation, more than half of the reporters interviewed wrote articles about orthorexia after learning of it from another news outlet, and many used this information as input.

Content imitation and recycling appears to have contributed to the homogenization of orthorexia coverage, visible in the sustained depiction of orthorexia as a novel eating disorder, despite its unofficial status. The recurrence of the biomedical framing of orthorexia; the persistence of the four narratives depicting orthorexia as absurd, obnoxious, paradoxical, and dangerous; and the shift from food-centered to technologically-focused explanations all exemplify how media interest feeds off itself and relies on shared templates (Fishman, 1980; Kitzinger, 2000). It seems plausible, especially when considering the accounts of the journalists, that imitation may also have contributed to the reliance on similar sources, as reporters turned to previous publications to guide them in finding and choosing who quote.

The increasingly central role of the internet in modern journalistic information-gathering practices, previously documented by news scholars (Boczkowski, 2010; Cochran, 1997), proves to have been crucial to the spread of orthorexia news, as reporters can now easily monitor
content from other outlets, even in other countries. This does not mean monitoring and imitation entirely lack a physical anchor—indeed the geographic clusters where imitation prevailed indicate the persistence of contextual and geopolitical dynamics in shaping these practices. However, it does suggest they are much less constrained than they once were. The journalist interviews provide evidence for other ways information technologies shape news gathering practices, including how journalists use the internet to identify and communicate with sources. As a result, an individual’s online visibility and public association with orthorexia contributed to their likelihood of appearing in orthorexia coverage.

In addition to these macro-forces, professional norms and practices also shaped interest in orthorexia and how coverage was executed. First and foremost, shared news values determining what kinds of content journalists deem newsworthy (Galtung & Ruge, 1965; Harcup & O’Neill, 2016), mapped easily onto the orthorexia, helping explain why it was so appealing to reporters, as a topic that appeared novel, surprising/paradoxical, entertaining, and of public interest. The large volume of feature stories reflects precisely the popularity of lifestyle or human-interest approaches to orthorexia news. Furthermore, similar to anorexia coverage (Shepherd & Seale, 2010), orthorexia was easily associated with celebrities, including micro-celebrities like Younger, who contributed to the appeal of stories.

Ongoing norms and standards of professional practice also contributed to how orthorexia was depicted. The fact that over half of the publications addressed orthorexia as a settled diagnosis is consistent with of a study on orthorexia in Swedish news media between 1998 and 2013, which found that, early on, orthorexia was framed as an eating disorder, a pattern the persisted over time (Håman et al., 2016). It also echoes previous research suggesting reporters
tend to prefer “certain” scientific results that offer audiences concrete information with clear significance (Corbett & Durfee, 2004; Stocking, 1999; Summ & Volpers, 2016). Even articles that did acknowledge the unofficial status often legitimized the diagnosis rhetorically. Thus, orthorexia was predominantly constructed as a de facto pathology, associated with formally accepted eating disorders, and used to explain (i.e., diagnose) extreme health-focused eating. This widespread practice early on led to a symbolic resolution of orthorexia’s status in public discourse on the subject.

Based on the interviews we can also infer that many writers did not perceive the diagnosis as uncertain at all, and those who did, chose to cover it based on their own rationales or a professional logic in which the urgency of warning readers about a possible health risk took precedence over waiting for definitive conclusions from the scientific community. This echoes Packard et al.’s (2004) suggestion that on rare occasions media coverage may precede public health concerns, as writers may “be the first in identifying an emerging health problem or breakthrough in the hope of getting a scoop” (16–17). Unlike science communication in academic settings, reporting obeys the professional logic of journalism, which centers on novel events, developments, and conflicts (Picard & Yeo, 2011; Seale, 2002). The idea that orthorexia’s unofficial status could contribute to the story’s news value, making it “a bit more interesting if anything,” further exemplifies these differences.

Journalistic norms and practices also help account for the sources used. Practical issues, like availability and clarity communicating, have previously been shown to shape expert source selection in science and medical stories (Conrad, 1999; Dunwoody & Ryan, 1987; K. Holland, 2017). In medical reporting, journalists have historically turned to scientists and doctors as
authorized health experts (Karpf, 1988). However, they have also been shown to assign experts authority in areas outside their professional competence (A. Anderson et al., 2005; Nelkin, 1995; Wilkinson, 2004), and lend credibility to “maverick” scientists (Dearing, 1995). Bratman was ideal as a news source, providing both professional authority and a human face. At the same time, by giving him a public platform, journalists contributed to both legitimizing his arguments and granting him an expert role. This is especially meaningful when acknowledging that he was advancing an unorthodox argument about a psychiatric diagnosis as an outsider to psychiatry. Nevertheless, the data suggest his doctor status sufficed to grant him authority on health-related topic.

A similar argument can be made regarding the predominance of dietitians over professionals from psy disciplines. At first glance, reliance on nutrition experts makes sense when considering they are on the frontline of food instruction; as one journalist reasoned, orthorexia “has to do with food.” However, it is one thing to identify behaviors, and another to declare them pathological. While dietitians participate actively in eating disorder treatment, in clinical settings they do not technically diagnose or treat the mental illness—much less determine what constitutes a mental pathology. Nonetheless, they functioned as primary news sources advancing the legitimacy of orthorexia. The predominance of dietitians as columnists, their willingness to talk to reporters, and their association with orthorexia via online profiles, suggest nutrition experts themselves were also eager to claim expertise.

The perception of charity representatives as experts also reflects journalistic interpretations of credibility, which may have more to do with influence and visibility, than technical expertise (Dunwoody & Peters, 1992). The prevalence of charities, affected
individuals, and clinic representatives as sources, alongside journalists’ mentions of PR representatives, all reflect broader trends in health news, where scholars have documented a growing presence of laypersons, alongside actors like NGOs, clinics, and public relations professionals (Briggs & Hallin, 2016; Lewis, Williams, & Franklin, 2008). This trend also appears to be indicative of increasingly muddled categories of experts, laypeople, industry actors, and activists.

The expression of professional norms like attribution and balance did not manifest uniformly in orthorexia coverage. Instead, they interacted with factors like the salience of the topic or the article type, helping explain some variance within the sample and demonstrating the contextual nature of how professional norms are enacted. For instance, the large volume of affected individuals in the sample reflects the predominance of feature stories. Furthermore, the idea espoused by several reporters that human interest pieces were not “about the issue in general” and could thus rely on a single source, reflect how article genre may shape the selection of sources. While source use was low across all article types, hard news adhered most to traditional attribution standards, whereas “other” and opinion articles displayed the greatest proportion of unsourced stories, perhaps because authors considered sourcing unnecessary, or in the case of columnists, because they viewed their own expertise as sufficient.

The fact that hard news stories disproportionately addressed orthorexia as a settled diagnosis may seem counterintuitive given that hard news is usually associated with straight facts; however, it also suggests this genre may be less amenable to uncertain or ambiguous uses of medical knowledges than other genres. Indeed, this category also contained the lowest proportion of “undeclared” articles. In contrast, features (the most common genre in the sample)
may be more open to acknowledging medical uncertainty or using medical terms more ambiguously, precisely because their primary objective is to tell compelling stories, rather than make medical arguments—even if inadvertently doing both. Consistent with this explanation, the interviews suggest journalists writing human interest stories may not have perceived their articles as science or medicine stories at all, loosening professional constraints for reporting about such topics. This also helps account for the prevalence of moralistic and colorful language, most explicit in the “absurd” and “obnoxious” narratives.

Finally, and at the micro-level, several individual factors emerged as relevant to news coverage of orthorexia. The relatively high number of autobiographical stories in the sample, alongside the multiple TV show hosts interviewed claiming personal experience with orthorexia, both reflect a personal interest in—and resonance with—orthorexia, and a disposition to interpret it as a mental illness. The journalistic sympathy toward orthorexia may be indicative of the world views of educated elites espoused by reporters. Historically, upper-class persons and women have labelled a greater amount and range of behaviors as mental illness, a pattern Horwitz (1982) associates with the adoption of a humanistic and cosmopolitan value system, and a greater tendency among women to adopt an introspective worldview compatible with the psychiatric viewpoint. The overwhelming majority of women writers in the sample, reflected by the entirely female subsample of interviewees,\(^8\) supports these predictions. It may be that women identified with orthorexic symptoms and experiences more than their male counterparts or had a greater sensitivity to eating disorders, given the overrepresentation of women among affected populations (Gordon, 2000; Striegel-Moore et al., 2009). However, it may also reflect broader

\(^8\) While the initial sample of nearly 40 journalists contacted included two men, neither of them responded. For more on the methods, see Appendix A.
gender dynamics within journalism as a profession, in which female writers tend to dominate human interest stories and features (Steiner, 2019). It is thus probable that women were more likely to adopt or be assigned these stories by their editors.

**News Media as Knowledge Producers**

This chapter examined the spread of media interest in orthorexia and how news outlets across the world have collectively constructed and circulated orthorexia as a diagnosis. The findings demonstrate that news interest in orthorexia preceded scientific research on the topic, and spikes in research succeeded news waves. Furthermore, mentions of scholarship were rare. While the exclusion of research in the first years of coverage was largely a product of circumstance as no research yet existed, inattention to scholarship did not subside even as studies materialized. Together, these findings suggest news interest not only preceded academic interest in orthorexia but may actually have contributed to creating it. By situating news as potential contributors to orthorexia knowledge—at the very least helping set the orthorexia agenda in academic scholarship—these findings echo the argument that media content can reverberate in scientific literature (Hilgartner, 1990; Phillips, Kanter, Bednarczyk, & Tastad, 1991), and further problematize notions of news as mere disseminators of knowledge from scientific venues.

The findings also illustrate various ways news media logics have shaped the interest in and spread of coverage in patterned ways. While couched in a medical framework, orthorexia news waves have not reflected scientific research, norms, or standards. Instead, they have exemplified the issue-attention cycle (Cacciatore et al., 2012), in which certain “news pegs” facilitated spikes in coverage. Orthorexia news waves derived from non-scientific but newsworthy events and happenings (Picard & Yeo, 2011; Seale, 2002), namely the publication
of pop articles and books, and statements from public figures. News logics also contributed to the symbolic settling of orthorexia’s status as a real and legitimate diagnosis and directed the newsworthiness criteria that shaped orthorexia narratives. Finally, professional norms and practices shaped source selection, defining which claims and claims-makers were heard and legitimized.

The entrepreneurial work of Bratman alongside other individuals like Jordan Younger, NCFED founder Deanne Jade, and writer Michal Pollan stands out, as none were involved in formal knowledge-production through academic publications or research. The collective contribution of dietitians as sources and columnists also merits acknowledgement, in addition to the contributions of non-profit organizations and affected individuals. Indeed, the effectiveness of any diagnostic entrepreneur in “supplying the push necessary” to get a diagnosis recognized depends partly on their ability to have their claims heard and taken seriously. However, reducing media to mere sites for entrepreneurs to supply this “push” overlooks the journalistic agency in seeking out (or “pulling”) particular sources, determining who is heard, and constituting authorities in particular subjects, based instead on journalistic norms and practices. Indeed, news media may amplify or dampen the reach of existing entrepreneurs or help constitute new ones.

Acknowledging the news media’s role in the co-production of orthorexia as a medical object (and of its subjects) further challenges popularization models, but also suggest that conceptualizing news media as mere sites for knowledge production also falls short. It is true, as Briggs and Hallin (2016, p. 32) point out, that health journalists mediate among different registers of knowledge, or competing perspectives on truth and value that contend in the field of health and medicine.” However, this mediation is not random. As complex assemblages in which
diverse knowledges and sources converge and interact with institutional logics in patterned ways, news media have become actors in orthorexia knowledge production in their own right. As we shall see in upcoming chapters, the impact of their diagnostic entrepreneurship has also been consequential, reverberating among experts and non-experts in different settings. Next, I will examine how orthorexia has been taken up in the scientific literature.
Chapter Three. Becoming a Science: Orthorexia Gets a Makeover

Despite its unorthodox genesis, orthorexia did find its way into the academic literature, first in book reviews and commentaries, and later on, in a flourishing body of empirical studies. After more than a decade with yearly publications in the low single digits, the volume of publications took off in 2015, the year after Younger’s announcement (Figure 3.1), almost tripling the previous year’s publication statistics with 17 publications. The number almost doubled again in 2017 with 32 publications. By the end of 2018, over 130 articles on orthorexia existed in the English-language academic literature with a citation rate that has grown exponentially in since 2015. Orthorexia, thus, appears to have consolidated itself as a legitimate object of inquiry in the medical establishment.

Figure 3.1. Growth in Academic Publications Per Year (1998–2018).
Just as news media has its own internal logics, the assemblage that constitutes academic scholarship is governed by the logics of scientific knowledge production, which tend to be exclusive of unscientific ways of knowing and non-expert participants. Reflective of scientific ideologies, biomedical research pursues standardized, generalizable, and replicable knowledge that can be used to generate prevalence estimates and prognoses. In addition to the promulgation of scientific methods, professional norms and practices constitute part of the “boundary work” done by scientists to demarcate their professional activities from non-science (Gieryn, 1983). For example, scholars are socialized to use certain kinds of language and to structure their arguments in particular ways. They are also encouraged to engage previously existing scientific knowledges, whereas they are dissuaded from using non-scientific sources. Practices like peer-review contribute to guarding professional norms and ways of knowing. Orthorexia poses a unique case to study how an unofficial concept, born in a non-scientific space, is reconstituted into a legitimate medical object.

The present chapter examines orthorexia’s trajectory in the academic literature between 1998 and 2018. I analyze how orthorexia’s passage through the scientific assemblage has been shaped by (1) professional conventions like the biomedical emphasis on quantification, and (2) the increasingly porous boundaries of the psy jurisdiction, which enable outside disciplines to play a decisive role in knowledge production—especially in the realm of eating disorders. In conceptualizing the mechanisms through which the scientific logics shape orthorexia knowledge production, I draw on metaphors of bottlenecks and turning points. Bottlenecks are helpful for thinking about how certain boundary marking rules and mechanisms constrain the knowledges that are able to progress through the pipeline. Turning points (Abbott, 2001), on the other hand,
direct attention to consequential events or publications that significantly shift the trajectory of the
diagnosis within the academic literature. We will see that certain entrepreneurs emerge at these
key junctures, whereas others make their contribution in more subtle but persistent ways.

The proliferation of orthorexia scholarship, I argue, was initially spearheaded by experts
in nutrition, and has relied heavily on the development of a measurement instrument, which
despite methodological flaws, transformed orthorexia into something that could be studied
empirically for the production of prevalence estimates and risk calculations. Furthermore, I
demonstrate that while the academic literature quickly erased the visibility of media
contributions, media were in fact fundamental to the establishment of the earliest orthorexia
literature and the persistent media interest in the subject has not gone unnoticed.

**From Media Diagnosis to Measurable Entity**

Orthorexia first entered the English-language academic literature in a book review of
*Health Food Junkies*. The review appeared in the *Journal of the American Medical Association*
in 2001, by medical doctor and researcher Adriane Fugh-Berman, who described it as a “smart,
funny and insightful exposé of a new eating disorder” (Fugh-Berman, 2001, p. 2255). She
claimed Bratman made “an excellent case for the term orthorexia nervosa to enter the medical
lexicon” and encouraged him to “publish some version of his theory in the medical literature” (p.
2256). That same year, a commentary entitled “The Price of Perfection” appeared in a news
analysis section of the *Nutrition Bulletin*, a British nutrition journal. In 2004 the *Journal of
Orthomolecular Medicine* published another book review by nutrition writer, Jack Challem, who
joined Fugh-Berman in praising the book as “powerful” and “insightful” (Challem, 2004, p.
That same year, orthorexia appeared in a literature review about medical complexities among eating disordered patients in a nursing journal (Cartwright, 2004).

Fugh-Berman’s invitation to Bratman to publish his theory in “the medical literature,” points to an important bottleneck confronting orthorexia: that its circulation in popular (read, non-scientific) spaces made it difficult to approach by the academic literature, given professional norms about the appropriate avenues for knowledge production. Beyond its mention in a few book reviews and commentaries, orthorexia was stuck. It needed to be made-over it into a proper medical object; it needed someone to push it through the appropriate institutional pipelines and over the science/non-science boundary. Yet, as noted in the introduction, at the time of orthorexia’s inception, Bratman was not particularly interested in or perhaps even prepared to engage in claims-making among credentialed pys/eating disorder experts.

The individuals who eventually dislodged orthorexia from this bottleneck was a team of Italian researchers, who in 2004 published the first empirical study on orthorexia in the journal *Eating and Weight Disorders*. Lorenzo Donini and four other researchers at the school of Nutrition Sciences at the Sapienza University of Rome took on the task of creating an instrument to detect and measure the prevalence of orthorexia nervosa. It was published alongside a sister article the following year, which formally proposed an instrument to measure orthorexia—the ORTO-15 (Donini, Marsili, Graziani, Imbriale, & Cannella, 2005). These articles constitute a key turning point in the literature: they would become the two most cited orthorexia articles (see Table 3.1) and effectively laid the foundation for future orthorexia scholarship.
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<td>Donini et al.</td>
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<td>Donini et al.</td>
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<td>Fidan et al.</td>
<td>Comprehensive Psychiatry</td>
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<td>Prevalence of orthorexia nervosa in resident medical doctors in the faculty of medicine (Ankara, Turkey)</td>
<td>Bagci Bosi et al.</td>
<td>Appetite</td>
<td>57</td>
</tr>
<tr>
<td>2016</td>
<td>On orthorexia nervosa: A review of the literature and proposed diagnostic criteria</td>
<td>Dunn and Bratman</td>
<td>Eating Behaviors</td>
<td>52</td>
</tr>
<tr>
<td>2011</td>
<td>Media hype, diagnostic fad or genuine disorder? Professionals’ opinions about night eating syndrome, orthorexia, muscle Dysmorphia, and emetophobia</td>
<td>Vandereycken</td>
<td>Eating Disorders</td>
<td>52</td>
</tr>
<tr>
<td>2011</td>
<td>Orthorexia nervosa in the general population: A preliminary screening using a self-administered questionnaire</td>
<td>Ramacciotti et al.</td>
<td>Eating and Weight Disorders</td>
<td>50</td>
</tr>
<tr>
<td>2010</td>
<td>Eating behaviour and eating disorders in students of nutrition sciences</td>
<td>Korinth et al.</td>
<td>Public Health Nutrition</td>
<td>46</td>
</tr>
<tr>
<td>2005</td>
<td>What is orthorexia?</td>
<td>Mathieu</td>
<td>Journal of the American Dietetic Association</td>
<td>45</td>
</tr>
<tr>
<td>2015</td>
<td>The clinical basis of orthorexia nervosa: Emerging perspectives</td>
<td>Koven and Wabry</td>
<td>Neuropsychiatric Disease and Treatment</td>
<td>44</td>
</tr>
</tbody>
</table>
The 2004 article kicks-off with a very telling admission: “For some time now, the mass-media and experts in the field of nutrition have noticed a new eating behaviour disorder not yet recognised as a disease by DSM IV, called ‘orthorexia nervosa’” (Donini, Marsili, Graziani, Imbriale, & Cannella, 2004, p. 151). From the very first sentence, Donini has attributed orthorexia information to the mass media, invoked nutrition experts as key identifiers, and invoked through the word “yet” a hypothetical future with orthorexia’s inclusion. Below, I examine their “tentative proposal for the diagnosis of ON and the verification of its prevalence” (p. 152) in closer detail.

**Dissecting the ORTO-15.** Donini and colleagues’ first study focused on trying to measure the prevalence of orthorexia among 404 Italians and its association with other variables. The Italian team “diagnosed” orthorexia in the presence of both “health fanaticism” and “obsessive-compulsive traits and phobia” (Donini et al., 2004, p. 152). The procedure they used to determine health fanaticism was not laid out in detail, but involved evaluating participants’ food choices, which researchers rated depending on whether they were considered “healthy” or “non healthy.” The scores were used to develop a personal ratio that ranked all the participants based on their “health fanaticism.” To detect obsessive traits, they applied a scale from the already existing Minnesota Multiphasic Personality Inventory (MMPI). While they adopted the preestablished cutoff for the MMPI, they had to determine a threshold for the health fanaticism component, which they instituted at the 25th percentile mark. This resulted in the creation of a

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9 The conceptualization of orthorexia as an obsession (or “fixation”) persists throughout Bratman’s writings, and he associates orthorexia with obsessive compulsive disorder explicitly in his book, explaining that there are “dramatic similarities” between the two and that “orthorexia sometimes seems to be a form of this disorder [OCD], with numerous overlapping and similar features” (Bratman & Knight, 2000, p. 34). Bratman also associated discussed orthorexia as an addiction, but this perspective was not considered for the ORTO-15.
discrete pathological category for the responses in the lowest percentile, based on the deviance from the average.

These two tests were then used to categorize the participants into four groups, based on different combinations of outcomes (i.e., whether they were “normal” or “abnormal” in each measure). The fourth group, in which individuals fell within the “pathological” range for both their health fanaticism and MMPI tests (6.9% of the sample), were declared to be “suffering from orthorexia” (Donini et al., 2004, pp. 153–154). This study also collected other data on the participants including demographic information, anthropometric data, and diet information. They found statistically significant differences for several variables, including a slightly greater prevalence among men, and a slight increase in orthorexia with age, but no differences for variables like Body Mass Index (BMI) or profession.

The second Donini et al. study purported to formally propose and validate the measurement instrument: the ORTO-15 questionnaire. To understand how the ORTO-15 came into existence, we must return to Bratman’s book, which contains a ten-item quiz to “determine if you have orthorexia.” It includes questions like, “Do you spend more than three hours a day thinking about healthy food? (For four hours, give yourself two points),” “Do you care more about the virtue of what you eat than the pleasure you receive from eating it?,” and “Do you feel guilt or self-loathing when you stray from your diet?” (Bratman & Knight, 2000, pp. 48–52). The book explains: “If you answer yes to two or three of these questions, you have at least a touch of orthorexia. A score of four more means that you are in trouble. And if all these statements apply to you, you really need help. You don’t have a life—you have a menu!” (p. 47). At the end of the
quiz, Bratman instructs, “If you racked up enough points to diagnose orthorexia, it’s time to disinfect your mind” (Bratman & Knight, 2000, p. 52).

If the “orthorexia self-test” sound more like a quiz from a Cosmopolitan magazine than a medical instrument, this is likely because the quiz was not an actual diagnostic tool. Regardless, the Italian team took the test at face value, using it as the starting point for the ORTO-15. In describing their instrument, they explained it was based on “a previously existing Orthorexia nervosa model used by Bratman on a population in the U.S.A” (Donini et al., 2005, p. e29). Their description of Bratman’s book as a “model” used on a US “population” suggests they may have interpreted his quiz a literal diagnostic tool, grounded in scientific methods—replicable and capable of producing generalizable findings. In reality, the quiz was more of prompt for individual reflection than it was a “model”; moreover, it had never been applied to any population, as Bratman never conducted research on the subject.

The ORTO-15 also included some new components and changes to existing ones. The researchers reworded and used six of Bratman’s original items, and added others. They also “disguised some excessive assertiveness” they deemed too obvious in Bratman’s questions and converted the dichotomous answers to a four-point scale, which they considered more appropriate for the “socially more dialectic” culture of their Italian sample (Donini et al., 2005, p. e32). As a result, the test included a more complex scoring system, assigning the responses a score between 1 and 4, in which 1 was indicative of orthorexia and 4 was deemed “healthy.” Thus, the lower the score, the more orthorexic the individual.

The findings from the second study relied on the same 404 participants as the first study for the testing of the questionnaire, and an additional 121 people for its validation. Statistical
tests were used to show differences between the means of the four groups (the orthorexic group versus the three non-orthorexic groups) and for determining “optimal threshold values” that would achieve the best predictive value—that is, the threshold most effective at “differentiating the orthorexic subjects from healthy ones as a function of those threshold values” (Donini et al., 2005, p. e31). Ultimately, the cutoff line was drawn at the 40-point mark, meaning anyone scoring below 40 would qualify as orthorexic. In their discussion, they acknowledge that at a 40-point threshold, their questionnaire achieved “notable predictive capability concerning healthy eating behavior” but was “less efficient in discriminating” obsessive traits. In fact, the mean score did not vary between participants with pathological and non-pathological MMPI results; thus, they called for more research.

One of the most striking features of these studies—reminiscent of psychiatry’s longstanding failure to consistently define mental disorder and delimit its scope (Cooper, 2015; Kirk et al., 2017; Whooley, 2019)—is the absence of a substantive discussion about orthorexia’s validity as a disease; that is, whether or not extreme health-seeking behaviors actually constitute pathology, and if so, where that line should be drawn. By encoding “pathology” into statistical deviation cutoffs, they produced an appearance of neutrality that rendered the interpretive work going on underneath the surface invisible. As Bowker and Star (1999) point out, “when a seemingly neutral data collection mechanism is substituted for ethical conflict about the contents of the forms, the moral debate is partially erased” (p. 24). The determination of health fanaticism becoming “abnormal” at the 25th percentile mark reflects the increasingly common trend in biomedicine to rely on mathematical calculations and statistics for knowledge production (Porter, 1996). Lock and Nguyen (2010) point out that the adoption of statistical averages as guideposts
for the norm (the mathematical) and the normal (the moral) reinforce understandings of variation as pathological deviation: what counts as “normal” in actuality is a statistical “average” (p. 32). People on one extreme of the health fanatic ranking were literally declared “pathological” simply for differing from the mathematical norm.

The reliance on a complex and seemingly technical procedure to create the instrument, alongside the opacity involved in the process, helped these studies eschew external scrutiny and criticism—at least for a while. The assertion of orthorexia through a statistical formula that is unintelligible to non-expert readers is not unlike the black-boxing of diagnostic reliability through the kappa statistic, discussed in the introduction. The “health fanaticism” measure stands out as particularly obscure. Even so, what information is available hints at important deficiencies. For instance, the authors explained that this measure was based on a binary classification of each participant’s food choice, used to identify “health fanaticism.” However, this simplistic categorization of food overlooks the possibility of diverging interpretations of what foods are deemed healthy versus unhealthy and different or multiple motivations behind food choice (e.g., whether or not a participant and/or research think milk is healthy; if a participant chose a food because they think it is healthy or delicious).

The ORTO-15 questionnaire contains additional shortcomings. The first is the use of ambiguous or unclear questions. For instance, item 2 asks: “When you go in a food shop do you feel confused?” but does not specify the substance or the origins of this confusion. Second, the instrument employs questions that may fail to capture what the authors intended. Item 15, presumably used to detect social isolation deriving from rigid eating, asks: “At present, are you alone when having meals?” Yet there can be many reasons why a person eats alone that have
nothing to do with their health-food orientation. The third, perhaps most disconcerting, problem is that many items appear to pathologize experiences that are not clearly disordered or abnormal—especially not in the context of healthist discourses and obesity panics. Such is the case of question 5, which asks if one’s eating choices are conditioned by a concern for one’s health status. Similarly, experiencing feelings of guilt after eating foods widely considered “bad” is hardly symptomatic of a dysfunction of the brain (item 13). These issues all make the soundness of the ORTO-15 suspect.

Despite these limitations, the Donini et al. sister articles were game-changers because they successfully transformed orthorexia into an object worthy of and amenable to scientific debate (Dunn & Bratman, 2016)—that is, they pushed it through the bottleneck. They achieved this in two fundamental ways. First, they transformed orthorexia into something that could be measured in a seemingly scientific manner. The esoteric terminology, the technical sounding name, and the reliance on complex statistical procedures, all contributed to creating “an aura of objectivity and scientific rigour” (Cohen, 1993, p. 510). The instrument also set the stage for researchers to measure orthorexia’s prevalence and relationship to other variables, two biomedical practices central to epidemiology and public health, which are centered on quantifiable risk (Lock & Nguyen, 2010). Measurement practices have become increasingly central to the study of mental illness following psychiatry’s biomedical turn (Kirk et al., 2017; Kirk & Kutchins, 1992). Thus, the ORTO-15 molded orthorexia into an apparently scientific object of study that could be tamed and adapted to biomedical knowledge production practices.

Second, and on a more symbolic level, the articles bridged the gap between popular and scientific knowledge, as references that could be more easily cited by academic peers, in
adherence to the conventions of scholarly publishing. Indeed, they relied on a somewhat unconventional constellation of references, including Bratman’s article and book, which were essentially self-help literature for lay audiences and did not engage medical scholarship directly. Furthermore, half of their citations—and all sources on orthorexia—were of non-scholarly publication, including an assortment of websites, such as www.something-fishy.org (a site “dedicated to raising awareness about Safe Health Supplements and Fitness Products”), www.beyondveg.com (a website that collects diverse perspectives on the pitfalls of alternative or vegan diets), www.dolfzine.com (a now defunct fitness website), www.albanesi.it (an Italian lifestyle information website), and www.newbodycenter.it/ (a gym website), and some articles from mainstream Italian outlets. Having made this somewhat awkward leap, these articles turned orthorexia into properly citable literature, sparing future researchers from having to do the same.

A finally noteworthy aspect to consider is that Donini, the lead author of the ORTO-15 studies, is a physician specialized in food science and statistics, and despite an impressive publication record in the field of dietetics, he does not seem to have been formally trained in a psy disciplines or the creation of psychometric instruments prior to the publication of these studies. Furthermore, none of his co-authors had credentials in clinical psychology or psychiatry; rather, they were all affiliated with nutrition science programs. Thus, as outsiders to psychiatry and psychology, they created a measurement instrument that still remains dominant in the orthorexia literature.

**ORTO-15 as Turning Point: The Surge of Empirical Studies**

The Donini et al. articles constitute a turning point, effectively inserting orthorexia into the academic literature. In the beginning, the shift was subtle, with just a slow trickle of studies
over the years. However, over time, this trend solidified into a steady stream of articles. The ORTO-15 was first replicated in 2006 study by an interdisciplinary Austrian team (with experts in psychiatry, statistics, and public health) who examined orthorexia among dietitians, and found orthorexia among 13% of their sample, in addition to “some orthorectic behavior” in 35% of their sample (Kinzl, Hauer, Traweger, & Kiefer, 2006). The study also found that a high rate of their sample had a history of anorexia and bulimia, and this segment overlapped significantly with those displaying orthorexia symptoms. This led the authors to suggest that rather than viewing orthorexia as a gateway to anorexia, it should “be seen as a coping strategy, in the sense of a ‘surrogate drug’, for a more severe eating disorder” sample (Kinzl et al., 2006, p. 396).

In a similar vein, the second ORTO-15 study was carried out by a Turkish team among resident medical doctors in a 2007 study—now the fourth most cited orthorexia publication (Table 3.1). In this study, 45.5% of the surveyed population scored below 40, thus qualifying as orthorexic. The researchers attributed this high percentage not to a potentially flawed instrument, but to the “highly sensitive behavior towards health and proper nutrition” among medical professionals, and concluded that orthorexia constitutes “a major concern in the field of public health” (Bosi, Çamur, & Güler, 2007, pp. 665–666). The study also draws an explicit line between orthorexia and misinformation in acknowledging that 20% of their male subjects and 38.9% of their female subjects said their choice of food had been influenced by TV programs on healthy eating habits:

It is most interesting to note that such a large number of people with a high level of education can be so heavily influenced by the media. It is clear that our eating habits can be adversely affected by the media especially when people, whose main concern is to
attract attention, send out misleading messages to the public. (Bosi et al., 2007, pp. 665–666)

Thus, early on, the literature examined orthorexia as a matter involving the media, described as disseminating deceptive information as an attempt to seek attention. Moreover, misinformation emerged as a key contributor to orthorexia, as conceptualized by these researchers.

Modified versions of the ORTO-15 also began to emerge, translating the questionnaire to other languages, and eliminating items to improve its statistical properties. For example, a 2008 study introduced the ORTO-11, a Turkish version that removed four questions with weak statistical power, based on a factor analysis (Arusoglu, Kabakci, Koksal, & Merdol, 2008). A subsequent Polish study—co-authored by Donini—aimed at validating the ORTO-15 for a Polish population, also wound up removing six items (Anna Brytek-Matera, Krupa, Poggiogalle, & Donini, 2014). By 2018, nearly 60 published studies relied on the ORTO-15 or its offspring.

While dominant, the ORTO-15 is not the only measurement instrument for orthorexia in the literature. Since 2006, a subset of studies have used the quiz directly from Bratman’s book, rebranded with the more scientific sounding “Bratman Orthorexia Test” or BOT. In 2013, a trio of researchers from the US and Australia designed the 21-item Eating Habits Questionnaire (EHQ) as an alternative to the ORTO-15, to assess “the cognitions, behaviors, and feelings related to an extreme focus on healthy eating” (Gleaves, Graham, & Ambwani, 2013, p. 3). More recent instruments introduced into the English-language literature include the Dusseldorf Orthorexia Scale (DOS) in 2017,\(^\text{10}\) and the Teruel Orthorexia Scale (TOS) in 2018. However, thus far, none of these instruments come close to reaching the popularity of the ORTO-15, which

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\(^{10}\) The DOS first emerged in the academic literature in an article published in German in 2015; however, it did not enter the English-language literature until two years later.
accounts for two-thirds of the empirical studies on orthorexia to date: of the 132 articles published in academic venues between 2001 and 2018, 82 (62%) were quantitative studies aimed at measuring orthorexia prevalence among specific populations (Table 3.2); 53 of those (65%) used some version of the ORTO. In comparison, the BOT was used in 10 studies, the EHQ in six, the DOS in five, and the TOS, in one.

Orthorexia research has produced extremely variable findings, with prevalence estimates ranging from 1% to 81.8%, depending on the instrument used, the location of the study, and the population examined (for a systematic review of the literature, see Cena et al., 2018). Studies have resulted in inconsistent associations between orthorexia and variables like gender, BMI, and age. For example, some studies have found orthorexia to be more common among men (Donini et al., 2004; Fidan, Ertekin, Işikay, & Kirpınar, 2010), while others have suggested women are more prone to these behaviors (Cinosi et al., 2015; Ercan, Ok, Kiziltan, & Saka, 2016). Other studies, yet, have found no statistically significant gender differences (Anna Brytek-Matera, Fonte, Poggiogalle, Donini, & Cena, 2017; Sanlier, Yassibas, Bilici, Sahin, & Celik, 2016). One explanation proposed for the contradictory findings are “cultural differences” between the populations (Arusoglu et al., 2008; Márta Varga, Dukay-Szabó, Túry, & van Furth Eric, 2013).

The idea of orthorexia “risk” vis-à-vis certain occupations or activities has been of special interest. In addition to examining the orthorexia prevalence among health professionals, researchers have explored its association with endurance and/or aesthetic-related activities among athletes or fitness participants (Eriksson, Baigi, Marklund, & Lindgren, 2008; Farooq & Bradbury, 2016; Segura-García et al., 2012), yogis (Herranz Valera, Acuña Ruiz, Romero Valdespino, & Visioli, 2014), and performance artists (Aksoydan & Camci, 2009). The
overarching narrative has been that individuals belonging to these groups are at a greater risk due to heightened expectations for them to embody optimal health or endurance standards via diet practices. Most studies have not included control groups, making the comparison of their findings with those of highly variable prevalence estimates dubious. Nonetheless, the idea that these groups are at “high risk” has circulated widely in both the academic and non-academic literature. More recent lines of inquiry examine associations between orthorexia and body image distortions (Anna Brytek-Matera & Donini, 2018; Cerea, Bottesi, Pacelli, Paoli, & Ghisi, 2018), vegetarianism or veganism (Barthels, Meyer, & Pietrowsky, 2018; Dittfeld, Gwizdek, Jagielski, Brzęk, & Ziora, 2017), and social media use (P. G. Turner & Lefevre, 2017).


While questionnaire-based empirical research has driven the growth of publications, 15 studies are based on other methods, including case studies, experiments, interviews, focus groups, and a news analysis (Table 3.2). Empirical studies aside, 20 articles consist of literature reviews or overviews, 11 were commentaries, two were theoretical papers, and two were the initial book reviews. Scholars from psy disciplines (psychology and psychiatry) are the most predominant professional group among article authors, with at least one psy expert participating in 76 articles (Table 3.3). Experts in nutrition follow in second place, with participation in 53 articles, trailed by medicine, public health (including epidemiology and biostatistics), and nursing professionals, with 33, 19, and 12 articles, respectively. Another 23 articles had authors from an assortment of different disciplines, like sports studies and sociology.
Table 3.2: Distribution of Academic Articles by Type (2001–2018)

<table>
<thead>
<tr>
<th>Article type</th>
<th># of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empirical: Questionnaire</td>
<td>82</td>
</tr>
<tr>
<td>Empirical: Case study</td>
<td>6</td>
</tr>
<tr>
<td>Empirical: Other (experiments, interviews, focus groups, etc.)</td>
<td>9</td>
</tr>
<tr>
<td>Literature Review/Overview</td>
<td>20</td>
</tr>
<tr>
<td>Commentary</td>
<td>11</td>
</tr>
<tr>
<td>Book Review</td>
<td>2</td>
</tr>
<tr>
<td>Theoretical</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>132</strong></td>
</tr>
</tbody>
</table>

Table 3.3. Distribution of Academic Articles by Author Discipline (2001–2018)

<table>
<thead>
<tr>
<th>Author Discipline</th>
<th># of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psy</td>
<td>76</td>
</tr>
<tr>
<td>Nutrition</td>
<td>53</td>
</tr>
<tr>
<td>Medicine</td>
<td>33</td>
</tr>
<tr>
<td>Public health</td>
<td>19</td>
</tr>
<tr>
<td>Nursing</td>
<td>12</td>
</tr>
<tr>
<td>Others</td>
<td>23</td>
</tr>
</tbody>
</table>

*Note.* About one-third of articles were published by interdisciplinary teams, ranging from two to four different disciplines. Articles with authors from more than one discipline (either because the various authors came from more than one discipline or a single author who possessed multiple credentials) were counted in duplicate categories, to capture the categories of expertise represented (e.g., Donini, who has credentials in both medicine and nutrition, was counted in both categories). As a result, the total does not add up to 132. The “psy” category groups together psychiatry and psychology. The category of “medicine” includes experts from medical backgrounds (other than psychiatry and public health). The category of “public health” includes sub-disciplines like epidemiology and biostatistics.

The dominance of psy experts as authors of scholarly publications differs from the secondary role they played in news articles, reflecting, as one might expect, a greater observance of traditional professional jurisdictions in the academic field, namely the prominence of psy professionals in a matter framed as mental illness. However, the participation of scholars from other fields is hardly marginal. When combined, experts from other professions outnumber
psychologists and psychiatrists as authors of orthorexia articles. Moreover, the relevance of an emerging eating disorders field in facilitating and framing orthorexia research grows evident when examining venues where articles have been published. In terms of journal subject-matter, eating disorders journals tied in first place with psychology/psychiatry journals as preferential cites for orthorexia articles, with 34 articles each (Table 3.4). Nutrition journals were in second place with 15 articles, followed by medical journals with 13, nursing with eight, and eating and drinking in fifth place with seven articles. Less common journals were on sports medicine and health.

Table 3.4: Distribution of Academic Articles by Journal Discipline/Topic (2001–2018)

<table>
<thead>
<tr>
<th>Discipline/Topic</th>
<th># of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating Disorders</td>
<td>34</td>
</tr>
<tr>
<td>Psy</td>
<td>34</td>
</tr>
<tr>
<td>Nutrition</td>
<td>15</td>
</tr>
<tr>
<td>Medicine</td>
<td>13</td>
</tr>
<tr>
<td>Nursing</td>
<td>8</td>
</tr>
<tr>
<td>Eating and Drinking</td>
<td>7</td>
</tr>
<tr>
<td>Health</td>
<td>5</td>
</tr>
<tr>
<td>Medicine-Sports</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>132</strong></td>
</tr>
</tbody>
</table>

*Note.* Three of the nursing articles were specifically in psychiatric nursing journals.

When looking at specific journals, *Eating and Weight Disorders*, far out-performed any other single venue, with 30 publications between 2001 and 2018 (Table 3.5). Aside from publishing the two first and most cited empirical studies on orthorexia, this journal formally launched a “topical collection” on the subject in 2017, with the intention of increasing “awareness within the scientific community,” and providing “a decisive hub for scientific
discussion based on data” (Missbach & Barthels, 2017, p. 1). This topical collection had grown to 45 articles by January 2020.

Table 3.5: Journals with Most Orthorexia Publications (2001–2018)

<table>
<thead>
<tr>
<th>Journal Name</th>
<th># of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating and Weight Disorders</td>
<td>30</td>
</tr>
<tr>
<td>Appetite</td>
<td>7</td>
</tr>
<tr>
<td>BMC Psychiatry</td>
<td>4</td>
</tr>
<tr>
<td>Journal of the Academy of Nutrition and Dietetics</td>
<td>4</td>
</tr>
<tr>
<td>European Psychiatry</td>
<td>3</td>
</tr>
<tr>
<td>Neuropsychiatric disease and treatment</td>
<td>3</td>
</tr>
<tr>
<td>Scandinavian Journal of Medicine &amp; Science in Sports</td>
<td>3</td>
</tr>
</tbody>
</table>

In terms of the geographic distribution of authors by country, the US is in first place with 31 articles, followed by Italy, Poland, and Turkey with 22, 16, and 15 articles each (Table 3.6). A second cluster of contributors include Germany, Spain, Australia, Sweden, and the UK, each of which ranged from six to nine publications. Thirteen other countries published two or less articles, for a total of 21 countries with publications. Figure 3.2 breaks down the temporal distribution of the four countries with most publications (10+). Italy has the most evenly distributed publication record over time. Turkey’s publications are concentrated in two periods (2007–2010 and 2017–2018), while Poland is the latest joiner of the four, but the only country to publish every single year as of 2012. In other words, while the US now dominates, its participation is concentrated in the last three years (2016–2018), while countries like Italy, Turkey, and Poland were largely responsible for the initial academic interest. By region, Europe has been the biggest contributor, producing over 70% of articles.
Table 3.6: Distribution of Academic Articles by Country (2001–2018)

<table>
<thead>
<tr>
<th>Country</th>
<th># articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>31</td>
</tr>
<tr>
<td>Italy</td>
<td>22</td>
</tr>
<tr>
<td>Poland</td>
<td>16</td>
</tr>
<tr>
<td>Turkey</td>
<td>15</td>
</tr>
<tr>
<td>Germany</td>
<td>9</td>
</tr>
<tr>
<td>Spain</td>
<td>8</td>
</tr>
<tr>
<td>Australia</td>
<td>7</td>
</tr>
<tr>
<td>Sweden</td>
<td>6</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
</tr>
</tbody>
</table>

*Note.* Authors’ countries are based on the location of their institution at the time of the publication. Eight articles had authors from more than one country; in these cases, more than one country was assigned to each article, so the total does not add up to 132. Twelve countries with three articles or less were grouped into an “other” category, including Austria, Brazil, Hungary, India, Greece, Belgium, and Canada.

![Figure 3.2. Orthorexia Publication By Country Per Year (2008–2018). Overlapping data points have been jittered.](image-url)
Most top-publishing countries have at least one scholar with a clear orthorexia research program. The single most prolific author is Anna Brytek-Matera, a Polish psychologist, whose name appeared on 12 bylines between 2012 and 2018. Donini, from Italy, comes in second place with six articles between 2004 and 2018. In the US, psychologists Thomas Dunn, who began publishing on orthorexia in 2015 and Crystal Oberle, who first published on the topic in 2017, are tied with four publications, each. German psychologist Friederike Barthels also stands out as a key orthorexia researcher, with four publications in English between 2015 and 2018. Despite their different locations, most of these scholars have co-authored articles with each other.

The emergence of a committed group of academic claims-makers and the articulation of collaborative networks for orthorexia scholarship, alongside the consolidation of a journal with an explicit orthorexia agenda, denote a shared entrepreneurial project to legitimize orthorexia in the academic literature. The journal *Eating and Weight Disorders* appears central to these efforts. Donini currently co-edits said journal, where most of his orthorexia articles have been published, and Barthels is guest editor of the topical collection on orthorexia. Oberle is a Section Editor for the journal and Dunn is on the editorial board. Moreover, one recent literature review acknowledges that the Orthorexia Nervosa Task Force (ON-TF) was established in 2016 to help clarify the knowledge developed on orthorexia thus far and figure out where it would best within the DSM (Cena et al., 2019).

Table 3.7: Citations of Orthorexia Articles Per Year (2001–2018)

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<th>Year</th>
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2009  8
2010  21
2011  35
2012  68
2013  56
2014  69
2015  201
2016  166
2017  350
2018  520
Total 1525

Note. Citation overview conducted with Scopus database. The search included all English-language academic articles published through 2018 with orthorexia in the title, abstract, or keywords and excluded citations from books. The search produced a set of 119 articles.

The interest of the broader academic community in orthorexia, apparent in citations of articles about orthorexia, mirrors the growth in articles specifically about orthorexia. A citation overview on the Scopus database shows a slow and mostly upward trend (Table 3.7), with a dramatic increase in 2015, during the largest news surge, when the number of citations almost tripled the previous year’s 69, for a total of 201 citations that year alone. Following a small dip to 166 in 2016, the citations more than doubled to 350 in 2017, growing yet again to 520 citations in 2018. By the end of 2018, a total of 1,525 academic texts had cited articles on orthorexia, meaning over 80% of citations amassed from 2015 onward. This number has continued to expand, with over 1,000 additional citations of orthorexia articles in the first eight months of 2019. The dramatic growth in citations suggests orthorexia has established itself as a relevant topic not only among the researchers examining it, but among other scholars as well.

Scholarly Contention and Open Questions

Orthorexia has been taken seriously in the literature, but it has not gone entirely unquestioned. Some scholars have posed questions about whether orthorexia constitutes a new
pathology and whether the behaviors are intrinsically pathological. The most obvious example is
a commentary by Kummer, Dias, and Teixeira (2008), who attacked both the form and substance
of an early empirical study, underscoring not only orthorexia’s unconventional origins in “the
non-scientific Yoga Journal,” but also arguing there is nothing really new about orthorexia, since
anorexic individuals “usually do care about their food quality” (p. 395). They contend that to
qualify as such, a “psychiatric disorder must have caused and continue to cause significant
distress or negative consequences” and conclude orthorexia “is nothing but a psycho-
pathological characteristic which may be seen from the normal to the pathological.” Here we see
the boundary work in play, as they discredit orthorexia by underscoring both its illegitimate
conception and its substance.

Aside from the idea that orthorexia may simply be an expression of anorexia, some
scholars have suggested orthorexia may fit within the diagnosis of Avoidant Restrictive Food
Intake Disorder (ARFID), new to the DSM-5 (A. Brytek-Matera, Donini, Krupa, Poggiogalle, &
Hay, 2015). In a similar vein, Strahler, Hermann, Walter, and Stark (2018) challenged the notion
that orthorexia is sufficiently distinct to merit a separate diagnosis on empirical grounds. Based
on a survey applying the DOS alongside a battery of other measures, they “confirmed the
epidemiological and clinical relevance of orthorexic behaviors,” but suggest that “the strong
conceptual overlap with other mental health problems and pathological eating raise initial doubts
as to whether ON is a distinct mental health disorder category” (p. 1143). In these discussions, it
is the distinctness of orthorexia that merits scrutiny.

Other engagements with validity issues have been generally noncommittal or
inconclusive, typically presenting the question without taking sides and often resulting in unclear
conclusions (see, for example, Chaki, Pal, & Bandyopadhyay, 2013; Gramaglia, Brytek-Matera, Rogoza, & Zeppengo, 2017). M. Varga, Dukay-Szabó, Túry, and Furth (2013) are among the few to point out the violation of scientific procedure in orthorexia knowledge production, underscoring that they “found neither a uniform definition…nor any standardized or validated criteria” for orthorexia, concluding “there are insufficient data” to determine orthorexia’s merit as a disorder (p. 108). In her article “Orthorexia nervosa – an eating disorder, obsessive-compulsive disorder or disturbed eating habit?,” Anna Brytek-Matera (2012) argued that orthorexia did not qualify as an ED because it does not include an extreme fear of weight gain; however, as a “disturbance of eating habits…it ought to be treated as a disorder concerning abnormal eating behaviour inseparably linked with obsessive-compulsive symptoms” (p. 59).

The implications of these kinds of conclusions for orthorexia’s standing as a unique mental disorder and its location within the DSM are unclear.

Aside from questions about orthorexia’s standing as distinct disorder, some scholars have focused on discussing where in the DSM orthorexia belongs—namely if it more closely resembles obsessive compulsive disorder (OCD) or eating disorders. Several scholars have examined the overlap between orthorexia, OCD, and anorexia, depicting orthorexia as an intersection between anorexia and OCD (Koven & Abry, 2015; Koven & Senbonmatsu, 2013). Others have advocated for orthorexia’s inclusion in the DSM’s eating disorder “family” (Janas-Kozik et al., 2014). These unsettled questions are reminiscent of longstanding debates regarding whether eating disorders and OCD are simply alternate expressions of a shared, underlying condition (Altman & Shankman, 2009; Klein & Riso, 1993). Additional diagnoses proposed as possibly “related” to orthorexia include autism spectrum disorder (Dell'Osso et al., 2016),
somatic symptom disorders (Barthels, Meyer, & Pietrowsky, 2015; Anna Brytek-Matera, Rogoza, Gramaglia, & Zeppegno, 2015; Koven & Abry, 2015), and even psychotic spectrum disorders (Anna Brytek-Matera et al., 2015).

Questions about orthorexia’s validity and character usually rely on “insufficient data” or “more research needed” tropes, reinforcing the idea that data alone—presumably collected in some “natural” and uncontaminated state—can resolve the question of whether or not something constitutes a mental pathology. Statements suggesting, for instance, that “more research on ‘ON’ is necessary to clarify the nature of its overlap with OCD” (Gleaves et al., 2013, p. 3), draw upon, while also perpetuating, the idea of DSM diagnostic categories represent discrete disease entities in the natural world, waiting to be discovered and clarified, rather than human-made categories created to describe and classify behaviors. This biomedical language, depicting orthorexia research as a fundamentally scientific endeavor, rhetorically erases the productive character of these “differentiation” efforts (Timmermans, Bowker, & Star, 1998); the extent to which the diagnosis is produced through interpretations of what human behavior is acceptable and what behavior needs to be returned to normality—or from a Foucauldian perspective, “disciplined”—through therapeutic interventions.

These debates also reflect the reification of already established diagnoses as discrete disease entities within the DSM. As an “information infrastructure” (Bowker & Star, 1999), the DSM actively shapes what psychiatric knowledge can be produced. By informing the operationalization of disorders and reifying an ideal-typical version of pathology and normalcy, the DSM perversely influences the enactment of mental health research (Halpin, 2016, p. 157). Creating a new diagnosis, such as orthorexia, requires situating it within the broader
classification system, determining what “family” of disorders it belongs to and providing sufficient distinctions to separate it from already existing diagnoses. Here, the main challenge orthorexia confronts is one of distinction in relation to already stabilized diagnoses. Struggles to disentangle orthorexia from other diagnoses are not singular; they are just uniquely visible because of the active demarcation efforts (to separate orthorexia from normality and from other disorders) prevent its boundaries from being taken for granted.

Moreover, the validity issues are not matters data alone can resolve, and derive, in part, from the character of the current knowledge paradigm. The absence of a consistent definition of mental pathology (Cooper, 2015; Kirk et al., 2017; Whooley, 2019) and the reliance on a tautological system whereby diagnostic criteria simply describe what has been claimed a priori as a mental illness (Brinkmann, 2016; Kirk et al., 2017), offer little support to scientists trying to discern normal from pathological healthy eating—categories the paradigm asserts to be categorically different. While a discussion about the paradigm’s limitations in representing and addressing mental illness is far too enormous for these pages, let it suffice to reiterate that such difficulties span far beyond the confines of orthorexia literature (see Horwitz, 2002; Kirk et al., 2017; Poland, 2015 for some critical perspectives on the subject). Debates about diagnostic line-drawing (including subclinical expressions of current diagnoses and grouping of diagnoses), low diagnostic reliability, and high rates of “co-occurring disorders” all attest to the widespread difficulties of trying to map the orderly, clear-cut categories of the diagnostic system on to the messy and ever-changing reality of human behavior and distress.

Rethinking orthorexia measurement and demarcation. Despite its popularity, the ORTO-15 has confronted mounting attacks on its validity as a psychometric tool. Initially the
critiques were milder in tone and substance; however, in 2015, after nearly 25 studies using the
ORTO-15 had been published in peer-reviewed journals, the instrument confronted a more
aggressive critique in an article called, quite literally, “When Eating Right, Is Measured Wrong!”
(Missbach et al., 2015). The author, a mixed team of nutrition and psy experts, determined the
ORTO-15 to be “an instrument with only mediocre validity,” and went on to chastise the
scientific community for widely ignoring the tool’s psychometric flaws. They called on
researchers to develop new measurement instruments from scratch. Roncero, Barrada, and
Perpiñá (2017), a team of experts in psychology and psychometrics, reached similar conclusions.
Missbach12 has persisted in his efforts to halt the application of the ORTO-15. He reiterated his
call for the creation of “novel and valid” diagnostic tools in at least two commentaries, one of
which he co-authored with Barthels, who developed the competing DOS (Missbach & Barthels,
2017, p. 1; Missbach, Dunn, & König, 2017). These efforts have attempted to apply a tourniquet
to the rapidly growing flow of ORTO-15 studies by bringing their science into question.

Perhaps the most damning critique of the ORTO-15 appeared in 2016, when American
clinical neuropsychologist, Thomas M. Dunn, enrolled Steven Bratman to review the literature
on orthorexia in the journal Eating Behaviors. Significantly, this was the first time Bratman’s
name appeared on the byline of an academic article about orthorexia. Regarding Bratman’s
initial self-test, the article clarifies Bratman “never suggested that these items are scientifically
rigorous and created it only as an informal measure” and asserts the “scale is without basic
psychometric properties, such as data regarding validity, reliability, cut scores, or a reference

12 While belonging to a nutrition department, Missbach’s work has been at the intersection of nutrition and
psychology, with some of his work focusing on eating behavior health psychology. He holds a PhD in Nutritional
Science with a focus on cognitive-behavioral aspects of food intake.
group” (Dunn & Bratman, 2016, p. 13). With respect to the ORTO-15, the article commends Donini and his team for their “early, important first step in attempting to validate an orthorexia measure,” but ultimately denounces the instrument:

> There is inadequate evidence that the authors followed a traditional approach of test construction. Development of construct validity is not clearly articulated, the creation of an item pool is not discussed, standardization methods are absent, and no basic psychometric properties are provided; all are essential features of test construction. (Dunn & Bratman, 2016, p. 14)

The article also expresses concerns about the failure to assess whether the behaviors examined are clinically significant or inducing medical problems.

Having described the ORTO-15 literature as “unreliable,” the article turns to “convincing case studies and broad anecdotal evidence to conclude that sufficient evidence exists to pursue whether ON is a distinct condition” (Dunn & Bratman, 2016, p. 14). The authors propose that the first step to advance the field is not the creation of a new instrument, but the establishment of diagnostic criteria. Prior to this, only one peer-reviewed article Dunn co-authored had taken a stab at offering specific criteria for orthorexia (Moroze, Dunn, Craig Holland, Yager, & Weintraub, 2015). In the new criteria, Dunn and Bratman (2016) try to correct what they viewed as shortcomings of the previous attempt: inattention to weight loss in orthorexia, and the reduction of orthorexia to a single dietary theory.

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13 Jessica Setnick, a Certified Eating Disorders Registered Dietitian who currently sits on the orthorexia task force, was the first to actually publish detailed diagnostic criteria for orthorexia in 2013. These criteria appeared in her self-published “The Eating Disorders Pocket Guide” (Setnick, 2013). While Dunn and Bratman acknowledged the existence of her criteria, they did not cite her in the article, limiting themselves only to the “refereed literature”—an almost ironic decision when considering the origins of orthorexia.
Criterion A of their proposal involves an obsessive focus on eating food perceived as
“healthy” by the individual, marked by “exaggerated emotional distress in relationship to food
choices perceived as unhealthy,” and possible weight loss that is—crucially—not the primary
goal. Criterion B requires the compulsive behavior and mental preoccupation to become
“clinically impairing,” as signified by malnutrition or weight loss; intrapersonal distress or
impairment of social, academic, or vocational functioning; or positive body image, self-worth,
identity and/or satisfaction being “excessively dependent on compliance” with food rules (Dunn
& Bratman, 2016, p. 16).

The idea behind this proposal was that by better defining and outlining orthorexia,
scientists could create a more accurate psychometric instrument. Thus, while focusing their
scrutiny on measurement issues, the proposed criteria intervened in the differentiation debate too.
First, the authors distinguished orthorexia from two alternate diagnoses they viewed as most
competitive with the orthorexia category, ARFID and anorexia. They explicitly distinguished
orthorexia from ARFID, which they described as food avoidance associated with trauma or
aversive experiences, rather than health pursuit. Moreover, their criteria include a weight-loss
qualifier (i.e., that weight-loss is not the primary goal) that separates orthorexia from anorexia.
Having defended orthorexia’s distinctiveness, the proposal offers multiple “clinical impairment”
criteria in an effort to demarcate a threshold for disorder. By distinguishing orthorexia from
already existing diagnoses and drawing the line between pathological and non-pathological,
these criteria do a lot of work in terms of carving out a unique space for orthorexia. Finally, by
reducing the specificity of the content of the dieting practices at stake, they made the diagnosis
applicable to a broad array of food theories.
The second criterion draws directly from the standard of “clinical significance,” added to over half of the diagnoses in DSM-IV, published in 2004, which requires symptoms to cause “clinically significant” distress or impairment in social, occupational, or other important areas of functioning in order to be considered disordered (Spitzer & Wakefield, 1999). The invocation of harm or distress as a proxy for pathology can be traced back to the heated debates about the medical status of homosexuality, when many gay activists pointed out that homosexuality is not intrinsically harmful or distressing. Dunn and Bratman (2016) point out this constitutes a “widely accepted practice to determine pathological behavior” (p. 14). However, as Cooper (2015) argues, the DSM’s conceptualization of the link between disorder and harm, a foundational matter for the determination of mental pathology has, from one edition to the next and without much open debate, shifted back and forth between being definitional and simply being common, downgraded again to the status of “common” in DSM-5. Moreover, the reliance on harm as a boundary-marker opens up another Pandora’s box of questions, including what it means for a disorder causes harm (Cooper, 2015, p. 94) and who gets to make the determination. Terms in the orthorexic diagnostic criteria like “exaggerated emotional distress,” “excessively dependent,” and “impairment” are hardly straightforward or judgment-free.

Nonetheless, the new diagnostic boundaries traced for orthorexia reduced the “impossibly high” prevalence rates that had been plaguing the literature, which exponentially exceeded the 2% prevalence of anorexia and bulimia (Dunn, Gibbs, Whitney, & Starosta, 2017). When adding proxy criteria for “clinical significance,” requiring individuals to both claim serious commitment to healthful eating and report their diet to be causing medical or social problems, Dunn et al. (2017) were able to reduce orthorexia prevalence among a college population from 71% using
the traditional ORTO-15 (with a 40-mark cut-off), to an acceptable, “less than 1%.” The article concludes the ORTO-15 “is likely detecting those who wish to follow healthy diets, but is not sensitive to pathology” (Dunn et al., 2017, p. 191). The clinical significance criteria appear to have shaved off enough of the prevalence number to make orthorexia practically feasible and handily in-line with the prevalence for presumably comparable eating disorders.

By reconfiguring orthorexia boundaries vis-à-vis pathology/non-pathology and already existing diagnoses, arguments like these serve to theoretically shield the orthorexia construct from being thrown out with the defective ORTO-15 bathwater. Although, to be clear, the bathwater hasn’t actually been thrown out. Despite the well-argued critiques of the instrument, the ORTO-15 seems to have collected sufficient momentum to make it difficult to tourniquet. While emerging instruments like the DOS and the EHQ offer scholar new alternatives, the volume of studies using the ORTO-15 continues to grow: 15 studies using the ORTO-15 were published in 2017, followed by 12 more in 2018. Many of these articles acknowledge the instrument as imperfect, but the matter is usually addressed as a caveat rather than a methodological deal-breaker. Whether the ORTO-15’s persistence reflects a misunderstanding of the implications of its flaws, or a practical attempt to salvage previously collected data, journals continue to publish studies using these methods, whose findings are then fed back into the literature and contribute to the narratives about orthorexia risk factors.

**Contributions of Popular Media and Literature**

In the previous chapter, by temporally comparing the growth curves of orthorexia news and scholarship, I suggested that news media, at the very least, contributed to setting the orthorexia agenda within the academic scholarship. Assessing the impact of popular media on
academic scholarship is a difficult task because of the scientific norms discouraging the use of extra-scientific knowledge. Thus, scholars have no incentive to cite non-scientific sources in their writing, even if these sources may have contributed to their knowledge of or interest in a subject. However, a closer look at the earliest literature, when scholars did not have a lot of citation options available to them, provides a glimpse into how popular media permeated scholarship during the earliest stages, which in turn shaped subsequent knowledge production.

The first and most obvious mechanism through which popular media seeped into the scientific literature was through Bratman’s writings, primarily his book, but also his *Yoga Journal* article, which he republished on his website as the original “orthorexia essay,” making it even more accessible for citation. Of the 132 articles analyzed, 98 directly cited at least one of these writings, and virtually all of the early scientific literature relied heavily on the ideas Bratman posited in these works. Thus, while Bratman was not initially targeting the academic community, nor did he submit his ideas to peer review, his ideas made their way into the scientific literature in a mechanism similar to that of the mainstream press. The fact that Bratman was a doctor, and that the practice of citing him became widespread so early on, may both have contributed to eliminating the taboo of citing his non-scientific work. Moreover, the reality that Bratman created the label may also have made his citation an ethical matter in terms of attribution.

While much less common, a second significant way popular media shaped the academic literature was through the direct citation of news publications and websites. As previously mentioned, the seminal Donini articles drew upon a repertoire of unconventional sources from the web, including fitness websites and online news publications, in constructing their orthorexia
narrative. The third most cited academic publication quoted not only Bratman’s website in its reference list, but also a 2004 article about orthorexia from Psychology Today (Fidan et al., 2010). Similarly, the fourth most cited article about orthorexia, published in 2007, included the essay from Bratman’s website, alongside an article called, “Less-well-known eating disorders and related problems” from an eating disorder charity website, and an article from Dolfzine (Bosi et al., 2007). A few other early but less influential articles also included popular media citations. However, as the body of scholarship on orthorexia grew, this practice became less necessary and soon disappeared, as the predecessors had effectively translated and repackaged unorthodox sources and their claims into readily citable material.

A third way popular media discourse infused the academic literature was through articles produced at the margins of academic journals. Here, two news commentary-type articles published in nutrition journals stand out. The first was the short, one-page commentary by nutrition scientist Claire Mac Evilly, mentioned earlier in this chapter, which discussed the content of a news article from The Observer Food monthly (Mac Evilly, 2001). The second was a lengthier text written by freelance writer Jennifer Mathieu and published in the Journal of the American Dietetic Association in 2005, which included an interview with Steven Bratman and several other mental health or nutrition experts. This text was essentially a news article and its opening paragraph directly alluded to a new obsession with dietary perfection that “has recently gained attention in the mainstream press” (Mathieu, 2005, p. 1510). However, unlike a news article, it included a reference list citing Bratman’s initial essay (via his website), a WebMD article about orthorexia, a PsyWeb article about the DSM-IV, and Donini et al.’s first study.
The Mac Evilly and Mathieu articles were both published in nutrition journals, appeared in “Beyond the Headlines” sections, and alluded to the news media as prompting them, while never citing the news articles. These two publications also seem to have operated as transitional texts that drew upon and mirrored news media conversations and conventions, but were circulated inside the pages of peer-reviewed journals, granting them greater visibility and legitimacy in the scientific community, even though they were not in themselves peer-reviewed materials. Both of these articles appeared often in early reference sections, including the Fidan et al. and the Bosi et al. articles mentioned above, and the Mathieu article remains one of the top ten cited orthorexia articles to date (Table 3.1). Thus, despite existing at the fringes of academic writing, their presence within more “proper” venues seems to have endorsed them as more citable than news texts.

Citation practices aside, brief mentions of the media hype surrounding orthorexia suggest that scholars were aware of the popular interest in the subject. One 2013 article described the literature on orthorexia in 2013 as “scant” and went on to acknowledge that “many popular media articles have been written about ON” (M. Varga et al., 2013, p. 108). This awareness became most obvious and explicit in the scholarship following the 2014–2015 news wave. In their article, Dunn and Bratman (2016) credited the expanding public interest in orthorexia to Jordan Younger’s going public about her orthorexia, pointing out that “major media outlets reported her plight,” which “inspired a flurry of other media coverage” (p. 12). That same year, another writer underscored the importance of better understanding orthorexia “given the focus on this disorder in the media and its presence in medical practice” (Peat, 2016, p. 76).
The idea of popular media driving the orthorexia conversation clearly generated anxiety for some scholars. Missbach et al. (2017) expressed concern that “research on Orthorexia Nervosa has been popularized by media mentions rather than by in-depth scientific discussions.” Other scholars granted the media debates more legitimacy, attributing them with improving orthorexia’s visibility. Cinquegrani and Brown (2018, p. 599) described orthorexia as a “seemingly new eating disorder” that “has gained visibility through the internet sphere and popular media, though scholarly attention has been scarce.” Similarly, Staudacher and Harer (2018, p. 668) posited that although orthorexia was “gaining traction in the news and on social media platforms,” there was “a paucity of peer-reviewed literature regarding treatment options.” Regardless of their evaluations of the media’s role, these authors all acknowledged the popular conversations about orthorexia in mainstream media and the internet.

Bratman, of course, was also aware of the media interest in orthorexia, who he once accused of “running with the term and taking it too far (yes, but that’s what they always do)” (Bratman, n.d.). However, he appears to have been dissatisfied with the scientific literature, too. In 2017, Bratman solo-authored a commentary in Eating and Weight Disorders with a behind-the-scenes account of orthorexia’s origins, including the open acknowledgement that when he coined the term, he “did not intend to propose a new eating disorder” (Bratman, 2017, p. 381). He related how he had followed the literature from the sidelines with “surprise and interest” but only decided to co-author the article with Dunn in response to misunderstandings that were proliferating in both the academic literature and the media. His primary concerns were the mistaking of specific diet features as universal to all orthorexia, on the one hand, and the conflation of enthusiasm for false food theories with disordered eating, on the other. Bratman
posited that the latter “attitude found its way into popular media, where mere veganism or a
desire to avoid processed foods was often reduced to orthorexia” (Bratman, 2017, p. 382).
Regardless of where these assumptions originated, Bratman made clear that actors in both fields
were making assumptions he found problematic.

Bratman expressed preoccupation that these “misunderstandings” were potentially
alienating people who would most benefit from the concept of orthorexia. The vegan community
in particular took issue with having their lifestyle entangled in a psychiatric diagnosis, especially
following the publication of Younger’s book, *Breaking Vegan*. And while this was surely a
concern for Bratman, it is also likely that the personal attacks he was enduring online contributed
to his discomfort and decision to engage in the scholarship. Bratman encountered aggressive
backlash from many individuals and groups who felt alluded to and inappropriately pathologized
by orthorexia. He collected some of these attacks—with insults ranging from “awful terrible
worthless person” to “fucking imbecile” and accusations of serving the fast food industry—and
put them on display in a “Hatemail” section on his website (Bratman, n.d.).

However, reducing the muddled narratives on orthorexia to the misunderstandings of
others fails to acknowledge orthorexia’s legitimately confusing history for reporters and scholars
alike. While Bratman has been open about the fact that he did not intend to create a new eating
disorder, he has occasionally engaged in revisionist histories that overlook his unclear
conceptualization of orthorexia’s “nature,” his shifting opinions about orthorexia’s validity, and
his evolving thoughts on how to detect it, among other issues. Ultimately, Bratman’s decision to
participate in the academic literature was not merely about clarifying thing others misunderstood,
but about substantively redeveloping and reshaping orthorexia’s contours in response to new demands within and at the intersection of popular and scientific debates.

**Conclusion**

In this chapter, we have seen how scientific knowledge production practices and boundary work actively shaped the ethno-epistemic assemblage of orthorexia scholarship by more closely protecting science ideologies. Yet even in the most stringent professional context, we can see hybridization work at play in the complex entanglements between the popular media and academic literature. The findings in this chapter show how the earliest writings, many of which became fixtures within the academic literature, drew directly from a variety of media, ranging from Bratman’s book and news articles, to fitness and eating disorder charity websites. While the claims from these non-academic sources undergird the early scholarly publications on which orthorexia literature is now based, their role has been overwritten and mostly rendered invisible by academic citation practices (with the exception of Bratman’s work). The contribution of popular media in fueling academic interest in the subject is visible in the dramatic growth in orthorexia publications and citations following the 2014–2015 news wave driven by Younger’s announcement, and the recurring allusions to media interest in many of the academic articles. It is hard to imagine the current state of affairs in orthorexia scholarship without the contribution of mainstream media.

Second, these findings suggest the psy discipline’s eroded professional control is magnified at the fringes and intersections of knowledge production. Professionals in nutrition, rather than psy experts, were the first to introduce orthorexia to the academic literature through book reviews, commentaries, and empirical studies. While psychologists and psychiatrists
eventually joined the conversation and have tried to recover control over the methods of orthorexia measurement through critiques of the ORTO-15, other disciplines continue to produce a significant portion of the scholarship. Similarly, the initial literature was published in medical, nutrition, and eating disorder journals, with *Eating and Weight Disorders* playing a key role throughout. The idea that peripheral knowledge and interdisciplinary fields provide especially fertile grounds for interloping also suggest that these sites at the margins and the intersections of knowledge production are more susceptible to conceptual and practical disruptions that may counter and even violate the norms at the core of the literature—what we have been calling entrepreneurship. Thus, it is not only that “outsiders” are doing the work, but that they may are doing it differently. And even when scholars closer to the knowledge core have tried to institute makeshift bottlenecks to reassert their knowledge production principles, once there is sufficient momentum, knowledge production is difficult to cap.

Finally, this chapter tells a story about how knowledges with non-scientific origins—in this case, a term created as a “therapeutic trick”—are shaped and sculpted into the language and conventions of biomedicine. This process has been, in no small part, a rhetorical achievement attained through the quantification and technification of the orthorexia concept. It is important to note how the questions in Bratman’s quiz point us to a valuation framework that seems to counter that nutritionism. The detection of orthorexia is based on certain prescriptive ideas of what food should mean and do in our lives. The idea of healthy food mattering too much, requiring excessive time and attention, detracting from physical pleasure and social interactions are all a part of this diagnostic framework. These ideas reappear in the Donini texts, in assertions reaffirming values like balance and moderation: “The desire to eat healthy foods is not in itself a
disorder, but the obsession for these foods, together with the loss of moderation and balance and
the withdrawal from life caused by this food habit, can then lead to orthorexia” (Donini et al., 2004, p. 154). While these values are quickly codified in the scientific literature, they are
nonetheless central to the origins of the diagnosis and reflective of certain values underpinning it.

The descriptive character of the DSM provides the means to cloak the social values undergirding its diagnoses, by centering the attention on apparently scientific concerns with measurement accuracy and categorization. Although the methods and mechanisms underlying the ORTO-15 are now under fire by part of the scientific community, inertia has proven a powerful force in proliferating both the instrument and the findings achieved through it. Moreover, the concept of orthorexia itself seems to have been sufficiently stabilized to withstand the possible dismantling of its primary measurement instrument, with attacks being focused on the instrument rather than the proposed diagnosis.

At the same time, the demarcation efforts currently underway reconfigure the concept to match the needs of the DSM in terms of its internal principles of organization and of previously existing diagnoses. The pervasive influence of the classification system contained in the DSM may have less to do with its scientific soundness than with its bureaucratic and institutional significance, yet as an information infrastructure, it pervasively influences mental illness concepts, their operationalization and reification, and the knowledges produced about them (Bowker & Star, 1999; Halpin, 2016). However, the way the DSM and its concepts are taken up in different spaces is not identical. In the next chapter, I will turn to orthorexia in the context of clinical practice.
Chapter Four. Orthorexia in the Clinic: Dissonance and Ambivalence in Eating Disorder Treatment

The feminist therapist in me comes in and says, “I'm not even sure I'm going to put eating disorders in a mental illness category all the time.” And part of that is my training from Naropa [University], where a diagnostic framework isn't my starting ground. So, saying that from the get-go, do I think it [orthorexia] can limit people's lives? Yes.... I'm just not sure I would say that anything that impacts so many women should be so pathologized... I'm not going to say that the DSM is never useful, or the diagnostic labels are never useful, and I'm not going to say that anorexia and bulimia and binge eating aren't super-important and dangerous. And all of that is true. And I think I'm coming at it less from an individualized perspective and more from a broad, cultural—I think it's a cultural disorder, rather than an individual disorder. (Psychotherapist, ONHC-02)

You're talking to somebody who would prefer to just call them all eating disorders. Like, I think that there's a lot of problems [distinguishing] between anorexia binge/purge [subtype], and then bulimia. What's the difference there? Weight criteria...And we get people who slide back and forth from diagnosis to diagnosis. So [do] people in the process of recovering, who are a little bit weight restored but still have a lot of disordered thinking patterns...The diagnostic crossover depending on where people are in the recovery process is problematic, and clinicians give people very different diagnoses....Like, what diagnosis do they have today? And so, I think from a research position, it's important to have these strict diagnostic codes ... [but] going from the research field to the clinical field, it often doesn't match. (Social Worker, ONHC-17)

The quotes above are the responses of two different clinicians to the same interview question, inquiring about whether or not orthorexia constitutes a mental pathology. Informed by her feminist training, the psychotherapist—who is very well-esteemed in the field—challenged the biomedical approach to eating disorders as individual pathologies, opting instead for a sociocultural framework. The social worker also expressed reservations, but hers centered more on the reliability and validity of the DSM’s eating disorder categories. The concerns raised by these professionals and the differences between their approaches to eating disorders are illustrative of both the diverse theoretical frameworks informing clinicians’ understandings of disordered eating and the collective ambivalence surrounding the DSM categorization of eating
disorders. These are two of several relevant factors shaping orthorexia’s uptake among healthcare providers, that I will explore in this chapter.

Based on interviews with 35 clinicians, I examine how healthcare providers from different disciplines learn about, make sense of, address, and utilize orthorexia in their everyday practice. I show that the application of orthorexia in clinical settings is characterized by a high degree of theoretical dissonance across the professional spectrum, and fairly widespread ambivalence about the DSM’s validity, yet grounded in a very practical, shared concern with helping people in distress live more fulfilling and satisfying lives. This leads to the paradoxical result of clinicians overwhelmingly supporting the inclusion of orthorexia in the DSM for practical or bureaucratic purposes, while maintaining a critical stance on its status as a distinct mental pathology. And yet, despite its current state, they already use the diagnosis for a variety of different purposes.

Finally, I show how eating disorder treatment centers—increasingly intertwined with non-profit organization—and patients themselves emerge, alongside dietitians and media, as primary contributors to orthorexia entrepreneurship in a professional context that is ripe for diagnostic expansion. While driven by different motivations and interpreting the achievement in different ways, these actors ultimately collaborate in legitimizing the diagnostic category. I begin this chapter with an overview of the eating disorders conference through which I found most my interviewees.

Eating Disorders Conference as a Hybrid Forum
Since orthorexia has been successfully framed and appropriated by eating disorder specialists, I sought out the opinions of clinicians who worked—partly or entirely—with eating disorders. I conducted the interviews for this chapter following my attendance at the 2018 International Conference on Eating Disorders (ICED), an annual event hosted by the Academy for Eating Disorders (AED). In addition to volunteering at the event, I attended multiple panels and poster sessions, where I saw orthorexia presented on a couple of times—a poster with an ORTO-15 based study and a presentation by a physician specializing in medical complications of eating disorders, with a subsection on orthorexia.

Founded in 1993, AED is a global professional association “committed to leadership in eating disorders research, education, treatment, and prevention”; ICED is AED’s main event, promoted as a “scientific conference” (Academy for Eating Disorders, n.d.). However, in practice, AED is a uniquely hybrid forum. Reflective of the multidisciplinary treatment of eating disorders, AED brings together healthcare providers and researchers from a variety of health-related fields, including medicine, psychiatry, psychology, nursing, and nutrition. Perhaps more notorious is the active and valued participation of individuals who have experienced eating disorders firsthand or been involved in the care-taking of loved ones with eating disorders, not just as attendees, but as speakers. In 2018, AED changed the name of its “Patient-Carer Committee” to “Experts by Experience” (ExE), a decision intended to “recognize patients and their families as experts in their own illnesses” (Academy for Eating Disorders, 2018). Thus,

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14 While the similarities between orthorexia and obsessive compulsive disorder have also been pointed out, ultimately, it’s identity as an eating disorder has been solidified. We see this not only in the eating disorder journals and experts publishing most on the topic, but also in the active participation of eating disorder non-profits in sharing resources on the condition and disseminating information in media.
AED has increasingly incorporated and legitimized lived experience as a valuable kind of knowledge—of expertise, even—and situated it vis-à-vis professional knowledge.

At the ICED, the boundaries between distinct professional disciplines and paradigms, between researchers and clinicians, between experts and laypeople, between science, activism, and industry are effectively blurred. Healthcare providers and scholars from diverse fields and theoretical backgrounds interact and collaborate. Non-professional actors participate in panels alongside those with expert credentials. Moreover, many scholars, clinicians, and participants unapologetically advocate political stances on subjects relating to issues like beauty standards and weight stigma, reflecting the overflows at stake in eating disorders, where the technical and social are inseparable. A clear example of this is the Weight Stigma & Social Justice special interest group, which overtly grounds eating disorder knowledges in a social justice framework and actively involves itself in advocacy. Finally, for-profit treatment centers play an active role in sponsoring the AED and, alongside non-profit organization, participate in ICED, where they set up exhibition booths and distribute promotional materials, in addition to organizing parallel activities.

In addition, to these aspects the clinician/patient dichotomy proves unique, as a significant portion of eating disorders professionals have personal histories with disordered eating. During the conference, I saw many participants preface public introductions by acknowledging that they had recovered from eating disorders. This is not an anomaly. Previous scholarship with eating disorder professionals in both the US and UK has found that between one-third and one-fourth of providers in the field identified as having experienced an eating disorder in the past (Barbarich, 2002; C. Johnston, Smethurst, & Gowers, 2005). While there are
some concerns about individuals with a history of eating disorders treating others—the possibility of overinvolvement, a risk of personal harm (including relapse), and countertransference or a lack of objectivity (Costin & Johnson, 2002; de Vos, Netten, & Noordenbos, 2016; C. Johnston et al., 2005)—for the most part, studies among clinicians, patients, and carers suggest it is considered advantageous. Perceived benefits include greater empathy, insight, or understanding of the conditions (including greater expertise); an ability to serve as role models; greater trust and enhanced hope among patients; and shame abatement (Costin & Johnson, 2002; de Vos et al., 2016; C. Johnston et al., 2005).

I met some interviewees during the conference and was acquainted with others through treatment center professional relations liaisons, outreach managers, or administrators that I encountered at conference exhibition booths. In total, I spoke to 35 healthcare providers, mostly from the US, although a handful of clinicians Canada, the UK, and Australia also participated (see more on the sample in Appendix B). Participants were trained in psychology or psychiatry (34%; n = 12), nutrition or dietetics (37%, n = 13), nursing (11; n = 4), social work (9%; n = 3), and medicine (6%; n = 2). They varied in their professional experience, their familiarity with orthorexia, ranging from one dietitian on the orthorexia task force to psychologist just vaguely familiar with the term. The professionals also varied the populations they worked with, and their workplaces. I also sought out and included the opinions of three clinicians with openly critical stances on orthorexia to expand the range of opinions included.

**Clinician Sense-Making: Orthorexia, Pathology, and Dissonant Paradigms**

Orthorexia has been on the radars of eating disorders clinicians for some time. Among those interviewed, the amount of time was usually similar to their time in the field, ranging from
a few years to almost two decades. One psychologist with over 35 years of experience, noted clinicians had long been talking about the subgroup of people Bratman labelled orthorexic, even before he proposed the term; they simply did not know how to approach it:

This population of people…have always been there. I just think we haven’t known what to call them and whether or not to frame it through a lens of psychopathology or...a lens of these are the straight-A students of nutrition and exercise and they’re who we should aspire to. (ONHC-20)

It is not that orthorexics didn’t previously exist or that psy experts had failed to notice them, but that they didn’t fit into the existing diagnostic framework. As the “straight-A students of nutrition” phrase suggests, there was uncertainty whether orthorexia was actually a problem. This quote points to Abbott’s (1988) observation that uncategorized residual areas are certain to encourage extraprofessional invasion. The orthorexia label and claims-making effectively exploited this ambiguous zone—between healthy and unhealthy, but also between eating disorders and obsessive compulsive disorder—by resignifying practices considered extreme as disordered, and framing them through a logic that facilitated their inclusion into the jurisdiction.

Most clinicians (n = 25) favored orthorexia’s addition to the DSM either as a separate diagnosis or an explicitly articulated subtype—typically of anorexia, but also Other Specified Eating Disorders (OSFED). This widespread support is consistent with survey-based studies finding that orthorexia enjoys a notably high degree of acceptance among European and Australian healthcare providers (Reynolds & McMahon, 2019; Vandereycken, 2011). The dietitian on the DSM task force implied its inclusion was imminent, reassuring that the question under deliberation in the group “is no longer, ‘Is it enough to warrant its own code?’…but ‘What
are the criteria?” (ONHC-25). First and foremost, clinicians grounded their support of orthorexia in their own clinical experiences with patients displaying the various kinds of behaviors captured by the orthorexia label, which they associated with negative consequences like anxiety, unwillingness to attend social activities, and malnutrition. Consider the two vignettes below, based on two clinician’s descriptions of orthorexic patients.

- A very malnourished woman, without apparent concerns about weight or body size, enters inpatient eating disorder treatment convinced she is allergic most foods. This belief led her to shrink her diet down to only three food items—blueberries, salmon, and almonds—the only things she has been consuming for weeks. Despite serious medical complications, she is very hesitant to reincorporate other foods and her treatment team struggles to re-feed her because of her unwillingness to eat anything that isn’t a whole food. Moreover, she refuses to drink nutrition supplements out of a fear they might contain hydrogenated oils and artificial ingredients she deems harmful; she demands to see ingredient lists of anything that is not a whole food.

- A health coach, who on paper looks like the epitome of wellness, seeks support from a dietitian. She is eating abundant calories a day, physically feels fine, and has no body image concerns, but has begun to experience extreme fear and anxiety about her son’s upcoming wedding. In particular, she is terrified of finding herself in the position to have to eat the gluten-, sugar-, and trans-fat-containing chocolate cake that is going to be served. Her growing fear of not knowing what kinds of ingredients are used in foods cooked by others and how they may impact her health has become an increasingly disruptive of emotional well-being and her social interactions.

Unlike researchers who are in pursuit of standardized, generalizable, and replicable knowledge, healthcare providers derive much of their knowledge from experience and case-based reasoning, and are concerned, instead, with tending to the actual needs of patients (Whooley, 2016). These vignettes depict real-life examples of the kinds of cases clinicians encounter, which pose them and their patients with real problems, and yet don’t fit well into existing eating disorder categories, in part given the absence of body image concerns.
Furthermore, clinicians contended that a distinct diagnosis would improve their ability to support patients in multiple ways. The first was a bureaucratic advantage, by making it easier to mobilize the necessary resources to offer treatment to individuals who otherwise are unable to receive treatment or access insurance (ONHC-26). A second purported benefit of a separate diagnosis was an improvement in communication between treatment providers: “It would give us more information about the patient…[and help us] know what to expect,” explained a dietitian (ONHC-03). This clinician was referring to both the heuristic function and the predictive value of diagnosis in clinical practice, anticipating certain behaviors and outcomes. Finally, the use of the orthorexia label was believed to facilitate patient cooperation and reduce treatment resistance by offering a diagnosis that appropriately describes their experience. As the clinician on the task force explained,

Right now, all we can do is diagnose them with anorexia, even though they may not be endorsing a drive for thinness. And then what happens is that person gets mad at us because they say something like, “You think this is about being thin? I don’t care about my weight!” Right? And yet we basically call them liars—essentially. The diagnostic criteria call them liar. (ONHC-25, Dietitian)

A smaller subset of interviewees expressed ambivalence about orthorexia’s inclusion or countered the idea that a separate diagnosis was necessary or accurate. The main concern regarded orthorexia’s distinctiveness. Also grounded in practical experience, some clinicians doubted whether orthorexia could constitute a stand-alone disorder, as they had typically seen health-seeking behaviors co-exist with body dysmorphia and a desire to lose weight, making them wonder if it was just an extension of anorexia or bulimia. One psychiatrist also criticized
the tendency to “over-separate things and that sometimes that’s unhelpful,” adding that “characterizing it is absolutely fine, but actually calling it a separate diagnosis is potentially confusing. It implies there is a different etiology and I don’t think there is” (ONHC-28).

The psychiatrist’s reasoning is particularly telling of how, despite the DSM’s move towards a symptom-based, descriptive approach to diagnoses (Horwitz & Wakefield, 2012; Kirk & Kutchins, 1992), alternative conceptualizations of eating disorders persist in the imaginaries of mental health professionals. In theory, the manual does not address matters of etiology, and yet, for this psychiatrist, orthorexia’s etiology was a relevant and valid criterion to justify not creating a novel diagnosis. Her counter-biomedical approach was not anomalous in the sample; instead, a large variation of eating disorder paradigms proved to be the constant across the interviews. So, while there was almost unanimous consensus that healthy eating practices, when taken to the extreme, can become problematic and require professional interventions, understandings of orthorexia’s “nature” varied significantly. Some participants did view orthorexia through a biomedical framework as a mental pathology,15 for example, asserting, “I definitely think there’s psychopathology associated with it” (ONHC-20 Psychologist and ONHC-09, Nurse) or “I do think of it as the same kind of mental pathology [as other eating disorders]” (ONHC-21, Nurse) However, a variety of other conceptualizations of orthorexia also emerged, with important implications about what kind of problem orthorexia is.

One alternate perspective was to view orthorexia as a less severe expression (“subclinical” or “subthreshold”) of an eating disorder or as a pre- or post-illness stage. One psychologist explained, “To me, these are folks who are kind of hiding out in the wings. I see

15 Several clinicians not trained in psychology underscored that they were not experts in psychology, and were giving their opinion simply based on their experience working with eating disorders.
them as subclinical maybe, and/or just not understood to be fully eating disordered” (ONHC-20). Several clinicians suggested orthorexia could progress into other eating disorders (ONHC-01, Physician; ONHC-10, Dietitian) or succeed them, providing a veneer for people “hiding out in pseudo-recovery” (ONHC-20 Psychologist). Another psychologist’s description of orthorexia as “a sub-clinical risk zone” (ONHC-23) shows how biomedical discourses of susceptibility blur the boundaries between health and illness (Beck, 1992; N. S. Rose, 2002, 2006), and in doing so, make pre-, post-, and sub-disorder categories valid sites for intervention; that is, they expand the therapeutic jurisdiction on diagnostic (sub) and temporal (pre and post) dimensions, positioning people with orthorexia as not entirely or not yet ill, but partially or potentially/still pathological.

The medicalization of an ever-growing range of eating behaviors is not a recent occurrence. The expansion of eating disorder treatment to cases beyond the confines of specific diagnoses was institutionalized in 1994 with the creation of a residual category in DSM-IV, known as eating disorder not otherwise specified (EDNOS), which was intended to classify cases of “clinical severity” that did not meet full diagnostic criteria (Fairburn & Bohn, 2005), such as patients who, despite severe food restriction and medical complications, failed to lose sufficient weight to qualify for anorexia. EDNOS, replaced with the categories of OSFED and UFED (Unspecified Feeding and Eating Disorders) in DSM-5,16 became such a prevalent diagnosis, that

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16 The OSFED diagnosis is applied to cases with symptoms that are characteristic of those in the feeding and eating disorder class and cause clinical distress or impairment, but that fail to meet diagnostic criteria for another diagnosis. This includes atypical anorexia (where an individual meets all criteria for anorexia except for the fact that despite significant weight-loss, their weight is still within “normal” range), low frequency and/or duration bulimia, low frequency and/or duration binge eating disorder, purging disorder (purging symptoms without binging), and night eating syndrome. When using the OSFED diagnosis, clinicians communicate or “specify” why the patient does not meet full criteria (e.g., binge eating disorder, low frequency). The UFED diagnosis is used in cases with symptoms characteristic of feeding and eating disorders that cause clinical impairment but do not meet full criteria for any of the other diagnoses (including the five OSFED subtypes), or cases in which clinicians choose not to specify why the patient does not meet criteria, for example, in an emergency room setting where the clinician may not have enough information.
just ten years after its inclusion into the DSM, it constituted an estimated 60% of eating disorder diagnoses (Fairburn & Bohn, 2005). As a result, a primary goal of revamping the eating disorder section in DSM-5 was to decrease the number of cases categorized as EDNOS, a goal pursued by “expanding the boundaries” of anorexia and bulimia (Lindvall Dahlgren, Wisting, & Rø, 2017) and including new diagnoses. Indeed, the diagnostic criteria have become looser and the number of diagnoses in the eating disorder section has quadrupled from two diagnoses in DSM-III to eight in DSM-5. Orthorexia, thus, is not exceptional but symptomatic of the jurisdictional expansion and blurring boundaries of the eating disorder field.

Another conceptualization of orthorexia was not as a disease or disorder in itself, but as a pattern of behavior through which other pathologies are expressed. The dietitian on the orthorexia task force explained she saw orthorexia as a manifestation of anxiety, post-traumatic stress, or obsessive-compulsive disorder: “I don’t know that orthorexia itself is a disease, but the behaviors are evident of some kind of mental illness… That’s how I feel about all of the eating disorders” (ONHC-25, Dietitian). A dietitian who was critical of orthorexia espoused a similar view: “I think that some people can manifest other mental disorders through food…Somebody might have obsessive compulsive disorder, and then it gets manifested through food choices” (ONHC-33, Dietitian). Indeed, the relationship between anorexia and OCD discussed in the previous chapter, or between eating disorders and anxiety, has long been a subject of debate, with some arguing that anorexia is an expression of these other conditions (Fitzsimmons & Bardone-Cone, 2011; Serpell, Livingstone, Neiderman, & Lask, 2002). From the perspective of these clinicians, orthorexic behaviors are not reflective of a core orthorexia pathology; they are
the script through which another underlying pathology comes to life. Thus, food beliefs don’t cause orthorexic behaviors, they simply shape underlying anxieties or compulsions.

Another point of view, drawing from both psychodynamic and cognitive theories of coping (Ball & Lee, 2000; Lazarus & Folkman, 1984), was to frame orthorexic behaviors and eating disorders in general as “coping mechanisms to help reduce anxiety” (ONHC-21, Nurse), “maladaptive coping skills” (ONHC-17, Social Worker), or conditions in which “symptoms manifest as a way to manage other things” (ONHC-31, Dietitian). The social worker cited at the beginning of the chapter shied away from pathologizing orthorexic behaviors to focus, instead, on why individuals have “gone towards ritually controlling food intake to cope with life stressors and events” (ONHC-17). From a psychodynamic perspective, the objective of the therapeutic intervention is to help resolve underlying fears or neuroses provoking orthorexic behaviors (ONHC-32, Psychologist)—thus the popular mantra that eating disorders are “not really about the food” (ONHC-7, -10, -14, -21). From a behavioral approach, the objective is to help patients replace orthorexic behaviors with more adaptive coping skills. Neuroses or maladaptive behaviors, while problematic and requiring intervention, do not imply a diseased brain in the way the term pathology does.

Finally, a few interviewees with feminist backgrounds externalized reservations about cataloguing any eating disorders as individual pathologies. Instead, these clinicians, like the psychologist quoted at the opening of the chapter, advocated for approaching orthorexia from a sociocultural vantage point. A clinical psychologist with a long career in clinical and academic contexts, expressed concern about the biological reductionism and decontextualization of eating disorders through biomedical language, which led to misunderstandings about their nature:
I don’t believe that these psychological processes are the result of a lesion in the nervous system, or a growth in the nervous system, or some type of specifiable disease process.... This is not to say that the nervous system doesn’t become involved—that’s ridiculous—and not to say that the person over time can’t do damage to their nervous system and their body in ways that perpetuate the problem, but in terms of its development and its initial expression, “nervosa,” to me, suggests that there are underlying psychological and social issues going on. (ONHC-12)

These psychologists were uncomfortable with the biomedical framework insofar as it extricates orthorexic behaviors from their social context and implies neurological or genetic origins. To the contrary, they re-centered the cultural components believed to be central to not only shaping but actually causing the behaviors. These concerns echo those of feminist scholars who have emphasized the role of culture—including intersecting discourses on gender, slenderness, consumerism, etc.—in producing eating disorders (Bordo, 2003; Gremillion, 2003) and reflect broader discontents with the biomedical paradigm, especially as it relates to disordered eating.

**An Imperfect Diagnosis for a Flawed Manual**

Discussions of orthorexia’s validity as a diagnosis were inseparable from broader critiques of the DSM. Previous scholarship has found mental health practitioners to be critical interpreters and users of the manual, with ambivalence toward the standardized, disease-specific categories in it (Koehne, Hamilton, Sands, & Humphreys, 2012; Rafalovich, 2005; Smith, 2014; Whooley, 2010). Similarly, many of those who favored orthorexia’s inclusion in the DSM accompanied their opinions with the caveat that the manual is intrinsically flawed and an orthorexia diagnosis would reproduce these vices. The dietitian on the orthorexia task force
offered the broadest critique of the DSM’s descriptive approach, arguing that as mere compilations of symptoms, they “don’t actually reflect what the underlying illness is” (ONHC-25). Indeed, the descriptive approach of diagnostic psychiatry introduced with DSM-5 averts issues of causation and makes the symptoms themselves the primary foci for classification.

Furthermore, many interviewees criticized the discrete, categorical model of eating disorders, suggesting that while useful for research, it is a poor fit with the reality of clinical practice, where cases elude clear-cut distinctions and often shift across diagnoses. This led clinicians to interpret eating disorder diagnostic boundaries as arbitrary or “artificial”; even “something I don’t believe in” (ONHC-20, Psychologist). The inadequacy of the DSM was perhaps most evident in one psychologist who shared that she and her co-workers regularly ridiculed the diagnostic categories, sarcastically asking each other, “So what category are we in today for so and so patient?,” explaining that “If you have a small fluctuation in BMI, suddenly a person’s now on bulimia rather than anorexia binge-purge subtype” (ONHC-32, Psychologist). Thus, a patient could literally change diagnoses from one day to the next.

Moreover, providers pointed out that the behaviors at play often evolved over time. As one nurse explained, “I’ve seen so many patients come back into treatment and sometimes with a completely different set of symptoms—almost like a rolling thing” (ONHC-21). This forces clinicians to use diagnoses they “don’t think really fits, but whatever” (ONHC-17, Social Worker). Ultimately, the instability of symptoms—with tangible diagnostic implications—made clinicians skeptical about the utility of differentiating diagnoses “under the eating disorder categories” (ONHC-16, Psychologist), favoring instead an integrative view of eating disorders as falling under a single “umbrella” (ONHC-22, Nurse), or on a “continuum” (ONHC-20,
Psychologist) where orthorexia might “morph into bulimia, or…binge eating disorder” (ONHC-32, Psychologist). Admittedly, this umbrella would open up space for orthorexia without a concern about trying to theoretically tease it apart from other diagnoses, as they would cease to be considered categorically different.

Not only did clinicians describe the DSM categories as deficient or inaccurate, they characterized them as being unhelpful in directing treatment—presumably a key function of diagnoses. “My position as a therapist is we have to treat people where they’re at, and the diagnostic label does very little for me in how I determine that” explained one psychologist (ONHC-20). Another dietitian recognized that “the hospital needs that [categorization of patients], but, it doesn’t matter to me… I just deal with the symptoms that you’re exhibiting at this time, I don’t care what you call it” (ONHC-35). Some clinicians maintained that DSM diagnoses could actually interfere with their goal of helping people in need. One physician characterized current diagnoses as grounded in “a white supremacist, sizeist experience,” and argued that having the DSM be the only means to access services “is really problematic, from my perspective, ethically” (ONHC-01). Furthermore, the diagnostic criteria were described as too narrow: “There’s a lot of people that are struggling with quite intense illnesses that don’t fit into one of these categories. And it leaves people feeling…undeserving of help” (ONHC-29, Psychologist). Rather than an instrument to support their work, they depicted the DSM-based diagnosis as a bureaucratic hurdle to jump over or “work around” (Whooley, 2010).

On the flip side, clinicians with private practices that do not take insurance expressed relief at the fact they were not beholden to or “bound by diagnoses” (ONHC-20, Psychologist), stating that patients “didn’t have to have a diagnosis to come see me” (ONHC-01, Physician).
These private practices, thus, became sites that were less constrained by the DSM and its codified infrastructure, and thus able to treat orthorexia, regardless of its institutional status. The ability to not just “work around” but altogether jump the diagnostic hurdle in these circumstances was reserved for those individuals with sufficient resources to pay for ongoing mental health treatment out of pocket, while excluding all those who lack that kind of wealth.

**Concerns about overreach.** While clinicians mostly favored orthorexia’s institutionalization, some expressed apprehensions. The primary concern, spearheaded by the critics, was the idea that it was ill-defined or misunderstood in such a way that encouraged its overuse: its application to individuals who simply have passionate beliefs about the foods that they’re consuming. The physician specializing in weight management criticized, “As far as at least the lay public goes, and the way it’s bandied about in media and social media, I think it’s a diagnosis…or a condition that people are far too quick to ascribe to an individual” (ONHC-15, Physician). The dietitian specializing in food politics made a similar point: “I have a problem with dieticians who are quote, unquote ‘non-diet,’ calling everything that even feels like an effort to be healthy, orthorexic,” he explained (ONHC-14). He added that he had increasingly noticed colleagues, in “the eating disorder world, especially on social media” abusing the term: “The health at every size movement has become very judgmental of anything that is quote, unquote ‘diety.’ So, it becomes a really easy word to use as a way to pathologize someone who’s approaching a health issue differently than them.”

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17 The non-diet and *Health at Every Size®* (HAES) philosophies alluded to in the previous quotes have become increasingly popular approaches to health and nutrition among eating disorder professionals and fat acceptance movements trying to shift health focus away from restrictive eating and physical appearance or weight. Multiple of the interviewees with expertise in eating disorders advocated this approach explicitly.
These concerns were not limited to the critics; four other clinicians also expressed similar preoccupations. For example, one dietitian who favored orthorexia’s inclusion in the DSM, worried that the term was used too “loosely” and applied to “describe the kale junkie people that maybe don’t have a pathology but are just really religious about their food choices” (ONHC-18 Dietitian). Similarly, a nurse at an eating disorder clinic noted that a dietitian she worked with tended to stretch the label too far: “I know her intent was to really challenge [the] anxiety [of patients], but it was just constant fast food challenges…[and] if someone preferred an apple over a cupcake, like, ‘Hm, what’s wrong with them?’ kind of thing” (ONHC-21). This nurse believed her colleague was over-pathologizing any kind of preference for foods popularly considered healthy among her patients. Thus, the notion that orthorexia may be overused also extended to clinical settings, even if only among a minority of clinicians.

**Drawing the Line Between Healthy and Unhealthy**

So, where does one draw the line between healthy and unhealthy healthy eating in practice? Clinicians proposed various rationales for teasing the two apart. The first and most common was the impairment rationale, consistent with the Dunn and Bratman (2016) criteria. This approach asserts that for extreme healthy eating to be considered disordered it needs to produce some kind of debilitating or adverse consequence. However, interpretations of impairment were variable and expansive, including “psychological, emotional, social, physiological” dimensions (ONHC-31, Dietitian) or abstract ideas like the “ability to live a really full, satisfying life” (ONHC-02). Examples of impairment varied from weight and nutrient deficiencies, to fear and anxiety surrounding food consumption, and the inability or unwillingness to participate in social activities. Some clinicians focused on a single dimension,
like one dietitian, who viewed emotional distress in response to certain foods as symptomatic of the disorder:

I think it has to do with the feelings around food more than it has to do with the behaviors around food. If food is a scary thing—if I sit in session with a client and I’m pulling out the jar of peanut butter and they are visibly anxious—because my peanut butter also has chocolate in it because of course it does—that, to me, is where the pathology lies.

(ONHC-18)

The determination of impairment tended to be implicitly associated with a specific value: flexibility. In the words of one nutritionist: “I would have to definitely draw the line when I see patients who are super fixated on it, and can’t try new things or try variety, especially when it comes to ‘processed foods,’ ‘sugary foods,’ ‘high carb foods’” (ONHC-22). Similarly, a psychologist explained: “I feel like that’s the impairment…if you’re not able to be flexible at all. If it’s so rigid, then I think that’s one of the lines I would use diagnostically” (ONHC-16). In fact, several healthcare providers offered litmus tests that revolved precisely around patients’ ability to make exceptions—that is, eat foods they typically considered off limits, for example, when on vacations or at special events. In line with this idea, several clinicians reaffirmed the belief that no foods should be entirely off limits and that all nutritional guidelines should be able to be broken without causing severe emotional distress.” If a Twinkie is never permitted, that’s where we have a problem” (ONHC-18). It is important to underscore that ideas of what constitutes rigid versus flexible eating were based on culturally specific eating habits. For example, some treatment centers were willing to accommodate vegetarianism but not veganism
in patient’s meal plans, deeming veganism to be excessively restrictive, unless food allergies were at stake.

While this take on flexibility was widespread among eating disorder experts, the physician specializing in bariatric surgery suggested that the notion of harm should be subjective. To make his point, he described several “ardent vegan” friends who determine the events they attend based on the availability of vegan foods, yet don’t experience this restriction as distressing. “I think that there will be plenty of people whose lives are affected by their dietary belief systems, though the effect is not considered to be a negative effect” (ONHC-15). His concern was that orthorexia was being used to impose foods on people who are making a rational choice to not consume them. A counterpoint to his approach, mentioned by eating disorder experts, was that patients often experience distorted perceptions or denial about the negative consequences of their behaviors, as tends to occur with weight loss in anorexia. Thus, basing a diagnosis on a patient’s perception becomes problematic. Anorexic patients are frequently characterized as resistant to change, resulting from their “denial and intellectualization” of the problem (Abbate-Daga, Amianto, Delsedime, De-Bacco, & Fassino, 2013), something clinicians thought applied to orthorexia, too. “A lot of times there’s not that self-awareness; it’s other people going, ‘Hey, this is really a problem, and this is interfering in all those ways,’ explained a social worker (ONHC-16). “It’s rationalized very easily by patients,” added a nurse (ONHC-22). Thus, an external arbiter needs to make the final call.

A second strategy to discern healthy from unhealthy behaviors, especially among dietitians, was to examine the motivations underlying a person’s eating choices, especially the reasons for avoiding specific foods, based on the assumption that some motivations were healthy
while others were disordered. One dietitian explained, “[Where to draw the line is] a hard question…Intention. I think it really comes down to intention” (ONHC-11). Another dietitian added, “I really try and help clients understand why they are making these choices” (ONHC-10). Motivations clinicians considered problematic included avoiding shame, guilt, or fear regarding certain foods (ONHC-10, ONHC-11, ONH-13); using food to feel a sense of control (ONHC-20); and feeling a sense of superiority for choosing “healthy” options (ONHC-07). On the flip side, motivations considered appropriate for determining food consumption included animal rights or ethical concerns (ONHC-03, ONHC-19); feeling good (ONHC-14); well-being (ONHC-20); and compassion and nonjudgement (ONHC-10). Clinicians seemed to presuppose that patients were sometimes unaware of or dishonest about their real motivations, which required a careful inquiry into the matter, and that there was always a single, true motivation, rather than multiple, coexisting motivations.

A final point brought up by a handful of healthcare providers in order to determine whether or not healthy eating had crossed the line is personal context. That is, symptoms without context are insufficient to determine the presence of a disorder. Clinicians who made this point argued that some people have health conditions or personal characteristics that interact with diet in significant ways, making strict dieting a logical choice. For example, one psychologist recalled the experience of a friend who developed extremely rigid eating after a heart attack, which she did not consider to be “unreasonable” (ONHC-06). The critical dietitian focusing on food politics suggested some people may in fact be more sensitive to nutrition, which makes them experience side effects of certain foods more intensely, and thus led them eliminate them from their diet (ONHC-14). Thus, very restrictive or rigid eating could be sensible and justified
in certain cases. This perspective counters the DSM’s decontextualized approach to diagnosis, but echoes previous studies where mental health providers also critiqued context-ignorant diagnoses (Halpin, 2016; Koehne et al., 2012; Whooley, 2014).

Orthorexia Diagnosis in Practice: More Than a Bureaucratic Tool

Given orthorexia’s absence from the DSM, healthcare providers relied on other diagnostic codes to fulfill required bureaucratic duties, such as clinic and insurance paperwork—even if they did not entirely fit. The most common diagnoses assigned to orthorexic patients were anorexia nervosa and OSFED, and less often, bulimia and binge eating disorder (BED). Several clinicians said they had seen “orthorexic tendencies” across the board of eating disorders and the idea that orthorexia frequently co-occurred with other eating disorder behaviors was widespread. While many interviewees lacked the credentials to formally assign diagnoses (dietitians and nurses), even non-diagnosing clinicians said they routinely provided data to help with the diagnosis, participated in discussions about diagnoses with colleagues, were aware of clients’ diagnoses, and used said labels in a variety of ways.

Bureaucracy aside, three-quarters of the providers said they used the orthorexia label in their clinical practice. More than a third of interviewees (n = 13) used it to communicate with their colleagues, for example, discussing patients with an “orthorexia presentation” (OHNHC-05, Dietitian). This practice was concentrated among providers working in eating disorder clinics rather than those working in general services, regardless of the discipline. The director of an

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18 One dietitian also admitted that while “technically the person making the diagnosis is either the referring physician” or “the mental health professional,” she was often the “most informed or the more specialized person on the treatment team” with access to “more detailed data on food, exercise and body image behaviors.” Thus, she was often “labeling the diagnosis” herself, which she acknowledged she “is not technically…allowed to do…but I do it all the time” (ONHC-31).
eating disorder treatment center said people on his team sometimes use it “as a clinical shorthand” because most other clinicians would “understand what you mean” (ONHC-04). Similarly, a dietitian said her colleagues use the word “all the time…like if we’re discussing a patient, we’ll say something like, ‘Oh…this person is very orthorexic.’ That simplifies it” (ONHC-13). By using the label, “we know that when we have that person in the meal where we’re eating donuts, their preoccupation is not going to be so much about the calories as it is about the fact it’s white flower and sugar…We kind of communicate that in one word.” These statements point to the value of diagnosis in the clinical setting as a tool that facilitates synthesis, communication, and anticipation of behaviors.

In addition, two-thirds (n = 23) of providers said they had used the term in communicating with patients. According to one social worker, when her clients look up the term on Google, “there’s not a lot that says this is a ridiculous diagnosis,” which she finds to support her intervention. Similarly a psychologist said she often gives her patients “articles [from a blog] and things to show them that this is not just something that I’d created, this isn’t just my idea; and to help people really recognize…this is a problem” (ONHC-23). In other words, the label “might help them conceptualize what’s happening” (ONHC-04, Psychologist). Moreover, orthorexia patients often felt misidentified by the anorexia label, making it “nice to be able to use a different terminology that explains what their experience is” (ONHC-19, Social Worker). For these clinicians, the label—and the information available about it online—helped legitimize their claims that extreme health-seeking behaviors could be problematic, draw a symbolic line between “normal” and “abnormal” healthy eating, and potentially offer patients a term that more accurately represents and explains their experience.
Nonetheless, some clinicians who found the term helpful had qualms about using an unofficial label. In response, they adopted strategies for introducing the term indirectly, without actually applying it to their patients—instead, they hinted at it. Diagnosis by implication was the approach of one dietitian, who explained: “I don’t usually tell somebody, ‘You have orthorexia,’ because it’s not a diagnosis. I might mention something like, ‘Have you ever heard of this? I just want to let you know that it’s something that is out there that people are talking about...’” (ONHC-13). Similarly, a psychiatrist explained that she sometimes brings orthorexia up to inform patients that “people call this orthorexia,” in order “to make sure that they’re aware that it’s a term that’s around” (ONHC-28). These clinicians were inviting their patients to explore the term and perhaps even apply it to themselves, even though they had qualms about directly doing it as clinicians, who presumably adhere to certain institutional norms.

A second strategy was to turn orthorexia into an adjective and speak to clients about their “orthorexic tendencies” or “orthorexic behaviors,” rather than “orthorexia,” in such a way that harnessed the descriptive power of the term, without directly applying an illegitimate diagnosis. The use of orthorexia as an adjective accompanied by a tempering word like “traits” was a practice a couple of clinicians overtly acknowledged, but also came up quite frequently during the interviews. Koehne et al. (2012) also found the use of “hedges”—terms like “sort of” “relatively,” “whose job is to make things fuzzier or less fuzzy” (Lakoff, 1973, p. 471)—to be common among clinicians treating youth with borderline personality disorder (BPD), in an effort to “offset the permanency otherwise associated” (p. 460). By turning orthorexia into an adjective that qualifies behaviors rather a diagnosis to classify individuals, and accompanying the
adjective with a hedge, these clinicians doubly softened the bearing of the term and bypassed the act of diagnosing, while still invoking the meanings signified by the diagnosis.

Some clinicians said they used orthorexia in clinical settings but only if the client brought it up first—something remarkably common. In fact, one clinician recalled first hearing about orthorexia through a patient’s parent. Close to one-third of clinicians related experiences of patients being the ones to introduce the label into the therapeutic conversation. For example, one dietitian indicated that she had “people come in very self-identified…like [saying], ‘I kind of feel like I’m orthorexic.’ It almost is something that sometimes gives them permission to come in and get help” (ONHC-31). A psychologist assured that “patients definitely identify themselves; they’ll show up saying, ‘Somebody told me I had orthorexia’” (ONHC-16). Another dietitian explained, “I’ll describe characteristics and I have had clients say to me, ‘Are you talking about orthorexia?’ So they’ve identified it as something. Or they say, ‘I think this might be my problem, this orthorexia thing.’ I’ve had that happen, too” (ONHC-11). This clinician described two different kinds of circumstances—with and without prompts—in which patients themselves introduced the label to the conversation, based on previously acquired knowledge. By using the actual term only after introduced by their patients, these clinicians were able to bypass the act of assigning an unofficial diagnosis. The practice of prompting patients to produce the orthorexia label themselves by describing the characteristics of the condition without actually using the term, thus, constitutes a third strategy used by clinicians to indirectly introduce orthorexia.

While some interviewees implied that their reluctance to use the orthorexia label derived primarily from its unofficial status, others ($n = 9$) expressed unease with employing diagnoses with patients at all, out of a concern that the diagnosis may have negative, unintended
consequences. These apprehensions included the belief that diagnoses were “dehumanizing” (ONHC-26); invite a sense “of powerlessness to ever being able to change” (ONHC-23); incite overidentification (ONHC-32); may lead clients to justify their behaviors through the diagnosis (ONHC-21); or even become a desirable state (ONHC-03). These clinicians either abstained from using diagnoses or used them on a case-by-case basis, depending on how they anticipated a specific client would respond.

**Multidisciplinary Treatment: The Expanding Role of Dietitians**

Clinicians played somewhat different roles in treating patients, depending on their professional background and the treatment setting. For example, therapists (psychiatrists, psychologists, counsellors, and licensed clinical social workers) were described as dealing with the “underlying” factors believed to cause behaviors (ONHC-23), “emotional work,” (ONHC-03), or linking behaviors to past experiences (ONHC-32). Meanwhile, dietitians focused on creating meal plans (ONHC-03), addressing “food and eating behaviors” (ONHC-23), discussing physiological responses to food, and handling nutrition education. Physicians were responsible for managing medical symptoms, such as digestive or hormonal issues, bone density, etc. (ONHC-01). And nurses described their work as following up on lab work and vital signs, supporting the physical recovery of patients (e.g., monitoring bowel movements, wound care), and being the “eyes and ears” of the treatment team (ONHC-21, ONHC-22).

In practice, clinicians agreed professional boundaries proved to be “very fuzzy” (ONHC-14) or “more of a Venn diagram with lots of realms of overlap” (ONHC-04). The most palpable overlap reflects the expansive role of dietitians in treatment settings. First, several dietitians I spoke to had certifications that provided them with a degree of bureaucratic power, even though
they could not diagnose. “[As a] certified eating disorder registered dietician…I can actually provide supervision to providers who can diagnose. I have a much stronger understanding of eating disorders than some providers I may be collaborating with,” explained one dietitian (ONHC-05). She added that what she loved about the treatment centers was how dietitians overlap “with our medical team to address basic nutrition needs,” and “with our therapeutic team to address normalization of food beliefs and behaviors.” Another dietitian provided a similar description of her work a bridging multidisciplinary treatment together: “The way that I frame my role as the dietician on the team is that I am if I’m doing my job well, I’m the bridge point between the medical and physiological reality of what’s going on, as well the meaning around the psychological and the emotional pieces” (ONHC-03).

Because orthorexia directly implicates emotions and behaviors regarding food and health, dietitians often found themselves navigating the murky territory of emotions. “Working in the eating disorder population, we certainly talk about the emotions that come up with food challenges or difficulties following their meal plan…so certainly there’s some pieces—therapeutic work—that we are doing…but we’re trying to keep it focused around food,” explained one dietitian (ONHC-03). Another person acknowledged he regularly touched on issues associated with eating and embodiment, which “tend to be emotional” (ONHC-10). He clarified, “I’m bringing it [emotions] up in the context of food and bodies, where they’re [therapists] bringing it up in context of family systems, anxiety, trauma” (ONHC-10). In other words, dietitians address issues spanning far beyond food science, within the realm of emotions and psychology; however, this work was only viewed as acceptable when emotions were discussed vis-à-vis food, while other psychological topics were off-limits.
While this expanded therapeutic role appears to hold steady across eating disorder diagnoses, dietitians’ participation proved especially relevant in the case of orthorexia where technical knowledge about nutrition was deemed especially important for countering false beliefs and for the nutritional (re)education of clients—outside the scope of what mental health experts were equipped to address. Orthorexic patients were described as often having collections of (mis)information resources, such as documentaries or books that they “clung to” (ONHC-13, Dietitian). “People can be so certain that they’re quite right because there’s enough dogma out there around it. Sometimes, this is where you’re battling between which bit of evidence and advice can actually prove,” explained one nurse (ONHC-34). In order to counter beliefs considered inaccurate, dietitians often had to bring in research or other kinds evidence to back up their own claims. Thus, one social worker underscored that the need to contest misinformation makes dietitians indispensable to orthorexia treatment: “This particular population absolutely has to have a dietician involved…I wouldn’t feel comfortable working without [one]” (ONHC-19). She added that she worked with two dietitians, “who are phenomenal with explaining things to these clients on a cellular level. We take away the misinformation that is floating around…and help them understand what is actually happening when they remove certain [food] items.”

However, not all patients had behaviors based on clearly inaccurate knowledge. As a few clinicians recognized, a lot of nutritional knowledge is contested and there is fairly widespread agreement that certain substances (e.g., trans fats) are consistently detrimental to human health, making fears of certain foods comprehensible. Thus, sometimes informational re-education involved changing patients’ perceptions of the degree of risk involved or placing the risk in context. For example, a clinician might try to persuade clients that eating refined sugars and
processed food items on occasion will not have a relevant impact on their health. A different approach was to expand the definition of health in such a way that the anxiety and social isolation deriving from patients’ efforts to eat only health foods was framed as worse for their health than the food items they were trying to avoid. Thus, health was redefined or reconceptualized beyond the physical, yet the super-value of “health” always prevailed.

How Healthcare Providers Learn About Orthorexia

Healthcare providers learned about orthorexia from a variety of sources. The most frequently referenced source was media. Close to four out of five interviewees recalled seeing orthorexia in news stories on and offline; 41% (n = 14) had seen orthorexia on social media, for example, through news articles or posts shared by colleagues, or academic articles shared in professional groups on Facebook, on Twitter, or through YouTube vloggers; 43% (n = 15) had seen orthorexia on colleagues’ blogs or websites (including the websites of non-profits like NEDA and Bratman’s site); and 11% (n = 4), each, mentioned professional LISTSERVs and Google searches. As the distinct forms of media listed above suggest, information sources were often intertwined: “I have read about it in the media, and it may have been linked from Facebook…I [also]read the New York Times…[and] I certainly feel like I read about it in there (ONHC-16), recalled a psychologist. “I follow several dieticians just on social media platforms that I think are helpful just from my own ongoing education; knowledgeable people that write helpful blog articles and cite research well,” added a dietitian (ONHC-24).

The second most common information source, mentioned by 60% (n = 21) of the clinicians, were professional activities like conferences. Five interviewees had presented on orthorexia themselves, four of whom were dietitians. Several clinicians posited that, while still a
fairly marginal topic in the eating disorder realm, when compared to formal diagnoses, orthorexia had become increasingly relevant in recent years. There also seemed to be consensus among dietitians that interest in orthorexia was greater at the dietetic conferences they attended. One dietitian asserted that “if the conference is focused around dietitians, they tend to talk a lot more about orthorexia in particular than conferences more focused towards psychologists or therapists” (ONHC-04). Another dietitian contrasted her experience at an eating disorders conference where her proposal for an orthorexia workshop was rejected, with the enormous popularity of her presentation on the subject at the Food & Nutrition Conference & Expo (FNCE), the largest meeting of food and nutrition experts worldwide:

> It is a topic that holds so many people’s attention; it is a term that a number of people resonate with....When we gave our talk at FNCE...we had over 3,000 people there, which for...a breakout session and not a keynote, is a huge number of people. We were shocked. People kept pouring in, which you wouldn’t have on any other topic related to an eating disorder. (ONHC-31)

These quotes suggest that within the professional realm, the field of nutrition is both uniquely open to and interested in orthorexia as a topic.

Professional development activities organized by eating disorder treatment centers, including private training activities, symposia, and webinars, were also mentioned by multiple American clinicians. “I’ve seen webinars advertised for it, sponsored by like a treatment facility, ’cause I’m on a list for the A[cademy for] E[ating] Disorders,” recalled one dietitian (ONHC-16). Another provider said she actively sought out continuing education activities on orthorexia: “I will find those continuing education credits and they tend to be by either psychologists or
dietitians or some combination, which is my favorite” (ONHC-11). Several interviewees mentioned that they had also received orthorexia information directly from residential centers, for example, through mailed pamphlets or on websites.

Academic literature was a third information source mentioned by half of the healthcare providers interviewed (n = 19). Only a handful of interviewees said they had proactively reviewed orthorexia literature, primarily for their own research or writing, or in preparation for a presentation on the subject. In fact, one interviewee had a forthcoming book at the time of the interview with a chapter devoted to orthorexia. However, the majority of clinicians had only stumbled across one or two orthorexia articles, through professional groups on social media. Although most in this latter group didn’t tend to recall the substance of the articles with much detail when asked, the couple that did, found the research findings convincing. For example, one dietitian remembered an article “talking about approximately 50% of dieticians in the US had orthorexic tendencies, so that was a big eye opener” (ONHC-18). Reading isolated scholarly articles about orthorexia seemed to produce a legitimizing effect, obscuring the controversy about the diagnosis and its measurement that might be appreciated through a critical review of the literature, something most professionals don’t have time to do.

Aside from peer-reviewed literature, five people mentioned trade books like Bratman’s Health Food Junkies or the more recently published Orthorexia: When Healthy Eating Goes Bad, by British dietitian, Renee McGregor. A fairly new orthorexia entrepreneur, McGregor merits further consideration in the orthorexia knowledge-production ecosystem. The second professional to publish a book on orthorexia (after Bratman), McGregor is not a researcher but a clinician; thus, she has not conducted any formal scholarship on the subject or published peer-
reviewed literature. Instead, like Bratman, her book is largely based on her professional experience treating athletes and other purportedly orthorexic individuals. While much of her monograph focuses on debunking false nutritional beliefs, the area in which she is a credentialed expert, and she explicitly acknowledges that she is “not qualified to treat the underlying psychology of the condition” (McGregor, 2017, p. 47), she also continually affirms the legitimacy of orthorexia as a valid mental pathology throughout the text. Furthermore, in the book she asserts the importance of nutritional information—or more precisely, misinformation—abundance on social media and the Internet as a key “external trigger” of orthorexia, one that dietitians are uniquely equipped to address. In doing so, she situates dietitians alongside psy experts as essential to orthorexia treatment.

Another information source mentioned by half of the interviewees (n = 17), almost all of whom worked in private treatment centers, were face-to-face interactions with colleagues, most commonly mentioned in the context of treatment, like clinical rounds (ONHC-26, Psychologist) or staff meetings (ONHC-06, Psychologist). For example, one psychologist said she had acquired knowledge about orthorexia “from talking to my colleagues; dieticians and therapists who also work in the field of eating disorders and kind of learning from them” (ONHC-32) or a dietitian who said she had learned from “hearing lots of colleagues [in the eating disorder world] talk about it” (ONHC-11). Of course, this source rarely came up among clinicians working in private practices, as their interactions with colleagues were much less frequent.

Five providers (14%) also mentioned their own professional experience with clients as a key knowledge source. “A lot of my personal experience with patients… has [helped me]
understand what…orthorexia is,” explained one nurse (ONHC-21). A psychologist took a more emphatic stance on the importance of clinical experience as a knowledge source:

I would say I probably learn most about it from actually talking to my clients. That would be my single [most important] source…Nobody’s gonna have done the research that’s gonna demonstrate what’s gonna be effective. That research really doesn't even exist well for anorexia nervosa… So my primary source of information is just really trying to understand the feelings and experiences underlying my clients’ experiences.... There’s no better source of information than people’s experience (ONHC-26).

Academic settings, both undergraduate and graduate, were a final information source mentioned by 17% (n = 6) clinicians. All but one of these clinicians were dietitians who had been assigned some kind of reading on the subject, whereas the sole psychologist who said she had learned about orthorexia in college had chosen to write a paper on the subject. This suggests programs focusing on food and nutrition are not only more drawn to the subject of orthorexia, but may be more comfortable discussing an unofficial diagnosis than psychology programs.

The Commercialization of Eating Disorder Treatment

Before concluding this chapter, I will examine some additional ways in which market logics, increasingly permeating the eating disorder field, have transformed care over the past three decades. Specialized treatment centers and clinics began to multiply in the 1990s, when managed care shortened hospital stays for eating disorder patients, resulting in the proliferation of for-profit residential programs to meet increased demand (Attia, Blackwood, Guarda, Marcus, & Rothman, 2016, p. 664). The Affordable Care Act and changes in health insurance laws vis-à-vis mental health care have further propelled the expansion of treatment programs over the past
decade (Goode, 2016), attracting greater investments from private equity firms. Today, academic medical centers and private practices operate alongside an abundance of for-profit companies, some of which have expanded to include facilities across the US. The number of residential eating disorder programs more than tripled from 22 in 2006 to 75 in 2016, paralleled by a growth in the number of establishments (from 250 to 395) and employees (from 5,103 to 8,442) in the same time period (Oliver, 2018).

With residential treatment costs running at an average of $30,000 per month, and patients often requiring multiple months of treatment—not to mention months or years of follow-up care—eating disorder treatment can be a highly lucrative business. Nationwide revenues for the eating disorder industry currently exceed $1.1 billion and are projected to continue to grow (Oliver, 2018). The profitable potential of behavioral health services has not gone unnoticed by financial advisory firms like BDO, who point out in an analysis that the ease of billing, the supply/demand imbalance, and the newly mandated insurance coverage for millions of new patients, all contribute to the high financial margins of behavioral health programs, which commonly reach 20% to 30% (Bithoney, 2015). Due to the high chronicity and relapse rates of the conditions treated by these services, the analysis adds, “these revenue streams are secure.”

Unsurprisingly, the expansion of for-profit behavioral health programs has come in hand with sophisticated marketing and advertising tactics, raising ethical concerns. In 2016, five scholar-practitioners published an open forum article in the journal Psychiatric Services, criticizing the use of inaccurate or dishonest promotional materials and calling for greater scrutiny and oversight of the marketing strategies used by some residential treatment centers to cultivate patient referrals—not unlike those used until recently by the pharmaceutical industry.
(Attia et al., 2016). These practices range from sponsorship and exhibits at professional eating disorders conferences to free trips to tour facilities, which according to the article, may even include flights, accommodations, and recreational activities. For example, through the ICED conference, I was invited to and attended a pre-ICED dinner hosted by large treatment center (with over a dozen locations across the US) at a restaurant in Chicago’s upscale Magnificent Mile. At the event, attendees were gifted fine dining, drinks, chocolates, and a large information packet; we were also invited to join a tour of the local facilities. Moreover, as mentioned in the previous section, private conferences are often sponsored directly by clinics or through separate but affiliated non-profits, who recruit specialists to speak and provide low- or no-cost continuing education credits for local clinicians (Attia et al., 2016).

A Google search of US eating disorder treatment programs shows that despite its unofficial standing, over a dozen private clinic websites list orthorexia among the conditions they treat, alongside descriptions of the condition and symptoms list, a practice concentrated almost exclusively among American for-profit treatment centers. Although most of these websites mention orthorexia’s unofficial status, they also discuss it in terms that are analogous to formally accepted eating disorders. For example, one treatment center explains that “An individual with orthorexia will spend an exceptional amount of time thinking about food, which is similar to someone with anorexia or bulimia” (Carolina House, n.d.). Another treatment center (Figure 4.1.) describes orthorexia’s “signs and symptoms” under a heading affirming that “Orthorexia can be difficult to identify. If you’re concerned you or a loved one is struggling with orthorexia, this page outlines the warning signs, symptoms, and causes of this disorder” (Timberline Knolls
Residential Treatment Center, n.d.). Here they catalogue orthorexia as a “disorder” with warning signs to be on the lookout for.

Figure 4.1: Screenshot of Carolina House Website. (Carolina House, n.d., screenshot by author)

Figure 4.2: Screenshot of Timberline Knolls Residential Treatment Center Website.
Beyond framing orthorexia as an eating disorder, these centers reaffirm the notion that orthorexia requires medical/psychological interventions, and that they are equipped to provide them. One treatment center (Figure 4.3) postulates that despite orthorexia’s unofficial status, “it is a condition that requires medical and psychological care” (Walden Behavioral Care, n.d.). The implication is that orthorexia’s unofficial status in no way negates the need for medical and psychological treatment, which they offer at various levels of care. Another treatment center (Figure 4.3) includes Bratman’s original 10-item self-test for website visitors to screen themselves, and goes on to claim that “Treatment begins with a safe and supportive environment that is found only in a small, holistic treatment center such as Mirasol” (Mirasol Recovery Centers, n.d.). Thus, orthorexia information intersects with active promotion of services, and appears alongside phone numbers and contact buttons to begin admissions processes.

Figure 4.3: Screenshot of Walden Behavioral Care Website.
Orthorexia also appears on the websites of some non-profit organizations. Most notorious, given the authority it has accrued in the field, is the website of the NEDA (Figure 4.5). The NEDA website begins its description about orthorexia acknowledging that it is not “not formally recognized” by the DSM, but points out that “awareness about orthorexia is on the rise” (National Eating Disorders Association, n.d.), implying that the problem at stake with orthorexia is one of attentiveness, rather than legitimacy. The webpage also discusses orthorexia symptoms and even lists orthorexia separately in their section of “Information by Eating Disorder” (see the left hand menu in Figure 4.5). We might recall from the news chapter that NEDA was quoted in multiple news stories; it is also cited on the websites of several eating disorder treatment centers.
(see Figure 4.4 for an example). Thus, clinics and non-profits alike circulate the orthorexia label in a way that contributes to its legitimation.

Figure 4.5: Screenshot of NEDA Website. (National Eating Disorders Association, n.d., screenshot by author)

**Conclusion**

This chapter has explored the assemblage forming around eating disorder clinical practice. Clinicians’ sense-making and utilization of orthorexia is grounded in professional experiences, problems, and objectives. The extreme health obsessive behaviors described by orthorexia are evident in their clinical experiences with patients. These orthorexic behaviors are often experienced by patients as distressing and/or create tangible, consequential problems, like medical complications. Whether or not these behaviors reflect a new, underlying mental pathology is less relevant to clinicians than their practical need to offer patients the therapeutic
support believed to be helpful, something potentially expedited by creating a new diagnostic category. Thus, clinicians mostly support orthorexia’s inclusion in the DSM not because they are convinced of its diagnostic validity, but because they think it can help them address practical problems. Furthermore, the ambivalence toward the DSM leads many clinicians to not take orthorexia’s inclusion in the DSM so literally.

Clinicians’ understandings of orthorexia are embedded in a context of theoretical dissonance, which characterizes the eating disorder of field writ large. Clinicians draw from biomedical, psychodynamic, behavioral, and feminist-inspired sociocultural approaches to eating disorders, which led to diverging understandings about the most basic question of whether orthorexia constitutes a mental pathology. These fundamental disagreements about the nature of eating disorders are emblematic of psychiatry’s historic ignorance problem, which has driven the profession to vacillate “between drastically visions of knowledge or ‘styles of reasoning’” (Whooley, 2019, p. 5). What this case brings into focus is the extent to which alternative epistemic frameworks co-exist in the field, something achieved through the ambiguous meanings attached to the diagnosis. While clinicians differ in their interpretations and sense-making, they nonetheless agreed these are problem behaviors in need of therapeutic intervention.

At the same time, rationales like flexibility and personal motivations for determining the boundary between healthy and unhealthy eating point to the subtle but persistent presence of alternate “orders of worth” (Stark, 2011) at stake in clinical practice as clinicians from different disciplines and theoretical frameworks interact. For example, the idea that certain motivations guiding food restriction, like feeling good or a concern for animal rights are appropriate, whereas shame or a desire to alter one’s appearance are not. These valuation principles become more
obvious as they bump up against those espoused by the critics, concerned the diagnosis may be used as a form of control. Nonetheless, they are asserted as clinical criteria, often through an increasingly expansive understanding of what constitutes impairment.

The role of media as the number one information source about orthorexia among healthcare providers reaffirms the importance of mediatization as a disruptive force in producing and circulating medical knowledges that extend beyond lay settings and into the realm of experts, all the while blurring these categories as different actors participating in and engage with claims-making. News media and their logics operate alongside a complex hybrid assemblage of knowledges—expert, lay, and everything in between—that flow and intertwine without the professional constraints of formal knowledge production pipelines like academic journals.

Equally persistent in the realm of healthcare is the entrepreneurial activity of dietetics as a professional field, and of individual dietitians, like the one on the DSM task force and the author of the new trade book on orthorexia. Dietitians viewed themselves as central to eating disorder treatment and more so in the case of orthorexia, where technical knowledge about nutrition is deemed vital. At the same time, academic programs and conferences belonging to the discipline appeared to be especially open to the circulation of orthorexia knowledge. This diagnostic entrepreneurship is symptomatic of the ongoing erosion of the jurisdiction of mental health within the eating disorder field, with dietitians legitimizing the orthorexia diagnosis and staking a special claim in its treatment.

Two additional diagnostic entrepreneurs re-emerge in the context of clinical practice. The first of these are patients identifying with orthorexia. The prevalence of patient-led diagnosing mentioned by clinicians is not only indicative of the term’s widespread circulation in popular
media, but also of an expansion of the diagnostic moment, which is hardly contained in the therapeutic encounter. Indeed, clinicians spoke of multiple patients who sought out treatment after having self-diagnosed themselves. For these actors, orthorexia legitimized their experiences of distress by rendering them articulable in medical language.

The second kind of entrepreneurs are for-profit eating disorder treatment centers. The proliferation of orthorexia on clinic websites and the recurring mention of clinics as sources of orthorexia knowledge via sponsored webinars and advertising materials, all suggest that these centers have a vested interest in institutionalizing the label and making these behaviors subject to treatment at their facilities. By including orthorexia in their professional development offering, clinics help shape the knowledge that circulates on the subject and situates the diagnosis in the toolkits of professionals, who in turn may refer their patients and clients to the clinics for orthorexia treatment. Furthermore, professionals in these clinics were more inclined to use the orthorexia label than those working in academic or public hospitals, which appears to be a byproduct of the ongoing interactions with between clinicians.

Despite orthorexia’s unofficial status, clinicians already mobilize the diagnosis in their clinical practice. There are obvious limitations as to how an unofficial diagnosis can be used, but as Jutel (2011a, 2011b) points out, part of what makes diagnoses so powerful is that they can fulfill a multiplicity of functions, not all of which are constrained by bureaucratic strictures. Grounded in their practical needs, clinicians deploy the term for a variety of purposes, such as communicating with others on treatment teams, providing patients with a relatable diagnosis, or in the case of those resisting treatment, persuading them that their behaviors are legitimately problematic. Thus, despite their ambivalence toward the diagnosis and its implications, clinicians
were often willing to employ it for the sake of its rhetorical power. At the same time, concerns
about using a diagnosis that has not been formally endorsed by the medical establishment and/or
which they believe can impact their patients’ perceptions and behaviors, led many clinicians to
adopt a variety of strategies to invoke its meaning without directly diagnosing patients.
Chapter Five. Orthorexia Online: Networked Recoveries on Instagram

On June 23, 2014, Jordan Younger published a blog post called “Why I’m Transitioning Away from Veganism…” Within minutes, her website had crashed due to heavy traffic (Younger, 2015, p. 114). The post came as a huge surprise to her tens of thousands of followers, not only because many of them were also vegan, but because she had actively promoted veganism as the ultimate pathway to well-being through her wellness brand and public persona, The Blonde Vegan. Younger’s brand was born on Instagram and expanded beyond the platform as she quit graduate school to work as a full-time blogger. In her polemic post, Younger detailed the evolution of her plant-based lifestyle into a highly restrictive diet (in addition to animal products, “free” of all kinds of food stuffs, such as gluten, oil, refined sugar, sauce, etc.) that was creating enormous anxiety and no longer serving her body. She spoke about the need to “admit I had developed some variation of an eating disorder” (Younger, 2014) and in the second-to-last paragraph of the lengthy post, introduced the term orthorexia. The post served as a preamble to her memoir, “Breaking Vegan,” published the following year. Both drew the enthusiastic attention of the mainstream media.

Younger’s claims invoked very polarized responses, including the wrath of a very passionate vegan community. Nonetheless, she persisted in relating her personal experience and enlisted Bratman to write the foreword for her book. She ultimately survived the transition away from her vegan personality, rebranding as “The Balanced Blonde,” and has nearly tripled the size of her account since the time of the announcement, attracting upward of 210,000 followers on Instagram.19 Because of her popularity online and the controversy surrounding her claims,

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19 Although Younger ceased to be vegan for some time, in 2017 she returned to her plant-based diet as a part of her “healing journey” from Lyme disease and in November of 2019, identified again in her profile bio as “vegan.”
Younger’s orthorexia announcement received widespread attention and reverberated in many different spaces—as seen in previous chapters—including the platform that made her a micro-celebrity: Instagram.

While the orthorexia label was important to Younger’s story and memoir, even appearing in the book’s subtitle, she did not heavily push the term on Instagram; she only discussed orthorexia and used the #orthorexia hashtag in a few posts, mainly about media coverage of her story. However, she did intensely promote her book, and at the time of the polemic announcement, there was already a burgeoning community on Instagram engaging in topics of eating disorder recovery. The enthusiastic interest of the mainstream media, alongside Younger’s popularity on Instagram, and the existence of an already consolidated eating disorder recovery community, all provided momentum for the term and hashtag to gain steam. Today, an ever-growing collection of posts on Instagram sport orthorexia hashtags, as individuals use the label to describe their own distressing experiences with extreme health pursuits. As of January of 2020, close to 160,000 posts carried an #orthorexia hashtag, with over 80,000 more using the hashtag #orthorexiarecovery. While modest in comparison to the 2.2 million posts with the #anorexiarecovery hashtag, it nonetheless demonstrates an expanding interest in and identification with a diagnosis that does not currently exist in diagnostic manuals.

The next two chapters explore the proliferation of accounts on Instagram that address eating disorder recovery, and specifically, orthorexia recovery. In this chapter, I present a general overview of Instagram and the community addressing orthorexia that has developed on the

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Balanced Blonde brand has expanded to a podcast, online courses, live events, and has presence on various social media platforms.
platform. I analyze the different kinds of users who participate, I describe some of Instagram’s primary features as they are taken up by users addressing orthorexia online, and present users’ primary motivations to adopt the social network site for this purpose. We shall see how the platform’s media logics shape the practices and relationships through which users collectively construct the diagnosis and a shared community around it. This chapter sets the stage for an examination of the deeper symbolic work that takes place through these sustained interactions in the following chapter.

**Instagram and Mental Health**

Instagram was first launched in October of 2010 as a highly visually platform focused on sharing—typically filtered or edited—photographs. The platform, purchased by Facebook in 2012, has grown dramatically, amassing over one million advertisers by 2017 ("Welcoming 1 Million Advertisers," 2017) and surpassing one billion users by mid-2018 (Carman, 2018).

Instagram has undergone many changes over the course of its near decade of existence, most of which have expanded the variety of things users can do on the platform. However, its emphasis on visual and aesthetic appeal and its networked structure have both remained central to its logics. While many uses are possible, surveys among Instagrammers suggest users primarily adopt the platform for surveillance or knowledge about others, social interaction, documentation, self-expression, entertainment, creativity, coolness, and escapism (Al-Kandari, R Melkote, & Sharif, 2016; E. Lee, Lee, Moon, & Sung, 2015; Sheldon & Bryant, 2016).

Despite its popularity, Instagram has attracted widespread criticism. Damning reviews prevail on mainstream media, condemning the platform for its “relentless emphasis on promoting ‘perfect’ lifestyles” (Hern, 2018) and its encouragement of “self-absorption, stalking, pastel-pink
blandness” (Oyler, 2017). Scholarship has associated Instagram with a desire for stylized self-presentation (Boczkowski, Matassi, & Mitchelstein, 2018) and narcissism (Sheldon & Bryant, 2016). In 2017, a report by the Royal Society for Public Health (RSPH) declared Instagram the most detrimental social media platform for mental health (Royal Society for Public Health, 2017). Regarding eating disorder issues, the platform has been blamed for promoting body dissatisfaction and disordered eating among users (Fardouly, Willburger, & Vartanian, 2018; G. Holland & Tiggemann, 2016), and criticized for its failure to censure pro-eating disorder content (Gerrard, 2018). Of the leading social media platforms, Instagram has drawn the most vociferous critiques vis-à-vis mental health, conceptualized as superficial and alienating—an unrealistic place where users provide each other with idealized versions of themselves, a practice presumably encouraged by filters and editing tools.

At the same time, experts have acknowledged the potential for social media to facilitate human connection and social support, which are considered beneficial for mental health outcomes. Even the critical RSPH report recognized that “nearly seven in 10 teens report receiving support on social media during tough or challenging times” (Royal Society for Public Health, 2017, p. 14). Alongside its widespread conceptualization as a highlight reel of people’s lives, Instagram has witnessed a seemingly paradoxical expansion of accounts discussing stigmatized mental illnesses, including eating disorders. This reality has not gone unnoticed by the platform’s administrators, who in 2017 launched its #HereForYou campaign, intended to highlight how the app has helped users struggling with mental illnesses come together to help each other (Systrom, 2017).²⁰ Instagram’s co-founder and CEO at the time, Kevin Systrom,

²⁰ In the press release announcing its campaign, Instagram also underscored its efforts to foster safer experiences for users, including modifications in the design of the application to warn users of triggering
invited users to “find your support community on Instagram” and in the campaign press release included a one-minute video featuring “members of the Instagram community” who discuss their mental health “journeys.” The video provided the usernames of each mental health account featured, and suggested several hashtags including #RecoveryIsPossible and #EDWarrior.

Regardless of the motivations driving the campaign amid mounting critiques, it was accurate in noting that worldwide networks discussing mental illnesses have thrived on Instagram.

Previous scholarship about online support groups (OSG) has centered primarily on platforms like discussion forums and email lists, rather than social networking sites (SNS). These studies have found that individuals experiencing various health conditions use OSG for many functions, including information seeking, provision and reception of emotional support, sharing experiences, and reducing their sense of isolation (Barnett & Hwang, 2006; Buchanan & Coulson, 2007; Coulson, 2005; S. H. Malik & Coulson, 2008). One study about an OSG with some social networking features found that users make selective use of features depending on their needs, and that different features are associated with emotional versus informational support (Chung, 2014).

Regarding eating disorders specifically, one study collected messages from a charity forum and found that it was experienced by users as a safe space that enabled peer support for recovery and relapse prevention (Kendal, Kirk, Elvey, Catchpole, & Pryjmachuk, 2017). It also documented the formation of mentorships and friendships. Another study about the adoption of Information Communication Technologies among women with eating disorders found they used platforms like Instagram, Facebook, YouTube, and Google for information seeking, tracking content before displaying it, to help identify individuals in distress (via anonymous reports that are reviewed 24 hours a day by support teams), and to help connect these people with support resources.
their recovery, reducing stigma, and creating a community of support (Eikey & Booth, 2017). Instagram, the most common platform mentioned by users in the latter study, amasses millions of posts, which far from promoting ED, engage with the topic from a recovery-oriented standpoint. The only study to date focusing specifically on Instagram use for recovery purposes is a content analysis that found the platform provides a way for individuals to document progress, interact with similar others, and make their struggles visible (LaMarre & Rice, 2017).

**Instagram Users’ Beliefs about Orthorexia**

Many orthorexia-related posts on Instagram belong to accounts who only engage the subject sporadically. However, there is also a core group of users who employ the hashtag on a regular basis and for prolonged periods of time, signaling an identification and/or desire to participate in the conversation and community—these were the users I focused on following during my fieldwork and, many of which, I subsequently interviewed (for more on methods, see Appendix A). While a handful of these accounts focused specifically on orthorexia, most addressed eating disorders more broadly, invoking multiple diagnoses like anorexia and bulimia, and used various corresponding hashtags. Regardless, orthorexia was discussed with the same seriousness as formally acknowledged eating disorders. Of the 34 users I interviewed, 30 personally identified with orthorexia (or “orthorexic behaviors”) in their past or present, whereas the remaining four identified with a different eating disorder (for more information on the interviewees, see Appendix B). The hashtag crossover was due, in large part, to a widespread understanding that eating disorder experiences and recovery principles were highly relatable and applicable across diagnoses. Furthermore, many users identified with more than one eating disorder over the course of their lives (e.g., that they had both anorexia and orthorexia) or
believed their eating disorder had evolved, (e.g., that they previously had anorexia and now they had orthorexia or vice versa).

The majority of users I encountered during my fieldwork appeared to be teenagers and young adults (from late teens through early 30s), white, female, from middle and high-socioeconomic classes, and living in countries in the Global North, namely the US and Europe. The sampling for the interviews reflects this demographic distribution: they were predominantly female (91%; n=31) and their ages ranged from 18 to 47, with a mean age of 28. More than half (65%; n=22) lived in the United States, while a smaller proportion resided in Canada (12%; n=4), the UK (12%; n=4), Germany (3%; n=1), Estonia (3%; n=1), the Netherlands (3%; n=1), and Mexico (3%; n=1). Most identified as White (94%; n=32), with only two Latinas (6%; n=2).

The accounts varied in following, spanning from 42 to over 90,000 at the time of the interview, with a mean size of 5,280 followers.

Unsurprising given their uptake of the orthorexia hashtag, there was overwhelming consensus among the interviewees that orthorexia was a real condition, a belief based primarily on their own personal experiences. In the words of Leah, age 34, “I lived with it, so I know it’s real.” Most suggested that orthorexia “definitely resonated” with their experience and many described epiphany-like moments in which they discovered the term and saw themselves in it. Erica, who was 21 years old, did not discover orthorexia until after she had undergone most of her recovery process, but said she never identified with anorexia. “Once I read about orthorexia,

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21 This was apparent in the kinds of foods they had access to, the kinds of places they went on vacation, the recreational activities they mentioned (e.g. attendance to yoga studios), their clothing, and pictures or stories where their homes or bedrooms were visible.

22 The age of the interviewees skewed higher than the actual distribution in the accounts because I only recruited people 18 years and older for interviews.
I was like, ‘Oh my gosh, this this was me,’” she recalled. Similarly, Lauren, who was 18, remembered: “I read it and I was like, ‘That’s me! Because up until then, I never quite fit any of the other categories.” Amber, 31, described the comfort she found in that moment: “That diagnosis, once you hear it, you’re like, “Oh my God, I’m not crazy, like this is a real thing.””

These quotes underscore the extent to which the orthorexia diagnosis conferred individuals and their distress or feelings of being out of control a sense of validation.

The interviewees saw value in creating a separate diagnosis for orthorexia for several reasons. The first was because they believed it would make it easier for people to access professional support. Helen, who was 34-year-old life coach, explained, “Because we work in a system where there are labels [and] boxes to check, I think it would do more good than harm right now to actually classify it…so that people can get treatment.” Second, some interviewees believed that having a more accurate diagnosis may help people identify and accept their problem. On a related note, a few individuals said the label was useful because it offered them a productive way to reframe their distressing healthful eating and in doing so offered them a pathway out of it. “I just had really obsessive behaviors around food, and that’s also why I didn’t think there was a problem, because there wasn’t a word for it, right?,” explained Marion. Finally, the label made it easier to find others with a relatable experience, as illuminated by Audrey:

[The distinctive label] was helpful to find like-minded people [on Instagram]. Whether it’s a disease and all that stuff, I’m not an expert on it. But the people that are using that terminology have the same issues with food that I did on different levels. So finding those types of like-minded people helped.
Similar to the clinicians, a few people expressed concerns about the impact of diagnostic labels. Helen, the coach from the previous paragraph, viewed diagnoses as constraining and explained, “I don’t want to be put in a box”; she also underscored that over-identification with a diagnosis may be problematic and inhibit growth. Similarly, Jenna, who was 28, said she was careful not to attach her sense of self to the label. A related point made by Dana, a dietitian, was that diagnoses can become “self-fulfilling prophesies” or, in the words of Olivia, “give people a mold they have to fit into” in order to be acknowledged as ill. An additional concern externalized by Olivia was that the orthorexia diagnosis may be experienced by patients as a status symbol, rather than a problem, vis-à-vis other eating disorders. “I’m sure, when it comes down to it, it [the label] was probably damaging, but it wasn’t false, you know?” She added that at one point she felt a sense of superiority because of the diagnosis’ association with fitness and health.

Regarding their formal medical status, many of the users I observed had been diagnosed with and treated for an eating disorder. Some were currently in treatment. Others joined the community as they were in waitlists for inpatient centers. Among the interviewees, a few were unaware of the formal diagnosis on their paperwork and many were accustomed to their clinicians speaking to them in terms of the “eating disorder” rather than a specific diagnosis, also consistent with the findings among healthcare providers. However, those who did know their diagnosis most often said anorexia was used, followed by Other Specified Eating Disorder (OSFED). About half of the interviewees who identified with orthorexia believed it coexisted with another eating disorder. Andrea, a 27-year-old, explained: “In recovery I definitely saw how I kind of—it’s not that I shifted to orthorexia, it’s just that, yeah, they all kind of become
Anne, who is 21, clarified, “Orthorexia is not the only thing I struggle with. It blends and mixes together for me.”

However, the other half believed their official diagnosis was altogether inaccurate and orthorexia was the appropriate fit. Danielle, a 26-year-old woman who used to be a competitive runner, expressed, “No, I just never identified with that [anorexia]. I don’t really care what they label it [in my medical file], because it’s my own. I know what I’m dealing with.” Lana, a 19-year-old college student, recalled a disagreement regarding her official diagnosis. “I remember going to an assessment with someone. They asked me all these questions and stuff. In the end they diagnosed me with anorexia, but I knew I wasn’t anorexic. It wasn’t like that.” Similarly, Erica, who had also been a competitive runner, explained that she never worried about her weight or calories in food: “I was honestly just concerned about not eating processed foods and just weird food rules about health.” Whether it was due to a lack of concern over body image and weight or because they believed they ate abundantly, these women found the orthorexia diagnosis to best describe their experience.

Nine of the interviewees said the term orthorexia had come up in their treatment setting, with a few individuals saying their clinicians had diagnosed them with orthorexia. Four people said orthorexia had been brought up by their therapist, four said it was mentioned by their dietitians, and two said it was mentioned by general practitioners. Eighteen others said they had self-diagnosed themselves with orthorexia, typically based on information and diagnostic tools they encountered online. Thus, most of those addressing orthorexia online had applied the label to themselves in the present or retroactively.
“The internet” was the most common place to find information about orthorexia, mentioned by almost all of the interviewees. Social media was the primary online source of information, mentioned by 25 people, with 19 individuals saying they had learned about orthorexia on Instagram, nine on YouTube, and two on Facebook. In addition, 20 of the interviewees said they acquired knowledge on websites or blogs, including non-profit and clinic websites, and 16 individuals said they conducted Google searches on the subject. Podcasts were a much less common digital information source mentioned by only two individuals. These online sources were also where most users had first heard about orthorexia. Aside from the internet, 16 interviewees said they acquired knowledge about orthorexia through news outlets (on and offline), while seven mentioned research or academic settings (e.g., college courses), five mentioned family and friends, three cited healthcare providers, and two, each, brought up books and other patients they went to treatment with.

**Typology of Accounts Addressing Orthorexia**

The orthorexia collective on Instagram involved a heterogenous group of participants in terms of goals and standpoints. Accounts regularly addressing orthorexia in posts or using orthorexia hashtags typically belonged to one of five ideal types: individuals in recovery, recovered individuals with motivational accounts, coaches, professionals, and organizations. These categories were often blurry and many evolved over time, as did the needs and/or characteristics of their users. Indeed, there is no clear line separating a person in recovery from one who identifies as “recovered,” and no force keeping them in place; rather, recovery was an unstable and non-linear process. However, these ideal types help make sense of the spectrum of accounts and patterns most commonly associated with each.
In recovery. By far, the most common type of user were individuals who identified as being in recovery, that is, individuals who wanted to get better from their eating disorder and, for the most part, were actively trying. Individuals in recovery identified explicitly with one or more mental health diagnoses (usually orthorexia but also sometimes anorexia, anxiety, depression etc.) and/or broader diagnostic categories like eating disorders or even mental illness, which they featured in their account bios, captions, and/or hashtags. These became unifying concepts that framed and connected their experiences of distress relating to food, their bodies, and life in general. For these individuals, orthorexia presented an everyday challenge they had to live with and confront—a struggle. Instagram became a tool that they used to cope.

Individuals in recovery were typically already Instagram users but created a separate—and often hidden—account to address the subject, which did not connect with non-recovery acquaintances. In fact, many kept the account entirely hidden from friends and family. Thus, they often maintained separate and simultaneous accounts, although the recovery account tended to be predominant. Their usernames usually alluded to recovery in some way, with handles like recovery_for_chocolate, seekingmybalance, or fightingforfreedom. They were also more frequently younger (teenagers and early twenties) and more protective of their identities, sharing limited identifying pictures or information. Furthermore, users in recovery tended to both seek and offer support in their online activities, and were overall more inclined to share “negative” content, for example, admitting current disordered behaviors, or expressing anger, hopelessness, or shame. These accounts were not mostly negative, they simply contained more negative

23 While inspired in real examples, these usernames are all fictitious and none existed when I wrote the text.
content than the other types. Furthermore, users belonging to this category were most inclined to follow accounts belonging to any of the five categories of accounts.

**Recovered/Motivators.** The second ideal type consisted of users who maintained primarily motivational accounts after having entirely or mostly recovered from orthorexia and/or other eating disorders. Users with motivational accounts often reminisced and reflected on their histories with disordered eating, and how much their lives had improved since they had gotten better. They also shared practical advice for those trying to heal, including tips and suggestions of things they had done in their own processes. Unlike the accounts of people in recovery, they tended to be more consistently positive or uplifting and more other-oriented, offering advice and motivation more often than requesting it from others or venting about their own problems. These users were also more open about their identities, using full names and/or identifiable pictures of themselves more regularly, and sometimes including links to their own content outside of Instagram, like blogs, YouTube channels, and even podcasts.

Temporally speaking, most of these individuals’ accounts had previously belong to the “in recovery” category, but had shifted in their objectives as users recovered. This usually involved becoming more public about their identity as they went through the recovery process online. These individuals often followed and interacted with users trying to recover, but also followed other motivators like them, in addition to coaches, professionals, and organizational accounts. Moreover, several of these users shared an express interest in professionalizing their support by pursuing careers in related fields. For example, Olivia began her account in late 2017, soon after getting out of an inpatient treatment center. While she initially intended to use her account to document all the foods she had been missing out on for so many years, she soon
discovered the recovery world, and shifted toward a recovery-centered account, which straddled the line between in recovery and motivator categories. By the following year she was applying to several programs to become a therapist. Olivia has remained active on her account, and is currently completing internships toward her degree.

Coaches. A third category of accounts belonged to individuals who identified as coaches. The precise character of the coaching services varied, with descriptions ranging from life coach, to eating disorder recovery coach, body image mentor, food freedom coach, and healthy hormone coach, among others. Credentials also ranged from some health-related professional training (e.g., a Registered Nurse) or certifications in life coaching or intuitive eating, to basing their work entirely on empirical knowledge. Nonetheless, all made themselves explicitly available to coaching others during their recovery process. All the coaches I interviewed had personal histories with eating disorders, and all but one identified with orthorexia specifically. The recovered identity was usually central to their social media persona, and they often drew on past experiences in their posts as the vantage point from which they offered counsel or advice.

Similar to users who were recovered, their posts focused on providing advice and inspiration, but this was often attached to websites where they more formally coordinated the provision of resources like e-books and coaching services. Their posts and websites often tended to display a more intentional online branding, than the previous two kinds of accounts. Coaches were also usually older than those in recovery (in their mid- to late-20s and early 30s), completely open about their identities, and less likely to follow users trying to recover; instead they followed other coaches, professionals, and some motivational accounts.
Professionals. The fourth ideal type of users were healthcare professionals with formal training in a field associated with eating disorders, mostly in dietetics; only a couple of these accounts were trained in counselling or psychotherapy. These accounts also focused on sharing advice and knowledge, and while some drew on personal experience, they more often grounded their content in their respective fields of expertise, at times citing research or scientific knowledge. While having been trained formally—mostly as Registered Dietitians—and including their credentials in their profiles, they often qualified these credentials with other titles that hinted at alternative approaches to nutrition, for example, expressing adherence to the Health at Every Size (HAES) philosophy, or identifying as “non-diet dietitians” in their bios or usernames. Like coaches, healthcare professionals were also usually involved in promoting services, providing access to some free resources while also offering virtual consultation packages that required payment. These users were also mostly in their late 20s and 30s, open about their offline identities, and even less likely than coaches to follow accounts of people in recovery. Curiously, all the dieticians I interviewed also identified as having suffered from orthorexia or “orthorexic behaviors” in the past, even though not all of them spoke of this history as regularly as coaches.

During my fieldwork, I encountered two specific dietitians who merit special acknowledgement given their significance. The first was Renee McGregor, the dietitian discussed in the previous chapter, who published a book on orthorexia. McGregor’s Instagram posts were not primarily about orthorexia; as a dietitian specializing in sport and eating disorders

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24 Eating disorder therapists and psychologists are visible and active on Instagram; I simply did not find many that were regularly addressing orthorexia by name or hashtag.

25 I did not actually “follow” these two clinicians because they did not meet inclusion criteria but did encounter them a few times through the hashtags, and explored their profiles and recent posts, when I did.
and a runner herself, she discussed a variety of topics and used different hashtags. However, she did post about orthorexia every so often, using relevant hashtags when she did. In these posts, she shared information about the condition and sometimes plugged her book or included a picture of its cover. In one such post in January of 2018, she shared the news that she had been invited on the International Task Force for Orthorexia “to help make it a recognised diagnosable condition within the DSM-5.” I saw allusions to her on Instagram on a few occasions during my fieldwork (e.g., people tagging in her discussing orthorexia), including some who recognized she was on said task force. McGregor has participated actively in raising awareness about disordered eating among athletes, even co-founding a campaign online, #TRAINBRAVE. While she was not active on the subject during the time of the news sample, I have since seen her quoted in multiple news outlets discussing orthorexia, including TIME magazine and the Daily Mail.

Perhaps even more relevant given her large reach on the platform, is Pixie Turner, a dietitian and micro-celebrity who at the time of my fieldwork went by the username plantbased_pixie, although she has since changed her name to pixienutrition.26 With over 120,000 followers, Turner also posted on orthorexia sporadically within the context of her broader account, which focuses on debunking nutrition myths. On her website, she identifies as a nutritionist and a science communicator. Turner stands out because in addition to her Instagram popularity (she even has a verified Instagram account, hinting at her “public figure” status), she spans the four assemblages in her orthorexia contributions. Not only has she appeared in popular media discussing her personal experience with orthorexia, she has also published two books—

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26 In a blog post, Turner explained that she had adopted her previous username six years earlier when she was in the throes of her wellness obsession. She explained that she changed her name because she was “not that person anymore” and those ideals no longer reflect her as a person (P. Turner, 2018).
The Wellness Rebel and The No Need To Diet Book—directed at lay audiences, which are not exclusively about orthorexia, include subsections on the subject. Moreover, Turner co-authored the study published in Eating and Weight Disorders about the link between Instagram use and orthorexia symptoms, which was also based on the ORTO-15 (P. G. Turner & Lefevre, 2017). Turner has shared her research findings and books on her own Instagram account and maintains an active blog, where she posts on many topics, including orthorexia.

Organizations. The final, somewhat distinct, category of accounts addressing orthorexia belonged to organizations rather than individuals. More specifically, these accounts were maintained by eating disorder non-profits or charities (or chapters), most of which are involved in activism, social support, and awareness raising. While there were not many accounts in this category, the most popular ones amassed a large volume of followers in all categories. Follower-wise, the most important account in this category belonged to a volunteer-run support network for people with eating disorders called Beating Eating Disorders, which had around 26,000 followers when I began my fieldwork, and regularly included orthorexia as a hashtag in its motivational posts. This account, which has since doubled in following, was followed by dozens of the users I followed.

Organizational accounts usually focused on sharing inspiring stories and quotes directed at all people with eating disorders, including orthorexia. Non-profits typically selected and reposted what they considered to be valuable content shared by other users, functioning to an extent like a potent aggregation service, rather than producing their own content. These accounts, too, often directed toward external websites and shared content from individuals who had recovered. In addition to non-profit or volunteer organizations, I also encountered a couple of
accounts belonging to treatment centers or private practices, who also included orthorexia hashtags on occasion, but these were usually smaller and less influential.

Figure 5.1 breaks down some general trends associated with the four ideal types of individual accounts on Instagram addressing orthorexia (organizational accounts are excluded because they are distinct). These types are best conceptualized as existing on a continuum, with individuals in recovery on one end and professionals on the other. The continuum is intended to acknowledge certain tendencies across the spectrum of ideal types, while also accounting for areas of overlap and the potential fluidity in categories over time. During my fieldwork, I observed many instances of individuals shifting from a primarily “in recovery” to a “recovered/motivator” account, and even a few instances transitioning from motivator to coaching or professional, as in Olivia’s case. I also observed cases of individuals who relapsed and went from motivational accounts to “in recovery.” It is crucial to note that the kind of account did not correlate with the volume of followers in any significant ways. Individuals in recovery and motivators often had much larger accounts than professionals and coaches. This is in large part because the logics of the platform do not center on professional credentials.

Users on the left side of the spectrum experienced orthorexia as a part of their current life experience, whereas users toward the right of the spectrum typically viewed orthorexia or orthorexic behaviors as being a part of their past. Similarly, those in recovery and to a lesser extent those identifying as recovered, engaged in both support-seeking and support-offering, whereas coaches and professionals skewed toward supporting others. Users on the left side of the spectrum were also more inclined to express distress or emotions with a negative valence (in addition to positive and uplifting content) and disclose more personal information than those on
the opposite side. However, they also tended to be more protective of their identity (name, images of face, location). Thus, an inverse relationship existed between personal experience sharing and openness regarding their identity, perhaps because individuals who hid their offline identity felt more comfortable sharing private and potentially stigmatizing information, but also because they were already experiencing most distress.

Users toward the left side of the continuum were also more inclined to base their posts on embodied knowledge, whereas those on the right side drew on both embodied knowledge and professional or medical knowledge, for instance, relating personal experiences in the past with scientific research. Finally, alongside the professionalization on the right side of the spectrum, there was also a greater commodification of support, as users, in addition to offering advice and reflections, also promoted variety of services available for purchase.

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<th>In recovery</th>
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<th>Coaches</th>
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<td>Temporality of illness experience</td>
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Figure 5.1: Individual Account Types and Characteristics.

**Features and Affordances of Instagram**

The fact that orthorexia has proliferated on Instagram is not just an interesting detail—it is a defining feature. Unlike online forums and discussion boards, users do not enter a clearly
contained space where orthorexia is the shared topic of discussion. Instead, Instagram networks are porous, malleable, and unruly and the platform’s affordances or “possibilities for action” (Gibson, 1977) are central to the uses and collective practices. Thus, understanding how users employ Instagram to engage the subject of orthorexia requires accounting for how the platform’s affordances enable and constrain action through it features and its architecture (Papacharissi, 2009), and the social practices that arise in relation to them. I will describe some of these key features below, as taken up by users in the recovery space.

**The profile.** Instagram is a profile-centric platform in which users are required to open a personal profile through which they can participate in and navigate the platform. A profile is necessary to create content and build connections with other users. Profiles include a slot for an identifying image, a name, a unique username or handle, and the possibility of including a brief, 150-character description or “bio,” which can include text, emojis, and links. In addition, each profile publicly displays three statistics relative to the account: the number of posts, the number of followers, and the number of accounts followed. Most users I spoke to, regardless of the account type, were well aware of their user counts, and interested in making them grow. When visiting another person’s profile, the platform also privileges information about shared connections, that is, users both follow, thus reaffirming the networked structure. Below the fixed information in a user’s profile is a compilation of their posts in reverse-chronological order, which can be scrolled through in thumbnails or full-sized images.

As suggested previously, individuals in recovery more often opted for full anonymity in their accounts—using a nickname, or a first name only, and non-identifying profile pictures—while coaches and professionals more often included a full name with a picture of themselves,
fully disclosing their identities. The content in the bio was variable depending on the type of account, but typically included words synthesizing the user’s salient identities on the account (their diagnosis, food philosophy, exercise, religion, etc.), their interests or aspirations, or recovery focused affirmations. Additional information some users opted to include in bios were age (especially common among younger users), credentials (in the case of professionals), recovery information (such as time in recovery or number of hospitalizations), warnings of triggering content, and links to other online profiles or sites. For example, the profile in Figure 5.2, included a first name in the bio (blurred for privacy), followed by an identification with “Eating disorder, orthorexia, anxiety, social anxiety, depression,” and a brief description of herself as “Looking for strength and reasons to fight.” She also included a “T[trigger] W[arning] just in case” and assured that her “Dms [Direct Messages are] always open,” in addition to providing the link to her Sarahah account (Fieldnotes, 01/10/18).

Figure 5.2: Photographic Intervention of Recovery Profile.
The network. Another fundamental feature of SNS like Instagram is its networked structure. boyd (2008, 2010) conceptualizes SNS as networked publics; publics that are restructured through networked technologies. Networked publics are imagined collectives that emerge as a result of the intersection of people, technology, and practice (boyd, 2010, p. 39). The networked architecture of Instagram enables users to participate in two simultaneous kinds of networks. The first are user-based networks organized around each specific profile and the connections they make online. Like other SNS, Instagram articulates lists of shared connections, which are visible and traversable by other users (only followers, in the case of private accounts) (boyd & Ellison, 2007, p. 211). Instagram employs a unidirectional connection system, which unlike the reciprocal friending logic of Facebook accounts, enables users to unilaterally “follow” other accounts. A person’s primary network, thus, encompasses the collection of accounts they choose to follow—but don’t necessarily follow them back—and whose content, in aggregate, populates their personalized “feed.” At the same time, those who follow them can view their posts and interact on them, but their content does not appear in the accounts’ feed. User-based networks are thus unique, based on personal connections.

Hashtags. The second kind of networks operating on Instagram are thematic networks that come into being through hashtags. Hashtags are words or phrases preceded by a hash sign (#) that users can apply to their posts on Instagram. Hashtags like #orthorexia and

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27 All the images used to illustrate Instagram findings are photographic interventions of screenshots taken during fieldwork on my smartphone. This means that the photos have been significantly altered with illustration techniques on Adobe Photoshop, which makes them look more like illustrations than pictures. The decision to intervene the images addresses ethical concerns about potential negative consequences to the creators by helping protect their identity. In exchange, I sacrifice clarity and accuracy. Nonetheless, efforts have been made to conserve the key components of the image that are being analyzed.
#orthorexiarecovery simultaneously function as discursive signifiers and meta-data tags, which symbolically and materially associate posts with other content using the same tags (Rambukkana, 2015). Hashtags help users addressing orthorexia find each other’s posts and accounts. They also play an instrumental function as tools for growing an account by making posts visible to others searching those tags.

Instagram enables different hashtag aggregation options. The first is based on the application of an opaque, proprietary algorithm to organize and display current “Top” posts (Figure 5.3). How Instagram determines top posts is unknown to users, but it constitutes one potent way the platform intervenes in the constitution of the aggregated orthorexia public (Gillespie, 2015, 2018). The second aggregation option allows users to sort orthorexia posts based on temporality, whereby the platform displays posts using the hashtag in reverse-chronological order. Both options can be accessed by typing the term into the search function or by tapping on a hashtag from a post, and both enable users to invoke an ongoing stream of content connected with a term, such as orthorexia, and interact with it. At the time of my fieldwork, Instagram had recently introduced a feature enabling people to follow hashtags in addition to accounts. Thus, a user could populate their feed not only with content posted by other people they followed, but also by the “top” weekly content corresponding to any given hashtag. Several users I spoke to followed orthorexia hashtags, as did I.
Orthorexia hashtags were frequently used alongside eating disorder recovery hashtags like #edwarrior and #edfamily and concepts allusive to recovery like #intuitiveeating, #foodfreedom, and #selfcompassion. The users I followed employed an assortment of hashtags in each post, sometimes upward of 15, in an effort to reach more people across a variety of themes or identifiers. Many used the same group of hashtags for every post, regardless of the specific topic. Others, however, had a core set of hashtags, and then added post-specific tags, or constantly changed their hashtags. By using the same hashtag, users were symbolically and materially linked together, creating the sensation that they were part of something larger, regardless of whether they followed each other or not.

**Content production.** At the time of my fieldwork, Instagram users could produce three primary kinds of content. The first were traditional Instagram posts, which, at the very least,
consist of one or more images or videos that could be altered with filters and other various editing tools, and typically include a caption with text and hashtags. Posts can be viewed, commented on, liked, and bookmarked by other users. Posts are permanent in the sense that they remain on an individual’s profile unless deleted. Images in the orthorexia community were most frequently pictures—usually of food, people, or quotes (Figure 5.4). Other images like illustrations and memes were less common. Among professionals and coaches, posts with images of their own—presumably sharable—quotes using a consistent format (e.g., same font, colors, and personal logo or username handle), grew especially popular during my fieldwork, and even more so since then. Users often patterned their posts strategically, for instance, alternating between a picture of food and a quote, such that the person’s profile grid became an appealing visual object in itself. While users had different skill levels in terms of taking aesthetically attractive pictures, in general, photographs reflected a great degree of care and skill regarding composition, lighting, and coloring. Pictures of meals, which were among the most common type of post, usually involved thoughtful food styling and ingredients. Users sometimes included multiple images in a single post, for example showing their food from different angles.
While the captions sometimes referred directly to the image, many times the two were disconnected. Indeed, while the platform requires posts to include images—and these are central to its functioning—these often appeared less central to the posts than the captions, where users wrote lengthy, thoughtful texts about their experiences and emotions in recovery, which often spilled into other life struggles involving relationships, studies, and work. I regularly encountered posts with pictures of faces or food that contained captions with a brief description of what was in the picture, followed by a longer text reflecting on current struggles or achievements. Those who were recovered, coaches, or dietitians used captions to share knowledge, tips, and motivating messages. Captions were often lengthy, sometimes continuing in the comment section when the 2,200 character caption limit had been maxed out.

Over time, users developed and refined a personal style of both written and graphic communication, which constituted a crucial part of their self-presentation. This personal style involved a certain degree of consistency with regards to language use, attitude or tone (optimistic or pessimistic), use of humor, and topics, among others. I found that the most popular user profiles—those with most followers—tended to use a unique, visually attractive, and somewhat consistent aesthetic across their posts, (e.g., by posting similar kinds of things or applying the same filters). This often involved aesthetically pleasing pictures of food or bodies in ways that sometimes conflicted with recovery values. Popular accounts also tended to have a memorable, open and honest (described by users as “vulnerable”), and ultimately uplifting style.
A second type of content were “stories,” which Instagram introduced in August of 2016 in response to the growing popularity of Snapchat. Instagram stories were displayed on a toolbar at the very top of the content feed, which could be scrolled through horizontally, in contrast to the vertical scrolling of regular posts. The defining characteristic of stories was their ephemeral character: they disappeared every 24 hours. Stories could include multiple—even dozens of—segments with images, videos (maximum 15 seconds each) and/or text, and which have a “slideshow format” that progresses automatically from one segment to the next. Stories allowed users to embed text on top of the images, which they often employed to directly comment on images or other media. For instance, a user might include a screenshot of a movie with written critique on top denouncing its promotion of disordered eating. Furthermore, due to their ephemeral nature, stories are broadly associated with greater spontaneity, humor, imperfection, and “authenticity” than regular Instagram posts (Constine, 2016). Unlike the carefully edited and curated nature of posts, stories were often unattractive and even seemed to be intentionally ugly, with dark and blurry pictures.

Users interpreted the short-lived nature of stories as an invitation to not only post more often but also disclose more personal, private, and identifying information. For example, users who did not post pictures of themselves in regular posts might include a selfie picture or video in a story (Figure 5.5, right). Some users shared very detailed accounts of distress or interpersonal conflict in their stories, including pictures of their blotched faces after crying, or images exposing parts of their bodies they struggled to accept (sometimes in underwear) or illustrating eating disorder and recovery side effects, such as distended midsections after eating, referred to as recovery “bloat” (Figure 5.5, center). At the same time, because users know stories disappear
every so often, stories compels them to return to the platform frequently to avoid running the risk of missing out on something important. I found users to include video in stories much more frequently than in regular posts, for instance, to “talk to” their followers. Furthermore, among teenagers, stories were also used to answer questions submitted through platforms like Sarahah and Tellonym, which allow others to anonymously communicate; these messages were often queries or critiques about their approach to recovery or their knowledge.

Figure 5.5. Photographic Intervention of an Instagram Story. These images illustrate three segments of a story shared by a user with a recovery account. The first image shows a screenshot of her Sarahah profile displaying questions and comments she received, with her answers superimposed using the story text tool. The second image illustrates a mirror selfie of the user showing her belly bloat as she reassures her followers this is normal. The third image illustrates a series of short selfie videos where the user is casually talking to her followers about several life issues, both recovery- and school-related. (Fieldnotes, 01/15/18)

Stories were experienced as more intimate due to the greater disclosure and because they allow for direct responses, which, unlike public post comments, take place on one-to-one basis.
Furthermore, stories offer more options for interactivity than regular posts, including an ever-growing library of GIFs and stickers. Just some weeks before I began my fieldwork, Instagram introduced a poll sticker and during my fieldwork, an additional question sticker was also introduced, allowing users to prompt followers to ask them questions they could publicly answer through another story. These stickers were popular among many people I followed, who would use them for interactive dynamics with their followers (e.g., asking if they preferred sweet or savory breakfasts) or also to ask their followers to weigh in on their appearance, upcoming food challenges, or vote on the kinds of content they found most helpful.

The third kind of posts available were “live” videos, which were also displayed in the story feed. This kind of post allowed users to stream or broadcast video in real time to their followers. While live videos do not include the interactive features of regular posts, they do include a live chat where people can publicly comment on the video as they watch; these comments are displayed on the bottom half of the screen and visible to the person broadcasting the video. Furthermore, the time limit of Instagram live is an hour—much longer than the 15 second snippets of the videos in stories. After they end, live videos can be added to stories, available for people to watch during the succeeding 24 hours. This feature was only used by a handful of accounts I followed. Olivia, one such follower, frequently did Instagram lives to answer her followers’ questions about recovery and related topics in real time.

**Content consumption.** Instagram offers several modalities to browse content, all of which is generated by other users but differentially organized and aggregated through the platform algorithms. The most obvious mechanism is to scroll through the post and story feeds, which compile the content produced by users and hashtags followed into an ongoing stream.
Since 2016, the platform implemented an algorithmic timeline (rather than the previous reverse-chronological order), which sorts content depending on its anticipated relevance to each user, a calculation based on factors like predicted interest, timeliness, and relationship (Lua, 2018).

When scrolling through their feeds, users also encounter content recommended by the platform, including sponsored posts and recommended hashtags and users, tailored for each user. Based on the accounts and hashtags I followed, Instagram often included recommendations of other users with recovery or food-oriented accounts in my feed and other food or recovery hashtags, such as #balancednotclean, #recoveryispossible, #intuitiveeating, #recoveryispossible, and #antidiet.

Second, users could consume content from a single profile by entering it and scrolling through the posts in reverse-chronological order. Third, users could scroll through specific hashtags, using the search function, previously described. Finally, users could view posts through the Instagram Explore tab, which recommends content from users not in one’s network that the algorithm predicts will be of interest, based “on things like the people you follow or the posts you like” (Instagram, n.d.). In sorting the posts and recommending new comment, the platform aggregate and uses past engagement and post metadata to predict—and to an extent incentivize—future content consumption. Thus, if many users simultaneously apply orthorexia hashtags with other eating disorder recovery hashtags, the platform is more likely to recommend it to users following, for example, anorexia and bulimia recovery content.

**Interactions.** Instagram affords several different kinds of interactions among users: following, liking (with a heart), commenting, tagging, and private messaging. Following is typically a one-time but uniquely meaningful interaction, whereby a user establishes a direct link with another. By following an account, users communicate, both to the platform and to the other
user, interest in their content. In contrast, liking is among the quickest and least consequential ways to interact with a post because it requires such little effort and commitment. Liking is the only immediate response enabled by Instagram for posts; in other words, the “emotional architecture” of the platform is tailored to promote pro-social forms of interaction, presumably to maximize engagement (Wahl-Jorgensen, 2018). In addition to the heart function, users can comment on each other’s posts, using letters and emoticons. Likes and comments are public and visible to other users who see the post, if the users expand the heart or comment displays. The platform privileges the visibility of interactions of other known users.

Users can tag each other in posts, stories, or comments by preceding the person’s unique username with an @ sign. Tagging serves as a virtual invocation to draw a user’s attention to a post presumably directed at or about them. Tags are also hyperlinks, providing a pathway for others to access the tagged profile. Users often tagged others they followed to solicit feedback on a post, or tagged large organizational accounts, or even brands, in hopes their content would be re-shared, a potential avenue for account growth. Users often employed tags to recommend to certain accounts they liked. While tagging often appeared to be organic and genuine, I also saw organized account growth dynamics among a handful of younger users in recovery, in which they would mutually tag each other in stories and recommend each other’s accounts to their followers, in dynamics like S4S (“Shoutout 4 Shoutout”) of F4F (“Follow 4 Follow). Finally, users could send each other direct messages (DM) through a private messaging function, which enabled them to maintain private, one-on-one conversations. Unlike hearts and comments, direct messages were not visible to users other than the recipients, and they have grown to include

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28 This stands in contrasts to YouTube, for example, where users can either like or dislike a video.
more features, including audio, photos, videos, and GIFs. Direct messaging often takes place on a one-to-one basis, although they can also include groups of people. Users in recovery often invited those struggling to “DM” them for a more intimate conversation. Many accounts also announced on their bios that their DMs are “always open” (see Figure 5.1).

Users with small accounts tended to be more reciprocal in their interactions, for instance, following back when they were followed, commenting on the posts of others who commented on theirs, and responding to comments. Many of the users I followed during my fieldwork followed me back, whereas others liked a picture in my profile as an act of reciprocity. The reciprocity norm functioned to create small, tight-knit networks of interaction and support with relationships that were sustained over time, especially among users that had more in common. Thus, the same five or six people would continually like and comment on each other’s posts. This was most common among users with the same account type: users in recovery with others in recovery, dietitians with other dietitians, etc. Users with a larger following were less prone to reciprocal behavior and seemed less expected to comply, in part because the digital capital they had acquired through their popularity relieved them of certain obligations, and in part because after a certain point, reciprocal behavior with thousands of followers became unsustainable.

However, other times, these same tools acquired a more utilitarian functioned, focused less on the social support function and aimed more at building a large following. Users actively trying to grow their accounts used a large variety of strategies like going on following sprees, following many other recovery accounts with the expectation of being followed back by at least some, only to unfollow them as soon as they achieved their goal. Others would actively like and comment on the accounts of people they did not follow in hopes of being followed. Erica, one of
my interviewees, acknowledged being in several “pods,” which were closed groups coordinated privately through DMs, where members would notify each other of new posts as a prompt for to like and comment on it. The intent of pods was to encourage account growth rather than genuine support, which users hoped to achieve by simulating organic interaction and popularity. While Erica expressed a genuine desire to help others with eating disorders, including orthorexia, she struggled with quantification logics of the platform, which distracted her from the priorities she wanted to embody. When we spoke, she was reevaluating her participation on Instagram, and eventually ceased posting altogether.

**Motivations for Using Instagram to Support Orthorexia Recovery**

Given the variety of features available on the platform and the distinct kinds of accounts described, the motivations for using Instagram to address orthorexia were very diverse and overlapping. However, every single interviewee mentioned both self-focused and other-focused aspects motivating their use. The desire to help others was integral to the decision to address orthorexia on Instagram and every person interviewed referred to helping others as a reason for participating online, even if those in recovery were also seeking out personal gain.

**Self-expression.** Self-expression was the most commonly cited motivation for using Instagram among the interviewees. For those in recovery, their accounts provided an outlet to get things off their chest, a public diary that provided numerous alternatives—images, videos, and text—to creatively express themselves. “Catharsis” and “venting” were two words frequently used among those actively in recovery, and rants were common in captions. Some users felt their recovery profiles provided a space to be sincere and open in a way that was difficult in non-recovery-oriented contexts, both on and offline, where the stigma of mental illness was more
likely to invoke feelings of shame and embarrassment. Others had nobody else to talk to about their struggles, and for those that did, Instagram gave them a place to turn to when their loved ones were worn down. Anne, a college student, explained, “Your family gets a little overwhelmed with all the visits to your team, and your breakdowns. It’s just a nice outlet… [where] I don’t feel like a burden.” Beyond simply having a space to express themselves, users valued the possibility of having their suffering seen and heard—the potential for an audience, afforded by the platform. Jason, a 28-year-old in the UK explained:

> It’s a place to express myself, kind of like a modern-day diary. I can do it in a way that’s a bit more creative than a diary, and also, it is actually open as well for other people to look at, not just to be hidden away and forgotten about.

**Documentation.** Instagram’s resemblance to a journal also proved relevant for a more utilitarian function: documentation. A widespread social media practice, documentation proved especially meaningful for individuals traversing a time characterized by dramatic change. At the most basic level, Instagram functioned as a food diary, with photographs and descriptions of meals—a practice that may be problematic in itself, when used to carefully track every last morsel. However, other users went beyond tracking their intake to focus on processing their experiences, struggles, and victories. Lauren summed it up explaining: “That was a very important time in my life and that account was a lot like my journal. I like to go back and look, and I think it’s just important information of things that happened that I don't want to lose.” Liam, an 18-year-old about to start college, valued that he could “document more of my experience so that I wouldn’t forget.” He also emphasized that knowing his online journal might be helpful to others gave him extra motivation to keep it up.
Modeling recovery. A unique form of documentation among those who were already recovered or were coaches or professionals, was modeling proper food and exercise behaviors. Those who achieved what they considered to be healthy relationships with food spoke about providing others still struggling with examples of what balanced eating looks like. Julia, a dietitian, said many followers were eager for permission to eat foods they had come to see as bad, and described one of her most popular posts ever: a picture of a bagel. She received dozens of new followers and comments thanking her for that post. “I was like, ‘Wow, it’s a damn bagel.’ It’s literally nothing in the picture but a bagel and cream cheese… I think a lot of the permissive posts are really what people are grateful for. Others tried to emphasize the benefits of overcoming orthorexia. Thus, users could literally show others what recovery looks like—a task made particularly easy on such a visual platform.

Connection. Another crucial motivator to use Instagram was the possibility of connecting with similar others, regardless of physical location. The desire to connect served a variety of overlapping functions, including relating to others, feeling less lonely, and feeling understood. The orthorexia label and hashtag made it easier to connect with people who could most closely relate with the struggles. Leah explained, “It’s wonderful to know that you’re not alone and you’ve got others going through the same thing, as well as a support system, and it’s just beautiful to see that other people care too about the same things”. Similarly, Clara, a 24-year-old from Holland, stated, “It is helpful to see how others deal with the same problem. It makes me feel like I am not the only one with an eating disorder, and that gives me a strange feeling of relief.” This relatedness was associated with shared experiences of distress and the
range of challenges confronted during recovery, including changes in appearance and identity, and other side effects.

Community was a recurring word used to describe the shared conversations and fellowship surrounding orthorexia and ED recovery, but not all people experienced it as such. While some developed meaningful friendships that translated offline to coffee dates or exchange of phone numbers and even care-packages, others proved unwilling or unable to forge such connections. Marion explained that she did see chatter among some of her contacts but hesitated to call her own network a community: “I don’t think my platform is big enough, and I’m not as connected to people.” Natalie, who participated on Instagram as a coach, said that while she thought there was a community, given her position, she participated from the sidelines “instead of being right in the middle of it.” I observed many instances of people, especially those new to the community or with small number of followers and weak connections, failing to receive any support or feedback on posts in which they expressed distress or anguish.

**Support and advice.** Another motivation to use Instagram was to give and receive encouragement and advice or validation about their struggles and the changes they were making in recovery. With few exceptions, users reported overwhelmingly positive experiences in their interactions. Comments ranged from praise or encouragement via likes and comments, to practical advice about how to confront a challenge. Lana explained, “I do get support back, like, ‘Oh, girl, you’ll get through it’… Or someone offering advice or maybe giving me a tool that’s helped for them or recommending a book or, yeah, something like that.” Mariana, a user from Mexico, added that “people in the community have great advice for when I want to give up on my recovery.” For many, this feedback was instrumental to their recovery process. On the flip
side, those like Luna, a 29-year-old from Canada, who were already recovered found a sense of purpose and satisfaction in helping: “My job as somebody who has gone through this and is almost recovered from this is to help other people…It’s very rewarding and stuff like that to help other people overcome this.”

Motivation. Many users sought other recovery-focused accounts on Instagram as sources of motivation, inspiration, and hope. Recovery was described as an exhausting process that often felt unsurmountable. Uplifting and encouraging messages from people who were going through the same thing or had overcome it often gave an extra boost. Karen, a 35-year-old woman from Connecticut, talked about motivational profiles she visited when things got tough: “I know there’s accounts I can go to when I’m having a bad day and kind of just read.” Motivational accounts often shared inspirational quotes, reminding others that their pain would pass or trying to help them refocus priorities. Sometimes, witnessing the progress of others offered hope simply by providing evidence that recovery was possible. “It’s motivating to see that people who were like me are now doing really well and have moved on and have a normal life,” reflected Charlotte. Thus, inspiration and hope sometimes came indirectly, simply by witnessing others who had overcome the struggle.

Behavior change. Users in recovery discussed concrete ways they used Instagram to help them change behaviors. Some talked about it providing a mechanism for accountability that encouraged them to stay committed to their recovery or follow through with changes. Carmen, a 24-year-old graduate student, explained, “I feel like making myself visible in that space is a type of accountability because if I just disappear, people will notice.” Another way users found Instagram to support behavior change was by providing incentives to challenge themselves with
foods they were afraid of. Sometimes the motivation derived from a desire to grow the account or please others. Paul admitted the wish to take colorful pictures was his main motivation to add variety into his diet: “If it wasn't for the Instagram thing, honestly, I would only eat porridge with whey protein and eggs and vitamin C tablets.”

**Information and resources.** Another benefit cited by users was the ability to find or share helpful resources and knowledge through images, captions, and links. Sometimes this information provided them with a new framework to understand their experience. Others learned about strategies or approaches that were practically helpful, like the intuitive eating, which several interviewees said they first discovered on Instagram. Circulation of medical information came in hand with a greater awareness of diverse experiences and concepts that were more clearly political, like body liberation and diet-culture. People in recovery and professionals alike celebrated this benefit, as described by Erica:

I didn’t know what fat phobia was; I didn't know what thin privilege was; I didn't realize the overlap with all different kinds of mental illnesses and things, like sexual abuse or drugs … I just learned a lot more just from the variety of everyone’s different experiences.

It also enabled professionals to network with like-minded colleagues. Some professionals spoke of social media explicitly as a marketing tool to grow their businesses, while others spoke in terms of reaching women who might need their help. Several coaches said Instagram was how they found most clients, including Ella, a Canadian motivator and micro-celebrity whose popularity eventually led her to provide online support: “I started building my audience and
people started asking me if I could maybe do some phone counseling with them or if I have an online course.”

Awareness-raising. Raising awareness about orthorexia was an important motivator to address the topic on Instagram in particular. While overlapping with the motivation to provide information and resources, this theme emphasizes the desire to also have an impact beyond the recovery conversation. Some achieved this simply by making their own experience visible; others offered more intentional messages to inform potential readers. Awareness-raising was viewed as important in terms of advancing orthorexia’s recognition among the population at large, and also for its preventive potential to warn others about extreme health-seeking behaviors. Furthermore, awareness-raising was intended to help those who were unaware of their illness, realize they had a problem. Charlotte, a 27-year-old living in the UK who recently began her recovery said, “I just wish that it was more out there…so that people that might be suffering from it might actually realize, ‘Oh actually I've got some of those symptoms, maybe I've gone a bit too far.’” To reach users outside the recovery conversation, users intentionally included hashtags they associated with increased risk, like #keto and #cleaneating. Other objectives included de-glamourizing eating disorders and destigmatizing mental illness.

Creating a recovery bubble. There was a broader and perhaps more important way in which individuals made their Instagram accounts conducive to recovery: by producing their own “recovery bubble.” This concept refers to the proactive and conscious effort users engaged in to immerse themselves in content that reaffirmed their recovery objectives. Here the profile-centered, networked logic of the platform was crucial, as each user could tailor their own recovery experience. Olivia explained how this bubble aided her as she transitioned out of
treatment: “When you get out, you are hit in the face with this world that is not recovering with you. I wanted to give people a platform that they had other people who were recovering with them.” Luna advised: “If you’re going to use social media as inspiration for recovery… It’s great, it works. I wouldn’t have recovered without it, but the people who were helping me were saying exactly what I’m saying right now: Don’t follow any accounts that do not fit in your recovery bubble.” Thus, the Instagram recovery bubble needed to be proactively created and maintained.

For many, making a recovery bubble meant giving their Instagram a complete makeover or starting a new account, after having participated in fitness or diet-oriented communities. Indeed, users like Liam believed their Instagram use previously contributed to the development of their disorder, making it a paradoxical space that “can provide almost the tools and information to go down that dark path really quickly, but it also has an abundance of spaces to help your way out of it.” This point also sheds light on how predictive content aggregation, based on algorithms and previous behavior, might contribute to obsessive thoughts and behaviors in certain individuals by continually feeding them content that they are interested in, but don’t necessarily benefit from consuming intensively.

**Networked Recoveries, Networked Uses**

The expansion of an orthorexia recovery community on Instagram after Younger’s public announcement was facilitated through the dissemination of #orthorexia hashtags and in the context of an already flourishing eating disorder recovery community. While users carved out a unique orthorexia niche, it was quite visibly embedded—through hashtags, connections, and shared practices—in a larger eating disorder network that legitimised and helped sustain it.
Instagram fulfilled a fundamental role in the production and dissemination of orthorexia knowledge among users. Many initially learned about orthorexia on the platform through individuals they followed or by noting the orthorexia hashtags, leading them to look it up. Moreover, users continually acquired knowledge about orthorexia and, perhaps more importantly, how to recover by engaging with other accounts and consuming their content. This shared conversation enabled the creation of a collective knowledge base about orthorexia, produced through tangible information and advice, or more tacitly through the sharing of individual experiences of orthorexia, showing what it looks like or how it feels in everyday life. Orthorexia knowledge and exemplars were thus intertwined on Instagram.

Hashtags were central to the coordination and organization of the orthorexia community. Individually, the use of orthorexia hashtags allows users to associate and frame their posts with the medicalizing lens of the diagnostic label, while also tapping into shared conversations about the concept. Collectively, the use of a shared hashtag brings a virtual, yet tangible and visible orthorexia collective into being, an “imagined community” (B. Anderson, 1991) of sorts, based on a shared diagnostic—rather than national—identification. Through hashtags, the platform, by way of its own aggregation principles, assembles aggregated hashtag publics—that do not exist a priori—into existence. As Sauter and Bruns (2015) posit, hashtags don’t just emerge out of shared experiences but are involved in shaping them (p. 47–48). Thus, Instagram users didn’t and in fact couldn’t congregate in some agreed upon physical or virtual space to participate in a shared conversation; instead, participation was effected through hashtag and personal networks. Furthermore, the possibility of adopting multiple and distinct hashtags at once allowed users to make their content specific (e.g., the vegan, Christian, orthorexic), while also situating their posts
in multiple conversations at once. This made information sharing and connection possible within but also beyond the immediate group.

The ability to invoke an imagined community of orthorexia also fulfilled an important legitimizing function. The prevalence of self-diagnosed individuals (over two-thirds diagnosed themselves with orthorexia) interacting through their shared identification with orthorexia, and the widespread sharing of recovery knowledge online, reflects a parallel medicalization structure online, which is less concerned with the recognition and support of the medical institution than with that of peers and online authorities. Indeed, while many people spoke of the need to raise awareness about orthorexia, this interest appeared to be more focused on helping others identify their problem than it was with advocating for its inclusion in the DSM—although they certainly believed it merited a separate diagnosis. In other words, users online could self-diagnose with orthorexia, seek peer validation of their experiences of suffering, find knowledge about how to recover, and even access formalized support of nutrition professionals or coaches without ever having to go to a doctor—who couldn’t formally offer an orthorexia diagnosis anyway.

Unlike online support groups in contained platforms like forums and discussion boards, the recovery community on Instagram was not solely comprised of individuals suffering from the disorders; instead, it also included those who had overcome the condition and those more formally offering support to others. Most of these participants, including the professionals, identified with having experienced orthorexia themselves, similar to what we noted in the previous chapter. What stands out, once again, is the predominance of nutrition, rather than psychology, experts in the orthorexia community on Instagram. Moreover, the fact that all the dietitians interviewed identified with orthorexia (in their past) is striking, and may suggest that
those who personally identified with the diagnosis felt more compelled—or less inhibited—to regularly discuss the diagnosis from a professional standpoint despite its unofficial status.

The platform’s architecture and affordances shapes users’ experiences and interactions in many ways. For example, because Instagram’s interactions are largely centered on individual profiles, users tended to develop an online identity that revolved in some way around orthorexia, food, and disordered eating. These issues became the primary matter their interactions, but also their own self-presentation, revolved around. Moreover, the platform’s emphasis on the quantification of interactions—listing numbers of follows, likes, comments—also shaped users’ experiences and practices. Functions available for offering social support, thus, were sometimes reduced to account-growing tools, less concerned with helping and connecting with others, and more concerned with achieving status within the recovery community through a large following. Instagram’s recent experimentation with removing like counts on posts could partially help deter these kinds of practices, but is unlikely to eliminate them entirely, while other metrics like number of followers remain.

The hybrid network of users was made possible in large part due to the relative flexibility of the platform’s affordances, which enabled people with very different needs, objectives, and vantage points to participate in the platform in highly variable ways. Yet, the primary uses invoked by people were fundamentally social (like seeking connection) or involved a key social dimension. Thus, even practices like self-expression and documentation, which on other kinds of platforms could constitute individual activities, became the bases for social interaction. For example sharing one’s personal struggles was simultaneously helpful as a form of self-expression, while also giving suffering a sense of purpose, and helping others feel less alone.
This was afforded precisely because the collective conversation was sustained through individual profiles and their networked connections. In other words, Instagram’s affordances shaped the variety of ways people used the platform, making certain types of uses possible, but—significantly—also interconnected and simultaneous.
Chapter Six. Recovery as Subculture: Subversions and Extensions of Medical Knowledges

The web of networks addressing recovery from orthorexia and eating disorders fulfilled many supportive functions for individuals struggling with food anxieties and body dissatisfaction. However, examining the community on Instagram simply as an online support group—or network—overlooks the deeper cultural work taking place through the posts and interactions, which as I will show in this chapter, created an overarching sense of cohesion among the participants, while also fulfilling an important subversive function. To appreciate the symbolic, subversive work taking place, I approach the online recovery community as a kind of subculture. Both Conrad, Bandini, and Vasquez (2016); Conrad and Stults (2010) use the illness subculture concept interchangeably with other terms like illness communities and groups. However, I suggest taking the subculture framework more seriously to analyze and make sense of these online interactions.

When we think of subcultures, images of gangs, punks, and goths come to mind. Indeed, subcultural studies originated and have historically skewed toward the delinquent, the young, the impoverished, and male. However, I argue that the predominantly white, female, and affluent members of the online recovery group in many ways constitutes a subcultural formation—one that draws heavily from feminist discourses about the body, while also intersecting with more mainstream ethos of self-improvement. Most meaningfully, the recovery subculture centers the body, rather than the rational mind, as a superior form of knowledge, in ways that resist medicalized quantification and surveillance, while somewhat paradoxically, medicalizing their own suffering.
My approach to subcultures is theoretically informed by the Birmingham Centre for Contemporary Cultural Studies’ (CCCS) emphasis on the measures used by groups “to resist the dominant culture by creating their own meanings” (Valentine, Skelton, & Chambers, 1999, p. 13). Despite critiques of the CCCS tradition for, among other things, being overly theoretical and empirically wanting, like Blackman (1999), I find the notion of resistance to be “ethnographically useful” for exploring users’ “real degree of struggle and challenge” (p. 212) with respect to health imperatives in the culture writ-large and their intersections with diet and fitness discourses online. In other words, the subcultural project of the recovery community is not random, but in many ways, directly oppositional to dominant health discourses. The subcultural framework helps us appreciate the subcultural character of the recovery community vis-à-vis these discourses and appreciate their subversive value.

I draw on Haenfler’s definition of subcultures as “relatively diffuse social networks that have shared identities, distinctive meanings around certain ideas, practices, and objects, and a sense of marginalization from or resistance to a perceived ‘conventional’ society” (p. 16). Subcultural meanings and means of expression provide members with the symbolic resources to negotiate or oppose the dominant meaning system in “their attempt to make sense of their own specific situation and construct a viable identity” (Murdock, 1974, p. 213). Subcultures tend to develop a distinctive group style, which involves the “active organisation of objects with activities and outlooks, which produce an organised group-identity in the form and shape of a coherent and distinctive way of ‘being-in-the-world’” (J. Clarke, Hall, Jefferson, & Roberts, 1993, p. 54). In the sections below, I explore how the recovery accounts seemingly converged into a unique subculture, with unique forms of expression, rituals, resignification practices, and
conceptions of knowledge about the body, which in many ways countered widespread health imperatives and the perfectionistic depictions of the self that proliferate on Instagram.

**Recovery Identities, Marginalization, and Stigma**

Sociologists have long been interested in the relationship between illness and identity. Scholars have shown the potential for chronic illness to alter subjective experiences as individuals incorporate illness into their sense of self (Charmaz, 1995). Illness identities shape the way individuals make sense of their experiences, as they “reinforce particular personal or social characteristics to help individuals deal with medical uncertainty and changes in their lives, or to reconstruct their personal biographies” (Sulik, 2011, p. 464). Collective illness identities refer to the cognitive, moral, and emotional connections individuals establish with a broader community of illness sufferers (P. Brown et al., 2011, p. 22). Collective illness identities are organized through shared narratives that unify dissimilar experiences and help give the illness experiences structure, meaning, and legitimacy (Barker, 2002, p. 284). In the previous chapter we saw some of the ways this shared identity brings people together for support. However, collective illness identities can also cohere into an “oppositional consciousness” that opposes dominant ways of thinking (Brown et al., 2011, p. 22).

Illness identities can involve a significant degree of stigma. It is no coincidence that Goffman’s (1963) exposé about the management of “spoiled identities” drew heavily on cases of mental illness. While medicalized approaches to deviant behaviors such as eating disorders may partially remove blame from the individuals experiencing from them, those diagnosed nonetheless maintain a status of “second-class” citizens (Conrad & Schneider, 1980, p. 249). They escape blame not because their actions cease to have moral import, but because they are
understood to have a diminished capacity for moral behavior: “In this way, the medicalization of devian
tce reduces the person’s ‘social being’” (Kirmayer, 1988, p. 81). This reduced status, as Goffman (1963)
points out, leads individuals with stigmatized identities to find support in others who share the stigma. It is thus unsurprising that individuals are more inclined to seek support groups both on and offline when their conditions are viewed as more stigmatizing or embarrassing, such as anorexia and AIDS (Davison, Pennebaker, & Dickerson, 2000). The stigma experienced by individuals with mental illnesses as they acknowledge how they are perceived by others and internalize these perceptions, creates a relevant parallel between the orthorexia community and that of deviant communities studied from a subcultural framework.

One irony of orthorexia as “an illness you have to fight to get” (Dumit, 2006) is that in vying for the recognition of their distress, orthorexia-identifying individuals must assume a stigmatized identity—that of being mentally ill. This is not unlike other contemporary subculturists who, like goths or skinheads, “in a sense ‘choose’ their marginalization” (Haenfler, 2013, p. 17). However, characterizing the community on Instagram merely as a collective illness community to an extent misrepresents the foci of identification. The individuals I observed online did not only adopt an orthorexic identity; while they acknowledged orthorexia as a part of their life, they also symbolically distanced themselves from it by positioning themselves within a recovery identity. Thus, their participation in the recovery subculture was contingent on framing their experiences in terms of the healing process, and often times, in direct opposition to the illness, which in the case of orthorexia, meant opposing extreme health-seeking.29 This is not to

29 For more on pro-ana and pro-mia communities, see Gavin, Rodham, and Poyer (2008), Brotsky and Giles (2007) and Vellar (2018).
say that there aren’t also illness communities and subcultures on Instagram, including the widely studied pro-anorexia and pro-bulimia groups, but that the recovery subculture is distinct.

Recovery accounts often made this point in their profile bios, clarifying their adherence to recovery, with descriptions like: “vegan anorexia and orthorexia recovery,” “ED recovery warriors,” and “ED recovery journey,” or in the case of coaches, descriptions like: “ED Recovery Coach; I train Food Freedom Warriors to heal their relationship with food…holistic self-healing…binge eating + orthorexia.” These accounts were situated vis-à-vis their recovery status: in recovery, recovered, and helping others recover. This identification with recovery rather than illness itself has been recently noted in psychological research of people recovering from addiction and eating disorders (Hastings, McNamara, Allan, & Marriott, 2016; McNamara & Parsons, 2016). The recovery identity is a liminal identity, located somewhere between health and illness. It is also a striving identity based on an ethos of self-improvement, although the substance of the betterment project counters the fitness and weight-loss discourses that proliferate on Instagram and in public health promotion. Attaining recovery was not simply about returning to the same state prior to the illness but adopting a new, oppositional approach to health—one that would secure ongoing wellness.

Users marked their membership in the recovery subculture through their use of shared hashtags. However, some also marked their identification in other ways, for example, posting pictures of themselves displaying or wearing the shared recovery symbol on a shirt, bracelet, or a sticker. The prevalent sign used is the NEDA logo, which depending on the interpretation, resembles a flame, a heart, or a female silhouette (see the original logo in Figure 4.5, Chapter Four). In addition, multiple individuals shared pictures of their temporary or permanent tattoos.
with the symbol, which served as a personal reminder to fight for recovery and a silent means of communicating to others around them, especially those familiar with the symbol, that they belonged. Figure 6.1 has several examples of pictures posted by users showing their tattoos. While some individuals had large and obvious versions (right), others were smaller (center), or even somewhat hidden, like the small elephant tattoo one user got for her 17th birthday, with the symbol embedded in a larger elephant tattoo (left).

Most individuals in recovery had previously invested themselves in food, health, or fitness lifestyles and identities, such as veganism and body building, with matching accounts. Some recovery accounts came to replace these health and fitness focused identities, whereas other users slowly transitioned from one to the other on the same account, changing their bios and username’s in the process, often deleting previous posts. Some users maintained a partial attachment to past identities, especially when they could justify them on non-health oriented
terms that were compatible with recovery values (e.g., users who were trying to recover while remaining vegan but for ethical rather than health reasons), although there was widespread consensus that overly-identifying with health and food risked recovery. Nonetheless, the identity and status accrued through those identities was difficult to let go of. As one young woman wrote: “I suppose I’m afraid of letting go of that ‘healthy persona’ I’ve lived my entire life” (Fieldnotes, 03/17/18). The changes that took place during the recovery process often led individuals to experience a sense of marginalization, either from their previous health and fitness communities or from the broader health-oriented culture.

Charlotte, a 27-year-old in the UK, who had become very focused on fitness and clean eating, recalled all the social validation she used to receive before recovery, which was still visible at the time of the fieldwork on comments of older, fitness-oriented posts she had shared before beginning recovering and transforming her Instagram account. “I had people coming up to me at the gym and people commenting saying, ‘Oh, you look amazing,’ ‘You’re so dedicated,’ ‘How’d you get so lean?’ and people always asking me for advice…People wanted to be like me…,” she recalled. “Whereas, obviously, now I don’t get anything like that.” However, she clarified that since becoming a part of the community, “I do get a lot of comments from other people in recovery saying, “Well done, you look so much better,’” ‘You look so much healthier,’ ‘You look so much happier.”’ Orthorexia served as a mechanism to reframe her health-obsessive—albeit status building—past as pathological rather than ideal, while positioning the change as a pathway to healing and true wellbeing.

30 Quotes from users I interviewed are included under the same pseudonyms used for the interviews, and whose characteristics are available in Appendix B. Quotes from users that were not interviewed are referred to more vaguely, without a name. Quotes taken from fieldnotes, rather than interviews, are labelled as such.
Moreover, like many other subcultures, the online community offered users a social support system that validated their experiences and decision to change, something they were often unable to find elsewhere. People outside of the subculture did not always understand what was “wrong with” the behaviors labeled orthorexia, which they read as disciplined and healthy. Discussions about not being acknowledged by friends, family, and medical providers as “sick enough” to receive help were common among those in recovery. One young woman wrote about her difficulties trying to access medical care in Canada: “Being put at the bottom of the waitlist and told I must wait months for treatment only reinforces the dangerous notion that I’m ‘not sick enough’ to deserve help,” she lamented (Fieldnotes, 03/02/18). Similarly, a college student in the US remembered the frustration she experienced when she began her orthorexia recovery precisely because others around her did not believe she had a problem:

I recall when I first began looking at myself honestly and sharing with those around me about the restrictive thoughts I was having, as I felt myself slipping into an eating disorder. One person told me I was exaggerating: “You are fine. You do not have an eating disorder.” (…) Just because my disordered thinking didn’t become more severe, like anorexia or bulimia (something I am deeply grateful for), that doesn’t mean they haven’t harmed me. What to say of the panic attacks I experienced right before events where I didn’t know what kinds of foods would be served? Or when I had to take more than a single rest day [at the gym]? (Fieldnotes, 03/02/18)31

Different kinds of validation—of the disease status of orthorexia, of the experiences of suffering associated with it, of deserving help, and of the disordered character of previous health-

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31 Texts that are readily identifiable through search engines either on blog or Instagram posts have been altered, with some light rewording and reordering of words, in order to protect users’ identities.
seeking behaviors—were a central part of the subculture. Self-validation was a widespread practice, but many times the validation was offered to or came from others. For instance, one teenager who was undergoing a variety of tests prior to entering treatment shared that she was “not sick enough…to be worthy of treatment.” Those in her support network validated her in the comments through responses reminding her that “you will never be ‘sick enough’ for your ed [eating disorder]” or that “we can see how much you have been struggling and that in itself makes you deserve recovery…It’s about how you feel…Your struggles are valid” (Fieldnotes, 05/27/18). Thus, validation was about emotional support but also about endorsing extreme health-seeking behaviors as pathological and encouraging recovery.

Communicating Orthorexia: Shared Language in the Recovery Subculture

Like many other subcultures, individuals in recovery often employed distinctive ways of communicating with each other and making sense of their experiences. This shared language was inextricably linked to shared practices and norms that, in conjunction, constituted a distinctive subcultural style. Here I review some recurring terms and themes in the vocabulary of those recovering. Because many participants were currently—or had previously been—in formal eating disorder treatment settings, much shared language drew heavily from therapeutic jargon. Widespread use of these terms alongside recurring acronyms (some drawing from the broader Internet culture and others exclusive to the community) and other figures of speech, in conjunction, led to a relatively standardized speech pattern across the networked accounts addressing recovery. While I will not explore examples here, because individuals recovering from orthorexia were often highly literate in medical and nutritional language, they also relied on
medical terminology to interpret physical sensations read as symptoms of the disorder or recovery process (e.g., terms like water retention, bloating, amenorrhea, bradycardia).

**Therapeutic language.** Therapeutic language, commonly used by mental health professionals treating eating disorder patients and reflective of specific approaches to eating disorder treatment, such as, Cognitive Behavioral Therapy and Dialectical Behavior Therapy, were common in the recovery space. Through their interactions, those who had been in therapeutic settings transmitted it to those who had not. Perhaps most obviously, participants used diagnostic labels frequently in their captions and their hashtags, alongside terms like “restriction,” (the conscious and self-imposed limiting or withholding of food for weight or health manipulation purposes) “binging,” (the consumption of an excessive and unnecessary amount of food), and “purging” (strategies used to counter the consumption of calories in an effort to control health or weight, like vomiting, laxatives, exercising) to simultaneously describe and problematize the behaviors they were referring to. These behaviors were often spoken about in the abstract or in the past-tense, as explicit discussion of present disordered behaviors was discouraged as unhelpful and upsetting.

For example, in a video story, one participant admitted to her followers that she was struggling with “really wanting to restrict again” (Fieldnotes, 01/15/18). Without requiring any further elaboration, this terminology both communicated to others that she was struggling with wanting to cut back or reduce her food consumption, (i.e., restrict), while framing the act as disordered, rather than, for instance, disciplined or controlled. Similarly, in a post, one user shared an experience she was proud of, where she had been able to eat and enjoy strawberries with sprinkled sugar on top, something her “orthorexic mind also would’ve SCREAMED at me”
for doing in the past. In a response, a friend she regularly interacted with reaffirmed her decision: “I am so proud of you for choosing nourishment over restriction today. Love you!!!” (Fieldnotes, 01/27/18). This response drew on the shared language of “restriction” to frame the alternative option of withholding sugar as a form of restriction, which was tacitly reaffirmed as disordered and undesirable.

Other terms therapeutic terms came up regularly in posts and interactions. The notion of “using behaviors” involved a more abstract and preferable way of referring to eating disordered behaviors like those mentioned above (e.g., “went a year without behaviors and then struggled again for a bit. it’s ok!! it doesn’t negate all that progress” [Fieldnotes, 06/11/18]). “Urges” referred to visceral impulses or desires to engage in disordered behaviors (e.g., “the guilt and urges are high, but I’m going to fight those urges and get on with my day” ([Fieldnotes, 02/21/18]). “Compensation” labelled to inappropriate attempts to make up for or revert the impacts of having eaten certain foods (e.g., “the guilt is there and urges to compensate are high” [Fieldnotes, 08/06/18]). “Slips” or “slip ups” described presumably anomalous lapses in an otherwise consolidated recovery process (“One slip does not mean you tumble all the way back down. It’s not too late to catch yourself” [Fieldnotes, 05/25/18]). Unlike “relapses,” which signal patterned and recurring usage of disordered behaviors, “slips” were typically considered exceptional and thus not bringing the recovery into questions. “Triggers” were stimuli that set off or elicit disordered behaviors, while “getting triggered” referred to the act of getting set off.

Posts by individuals struggling with their recovery process often included “trigger warnings” or more frequently “TW” (some used “PTW,” Possible Trigger Warning, when they were unsure), which signaled a recognition that the post content might be experienced as
triggering to others. Content deemed triggering usually involved some degree of explicitness in discussing disordered behaviors (rather than the vaguer “using behaviors”) and number talk involving weight and nutrition (pounds, calories, food components like grams of fat, etc.). Users unfamiliar with these subcultural norms—which largely mirrored the practices in group therapy settings in eating disorder treatment programs, where elaboration on specific behaviors is also discouraged—had to learn what was deemed triggering in the recovery context. Several novices I observed from the moment of their entry into the recovery subculture initially included calorie counts for all the meals they posted. However, they usually ceased the practice fairly quickly after observing that nobody else was doing so—or on occasion, after getting called out. I observed one such instance in a response to a post that was meant to be inspiring and reaffirming about gaining weight in recovery, by a user whose account was not specifically about recovery and who did not frequent the recovery subculture, but who occasionally posted on the subject. The post initially contained explicit numbers about how much weight she had gained. Following a dozen comments from individuals who appeared to be her friends, celebrating the post, a user more familiar with the recovery subculture suggested, very non-confrontationally:

Can I very gently say that it can be difficult for people in recovery to see numbers?
Mentioning the total of pounds you’ve gained is not usually something we encourage in recovery circles and I’m sure with many of your followers being in recovery from an ED it may just be something worth taking into account. I love your message and page though! (Fieldnotes, 02/09/18)

This comment prompted a back and forth from the poster, who was very receptive to the feedback, thanking her and inquiring if more vaguely discussion “weight gain” was acceptable.
The commenter approved. By the time I read the post, the numbers had been entirely removed from the caption and the only traces left were in the comments prompting their removal. It was not just that sharing numbers was considered upsetting, it was also that knowing and documenting numbers in the first place was seen as conflicting with recovery.

**Diet culture.** “Diet culture” was a pejorative term, widely used in the recovery space, to refer to the wide assemblage of discourses and practices promoting dieting and weight loss, which permeate culture, including media, public health promotion, and industries peddling wellness and fitness. Diet culture was viewed as oppressive, injurious, and deceitful, contributing to body dissatisfaction and eating disorders. The term, shared with movements like the body positivity and the HAES movements, was deployed to disparage widespread beliefs that countered with those celebrated in recovery. It was also a politically loaded term, invoking resistance. As such, it points to a dimension of the subculture that more closely resembled a social movement and overlapped with those sharing compatible goals.

Some users identified as being “anti-diet culture” or “diet culture dropouts” in their bios, and many wrote about it or invoked the term in posts, for instance, asserting that their body hatred was “something that diet culture taught me” (Fieldnotes, 03/18/18). One dietitian shared a post describing the concept to her followers, asserting that diet culture “tells us that our weight and the shape of our bodies is more important than overall health” and “tells you to not eat X, Y, Z because its ‘bad’; assigning morality to foods” (Fieldnotes, 03/24/18). A teenager in recovery ranted about the fact that, as a society, “we changed physical movement into a weight loss tool,” and “All activity-related things are now infused with diet culture and it’s increasingly difficult to separate moving your body from diet propaganda” (Fieldnotes, 05/18/18).
Erica, who had a recovery account and blog, made t-shirts with the text “Anti Diet Culture Queen” printed on them, which she sold or gifted to certain individuals with influential recovery accounts. In a post with a picture of herself wearing one of these shirts, she wrote about feeling “super discouraged” about the potency of “diet culture”:

I get exasperated when I see people reproducing these diet-y, weight loss centered or ‘health’ obsessed behaviors. It makes me want to stop and scream in their faces:

“PLEASE DON’T DO THIS!! YOU ARE MISSING OUT ON LIFE!!! YOU DON’T HAVE TO BE A SLAVE TO THE NUMBER ON YOUR SCALE OR THE ‘QUALITY’ OF YOUR FOOD. (Fieldnotes, 02/12/18)

Reflecting on her own internalization of diet culture, she confessed that her anger derived from the fact that a part of her still wanted to participate and how, despite having gone down that road and having “crashed and burned BIG TIME,” there was still “a little voice taunting” her, telling her it would work next time. Recovery is “so damn hard… when the world that surrounds us reinforces those voices by repeating the exact same things.” Diet culture was seen as working on the self through external pressure to conform but also through internalization, become “a little voice” within that made recovery—resistance—so difficult.

**Fear foods and recovery wins.** Additional terms came up frequently in posts and interactions with less obvious therapeutic origins (although possibly used in some therapeutic spaces, too). Some of these terms catalogued foods based on the level of difficulty they posed individuals. “Fear foods” referred to items an individual found to be particularly scary or distressing to eat, resulting in their avoidance, typically because they were deemed unhealthy and fattening. Meanwhile, “safe foods” were individuals’ go-to food items experiences as
unthreatening. While there was much variation in the specific items each individual considered to be a fear food (because people came from highly variable dietary backgrounds), generally speaking, they were associated with fats and carbohydrates, especially those deemed unhealthy versions (like refined carbohydrates and saturated fat), whereas safe foods were more typically vegetables (lower in calories) and proteins (associated with muscle), in addition to diet foods. Avoidance of fear foods was interpreted as an expression of disordered eating; thus, fear foods were obstacles to be conquered during the recovery process. As one American teen reminded her followers in a story, “MY PSA FOR TODAY, If you keep eating ‘diet foods’, ‘safe foods’, etc. YOU AREN’T GOING TO RECOVER” (Fieldnotes, 02/15/18). Successful fear food challenges were rebranded “recovery wins,” enforcing the idea of achieving victory over the food.

**Figures of speech.** Certain figures of speech were commonly used among the recovery subculture. The first metaphor likened the recovery process to a journey—a long trajectory with ups and downs, victories and defeats, to be completed over time. Some users in recovery had the term in their bios, for instance, inviting others to “join me on my journey” (Fieldnotes, January 31, 2018). Others wrote about recovery in captions, for example, affirming the idea that “it doesn’t matter where you’re headed as long as you keep going forward. It’s not a straight line either: you’ll encounter turns and crossroads but it’s all part of the journey” (Fieldnotes, 02/02/2018). The journey metaphor was fully developed in a blog, where eating disorder recovery was compared with

…hiking Mount Everest. In the initial climb, the first months don’t feel so difficult, you even come to feel empowered by the journey, not knowing what lies ahead. The more you progress, the more challenging it becomes: you are exhausted, you feel restless, it is
hard and every day you ask yourself whether the expedition is really worth it. (Fieldnotes, 03/30/18)

The second was the metaphor comparing recovery to a battle or fight, equating those in recovery with warriors, as suggested by hashtags like #recoverywarriors, #edfighters, or more specifically, #orthorexiasoldier. Participants often urged each other to “keep fighting” (Fieldnotes, January 18, 2018) or celebrated seeing “so many of you fighting so hard” (Fieldnotes, January 28, 2018). Similarly, users referred to each other in similar terms, as in the case of one motivator who praised another on a post as “absolutely incredible and such a WARRIOR” (Fieldnotes, 01/30/18), or a young woman who expressed gratitude to another motivator, thanking her for never failing “to inspire motivate and uplift every single recovering warrior out there” and reaffirming the idea that “We are all in this together and this battle will help us turn into our greatest most beautiful versions!” (Fieldnotes, 04/11/18).

A final, especially prevalent, figure of speech employed was the personification of the eating disorder, with names like Ana (for anorexia) or Ed (for eating disorder), or simply referring to the eating disorder as an unnamed but distinct entity with agency, and who is responsible for motivating disordered thoughts and behaviors in detriment of a separate self. Thus, participants would say the “Ed hates” when they eat certain foods (Fieldnotes, 05/04/18), or suggesting that if ED “doesn’t like” something, “it’s a sign it’s good” (Fieldnotes, 05/23/18). In one post, a user shared a detailed description of the stringent food rules she had in place at the height of her orthorexia, adding “This is what an #eatingdisorder does. It controls you. Not just what you eat but when you eat. It’s an all-consuming beast” (Fieldnotes, 03/19/18). Another girl shared a personal victory in which she “didn’t listen to Ana” (Fieldnotes, 02/10/18) and went on
to “shush Ana” with her choices. The idea of “slaying Ana” was also widespread among a group of younger women (mostly teens) in recovery. Similarly, another user shared a post, asserting Orthorexia is a bad bitch. She has very little to do with weight now but gets louder than ever before when it comes to “health.” She screams at me when I feel chest pains, “That’s what you get for eating pizza.” She demands that I go to the doctor whenever she feels the slightest sense of discomfort. She is loud but I need to find a balance of what is genuinely “healthy.” (Fieldnotes, 07/20/18)

Recovery Bricolage: Re-signifying Foods and Bodies

Participants in subcultures are known for taking ordinary items or objects and transforming their meaning in way that come to define their subcultural style (Haenfler, 2013, p. 8). Levi Strauss’ concept of bricolage has been deployed by some subcultural theorists to understand “the re-ordering and re-contextualisation of objects to communicate fresh meanings, within a total system of significances” (J. Clarke, 1993, p. 177). Bricoleurs appropriate objects and imbue them with a new meaning as they relocate it within their discourse, often in direct opposition to the broader, “dominant” culture, to use CCCS language. The meanings produced through bricolage are not born from nothing, but result from a reconfiguration of what was previously signified; it is thus always situated in relation to the dominant readings: “Transformation and re-signification, to re-value life-styles previously disqualified…can take place because messages of that order were already ‘written-in’ there, in those commodities” (J. Clarke, 1993, p. 178). Thus, objects and meaning are not created from nothing, but result from the transformation and rearrangement of what is given.
Here I examine the resignification practices through which participants in the recovery subculture transformed the meanings of quotidian “objects,” namely foods and bodies. If we take Instagram—the architecture, affordances, shared practices—as a site where the performance of idealized versions of reality is widespread and quotidian (including the proliferating diet and fitness cultures), its consolidation as a crucial place for the subversive bricolage of the recovery subculture is no longer a bizarre paradox; instead, it become an obvious site for the contestation of meanings of health. I use two different types of resignification practices to show how bricolage takes place in the recovery realm.

**Fear food challenges.** The first example elaborates further on the concept of fear foods. As mentioned previously, fear foods typically mirrored those public health, diet, and fitness discourses would locate in categories of “unhealthy” or “fattening.” Prior to recovery, orthorexic individuals had a large, ever-growing list of foods that were off-limits. These lists were often based on very strict diets or at the intersection of multiple food theories and diet principles (e.g., grain free and low-fat and vegan), which when combined, made nourishment difficult to achieve. As the term “fear food” suggests, the thought of consuming these foods was terrifying, and consuming them often evoked overbearing feelings of shame, guilt, and even disgust. For those in recovery, these responses to food were read as indicative of the underlying pathology and thus needed to be overcome through practice, or in more therapeutic terms, “exposure.” The process was explained by one recovery coach: “The more you expose yourself to those foods the quicker you will come to normalize them, and they will lose their power over you” (Fieldnotes, 08/31/18). She added, “Challenging your fear foods is a key part of reprogramming your brain so you can truly enjoy them again and overcome your fear and obsession.”
To get over fear foods, participants individually or collectively took on “fear food challenges” in which they would purposefully consume distressing food items and report on their experience or work through the emotions they were feeling, afterwards. Amber, a recovered coach, explained the challenges associated with the process: “You’re going to go through digestive issues and anxiety and fears because you’re introducing all these…fear foods. The goal is to get to a point where food is just food to you, where nothing feels off-limits anymore.”

Danielle, a former athlete, who used her account intensively during her recovery from orthorexia, explained, that she would post pictures of her fear foods and write about them in the captions: “I really used to kind of dig down and go through all of my thoughts about a specific fear food or just anything that I was eating, everything that went around it.” One young woman from Germany ticked boxes on a list she had made with her fear foods and share the sheet on her Instagram stories, showing others the foods she was conquering, including juice, pasta, potatoes, and a McFlurry (ice cream), at one point adding colorful text celebrating she had “only two fear foods left” (Fieldnotes, 02/16/18).

Sometimes, fear food challenges involved group dynamics like #FearFoodFridays, a weekly event whereby participants who desired to, could document and share the food they ate—and chime into the stream of associated posts using the hashtag. Some coaches coordinated fear food challenges among their followers, for example, inviting them to challenge themselves several days in a row and report on their experience in the comments for support and accountability. Followers responded, for example, sharing, “I ate sushi with white rice! I typically have brown. I also ate more than the individual roll I ordered because I tried some of my sister’s”; or “I ate eggs for breakfast, which would have previously freaked me out because I
followed the autoimmune protocol for such a long time and developed a big fear of all ‘allergenic’ foods,” or “I am going to challenge myself to pizza. Yes, it will be gluten free organic blah blah blah, but after following a restrictive paleo diet, this is important progress for me.” Participants then received feedback and affirmation from the coach and other participants encouraging them to feel proud of themselves.

One recurring and ritualized fear food challenge were “pint parties” in which participants would eat a whole pint of ice cream—most often Ben & Jerry’s brand, notorious for its high fat and calorie content—presumably in one sitting, as an effort to push back against their fear of sugar, fat, dairy, etc. Pint parties were often done simultaneously by two or more individuals in recovery (in the same or different places), but were also undertaken solo. Figures 6.1 , below, shows the image shared by a woman undertaking a pint part with a Brownie Batter Core Ben & Jerry’s ice cream tub, with a caption saying, “I decided on a pint party tonight. Food freedom really changes your life. I’m enjoying ice cream just because tonight. I don’t need a reason to eat dessert anymore. Challenge yourself to something you’re craving that isn’t among your “safe” foods this week…Share a challenge you’re doing” (Fieldnotes, 08/28/18). Here ice cream was resignified as a healthy food choice, one conducive to “food freedom.” It is important to note that this is not how users ate most of the time. To the contrary, most accounts were flooded with pictures of high protein bars, zucchini oats, sprouted breads with nut butters, vegetables with chickpea pasta, etc. The meaningful meals, however, for the sake of recovery, were those that challenged orthorexia—that is, they were admittedly “unhealthy.”
The concept of self-improvement, what scholars have referred to as the “entrepreneurial self” (Monaghan, Hollands, & Pritchard, 2010; Petersen & Lupton, 2000), remained at the core of these shared projects. In other words, recovery accounts reflected a neoliberal ethos of ongoing betterment and prudence. However, fear food challenges changed the content of what was to be achieved through it from the abstinence to the consumption of presumably unhealthy, yet pleasurable foods. They did so not by subverting health as an ideal, but by redefining what was understood as healthy. Indeed, the celebration of eating Ben & Jerry’s ice cream as a commemorative health achievement would be hard to imagine in another context. Yet, by imbuing foods they previously experienced as unhealthy and bad with a therapeutic, recovery-oriented purpose, participants effectively re-signified these foods as healing. A conquered challenge became a “recovery win,” reframing otherwise distressing or shame-inducing experiences as prideful achievements to be applauded.
**Transformation photos.** The second example of bricolage involves the reinterpretation of physical bodies, and perhaps more importantly, of certain kinds of physical change. Before-and-after pictures of bodies have long infused advertising of diet and fitness programs and products, and more recently, have become popular on personal Instagram accounts of individuals documenting their own physical transformations. These photos are widely interpreted to communicate improvement; the “now” reflects the enhancement or betterment of the “then.” In the context of prevalent weight-loss and fitness discourses and industries, the before version typically involves more fat and/or less muscle, whereas the after photo show the decrease in fat and/or increase in muscle. A quick search of the #transformationtuesday hashtag on Instagram displays close to 15 million posts, most of which celebrate the abovementioned changes. However, in the recovery subculture, the assumption of weight-loss as superior was flipped on its head, and the appropriation of transformation photos often celebrated the increase in fat and the decrease in muscle during recovery, which was re-signified as restorative.

The practice of sharing before-and-after photos is widespread among the anorexia recovery community, where visibly emaciated bodies are compared with their improved, restored version—with more fat. To an extent, these bodies have been restored from their abject thinness to a state of “normality.” However, orthorexic-identifying individuals were not always under-weight to start out, and their transformations often countered mainstream images more starkly. In fact, the “before” versions were often of very muscular or “fit” bodies that could easily have been the “after” version of a fitness or weight-loss transformation image. And that was precisely the point of these posts: to bring into to question the widespread celebration of “thin” or “ripped” bodies, to argue instead that the work it takes many people to maintain bodies can be damaging.
Aside from using counter-normative images in the before and after slots, the resignification work was achieved through overlaid text in the image or captions that provided context for what was “really going on” in the pictures; that is, insight into what kinds of suffering were required to maintain that version of themselves. For example, Image 6.2 shows a post by a woman in recovery who shared a post comparing her current self (2018) with herself two years before (2016). While she was fully clothed in both images and more covered up with a loose sweater in the recent picture, the 2018 self was more corpulent and further from normative images of idealized thinness than the 2016 photo. The caption, however, clarified why the 2018 version was actually better off:

In the photo on the left I was at my thinnest weight ever. I was miserable because I was exercising to harsh extremes while under-eating foods that were exclusively low-fat, clean, and “pure.” I was genuinely sick both mentally and physically and going through one of the worst times in my life… I did not have my period, my hair started falling out, and my skin was covered in acne. In the photo on the right (taken just yesterday) I am still recovering from all this. I still experience muscular pain, my hormones are out of whack, and I still feel extreme hunger, not to mention that I have gained some weight. But that’s okay because I feel so much happier… I have been eating until I satisfy my hunger. The best part is that I have been enjoying eating things I love…I have faced all of my fears. The journey has not been easy, but I don’t regret it. (Fieldnotes, 03/08/18)
Several women commented on this post, affirming her changes. For example, one person reassured, “You look so much happier in the 2018 photo! There is a shine in your eyes,” and insisted that she was beautiful and inspiring. Another friend added, “The new picture is most definitely the person I’ve loved for so long. You look beautiful & healthy!” These supportive comments sanctioned the changes deriving from the recovery process.

A second example, shown below, is a post shared by Ella, a micro-celebrity with a very popular motivational account who did some coaching. The before and after image contained, on the left, a picture of herself some years earlier, holding up her shirt to show her demarcated six-pack abs, and on the right, a more recent picture where she is sitting in her underwear with her much thicker legs curled up and showing her tummy rolls, where the six-pack used to be. Ella began the post caption acknowledging, “This is not the before and after picture you are used to seeing in the media,” and went on to explain, “This is the before and after picture of a person
who suffered in silence for over a decade. Going across the entire spectrum and variety of eating disorders” (Fieldnotes, 03/18/18). In the post, she described her experiences restricting, binging, purging, and over-exercising, and went on to list some of the rigid diets she had followed, from Keto to raw veganism to clean eating, and her experience body building. “On the outside, I looked like a healthy happy girl who was thin and fit. On the inside, I was ripping myself to pieces,” she revealed. The post urged caution in judging the weight gain of others, as they too may be suffering in order to maintain thin or fit bodies. She added, “I would be lying if I claimed to love the after picture. But I recognize that hating the after body is something I learned from diet culture.” Given her status as a micro-celebrity, the post had hundreds of comments thanking her and praising her or sharing struggles.

Figure 6.4: Photographic Intervention of a Transformation Post.

This motivator used the side-by-side format frequently not only to encourage her followers to celebrate non-normative changes in body size, but also to shed light on the filtered or highly produced nature of Instagram photos more generally. For instance, she would compare
two photos of herself on the same day and in the same clothing standing versus sitting (and thus without versus with tummy rolls), sucking her belly in versus relaxing it (and thus flat versus round), or happy versus crying later on in the day—posts she referred to as “Instagram versus reality” posts, which were particularly popular. In doing so, she and others posting similar kinds of images, were attempting to subvert ideals of what health (and normality more broadly) looks like—which is, of course, closely intertwined with normative ideas of “beauty.” At the same time, they were subverting the before-and-after format in itself and its assumptions of what is better and worse, or its attempt to manipulate reality. Like the fear food challenges, the transformation photos maintained the self-improvement ideal in which the now was celebrated as healthier but subverted the content of what was considered as such.

While I focused on the transformation photos here due to their popularity, stand-alone pictures showing chubby or bloated tummies, cellulite, and fat were also common, as were single images of thinner or fitter pasts, with captions that rhetorically countered assumptions about what was healthy and beautiful. Recovery posts were not operating in a vacuum, they existed in tandem and often hand-in-hand with posts belonging to other groups encouraging body positivity and HAES. Regardless, by “repositioning and recontextualizing” everyday material “objects” like foods items and their own bodies, and by subverting the conventional readings of these objects, those in the recovery subculture opened up the world of objects to “new and covertly oppositional readings,” which was centered precisely on difference: “The communication of a significant difference, then (and the parallel communication of a group identity), is the ‘point’ behind the style” (Hebdige, 1979, p. 102).

Subversive Meaning-Making: Reconfiguring Healthy Eating
The shared identity, speech patterns, and resignification practices of the recovery subculture all point to a deeper reconfiguration of meaning-making surrounding health. Throughout their posts, comments, and conversations about orthorexia, eating disorders, and recovery, participants drew on and contributed to a particular understanding of what constitutes healthy eating and exercising. This shared, alternate paradigm distinguished the “disordered” (i.e., orthorexic) from the “non-disordered” (i.e., the truly healthy) in ways that directly contested mainstream health and nutrition discourses, or in the words of the recovery community, “diet culture.” I will briefly review several dimensions through which the subculture reconceptualized true health, based on oppositional beliefs, values, emotions, and behaviors.

**Beliefs.** The recovery subculture openly resisted the moralization of food, positing instead that food and health are amoral. In the words of Marion, “Food is not a moral issue” (Fieldnotes, 05/10/18), and “By changing my belief system and acknowledging that I had internalized fat and health as moral issues, I was able to free myself” (Fieldnotes, 06/21/18). Removing judgement was associated with eliminating moralistic labels like “good” and “bad” from all food discussions or putting these terms in scare quotes to signal sarcasm or irony. One coach, Natalie, asserted, “There’s no such thing as ‘perfect’ eating…. there are no good foods or bad foods and eating some foods instead of others doesn’t make you moral or immoral” (Fieldnotes, 03/27/18). Food labels, and the very terms “healthy” and “unhealthy” were also frowned upon, as they were viewed as carrying an implicit valence meant to judge others: “Stop labeling everything as “too sweet”, “fake”, “artificial”, “unhealthy”, “bad”, “too salty”, “too many ingredients”, shut up and fix yourself before judging others. Ugh I’m fired up,” exhorted
one young woman in recovery (Fieldnotes, 05/23/18). She added, “You’re really just judging people and trying to make yourself feel superior.”

A related belief was that following food rules—the foundation of diets—is detrimental to recovery and wellbeing. Food theories or diets, which may also translate into labels, were thus viewed as problematic. One young woman trying to recover from anorexia and orthorexia stated in one post that she didn’t “want to base my decisions about what I eat based on ANY rules, period” and lamented that she had spent most of her life “believing that food and exercise was the ultimate predictor of my health and happiness” (Fieldnotes, 07/20/18). Her followers agreed in a long stream of comments under the post, saying things like, “As someone who used to struggle and works in the diet industry, I also keep my distance from labels/diets/trends/lifestyles. No keto, paleo, vegan, low-calorie or anything else for me.” Instead, food consumption was to be regulated internally through intuition, an innate understanding of what is truly needed at any given time. A college student with a motivational account pointed out that calorie counting promote adherence to external rules: “I encourage you to learn to trust your own intuition around food, knowing that food choices are (and should be) determined based on mental, emotional, social, and spiritual health, not just physical health,” she wrote (Fieldnotes, March 15, 2018). I will elaborate on this point, below.

A third belief is that the healthfulness of certain foods or behaviors is relative. The relativity of healthfulness was conceptualized on two different levels. The first kind of relativity posited that healthfulness is relative to each individual. From this perspective, each body is viewed as different, making individual needs unique; thus the healthfulness of foods or behaviors can’t be defined a priori but only in context. Food choices are thus “incredibly personal and
individually specific” and depend on “a multitude of factors…so all you can do is eat what’s best for YOU” (Fieldnotes, 03/28/18). Another person made a similar point, claiming “Everyone’s version [of health] is entirely unique, what works for one person just doesn’t work for another, and that’s fine! Everyone is different” (Fieldnotes, 08/04/18). A second way healthfulness was viewed as relative involved the idea that there are different kinds of health (e.g., physical, mental, spiritual) and that achieving true health required tending to all kinds of health. “One could make the argument that asparagus has more nutritional benefits than a chocolate bar. However, what this fails to acknowledge is that there are other kinds of health benefits; primarily, mental health,” posted Ella, the coach, in one post (Fieldnotes, 03/07/18). Another shared a post in which she distinguished between “nutrient dense” and “healthy” to argue that a bowl of greens with tuna and avocado and a brownie could both be healthy: “If you choose a nutrient dense meal and are truly craving it, it’s a healthy choice. BUT if you are craving the cookie and choose the cookie, THATS HEALTHY TOO. Maybe not nutrient dense, but healthy as in you are listening to your body and enjoying it guilt free and getting on with your day” (Fieldnotes, 03/18/18). That is, nutritional density involved physical health, but satisfaction was necessary for mental health, making both options healthy.

**Values.** The primary value celebrated in the recovery subculture was that a freedom, which was situated in stark contrast to self-discipline or control. Breaking free from food rules and labels was described as liberating and empowering, and diets were often depicted through metaphors of subordination or imprisonment. Freedom was also discussed hand-in-hand with related values like flexibility and spontaneity. In a video about her recovery from orthorexia, one young woman shared about her decision to shed the “HCLF” (High Carb, Low Fat—a specific
kind of vegan diet) label from her identity, celebrating how liberating it felt to “not be a slave to a diet” (Fieldnotes, 01/26/18). On the flip side, recovery was discussed in terms of “food freedom,” which often came in the form of a hashtag. Participants encouraged others to “take a moment to reflect on the fact that dieting takes that ability to be free” and speculated that people encouraging these behaviors probably hadn’t “tasted the freedom from the chains of food rules and restrictions” (Fieldnotes, 03/25/18). Natalie, the coach, wrote:

Freedom. That’s how I describe letting go of fear around food and learning to listen to your body. No more counting calories or stressing out over whether a food is “on plan” or not. No more letting thoughts about food fill your mind. You are free, friend! You are strong, and beautiful, and fierce! Claim your freedom. Be daring. You won’t ever look back!” (Fieldnotes, 03/31/2018)

A second value celebrated in the recovery space was that of “balance,” which was situated in opposition to perfection and continual improvement. Balance, often invoked with the #balancednotclean hashtag, was conceptualized not in terms of balancing “macros” in a meal (i.e., fats, proteins, carbohydrates), but of balancing enjoyment and pleasure with nutritional quality—parallel to the idea of balancing physical and mental health. In the words of one individual in recovery, “It’s hard to balance physical health and mental health around food,” but “how beneficial is peak physical health if we’re riddled with anxiety to maintain it or fearful of food?” (Fieldnotes, February 2, 2018). Another person shared, “I used to feel guilty if I wasn’t working out every day and eating a perfect diet…Every time I screwed up, I would beat myself up and feel absolutely terrible…Today I’ve learned the importance of balance” (Fieldnotes,
Here, eating treats was not framed as a fault or a gaffe (in contrast with terms like “cheat days” in fitness circles) but as a part of a truly healthy diet.

A third value foregrounded in recovery discourse was that of connection—food was viewed as a crucial vehicle for connecting with other people. Avoidance of social activities and outings in an effort to safeguard healthy food consumption was viewed as contrary to this value, as was obsessing over food during these social events, as it distracted from the ability to connect. In the words of Liam, reflecting on his recovery from orthorexia, “I am grateful for food freedom and the ability to connect with others through it. I am thankful that by reevaluating my relationship with food, I’ve had to reassess my relationship to myself and the world around me” (Fieldnotes, 05/05/18). Marion, who worked as a trainer at a gym, shared a picture of a large crepe with whipped cream and a caramel sauce on top, with a caption positing, “Real connection means being present with others, enjoying food and conversation, not hiding behind your kale salad and skipping out on social events” (Fieldnotes, 05/10/18). Again, social life and relationships were grounded as more meaningful and valuable than living life “with a flat tummy.” The value of connection was also explored through a medical lens, like Julia, a dietitian who pointed out that “we have so much to research about how socialization is one of the leading causes of longevity” and about the negative health impacts of isolation, which she speculated may have something to do with “cortisol” in the body.

*Emotions*. Experiencing negative emotions in response to eating certain foods was read as indicative of orthorexia and thus deemed unhealthy. Those in the recovery community often shared their experiences of shame, built, fear, and anxiety around food, which they interpreted as disordered, and the aspiration to overcome these kinds of emotions when eating. Those who
identified as having recovered celebrated no longer being riddled by these emotions when indulging on pleasurable foods. One person recalled how it “took me about a year to unravel my unhealthy relationship with food and find my food freedom, free of guilt and shame” (Fieldnotes, 02/10/18). Another gave her followers “permission to enjoy a 1600 calorie Ghirardelli ice cream sundae, without feeling guilt or shame or trying to ‘make up’ for it afterwards (Fieldnotes, 02/17/18). Negative affect was also biologized in some instances, like Nora, a coach who posted a video about how “your mindset can affect your physical response to food” and that negative feelings like fear and shame could affect “the gut” or produce a nocebo effect (Fieldnotes, 02/12/18). Thus, negative emotions were viewed as biological processes producing a negative impact in the body.

On the flip side, pleasure, joy, and satisfaction represented recovery and health. As one young woman wrote: “After all, eating should not only make you feel full and healthy, it should also be fun” (Fieldnotes 02/27/18). Marion reminded her followers that it was okay to “eat for the sake of satisfaction and pleasure” (Fieldnotes, 06/22/18). In another post, she underscored that “pleasure in eating is so important and innate…Eating what sounds good to you when it sounds good without feelings of guilt or shame provides satisfaction” (Fieldnotes, 06/01/18). She explained that feeling satisfied was crucial to avoiding binging at a later time and thus crucial to a healthy relationship with food. Thus, pleasure was re-centered as a fundamental part of maintaining a healthy relationship with food.

**Behaviors.** In addition to their understandings about healthy beliefs, values, and emotions regarding food and eating, participants advocated for grounding eating behaviors in “intuitive eating.” First promoted by two dietitians in the 1990s, intuitive eating is an eating philosophy
that foregrounds the reliance on internal hunger cues, rather than external directives, to guide eating (Tribole & Resch, 2007). Instead of carefully regulating food intake through rules or measurements, intuitive eating is read as a way of letting go of control and trusting the ability of the body to regulate itself. Individuals across the spectrum of participants professed their adherence to intuitive as the ultimate goal to work towards in full recovery. Some of those who had been through formal treatment centers learned about this eating philosophy there, while other learned about it on Instagram. Ella explained intuitive eating to me in an interview, as follows:

We’re all born intuitive eaters: We eat when we’re hungry, we stop when we’re full. Babies cry when they’re hungry and when they’re full, they’re fine. They’re not always overeating, they’re not restricting or anything like that. As we grow older and get all these messages about what healthy is and what healthy isn’t, and as we struggle with body image, we kind of unlearn to be intuitive eaters, so eating intuitively is like relearning to listen to your body and honor your hunger, honor your fullness, and not be so hard of yourself.

Intuitive eating was understood as requiring unwavering trust in the body. “It’s getting back touch with hunger and fullness cues,” explained one young woman, adding that, “rather than relying on external rules to tell you how much you’re ‘allowed’ to eat, you learn to rebuild trust with your body so you can eat when you are hungry and stop when full” (Fieldnotes, 03/07/18). A teen in recovery shared pictures and a description of her “dinner + n/s” [night snack], consisting of lentil soup, a chia roll with vegan cheese, beans, sweetcorn, and an apple.

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32 Many people pointed out that intuitive eating was intended for those further in their recovery because people with full-blown eating disorders often required healing their bodies and restoring their weight in order to recuperate their ability to experience normalized hunger cues.
She reflected on her food choice: “That is what I craved so that is what I ate. My body knows what it needs and it is communicating with me all the time. I just need to understand and listen to it” (Fieldnotes, 03/21/18). Learning to trust the body was often scary or disconcerting. Andrea recalled her temporary “infatuation” with eggs during her recovery from anorexia and orthorexia. “My body was screaming for eggs. My body needed the combo of nutrients they provided,” she reasoned. After having allowed herself eggs multiple times a day for days on end, she overcame the infatuation, leading her to advise others: “Don’t fear your cravings in recovery…Right now, whatever you are feeling is very much needed. But it’s temporary, I promise you. Be patient and cooperate” (Fieldnotes, 02/09/18).

Beliefs about the value of intuition applied to exercise too. Learning to listen to the body’s needs for rest, for example, was particularly important to those who felt stuck in compulsive exercise patterns in addition to food compulsions. Achieving a healthy relationship with exercise, as with food, demanded awareness of the body’s needs at any given moment. As explained by Olivia: “I think that very much like I think that your body will tell you when it's thirsty, it will tell you when it needs to move.” One coach, Natalie, explained in a caption that she had skipped going to the gym all week in order to sleep in because she had been feeling exhausted. “Being more intuitive extends farther than just the way you eat. Being more mindful and intuitive with eating has helped me to be more relaxed in all areas of my life.” Thus, physical movement, alongside eating, was subjected to intuition and to be regulated in this way.

**Medicine, Expertise, and Personal Experience**

While the medical profession, its knowledges, and practitioners have acquired a privileged and powerful status within society (Conrad & Schneider, 1980; Seale, 2002), in the
orthorexia recovery realm, medical professionals and knowledges were often experienced as deficient and injurious, rather than productive. Medicine was recognized as imperfect and its knowledges as partial. Prescriptive and conflicting “science-based” advice was cited by many participants as a key contributor to orthorexia, alongside the broader cultural obsession with health and wellness, fueled by public health promotion. Furthermore, medicine was often experienced as complicit in diet culture, and its professionals as inadvertent accomplices. For many, orthorexia emerged after receiving medical instructions to lose weight or nutritional counsel from doctors and nutritionists.

Others maintained that their providers had played a negative role in their recoveries, especially when they were not trained in eating disorders specifically. In a post, one young woman expressed her distress and outrage at a physician she went to for a checkup, for showing her weight, despite the doctor beforehand that was “in active eating disorder recovery” (Fieldnotes, 02/17/18). In her interview, Andrea shared that while getting support from a dietitian helped her with her anorexia, the prescriptive food plan contributed to her developing orthorexic patterns: “I think nutritionists sometimes can have a detrimental role in one’s recovery, and it certainly was the case for me.” In a comment responding to another person’s post, Ella made a similar point: “I speak from experience when I say that I tried to work with professionals during my recovery who promoted very diet-focused messages and it was extremely triggering because I didn’t know any better at the time” (Fieldnotes, 06/05/18).

This perception of medical knowledge is what incentivized many to seek help on Instagram. Dietitians and coaches in the recovery space—and to an extent, those with consolidated recoveries—effectively fulfilled the roles of orthorexia recovery specialists
because of their embodied experiences and reliance on alternative approaches to nutrition (non-diet, HAES). Not only could they understand and identify with the orthorexic experience, their own pasts with disordered eating and recovery gave them unique credibility to advise on how to get better. Professional dietitians were most inclined to underscore professional credentials and use science-based advice, but they did so in ways that supported intuitive eating approaches, for instance, citing scientific evidence showing that long-term dieting is ineffective for weight-loss and a risk factor to disordered eating, or reviewing the work of scholars advocating for a paradigm shift in weight science, from a scientific perspective. For instance, Julia, a dietitian, shared a story quoting an academic and promoter of HAES: “Something is seriously wrong when we prescribe for fatter people the very habits that we diagnose as evidence of disease in thinner people. -Linda Bacon, PhD” (Fieldnotes, 04/04/18).

Coaches often included disclaimers on their websites, warning their counsel “should not be taken as medical advice,” nor was it intended to “diagnose, cure, or prevent any disease,” and urging people to consult healthcare professionals before making changes to their lifestyle (Fieldnotes, 04/02/18). However, in practice, coaches were readily available to support the healing process. They often offered digital resources, like e-books where they had “put all of my experience, tools, tips, tricks, pitfalls, mistakes and best practices to heal your body” (Nora, Fieldnotes, 03/15/18). Andrea, who acknowledged that she was not always open with her much older, male psychiatrist, pointed out that while she believed professionals were necessary for individual issues like underlying trauma or suicidal ideation, for individuals who did not have such serious problems, or who were receiving professional care for those issues, coaches were “very helpful” because they were unconstrained by rules and regulations limiting those working
within formal healthcare settings. “It’s kind of like your best friend or your mom or someone who you’re comfortable with, but that actually knows what you’re talking about,” she added. Luna, a Canadian woman in recovery, explained that after awful experiences with a formal healthcare provider, she found a recovery coach on YouTube, who ultimately helped her get better: “She documented her recovery on her YouTube channel. I saw that she recovered…She knows what I’m going through and she recovered, so she can help me recover.” Luna had access to professionals but preferred working with a coach, who had first-hand understanding and an approach she trusted more.

Given the centrality of intuition in the recovery space, the work of professionals and coaches was largely about helping individuals learn to listen to their bodies, again, rather than imposing prescriptive rules for how to eat. While dietitians were more likely to encourage individuals to seek the help of professionals working in non-diet paradigms, coaches more often encouraged them to recognize themselves as the “experts” of their own bodies. One coach shared in a post that people often asked her how they should eat, as if there was a magic answer: “But honestly, I’m not even close to being an expert in nutrition. Sure, I know a few things...But the real expert is YOU! By learning to tune into your body, you don’t need anything but your own intuition to tell you how to eat!” (Fieldnotes, 01/09/19). Natalie, another intuitive eating and body image coach reflected:

The problem with “healthy” eating (which can easily spiral into orthorexia, the obsession with eating foods considered to be healthy) is that it has us turning to “experts” outside of us while ignoring our own internal wisdom…And all of the “experts” appear to disagree with each other!...It’s easy to get caught up in what someone else decides is right and
wrong, good or bad...but this takes us away from what actually feels right for me right now?…Only we can know. WE are the ture experts. OUR BODIES are the experts.

(Fieldnotes 08/28/18)

**Shifting Sources of Knowledge: From Medicalized Quantification to Embodiment**

The alternate health paradigm professed in the recovery subculture maintains a complex relationship with medical knowledge. On the one hand, it relies heavily on medical and therapeutic language for framing extreme health seeking behaviors as disordered, interpreting the symptoms, and validating suffering or distress. By medicalizing orthorexic behaviors as pathological from a psychiatric perspective, participants in the orthorexia subculture created an entry point to resist and actively subvert widespread beliefs and practices about healthy eating. The orthorexia label serves to create a shared sense of identity centered on recovery and restoration, which is enacted and developed through shared language, bricolage practices, and subversive beliefs that challenged the meaning of health. Yet, despite the altered content of “health,” its supremacy as a super-value persists within the recovery space, alongside an equally obstinate and individualistic self-improvement and self-care ethos.

On the other hand, the health paradigm in the recovery subculture also signals an important rupture with conventional medical and nutritional knowledge that encourages, among other things, external regulation of food consumption through calorie or macro-counting and weighing (think of the ubiquity of nutrition labels and recommendations) and messaging about good and bad foods. Instead, the concept of intuition foregrounds embodied knowledge, which in the context of medical sociology, emphasizes the “nonfactual, subjective, idiosyncratic” (Lippman, 1999, p. 268). The phenomenological concept of embodiment enriches our
understanding of embodied knowledge in emphasizing the body, that is, the experience of having and using the body as a vehicle to know the world (Mears, 2011, p. 108; Shilling, 1993). Thus, we may understand embodied knowledge here as that which people develop about their bodies through their lived experience of their body. If health is relative and specific to each individual in their given context, sweeping health prescriptions are seen as less helpful than the subjective knowledge accumulated through embodied experience. Moreover, embodiment emphasizes how knowledge appears to be imprinted in the body, arising not through conscious cognition but through practice, enabling the body to respond and anticipate (O'Connor, 2005; Tanaka, 2011). This moves beyond a rationalistic approach to health, where logic and cognition are prized.

The value of embodied experience as a source of knowledge has been a central theme in feminist scholarship concerned with how medical and scientific knowledges have been used to privilege the position of powerful groups (Bell, 2009; Lupton, 2003). Women’s Health Movements in particular have fought for the recognition of the women’s “subjugated knowledges,” at times resisting medicalization and at times advocating for it (Foucault & Gordon, 1980; Morgan, 1998; Ruzek, 1978). Biomedical knowledges have historically drawn from discourses about the female body as intrinsically weak, vulnerable, and out of control, to medicalize a broad array of female conditions and experiences, and make the female body a site of intervention (Ehrenreich & English, 1978; Lock & Nguyen, 2010; Martin, 2001; Riessman, 1983). As Martin (2001, p. 194) points out, medicine has lent itself as an additional lens through which paternalistic science can interpret unruly bodies as objects, “carried along by forces beyond their control.” Feminists have thus demanded for women’s right to self-determination, and advocated for a recognition of knowledge deriving from embodied experiences.
Consistent with feminist efforts to re-center embodied knowledge, intuitive eating foregrounds intuition as a valuable form of wisdom, and positions it as superior to external cues like nutritional directives and labels, in guiding food choice. However, intuitive eating is about more than just self-determination, it is about centering the physical body as a source of wisdom. Intuition was often framed as a matter of respect toward and trust of the body, which in turn was believed to regulate its own appetites most effectively. This approach contests, on the one hand, the inferiority of the physical body as unruly and out of control—long been associated with womanhood and femininity—and on the other hand, the superiority of the rational mind and reason—associated with masculinity (Bordo, 2003). Intuitive eating does not debunk this Cartesian mind/body dualism; rather, it subverts the attributes of each component. Here, the rational mind, or the “brain” where the disorder is said to live, is viewed as corruptible—by diet culture and the orthorexic pathology it produces. Nutritional guidelines, labels, and quantified information constitute reductionistic, partial, and potentially damaging information that suppress one’s ability to access wise intuition. As Liam reflected, “I’ve have to trust my body and not my ‘prefrontal cortex’ to make my food choices” (Fieldnotes, 02/21/18). From an intuitive eating perspective, hunger and cravings were not urges to be resisted but valuable information that needed to be “honored” to achieve internal homeostasis.

As shown in the previous section, the privileging of embodied knowledge also reflects a general malaise with prescriptive medical instructions regarding optimal eating and exercising. Having experienced harm or suffering as byproduct their health pursuits, those in recovery grew skeptical about the expertise of the profession making these prescriptions and their ability to understand. Thus, embodied experience of orthorexia and recovery, became a better proxy for
the constitution and evaluation of recovery authorities within the subculture, aided by platform metrics determining popularity and status. This context was ripe for the proliferation of coaches, dietitians, and recovered motivators who openly shared and even capitalized on their personal history with orthorexia. Technical expertise about nutrition lost some of its appeal among this population, although dietitians professing alternative approaches to nutrition straddled the line. The trust in others who have experienced similar plights, above those with supposedly technical expertise, is just the newest chapter in the modern crisis of authority.

In addition to exalting embodied knowledge, the recovery subculture’s health paradigm attempted to resist the moralization of food based on health qualities. Food is uniquely amenable to moralization for many reasons. Diet constitutes a crucial site for the construction of morality, as beliefs previously grounded in religious doctrine shifted toward secularized knowledge about the biochemical constitution of food, while retaining concerns with worldly desires and the weakness of the flesh (Coveney, 2006). Binary categorizations of foods as “good” and “bad”—which have historically pervaded food discourses—now map onto categories of healthfulness and create a narrative in which eating “healthy” food is also morally correct (Lupton, 1996). In the orthorexia subculture, this subtle but pervasive morality, which may otherwise go unnoticed as objective, medical knowledge with seemingly neutral labels like “healthy” and “unhealthy” is made explicit and called out with phrases like “food is not a moral issue”—at least not in terms of healthfulness. By centering alternative values and bringing into question the intrinsic desirability and goodness of “healthy” foods, the recovery subculture contributed to effectively blurring the moralistic binary of food choice on the basis of healthfulness by granting good and bad food categories greater fluidity and relativism.
Finally, the recovery subculture tried to reclaim the value of pleasure within their health paradigm. Because of its association with pleasure, eating, like sexuality, is highly susceptible to social control (Mintz, 1997; Rozin, 1997). The recovery discourse, however, positioned pleasure, and satisfaction as central to recovery and wellbeing and encouraged satisfying experiences of food previously off-limits in the fear food challenges. Through these dynamics and meaning-making practices surrounding enjoyment, the recovery subculture transformed pleasure from a threatening or risky behavior to be controlled into an integral part of their understanding of “health”—something achieved in part by balancing different kinds of healthy. Here the adoption of the disease metaphor in the realm of human suffering and distress, as in mental health, serves to ground emotional experiences as relevant to the production of healthy human beings.
Two decades after the publication of Health Food Junkies, orthorexia’s institutional status as a diagnosis remains unsettled. And yet, despite its unofficial standing, we can appreciate throughout these chapters the amount of work that has been done through the label by various actors, ranging from individuals like Bratman and Jordan Younger, to professions like dietetics, to commercial and non-profit actors. Orthorexia has been used to redefine normality in eating by declaring certain behaviors undesirable and framing them as pathological. It has been deployed to expand professional jurisdictions and markets. It has also been used to symbolically diagnose individuals and determine proper avenues for treatment. Moreover, orthorexia has been used to solve practical problems in healthcare settings, legitimize distress, confer a collective identity, and empower subversive health practices. In sum, orthorexia has performed many of the diverse functions that characterize diagnoses and makes them so powerful (Jutel, 2009, 2011a), without requiring an official DSM endorsement.

That all of these functions have been possible in the absence of any formal resolution on part of the medical establishment demonstrate the difficulties in controlling knowledge flows as diverse actors make claims in many different spaces, which are differentially subjected to institutional constraints. The “divergent actors, social worlds, meanings, and uses” (Fujimura, 1992, p. 175) surrounding orthorexia all point to its utility as a boundary object, an object that is both “plastic enough to adapt to local needs and constraints of the several parties employing them, yet robust enough to maintain a common identity across sites” (Star & Griesemer, 1989, p. 393). Despite pursuing different goals and entertaining variable interpretations of orthorexia, the diverse actors examined in this dissertation overlapped sufficiently in their understandings of
extreme health-seeking behaviors as a legitimate problem to enable coordination. At the same
time, the ways certain knowledges and actors were came together varied significantly across
contexts.

In this conclusion, I will discuss how the case of orthorexia can contribute to our
understanding of scientific knowledge production in the context of mediatization. I argue that
media constitute increasingly prevalent and pervasive hybrid forums for knowledge production
in and of themselves, while also contributing to the hybridization—in terms of actors and
knowledges—of other spaces. Next, I draw on the sociology of professions to make sense of the
jurisdictional expansion of dietetics as a discipline within the context of a unique eating disorder
field. In the third section, I foreground the importance of embodied knowledges in the context of
orthorexia knowledge production, as a source of credibility. Finally, I draw from literature on
entrepreneurship in organizations and institutions to examine the orthorexia as a product of
creative friction.

**Hybridity in a Mediatized World**

The diverse media that make up the contemporary information ecosystem have played a
fundamental role in the production and circulation of orthorexia knowledges. As we saw in the
chapter about news and social media, the assemblages forming through specific media have been
shaped by the socio-technical logics governing their functioning. More than serving as mere sites
for claims-making to take place, the news media have actively contributed to the co-production
of orthorexia knowledges and experts through the professional logics and practices of
journalism, which have acted in consequential ways. Similarly, the social and technical
affordances of Instagram have enabled the constitution of particular orthorexia-centered
networks that bring together distinct orthorexia knowledges and experiences through hashtags and follows. The logics of both news and social media are not simply curious details—they are central to kinds of knowledges that can and do together and on what terms. In this way, we acknowledge the active, patterned, and consequential mediation of knowledges and knowers constitutes a crucial aspect of co-production. In doing so, we appreciate the mediatization of knowledge production as a social process through the increasingly relevant role of media, as they disrupt the social interactions and dynamics undergirding the social world (Couldry & Hepp, 2017, p. 15).

As socio-technical assemblages, media inform the structure and content of the components that are assembled through them. They do so in ways that contribute to hybridization by facilitating and encouraging encounters and interactions of diverse and disparate knowledges and actors. The heterogeneity of actors invoked by Callon et al. (2009) in their concept of hybrid forums is increasingly characteristic of knowledge production as it becomes mediatized. Stated differently, as ethno-epistemic assemblages in themselves, and as contributors to other interconnecting ethno-epistemic assemblages, media support, magnify, and oftentimes enable the interweaving and blurring of categories like science/non-science or expert/non-expert in ways that were previously unfeasible or difficult to sustain. And because, as a boundary object, orthorexia maintains a certain degree of ambiguity as it travels across the intersecting assemblages, we can appreciate the “many ‘natures’ and many ‘socials’” that are co-produced by multiple “co-actors who are themselves co-constructed as both lay and expert” (Irwin & Michael, 2003, p. 112)—that is, the many orthorexia objects and subjects that are produced as one moves through the assemblage in time and space. While orthorexia may be a
somewhat extreme example of this mixing and blurring, it is not categorically different from the kinds of odd mixtures arising around other issues and topics (see Irwin & Michael, 2003 for more examples).

This is not to say that media exert an equally hybridizing force in all contexts, or that all media contribute to hybridization in the same ways. We saw unique ways of understanding and determining authority in news articles based on journalistic norms, which privileged professional credentials and advocacy organizations for certain kinds of claims-making, and experiential suffering for others. On social media, we saw embodied knowledge emerge as a distinct form of currency, which intersected with certain social and aesthetic norms in helping determine popularity and reach. Media also contributed to the professional knowledge and application of orthorexia in clinical practice, as healthcare providers turn to the news and the web for their informational needs, connecting with news media, but also with colleagues and scholarship through social media. We also saw how hybridization was abated and resisted in institutional and professional spaces that depend largely on maintaining the original categories and distinctions intact. This is especially the case in the academic scholarship, where publications quickly expunged media claims from citations, even as subsequent knowledge continued to build off of those initial claims. Thus, we might predict, that the more central media are to a particular ethnoepistemic assemblage and its functioning, the greater the power of their logics in the constitution of the assemblage and the more potentially disruptive of professional logics and hierarchies. Nonetheless, the hybridity magnified through mediatization seems to reflect a weakened ability on part of traditional institutions to constrain knowledge production among lay actors and credentialed professionals, alike.
Not all areas of science are equally susceptible to hybridization—indeed, some are more or less hybridized from the start. The eating disorder field, for example, has been characterized by a remarkable openness to lay participation, grounded in feminist sensibilities to embodied or “subjugated knowledges.” In this way, the eating disorder field appears to welcome hybridization in a way that makes it unique. Distinct knowledges are also differentially vulnerable to external interference. We would expect sites with greater overflows of science and its techniques to motivate greater hybridization. As a science that continually interacts with and exerts its power on human bodies and experiences, medicine is highly susceptible when compared to other sciences—it is unsurprising, thus, that medicine is by far the most mediatized of the sciences (Bauer, 1998). Psychiatry, in particular, is further exposed by its history of professional ignorance and paradigm shifts, which reverberate in the eating disorder field through fragmented and contradictory beliefs about the most basic issues regarding the “nature” and causes of disordered eating. In other words, new or uncertain knowledges also appear to provide greater opportunity for science “outsiders” to stake claims.

Different assemblages enable the prominence of distinct diagnostic entrepreneurs, demonstrating how orthorexia entrepreneurship constitutes a collective endeavor that is distributed across diverse actors in different assemblages. Some entrepreneurs reemerged in multiple assemblages, acting as bridges, even if they have a different degree of centrality or recognition. Bratman, for example, played a central role in news media and in academic scholarship, but was less relevant on social media. Jordan Younger was most visible in news media and on social media, and less central to professional practice and scholarship. Other actors bridged clinical practice and/or scholarship with social media, like the dietitians Renee
McGregor and more notably Pixie Turner, who only posted about orthorexia sporadically but has an enormous following on Instagram and has addressed orthorexia across all four assemblages. We would expect media logics to have a greater import in determining which entrepreneurs acquire most traction and reach, the more central they are to an assemblage.

The scrambling of actors and knowledges that takes place in the ethno-epistemic assemblages of orthorexia extends beyond expert/lay categories to involve commercially and politically motivated actors and concerns, as well. We saw private treatment facilities and non-profit organizations emerge as important orthorexia knowledge sources in clinical settings and news media, and in the case of non-profits, on social media as well. There is no reason to believe that this tendency is unique to the case of orthorexia. Media scholars have documented the growing presence of laypersons, non-profits or patient groups, and industry actors alike in the sourcing of medical news over the past two decades (Briggs & Hallin, 2016; Nisbet & Lewenstein, 2002; Pitrelli, 2017). What does stand out is the extent to which these seemingly different actors and their functions have become intermeshed in the hybrid eating disorder field.

For example, some private treatment centers have their own foundations or financially support non-profit organizations and professional associations, which in turn, may provide them with a platform to promote their services. Non-profit organizations and treatment centers constitute information sources both through media and in professional development activities, where they contribute to shaping professional knowledges about eating disorders, including orthorexia. Furthermore, an Eating Disorders Coalition with representatives from treatment centers and non-profit organizations currently does political lobbying to improve insurance and Medicare coverage of certain eating disorder related services. When successful, these kinds of
efforts can simultaneously improve the access of individuals to treatment and support, while also increasing revenue for private clinics. This hybridity can be seen on an individual level too, as there are many boundary blurring individuals who participate in multiple different organizations and roles at the same time, including eating disorder professionals participating in advocacy work. We also saw how different kinds of Instagram accounts were more commodified, with professionals and coaches participating in a range of activities, ranging from orthorexia awareness-raising to personal branding and promotion of services. This intermeshing of functions is not intrinsically bad. Despite efforts to frame science and its practitioners as neutral and non-political, there is a strong argument to be made in favor of experts taking positions on matters with such obvious human consequence. Furthermore coordination and collaboration can make the work of disparate actors much more effective in helping individuals.

However, it also makes professional, political, and commercial commitments extremely difficult to disentangle. Most complex is the overlap between diagnostic claims-making (stating that orthorexia is a real mental disorder), awareness-raising (informing others that orthorexia and instructing on how to identify it), and marketing (selling services to treat orthorexia). We have seen how these different objectives, in the case of orthorexia, are sometimes simultaneous and effectuated through media. Scholars have previously expressed concerns about media and their contributions to “disease mongering,” the widening boundaries of treatable illness in order to expand markets for those who deliver treatments (Moynihan, Heath, & Henry, 2002; Woloshin & Schwartz, 2006). Indeed, the boundary between awareness-raising and disease mongering is not always clear. The entanglements between diagnostic entrepreneurship and commercial entrepreneurship requires ongoing scrutiny.
Professions in an Eating Disorder Field

The secondary role of psy experts in the production of orthorexia knowledge is striking across all of the assemblages examined, except scholarship—and here too, we see an eroded control, as “outsiders,” in this case, nutrition experts, were the ones to launch empirical research on the topic. Notably, the efforts to reclaim orthorexia on the part of psychology researchers have been not in detriment to orthorexia as a concept. Thus, while they have challenged the technical attributes of the proliferating ORTO-15, they have also made efforts to reassert the validity of the diagnosis. Across the four assemblages, the entrepreneurial work of non-psy actors becomes more obvious and central, including Bratman (in news and in scholarship, and to a lesser degree among clinicians), Younger (in news and social media), certain recovery-focused Instagrammers (on social media, including coaches and those in recovery), and most notably, dietitians (in all four assemblages).

Scholarship on professions is helpful for making sense of this pattern, as it relates to Bratman as an MD, and dietitians (such as clinicians actively presenting on the subject or the author of the orthorexia book, Renee McGregor). When approaching professions as forming part of an interrelated system where they compete for dominance over specific jurisdictions (Abbott, 1988), the prominence of other disciplines in orthorexia entrepreneurship is symptomatic of psy experts’ eroded control over their own field of study. As Whooley (2019) points out, a long history of paradigm shifts and professional crises, in conjunction with the efforts to reinvent the psychiatric profession along the lines of community psychiatry in the 1960s and 1970s, left psychiatry highly vulnerable to interlopers. As the very concept of “psy disciplines” implies,
mental health now encompasses much more than psychiatry, with clinical psychologists having largely displaced psychiatrists. In the eating disorder field, this erosion has been even greater.

Part of the problem arises from the substance of psy profession’s knowledges under the diagnostic approach to psychiatry. The biomedical paradigm’s inability to produce a consistent definition of mental disorder or technically determine the validity of its constructs has left the discipline exposed to interloping, as we have seen in the case of orthorexia. These problems are symptomatic of certain deficiencies of the abstract system of knowledge underlying the biomedical model, which as Abbott (1988) points out, is a central to maintaining professional control. If diagnostic criteria are mere collections of symptoms, which in turn are taken as confirmation of a valid disorder, then new diagnoses like orthorexia can, to an extent, be asserted into existence—so long as they are able to garner sufficient support. Moreover, as we saw in the chapter about healthcare providers, in the eating disorder healthcare, there is no single unified system of abstractions. Instead, we find a complex fusion of diverse viewpoints and theoretical frameworks that, in the aggregate, make it difficult for psy experts in eating disorders to coalesce into a single, coherent group capable of articulated boundary work.

The strong presence of other disciplines in orthorexia knowledge production may also derive partly from orthorexia’s location at the margins of mainstream knowledge. As Abbott (1988) points out, “Vulnerability begins not with the most commonly treated professional problems, but with the peripheral ones” (p. 44). One might predict, then, that emerging or unofficial psychiatric diagnoses like orthorexia provide fertile grounds for the invasion of “outside” professions. Paradoxically, as we can see in this case, these can be especially meaningful sites for knowledge production, as new knowledges and techniques are at stake.
We have also been able to appreciate the consolidation of a distinct eating disorder *field*, which more than constituting a subcategory of the larger *psy* field, has broken off into a somewhat distinct entity. While it still involves the key participation of *psy*-experts—and in this way still overlaps with the *psy* field—it also incorporates and centers various other disciplines, not to mention non-experts. *Psy* experts (which include licensed social workers and counsellors) maintain a certain degree of hierarchy within the eating disorder treatment structure as the diagnosing clinicians in charge of treating the “underlying problem.” However, dietitians have come to play an increasingly important and relevant part of eating disorder treatment, reflecting an effective jurisdictional expansion on their part. Crucial to understanding the apparent openness of *psy* actors to this expansion is the fact that the work of dietitians does not replace their work, it complements it. The broadening of the eating disorder framework to include orthorexia behaviors would thus prove mutually beneficial for all actors involved.

Yet, we can also see dietitians increasingly centering themselves within the field, as news sources, as social media figures, and as scholars. This shift is also notorious in healthcare settings, as we saw in Chapter Four, where several dietitians described their work as bridging together the multi-disciplinary treatment setting, transforming them into central rather than peripheral actors. The orthorexia diagnosis further consolidates these efforts by positioning technical knowledge about food composition as uniquely crucial to orthorexia treatment. Indeed, an obsession with *healthy eating* (rather than with, say, a thin *body*) makes itself remarkably appealing to the discipline that manages healthy eating and is already involved in the eating disorder field. Moreover, by framing orthorexia as partially a problem of misinformation,
dietitians situate themselves as indispensable to the healing process, as they possess the technical knowledge needed to set the nutritional record straight.

A professions perspective helps make sense of the incursion of nutrition as a discipline in orthorexia claims-making at a broad level, but it doesn’t tell us as much about the specific individuals doing the work, the kinds of claims they were making, and how these relate to conceptions of expertise. Moreover, orthorexia entrepreneurship has involved more than professional activities, which isn’t accounted for in an analysis of professions. To make sense of these contributions, I turn to scholarship on expertise and embodiment.

**Rethinking Expertise: Embodiment as Credibility**

Using Collins and Evans’ (2002) theory of expertise, L. Prior (2003, pp. 48-49) advocates for a nuanced conceptualization of lay and expert categories, to be achieved by classifying contributions to medical knowledge based on two dimensions: expertise and license. This is a helpful starting point for thinking about the kinds of knowledges that emerge and converge in the case of orthorexia. I understand expertise as the mastery of technical skills that enables a person to carry out tasks—practical or theoretical—that novices without said competence are unable to perform (Callon et al., 2009, p. 228; Goddiksen, 2014, p. 112). While lay individuals can develop expertise on medical issues, idiosyncratic knowledge cannot be automatically equated with technical understandings of the complexities of disease causation (L. Prior, 2003). From Prior’s perspective, four ideal types of actors participate in knowledge production: lay individuals who by definition lack formal credentials can be either experiential knowers (without expertise) or experience-based experts (with expertise); whereas professionals can be licensed
non-experts (when the licensing does not apply directly to the topic at hand) or licensed experts (when the licensing does directly apply).

Here, Bratman’s status as the proponent of orthorexia comes to the fore. As pointed out in the news chapter, Bratman was not a psychiatrist or a psychologist and, thus, did not possess formal credentials or a technical specialization in psychology or psychiatry, or in any realm of the eating disorder field, for that matter. In fact, on a previous version of his website he explicitly acknowledged he is “not an eating disorder expert” (Bratman, 2004). Instead, Bratman’s status at the time of his initial claims-making more closely resembled that of a non-licensed expert: a person with professional licensing that does not directly apply to the topic at hand, and which L. Prior (2003) maintains are “only one step removed from the lay public” (p. 52). Indeed, Bratman’s case is reminiscent of Prior’s analysis of a London-based gastroenterologist who, while lacking credentials in child psychiatry or epidemiology, contributed to spreading technically unsubstantiated claims about the dangers of the MMR vaccine. A similar argument can be made for dietitians who are not formally trained or credentialed in psy knowledge (although many working in eating disorder treatment on a regular basis may have acquired a degree of experience-based expertise).

A normative evaluation of the aforementioned contributions may be justifiable regarding licensed non-experts making claims in fields that are not those of their technical expertise, while benefiting from seemingly misplaced authority on the matter of mental pathology. Indeed, it is hard to imagine the orthorexia story playing out the same if the claims had initially been made by a yoga teacher or an artist. However, it may be helpful here to recall that Bratman’s initial claims were not fundamentally technical, perhaps because at the time he was more interested in trying to
help lay individuals address a practical problem, than make diagnostic argument. The fact that his two original texts were published in lay venues and appeared to be mostly directed at lay people, rather than mental health experts, certainly support this idea. Moreover, foreclosing this analysis as a simple instance of experts overstepping would neglect a fundamental insight that a distinct kind of knowledge, not adequately captured in Prior’s typology, appears to be doing important work in the case of orthorexia claims-making. I am referring to embodied knowledge. As discussed in the previous chapter, the concept of embodied knowledge refers to the knowledge people develop about their bodies through their lived experience of the body. Unlike experience-based expertise, embodied knowledge does not require any technical skills grounded in complex systems of meaning. Yet, by grouping all lay people together regardless of their personal experience, the concept of “lay knowledge” fails to capture the unique kind of knowledge that can be acquired through embodied experience.

Embodied knowledge, as I showed in the previous chapter, has been central to the social media subculture producing knowledge, identity, and community based on orthorexia and eating disorder recovery. Scholarship about health social movements has demonstrated a growing tendency to foreground personal experience in collective challenges to medical beliefs and practices. Embodied health movements (EHM) center firsthand awareness and understandings of bodies as a unifying and mobilizing force to contest medical knowledges (P. Brown et al., 2011; P. Brown et al., 2004). In many crucial ways, the orthorexia case aligns with many of the insights about EHM as conceptualized by these scholars. EHM, too, use boundary objects as they blur the boundaries between science/non-science and experts/laypeople (P. Brown et al., 2011; McCormick, Brown, & Zavestoski, 2003). However, unlike the blurring described in prior
accounts of “lay expertise” (Epstein, 1995, 1996) in which lay actors acquire medical knowledges and language, much of the blurring in the orthorexia case results from expert actors acknowledging their own personal experiences with orthorexia. And to an extent, orthorexia claims-making has been rooted in experts’ embodied experiences, rather than in technical expertise, although their expert status has certainly elevated their authority. Bratman and many of dietitians who identified with having experienced orthorexia first-hand (both in the news and on social media) spoke of the distress and personal harm associated with extreme health-seeking behaviors based on their embodied experiences, which gave them a special kind of credibility.

Irwin and Michael (2003, p. 124) have underscored the importance of trust in the rendering connections and relations that constitute an assemblage, which involves matters of credibility, authority, legitimacy, status, and power, but also identification across different categories. Perceptions of shared experiences with orthorexia certainly contributed to cementing the label itself, as we can see on social media, but also in the high degree of identification among journalists and clinicians. These common understandings of orthorexia were achieved in large part through what Irwin and Michael (2003, p. 124) refer to as the “performance of personal suffering” as a means to ground the claims being made. The “performance of personal suffering” draws on broader conventions of authenticity—an ethos of testimony, we might say—in order to warrant” (Irwin & Michael, 2003, p. 125) particular actions or stances, in the case, the acknowledgement of orthorexia as a valid disorder.

The prominence of embodied knowledge or personal suffering among experts is not unusual in the eating disorder field, as personal histories of eating disorders are common and esteemed as a unique asset, a kind of wisdom that credentials are unable to bestow. What we find
is thus the emergence a third dimension through which to assess knowledge production and credibility—embodiment—and new categories of “experts with embodied knowledge” (like Bratman and Turner) who alongside “embodied knowers” (like Younger and most of the Instagrammers interviewed), have played a fundamental role in orthorexia claims-making. Precisely because embodied knowledges have such a high currency in the eating disorder space, recovered individuals and coaches maintain such valuable authority in the Instagram recovery community, alongside professionals. Of course, the value of embodied knowledge is likely to vary from one space to another, but in the eating disorder realm, it seems to help build trust, which is central to the success of scientific claims-making. These shared embodied experiences also provide a foundation for identity work to take place. The orthorexia identity has functioned as a form of cohesion that transcends expert/non-expert binaries precisely because both experts and non-experts have identified with the diagnosis.

Ultimately, the active role of such varied non-psy experts in orthorexia knowledge production, ranging from what Prior would call credentialed and non-credentialed experts to embodied knowers, to experts with embodied knowledge, all suggest that Abbott’s take on professional jurisdictions alone is insufficient to account for the diverse contributors to orthorexia entrepreneurship. As Eyal (2013) aptly points out, “Jurisdictional struggles are waged not only between established professions but also between any groups that can lay a claim to expertise” (p. 869). Embodied knowledge, I posit, is one the bases on which definitional battles can be waged, but it can also serve as the foundation for collaborations aimed at jurisdictional expansion in joint efforts involving diverse professions, non-professional actors, and everything between.
Orthorexia Knowledge Production as Entrepreneurship

Finally, I draw on sociological scholarship on organizations and institutions as a productive point of entry to understand diagnostic expansion as a form of entrepreneurship and the substance of orthorexia as an innovative boundary object. From the perspective on institutionalism, uncertainty and controversy provide favorable initiating conditions for institutional entrepreneurship by motivating ideas for change (Hardy & Maguire, 2008, p. 204). This point is central to Stark’s (2011) work on the creative value of dissonance in organizations. He maintains that entrepreneurship exploits the uncertainty that arises as different “orders of worth” with dissonant principles of evaluation enter into friction, which “disrupts organizational taken-for-granteds, generates new knowledge, and makes possible the redefinition, redeployment, and recombination of resources” (Stark, 2011, pp. 18–19).

Furthermore, by keeping multiple evaluative principles in play and exploiting the uncertainty about which order of worth is operative, “entrepreneurship involves asset ambiguity. From ambiguity it makes an asset; and in creating assets that can operate in more than one game, it makes assets that are ambiguous” (Stark, 2011, p. 15). Boundary objects, of course, involve a degree of ambiguity, which is precisely what enables them to travel across different sites and adapt to their needs. This capacity to circulate and coordinate among heterogenous spaces and actors makes boundary objects especially relevant to innovation (Bartel & Garud, 2009; Doganova & Eyquem-Renault, 2009). As Doganova and Eyquem-Renault (2009) aptly point out, examples of boundary objects facilitating or enabling innovation are recurrent in the literature (for examples, see Carlile, 2002; Henderson, 1991). The findings in this dissertation reaffirm the
entrepreneurial utility of boundary objects in the production of new knowledges, including those that emerge at the intersection of expert and non-expert ways of knowing.

More specifically, I posit that orthorexia exploits the ambiguity arising at the overlap of diverse principles of evaluation regarding “good” and “bad” eating. The primary source of ambiguity reflects the tensions between healthist morality and its imperatives to reduce risk via disciplined food choice, and alternate evaluations of what constitutes desirable eating behavior. These tensions are not new. We can see these frictions within the medical institution in competing perspectives on weight and dieting. Here, the eating disorder field and its predication of bodily diversity through frameworks like HAES and philosophies like “intuitive eating” or “all foods fit,” stand in opposition to notions of “good” and “bad” foods and widespread discourses that encourage nutritional literacy and control, and have increasingly pathologized fatness.

These tensions also exist in society more broadly. As we saw in the introduction, people are tired of being told what to eat. More telling yet is Backett’s work in the early 1990s, which shows how lay people negotiate with health imperatives by integrating social, emotional, and spiritual elements into their calculus, while also privileging moderation and balance as values over health fanaticism (Backett, 1992; Backett et al., 1994). Respondents in these studies defended certain “risky” but pleasurable behaviors based on the rationale that they “could be ‘life enhancing’ even if they were not considered ‘health enhancing’” (Backett et al., 1994, p. 278). That is, their risk assessment took into consideration not only physiological context, but also social and environmental context. In addition, they criticized extreme behaviors, “healthy” and “unhealthy” alike, differentiating their own health-promoting practices from those who were
“fanatical” about it. Thus, they “regarded being a ‘health freak’ as just as much of a taboo as regularly indulging in excessively unhealthy behaviors” (Backett, 1992, p. 262).

The parallels between these lay valuations of desirable health-seeking behaviors and orthorexia discourses seen throughout this dissertation are striking and indicative of the disparate “orders of worth” at play, whose friction made possible the “redefinition, redeployment, and recombination of resources” (Stark, 2011, pp. 18–19) that resulted in the orthorexia label and its resonance. We see the taboo of “extreme” behaviors in the news discourses about the absurdity and obnoxiousness of orthorexic behaviors, and the derogatory descriptions of extreme eaters as fanatics, junkies, and zealots. We see the celebration of moderation and balance in the subversive definitions of healthy eating circulated on Instagram, and in clinicians’ reliance on flexibility as a value helping tease apart truly healthy eating from orthorexia. We see the collective valuing of pleasure in Bratman’s self-text asking readers if they care more about the virtue of the food they eat than the pleasure they receive from eating it (and the ORTO-15 version of this question). We also see it in the Instagram pint parties resignifying pleasure as a pathway to orthorexia recovery and the collection of posts on the social media platform celebrating values like freedom and human connection as superior.

However, and central to orthorexia as a medicalizing object, is the redefinition of these values through a medical framework—this is where the entrepreneurship takes place, as particular values regarding desirable behavior are combined with an eating disorder framework expansion to redefine extreme healthy eating as unhealthy. Unlike previous valuation frameworks that have collided with and even resisted healthist and nutritionist ideologies by including social and emotional factors into their calculus (Backett, 1992; Backett et al., 1994), or
engaging with food on different registers (Lupton, 1996; Phillipov, 2013), orthorexia addresses these concerns in biomedical terms: with a diagnosis. Orthorexia rhetoric relies heavily on metaphors of mental health, illness, and risk to speak to healthism in its own language, inviting a consideration of excessive preoccupation with healthy eating as not just as a social taboo but a mental disorder—that is “unhealthy.” While invoking somewhat different interpretations of the nature of the disorder and its causes, all the actors using the term benefit from the legitimation of the biomedical framework as it helps them advance their objectives.

Among experts, where technical definitions and understandings are presumably more salient, these values are redeployed through sprawling interpretations of “impairment,” an imperfect proxy for mental pathology that, nonetheless, has come to proliferate in psychiatry and psychology. The Dunn and Bratman (2016) criteria, explored in Chapter Three, illustrate this expansive move, suggesting that “clinical impairment” in orthorexia can be signified through a large variety of consequences ranging from malnutrition, to intrapersonal distress (including affected social, academic, or vocational functioning), to excessive dependence of body image, self-worth, on compliance of food rules (Dunn & Bratman, 2016, p. 16). The clinicians in Chapter Four allud to similarly expansive understandings of impairment as including “psychological, emotional, social, physiological” dimensions or abstract ideas like the “ability to live a really full, satisfying life.”

This expanded approach to impairment as symptomatic of disorder has advantages and disadvantages. The main advantage is that it acknowledges the complexity of human wellbeing as something that operates on multiple dimensions, many of which are excluded from physiological metrics reducing health, for example, to weight. However, it achieves this by
bringing these diverse dimensions into the purview of psychiatry and in doing so, further medicalizes them. Thus, it further expands healthist ideologies by simply shifting the content of “health” as a super-value to be individually pursued, rather than bringing it into question. From a biomedical approach, this also reaffirms the idea that many different kinds of distress, such as poor self-esteem or social isolation, are individual problems, presumably residing in the brain. As a result, appropriate therapeutic interventions would presumably target individuals and their behaviors, while overlooking social contributors.

Ultimately, moments of creative friction provide unique opportunities to acknowledge and examine values that may otherwise remain invisible. As Stark (2011) points out, “unsettling situations are special moments in which the researcher discovers what is at stake because it is in such situations that the actors themselves become cognizant of what had previously been taken for granted” (p. 32). Contentious diagnoses and knowledges, especially those relating to human behavior, thus, provide unique opportunities to examine the norms, conventions, and values that are typically taken for granted in biomedicine.

**From the fringes.** Institutional theory contributes some additional insights for making sense of seemingly unconventional actors in orthorexia entrepreneurship. Institutional scholars have suggested that actors promoting institutional change are often located at the peripheries or fringes of the institutions, as they are less embedded in institutional arrangements (Leblebici, Salancik, Copay, & King, 1991). As a doctor who had never been trained or practiced in the eating disorder field, Bratman’s conceptualization of extreme health practices appears to have been less embedded in existing eating disorder knowledges and categories and thus more susceptible to innovation than those on the frontlines. We can recall the veteran clinician in
Chapter Four who assured that healthcare providers had long seen orthorexic behaviors but “hadn’t known what to call them” or how to frame them. Moreover, clinicians often report orthorexic behaviors in the context of other eating disorders, which may invite a reading of these symptoms as part of the same problem, rather than a new and separate diagnosis. It may also be that because of their constant encounters with the shortcoming of the DSM categories, eating disorder clinicians are used dealing with multiple kinds of behaviors and symptoms that do not fit and were thus did not initially focus on or require a unique specification for this set of behaviors; indeed, the OSFED category proves a helpful solution for such cases.

Moreover, both Bratman and dietitians seem to have been more willing to assert the legitimacy of orthorexia as a new disorder in different spaces, despite its unofficial status, in violation of institutional norms of how mental disorder categories are to be produced and legitimimized. The limited instances of expert sources in the news underscoring that orthorexia was not an official diagnosis were almost exclusively psy experts. Similarly, on social media the regular use of orthorexia as a hashtag was concentrated among nutrition experts. These patterns suggest that psy experts may be more cautious and deferential to the institutional norms of psychiatric knowledge production than colleagues from other disciplines.

A second important point in considering Bratman’s—and then dietitians’—successful claims-making involves his own positionality within social “hierarchies of credibility” (Becker, 1967). In the news chapter, we saw how news media referred to Bratman as a doctor, sometimes confusing him with a psychologist or an eating disorder expert. Even within the medical literature, we saw mentions and citations of him based on his status as a doctor. His professional credentials, not to mention his positionality as a white man, appear to have done a lot of work in
terms of legitimizing his claims and his position as an authoritative claims-maker, even though his credentials were not directly applicable to the topic at hand. A similar pattern can be observed among nutrition experts, who were sought after by the news media and published on the topic.

**Limitations and Future Directions**

This dissertation has limitations. First, I did not interview any scholars or researchers for this study, limiting my ability to explore their knowledge production processes and rationales, behind the scenes. Second, while this study has taken seriously the role of media, foregrounding two different kind of media where orthorexia knowledge has circulated widely, this portrait remains incomplete. For example, a significant collection of websites, blog posts, YouTube videos, and podcasts have addressed orthorexia, and undoubtedly contributed to the assemblages described above. I had multiple opportunities to wander off of Instagram and into some of these spaces during my ethnographic fieldwork and as part of my broader research on the subject. However, my consideration of these sites is very limited. A systematic analysis of other kinds of media would likely contribute to more nuanced information about different kind of digital media and their contribution to hybridizing knowledges and actors.

Third, I did not actively seek out contention about orthorexia online, which as we saw in Bratman’s hate mail, certainly exists. News articles published online by large news outlets with comment sections, or posted on the social network accounts where followers may comment, often amass a mixture of opinions. I saw multiple examples of publications with comments both in favor and against orthorexia as a legitimate condition among the general lay population. I would also expect to encounter greater resistance toward orthorexia among certain food-centered
communities like vegans. Actively seeking out contentious sites like these may shed light into how actors outside the eating disorder field make sense of orthorexia and further quality the tensions at stake. While less relevant to orthorexia’s fate as a diagnosis, these sites are nonetheless relevant to understanding how the general public could potentially respond to the diagnosis.

Part of what makes orthorexia so fascinating is the extent of the medical expansion achieved through it. Much interest in medicalization has emphasized how the medical jurisdiction, and particularly psychiatry claimed professional stakes over behaviors whose deviance or badness was framed in other terms—as sin, as crime, etc. (Conrad & Schneider, 1980; Schneider, 1978). Medicalization has not only been used to reconceptualize deviance, but to assert it in the first place by positing that a wide range of conditions and experiences outside of the norm also constitute disease or disorder, for example those who are too hyper or shy. On an abstract level, orthorexia is a continuation of these medicalizing logics as they reassert normality: care about eating healthily, but not too much. However, unlike these examples, orthorexia takes on behaviors that while outside of the norm have been considered highly desirable, as the “straight-A students of nutrition” phrase indicates. In other words, it comes to medicalize what most people previously interpreted as goodness. It is here that what journalists conceptualize as the orthorexia paradox emerges. Practically speaking, it is a paradox—one that arises as medicalization reaches full circle, declaring the very behaviors it prescribes as disordered.

We can expect to see these kinds of tensions arise among other behaviors prescribed by public health as they collide with alternate valuation systems, most obviously, exercise. The
concept of “exercise addiction” already circulates online on its own terms and in some scholarship. The obsession with musculature was already included in the DSM-5 as a kind of Body Dysmorphic Disorder, and extreme exercising to compensate for binge eating is considered a kind of bulimia. There has also been a move to claim obsessive exercise as a part of orthorexia. Many clinicians I spoke to discussed the frequent co-incidence of health food and exercise obsession among their patients, and the Instagrammers I observed and spoke to shared similar experiences. In a 2016 post on his website, Bratman posted an orthorexia “update” on his website where he claimed that “one of the most dramatic changes in orthorexia is its current inclusion of exercise. It would now appear that the majority of people with orthorexia are also exercise enthusiasts of one sort or another, whether they do yoga, run or constantly work out at the gym” (Bratman, 2016). How the DSM will ultimately choose to confront the medicalization of extreme exercise as it overlaps with various types of disordered eating has yet to be seen.

While the medicalization of food and exercise-related anxieties is not without problems, it provides one avenue to legitimate and address very real human experiences of distress and affliction and the multiplicity of negative consequences deriving from them. Scrutinizing the complex processes that have gone into producing the orthorexia diagnosis in no way negates the reality of these experiences and their tangible and often painful impact on people’s lives. Indeed, complex and messy professional and social processes have gone into the production of all medical diagnoses, psychiatric and otherwise. Finally, the medicalization of orthorexia cannot be reduced to a process of medical social control. While orthorexia’s widespread use as a boundary object attests to the potency of medical logics in organizing and interpreting human experience and their complex intersections with professional and commercial rationales, the diverse ways
orthorexia has been taken up in different assemblages and by multiple actors also demonstrate how medical language and logics themselves can be put to use to subvert and actively resist health imperatives and technologies.
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Appendix A: Methods

Chapter Two

The news portion of the dissertation draws on 18 years of news coverage of orthorexia worldwide, and interviews with 13 reporters. The news analysis is based on a corpus of newspaper articles extracted from LexisNexis Academic NEWS, a full text information database with articles from more than 350 newspapers worldwide. The analysis included all articles published between 1998 and 2016, in English, that contained the word “orthorexia” anywhere in the text, which yielded a total of 492 articles. Since the term was first coined in 1997, the database contained no articles until 1998. Content like crossword puzzles, television programming, and press releases were excluded. The texts were analyzed using quantitative and qualitative methods with MAXQDA software.
Regarding the quantitative analyses, descriptive data was collected on each article, including publication year, country, article type (i.e., news story, feature story, opinion article, other), and salience of orthorexia in the article (i.e., primary, secondary, or mention). I used three categories to classify the articles, based on whether they depicted orthorexia as settled, unsettled, or undeclared. Articles were classified as “settled” if they depicted orthorexia as a definitive new medical condition, “unsettled” if they addressed it as a medical diagnosis but included some mention of its unofficial status, and “undeclared” if the text was unclear regarding the nature of the phenomenon or addressed orthorexia as a non-medical problem.

Furthermore, I counted the total number of sources per story, and the number of sources with professional credentials. I considered a “source” to be every instance in which a writer attributed information to someone else. Sources were only counted once per story, regardless of how many times they were cited. Sources addressing topics other than orthorexia were excluded. A variety of professional titles were used as proxies for reporters’ perceptions of relevant expertise. The broad category of “credentialed sources” included the categories of healthcare providers (with subcategories for dietitians, mental health experts, doctors, and Bratman), academics, and researchers. The category of “non-credentialed” sources included various “lay” contributors sorted into categories for non-profits organization representatives, the affected (with subcategories for public figures and non-public figures), and others (media outlets, dictionaries, writers, etc.). The total number of sources was a sum of both “credentialed” and “non-credentialed” sources.

In addition to the quantitative data, a qualitative content analysis provided an in-depth understanding of three primary topics: (1) primary narratives used in orthorexia stories; (2)
depictions of orthorexia’s status/legitimacy; and (3) source usage. This inductive analysis entailed a data reduction process by focusing on selected aspects of the data relevant to these three topics (Cho & Lee, 2014). Based on the topics, fragments of text were coded, refined, and arranged into subcategories through an iterative coding process (Hsieh & Shannon, 2005). The use of MAXQDA facilitated the extraction of the codes to identify the most common patterns within and across categories. Regarding the first topic I identified the recurrence of four primary narratives that presented orthorexia as fundamentally: absurd, obnoxious, paradoxical, and dangerous. Regarding orthorexia’s status, and mirroring the quantitative data, I coded three broad categories: the rhetorical production of legitimacy (implicit or explicit assertions about orthorexia as a legitimate mental health condition), the recognition and management of uncertainty (instances where the unsettled status was addressed), and the adoption of non-medical or ambiguous approaches (those in which non-medical language was used, for example, referring to orthorexia as a fad). For the third topic, all information attributed to sources was coded and sorted into the most fitting source category. An inductive approach was then used to analyze similarities and differences in the kinds of contributions made by each category. These contributions were refined and abstracted into specific functions (Elo & Kyngäs, 2008), including legitimation of the diagnosis, description, detection, explanation (of causes and consequences), exemplification, and elicitation of emotion.

In addition to the news analysis, I conducted exploratory interviews with journalists who wrote stories about orthorexia. Due to concerns about recall, only reporters who had written articles in which orthorexia was the primary in the five previous years (2013–2018) were included in this portion of the study. Almost 40 journalists from six countries were randomly
selected and contacted to participate. All but two were women, reflective of the strong female authorship in the sample. In total, 13 journalists participated—all were women, between 26 and 42 years of age, from the UK (4), US (5), Australia (2), India (1), and China (1). Three reporters covered health, two were freelance writers, two were feature writers, and two were generalists. Other beats included lifestyle, fitness, and technology and social media. In the interviews, I asked journalists about a variety of topics relating to their orthorexia coverage, including how they learned about orthorexia, their perception of the proposed diagnosis’ legitimacy, how and why they chose the sources for their stories, and how they approached the diagnosis’ uncertain status. The interviews were coded using an inductive analysis, similar to that used with the news stories.

**Chapter Three**

The research chapter based on an analysis of scholarly publications about orthorexia. I conducted the citation analysis through the Scopus database’s citation overview function. The search included all English-language academic articles published through 2018 with orthorexia in the title, abstract, or keywords and excluded citations from books. The search produced a set of 119 articles. This analysis enabled me to identify the most highly cited articles systematically and also track the citation indices of all orthorexia articles over time. The number of articles considered for the citation overview was slightly lower than the number of articles I compiled, because Scopus did not include some of the articles I was able to track down through other databases. The rest of the analysis was based on my own corpus of articles.

For the descriptive data provided on the publications, I compiled all the English-language articles about orthorexia published in peer-reviewed journals and conference proceedings or
abstracts between January 01, 1998 and December 31, 2018. The analysis includes all articles available in Google Scholar, PubMed, Scopus, and EBSCOhost, containing the word orthorexia in the title or abstract. The review excluded errata, posters, dissertations, and book chapters. For each article, I collected information about: the journal it was published in, the country of origin (based on the first/corresponding author’s institution at the time of the publication), the author’s discipline (based on the first/corresponding authors affiliation and credential available online), the journal discipline or field (in the case of cross-disciplinary journals, I privileged acknowledgment of psy categories, e.g., listing nutritional psychology journals as psy), article type, citations or mentions of Bratman, etc. For empirical studies, I also collected information about the population under study and its characteristics; whether or not an orthorexia instrument was used and if so which one; whether or not other scales or tests were used (including sociodemographic data), and conclusions.

Finally, in addition to the descriptive data, I also gave all of the articles a close reading, with a special emphasis on articles I identified as uniquely significant or meaningful in the literature. During this process, I remained attentive to multiple focal interests, including rhetorical framing of the problem, mentions of media, cross-citation practices, etc. Through this qualitative analysis, I was able to identify key publications within the literature, recurring authors, common concerns or assumptions across the literature, points of contention, etc.

**Chapter Four**

For the chapter about clinical practice, I relied on semi-structured interviews with clinician recruited through a purposive sampling technique, intended to encompass the diversity of disciplines, perspectives, and professional experiences involved in eating disorder treatment.
The interview questions were organized under three overarching themes: clinicians’ general knowledge and opinions about orthorexia (e.g., definitions of orthorexia, whether or not it constitutes a pathology, whether they thought it should be included in the DSM, its causes and consequences, etc.), knowledge sources (e.g., where they first learned about orthorexia, what their primary information sources were, where they had seen or read about it, etc.), and experiences with orthorexia in clinical practice (e.g., whether or not they had seen cases and if so, what they looked like, etc.). I conducted the interviews virtually using the online conferencing service, BlueJeans, following IRB approval and informed consent. The interviews lasted between 20 and 62 minutes, for an average of 35 minutes each, with video and/or audio. In total, 35 of the 56 healthcare providers I contacted agreed to be interviewed.

Most interviewees were women (83%; n = 29) and from the US (74%; n = 26), although several clinicians from Canada (14%; n = 5), the UK (6%; n = 2), and Australia (6% n = 2) also took part. They were trained in psychology or psychiatry (34%; n = 12), nutrition or dietetics (37%, n = 13), nursing (11; n = 4), social work (9%; n = 3), and medicine (6%; n = 2). The clinicians varied in their familiarity with orthorexia, spanning from one dietitian representing the US on the DSM’s orthorexia task-force to another who was only vaguely familiar with the term. The clinicians worked in a variety of different settings, including clinics, private practices, non-profit hospitals, and university centers, and had varying levels of work experience, from three years to over three decades. Furthermore, they worked with different populations (e.g. children, children,

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33 One of the psychologists interviewed (ONHC-12) was not a practicing clinician, but a retired psychology professor with a very long trajectory (over 30 years) in the eating disorder field. He was included in the sample because of his position at the interstices of academia, clinical practice, and activism. He has ample experience collaborating with clinicians, participating in eating disorder conferences with clinicians since the 1980s, and running a LISTSERV. He remains actively involved in the eating disorder context.
teens, college students, adults) and at different levels of care (e.g., outpatient, intensive outpatient, inpatient). While most specialized in eating disorders, some treated a wider range of conditions, for example at university healthcare centers.

I also sought out several healthcare providers with openly critical stances on orthorexia in order to diversify the range of opinions. I included three such providers in the sample: a dietitian specializing in eating disorders and addiction (ONHC-14), a physician specializing in weight management and bariatric surgery (ONHC-15), and a plant-based dietitian focusing on food politics (ONHC-33), all of whom had reservations or concerns about the diagnosis. While the latter two participants did not work in the eating disorder subfield, they were all familiar with orthorexia and had publicly engaged the subject, for example, in blogs posts or news interviews. Their professional opinions are not intended to represent the broad medical community; rather they are valuable in showing potential points of tension between the ED subfield and orthogonal areas of healthcare. When discussing their points of view, I identify them.

Using MAXQDA software, I inductively analyzed the interview data, which entailed a data reduction process focusing on selected aspects of the data relevant to orthorexia knowledge and sense-making, orthorexia knowledge acquisition, and professional experiences relating to orthorexia and eating disorder treatment more broadly (Cho & Lee, 2014). I then coded, refined, and arranged fragments into subcategories through an iterative coding process (Hsieh & Shannon, 2005), which allowed me to identify patterns throughout the data. For example, through this information distillation process, I was able to categorize and sort the diverse kinds of frameworks used in conceptualizing orthorexia, and the similarities and differences between them. I was also able to identify common themes and differences in how clinicians drew the line
between healthy and unhealthy behaviors, and how they used orthorexia in their clinical practices. The use of MAXQDA facilitated the extraction of the codes to identify the most common patterns within and across categories.

**Chapters Five and Six**

The Instagram portion of the dissertation is based on more than 350 hours of online ethnographic fieldwork and 34 interviews with Instagram users who have regularly engaged in conversations about orthorexia on their profiles, conducted between January and August 2018.

**Ethnographic research.** For the ethnographic work, I created a new Instagram account specifically for research purposes. On my account I posted a couple of selfies and a brief description identifying me as a researcher and PhD Candidate at Northwestern University, currently researching orthorexia on Instagram. Below my bio, I included a link to my personal website, where I created a special sub-site describing my research on Instagram, and inviting readers to contact me with any questions or if they did not want to be followed. In that site, I explained that I would not be following any private accounts and clarifying that any information used in my research would remain anonymous.

During my fieldwork, I followed users who regularly engaged with orthorexia or related subject matter. As a proxy, I used one of two different criteria for determining what users to follow: recurrent use of orthorexia hashtags (containing orthorexia hashtags in at least five of their previous 10 posts at the time of the follow) or identification with orthorexia in the profile bio. Furthermore, I followed both the #orthorexia and the #orthorexiarecovery hashtags, which enabled me to encounter new accounts using those hashtags regularly, and also survey the content of accounts only randomly or sporadically addressing the topic, although they were not
my primary interest. Throughout my fieldwork, I came to follow upward of 150 accounts. Upon following a person, I consistently liked their posts whenever I encountered them in my feed (unless it was content that I thought might be considered clearly upsetting to others, like self-harm), in an ongoing effort to make my presence known and ensure that their content would appear in my Instagram feed. Aside from regularly observing posts and stories, I limited my participation to liking. The online ethnographic approach enabled me to examine not only content, but also interactions between users and their evolution over time.

My stints of fieldwork ranged between 15 minutes and six hours, but typically lasted about two hours per day, sometimes in a single sitting, other times distributed throughout the day. I purposely scheduled my fieldwork at different times of the day and different days a week. I regularly took notes and screenshots of relevant posts as I conducted my fieldwork. I allowed my observation to flow across the platform, sometimes focusing on stories and other times focusing on posts. I also allowed myself to stray off the platform when users posted links or content from websites, blogs, and YouTube, they wanted to call their followers’ attention to. I analyzed the ethnographic notes on MAXQDA, using grounded theory, which involved simultaneous data collection and analysis. I inductively developed the analysis through ongoing and increasingly refined coding, data collection, and memo-writing to develop the conceptual categories I develop in Chapter Six (Charmaz, 2001, 2006).

**Interviews.** In addition to the ethnographic fieldwork, I also conducted online interviews with Instagram users addressing orthorexia. The interviews gave me access to systematic information regarding how users conceptualized orthorexia and Instagram as a tool to address it. I was also able to triangulate information from my ethnographic work regarding meaning-
making and “behind the scenes” practices. Participants for the interviews were selected from the pool of over 150 accounts followed during fieldwork, who regularly employed an orthorexia hashtag. Private accounts were excluded from the study. Following IRB approval, participants 18 years and older were recruited for the interview portion of the research. In total, 68 participants were contacted via an Instagram Direct Message (DM) and/or email. I made efforts to recruit participants that represented the various types of personal accounts identified as predominant in the orthorexia space during fieldwork. In the message, I briefly presented my research to them and inquired about their willingness to participate. Those who expressed interest received a follow-up email that detailed the study, the conditions and the types of topics that would be addressed. They were then invited to provide a date and time at their convenience to schedule their interview.

Most interviews were conducted on the videoconferencing service BlueJeans, between June and September of 2018. However, four participants requested to respond in written form due to personal anxiety, privacy issues, or limited connectivity. Prior to each interview, participants were read a document containing the name of the study, the research objectives, methods and ethical issues (including anticipated risks and benefits, details about anonymity and confidentiality and publication of findings). Participants provided verbal consent. The interviews lasted between 41 and 85 minutes, at an average of about 60 minutes each. The interviews were recorded and transcribed before being coded with MAXQDA mixed methods software.
### Appendix B: Interview Data

Table B.1: Information about Reporters Interviewed

<table>
<thead>
<tr>
<th>ID</th>
<th>Country</th>
<th>Year of publication</th>
<th>Gender</th>
<th>Age</th>
<th>Beat</th>
<th>Interview Duration</th>
<th>Date of Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONJ-01</td>
<td>India</td>
<td>2015</td>
<td>Female</td>
<td>Unknown</td>
<td>Feature writer</td>
<td>18</td>
<td>3/25/18</td>
</tr>
<tr>
<td>ONJ-02</td>
<td>USA</td>
<td>2016</td>
<td>Female</td>
<td>41</td>
<td>Fitness Editor when she wrote the story</td>
<td>17</td>
<td>3/27/18</td>
</tr>
<tr>
<td>ONJ-03</td>
<td>UK</td>
<td>2017</td>
<td>Female</td>
<td>26</td>
<td>Feature writer: women, education, lifestyle</td>
<td>22</td>
<td>4/6/18</td>
</tr>
<tr>
<td>ONJ-04</td>
<td>UK</td>
<td>2017</td>
<td>Female</td>
<td>30</td>
<td>Freelance writer</td>
<td>19</td>
<td>4/9/18</td>
</tr>
<tr>
<td>ONJ-05</td>
<td>USA</td>
<td>2015</td>
<td>Female</td>
<td>26</td>
<td>Freelance writer at the time of article</td>
<td>22</td>
<td>4/30/18</td>
</tr>
<tr>
<td>ONJ-06</td>
<td>UK</td>
<td>2015</td>
<td>Female</td>
<td>35</td>
<td>Unknown</td>
<td>15</td>
<td>5/5/18</td>
</tr>
<tr>
<td>ONJ-07</td>
<td>Australia</td>
<td>2018</td>
<td>Female</td>
<td>32</td>
<td>Lifestyle and entertainment reporter</td>
<td>7</td>
<td>5/10/18</td>
</tr>
<tr>
<td>ONJ-08</td>
<td>UK</td>
<td>2018</td>
<td>Female</td>
<td>26</td>
<td>Video and web</td>
<td>17</td>
<td>5/30/18</td>
</tr>
<tr>
<td>ONJ-09</td>
<td>China</td>
<td>2017</td>
<td>Female</td>
<td>42</td>
<td>Covers fashion, beauty, health, wellness, design, food, and travel</td>
<td>NA</td>
<td>8/19/19</td>
</tr>
<tr>
<td>ONJ-10</td>
<td>USA</td>
<td>2018</td>
<td>Female</td>
<td>23</td>
<td>Healthcare and immigration</td>
<td>NA</td>
<td>8/20/19</td>
</tr>
<tr>
<td>ONJ-11</td>
<td>USA</td>
<td>2018</td>
<td>Female</td>
<td>28</td>
<td>Covered technology and social media</td>
<td>26</td>
<td>8/22/19</td>
</tr>
<tr>
<td>ONJ-12</td>
<td>USA</td>
<td>2018</td>
<td>Female</td>
<td>23</td>
<td>Covered the science and technology beat</td>
<td>30</td>
<td>8/28/19</td>
</tr>
</tbody>
</table>
Table B.2: Information about Healthcare Providers Interviewed

<table>
<thead>
<tr>
<th>ID</th>
<th>Credentials and work</th>
<th>Discipline</th>
<th>Gender</th>
<th>Race</th>
<th>Country</th>
<th>Interview duration</th>
<th>Interview date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONHC-01</td>
<td>Internist (MD), Certified Eating Disorder Specialist, founder of Eating Disorder Treatment Center</td>
<td>Medicine</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>32 minutes</td>
<td>5/4/18</td>
</tr>
<tr>
<td>ONHC-02</td>
<td>Psychotherapist (Masters in Transpersonal Counseling Psychology), Private Practice</td>
<td>Psychology</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>43 minutes</td>
<td>5/16/18</td>
</tr>
<tr>
<td>ONHC-03</td>
<td>Registered Dietitian and Director of Nutrition in Eating Disorder Treatment Center</td>
<td>Dietetics</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>33 minutes</td>
<td>5/17/18</td>
</tr>
<tr>
<td>ONHC-04</td>
<td>Psychologist (PhD) and Director in Eating Disorder Treatment Center</td>
<td>Psychology</td>
<td>Male</td>
<td>Asian</td>
<td>USA</td>
<td>26 minutes</td>
<td>5/18/18</td>
</tr>
<tr>
<td>ONHC-05</td>
<td>Dietitian (RD), Head of Nutrition at an Eating Disorder treatment center</td>
<td>Dietetics</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>41 minutes</td>
<td>5/22/18</td>
</tr>
<tr>
<td>ONHC-06</td>
<td>Clinical Psychologist (PhD) at a university clinic</td>
<td>Psychology</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>--</td>
<td>5/22/18</td>
</tr>
<tr>
<td>ONHC-07</td>
<td>Licensed Clinical Social Worker at Counselling Center</td>
<td>Social Work</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>22 minutes</td>
<td>5/25/18</td>
</tr>
<tr>
<td>ONHC-08</td>
<td>Registered Dietitian and Director of Nutrition at an Eating Disorder treatment center</td>
<td>Dietetics</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>25 minutes</td>
<td>5/29/18</td>
</tr>
<tr>
<td>ONHC-09</td>
<td>Nurse Practitioner at a university clinic</td>
<td>Nursing</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>32 minutes</td>
<td>5/29/18</td>
</tr>
<tr>
<td>ONHC-10</td>
<td>Dietitian, Private Practice and Eating Disorder Treatment Center</td>
<td>Dietetics</td>
<td>Male</td>
<td>Latinx</td>
<td>USA</td>
<td>38 minutes</td>
<td>5/30/18</td>
</tr>
<tr>
<td>ONHC-11</td>
<td>Registered Dietitian, Private Practice</td>
<td>Dietetics</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>35 minutes</td>
<td>4-Jun</td>
</tr>
<tr>
<td>ONHC-12</td>
<td>Psychologist and researcher (PhD), Retired</td>
<td>Psychology</td>
<td>Male</td>
<td>White</td>
<td>USA</td>
<td>62 minutes</td>
<td>6/4/18</td>
</tr>
<tr>
<td>ONHC-13</td>
<td>Dietitian as Eating Disorder treatment center</td>
<td>Dietetics</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>35 minutes</td>
<td>6/4/18</td>
</tr>
<tr>
<td>ONHC-14*</td>
<td>Dietitian (RDN) at nutrition center specializing in addiction and eating disorders</td>
<td>Dietetics</td>
<td>Male</td>
<td>White</td>
<td>USA</td>
<td>39 minutes</td>
<td>6/4/18</td>
</tr>
<tr>
<td>ONHC-15*</td>
<td>Medical Doctor at Medical Institute</td>
<td>Medicine</td>
<td>Male</td>
<td>White</td>
<td>Canada</td>
<td>27 minutes</td>
<td>6/5/18</td>
</tr>
<tr>
<td>ONHC-16</td>
<td>Psychologist (PhD, LP) at a Children's Hospital</td>
<td>Psychology</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>38 minutes</td>
<td>6/6/18</td>
</tr>
<tr>
<td>ONHC-17</td>
<td>Social Worker (PhD)</td>
<td>Social Work</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>28 minutes</td>
<td>6/7/18</td>
</tr>
<tr>
<td>ONHC-18</td>
<td>Dietitian, Private Practice</td>
<td>Dietetics</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>44 minutes</td>
<td>6/7/18</td>
</tr>
<tr>
<td>ONHC-19</td>
<td>Social Work and Counselling (LCSW), Private Practice</td>
<td>Social Work</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>39 minutes</td>
<td>6/8/18</td>
</tr>
<tr>
<td>ONHC-20</td>
<td>Psychologist</td>
<td>Psychology</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>45 minutes</td>
<td>6/8/18</td>
</tr>
<tr>
<td>ONHC-21</td>
<td>Nurse, Director of Nursing at Eating Disorder treatment center</td>
<td>Nursing</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>39 minutes</td>
<td>6/8/18</td>
</tr>
<tr>
<td>ONHC-22</td>
<td>Nurse at an Eating Disorder treatment center</td>
<td>Nursing</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>31 minutes</td>
<td>6/12/18</td>
</tr>
<tr>
<td>ONHC-23</td>
<td>Psychologist, Director at a private mental health center</td>
<td>Psychology</td>
<td>Female</td>
<td>White</td>
<td>Australia</td>
<td>39 minutes</td>
<td>6/13/18</td>
</tr>
<tr>
<td>ONHC-24</td>
<td>Dietitian at an Eating Disorder treatment center</td>
<td>Nutrition</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>37 minutes</td>
<td>6/14/18</td>
</tr>
<tr>
<td>ONHC-25</td>
<td>Dietitian (RD, CEDRD-S)</td>
<td>Nutrition</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>34 minutes</td>
<td>6/18/18</td>
</tr>
<tr>
<td>ONHC-26</td>
<td>Clinical Psychologist (PhD) at children's hospital</td>
<td>Psychology</td>
<td>Female</td>
<td>White</td>
<td>Canada</td>
<td>52 minutes</td>
<td>6/19/18</td>
</tr>
<tr>
<td>ONHC-27</td>
<td>Counsellor at Eating Disorder treatment center</td>
<td>Counselling</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>32 minutes</td>
<td>6/19/18</td>
</tr>
<tr>
<td>ONHC-28</td>
<td>Child and Adolescent Psychiatrist with many years of experience (recently transitioned to academia)</td>
<td>Psychiatry</td>
<td>Female</td>
<td>White</td>
<td>UK</td>
<td>33 minutes</td>
<td>6/25/18</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------</td>
<td>-------</td>
<td>----</td>
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<td>--------</td>
</tr>
<tr>
<td>ONHC-29</td>
<td>Psychotherapist, Private Practice</td>
<td>Psychology</td>
<td>Female</td>
<td>White</td>
<td>Canada</td>
<td>25 minutes</td>
<td>7/11/18</td>
</tr>
<tr>
<td>ONHC-30</td>
<td>Clinical Psychologist (PhD), Eating Disorder treatment center</td>
<td>Psychology</td>
<td>Female</td>
<td>White</td>
<td>Canada</td>
<td>20 minutes</td>
<td>7/11/18</td>
</tr>
<tr>
<td>ONHC-31</td>
<td>Dietitian and clinical trainer at an Eating Disorder treatment center and Private practice</td>
<td>Dietetics</td>
<td>Female</td>
<td>White</td>
<td>USA</td>
<td>41 minutes</td>
<td>8/14/18</td>
</tr>
<tr>
<td>ONHC-32</td>
<td>Psychologist, Private Practice</td>
<td>Psychology</td>
<td>Female</td>
<td>White</td>
<td>UK</td>
<td>36 minutes</td>
<td>8/17/18</td>
</tr>
<tr>
<td>ONHC-33*</td>
<td>Dietitian, Writing and coaching</td>
<td>Dietetics</td>
<td>Male</td>
<td>White</td>
<td>USA</td>
<td>32 minutes</td>
<td>8/26/18</td>
</tr>
<tr>
<td>ONHC-34</td>
<td>Mental health nurse at Eating Disorder Treatment Center</td>
<td>Nursing</td>
<td>Female</td>
<td>White</td>
<td>Australia</td>
<td>32 minutes</td>
<td>8/29/18</td>
</tr>
<tr>
<td>ONHC-35</td>
<td>Dietitian at Children's Hospital</td>
<td>Dietetics</td>
<td>Female</td>
<td>White</td>
<td>Canada</td>
<td>25 minutes</td>
<td>8/29/18</td>
</tr>
</tbody>
</table>

*Healthcare providers marked with the asterisk were purposely sampled for oppositional opinion about orthorexia.
Table B.3: Information about Instagram Users Interviewed

<table>
<thead>
<tr>
<th>ID</th>
<th>Pseudonym</th>
<th>Age</th>
<th>Gender</th>
<th>Account type</th>
<th>Followers</th>
<th>Race</th>
<th>Country</th>
<th>Interview duration</th>
<th>Interview date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONIG-01</td>
<td>Karen</td>
<td>35</td>
<td>Female</td>
<td>In recovery</td>
<td>316</td>
<td>White</td>
<td>USA</td>
<td>44 minutes</td>
<td>6/18/18</td>
</tr>
<tr>
<td>ONIG-02</td>
<td>Olivia</td>
<td>24</td>
<td>Female</td>
<td>Motivator</td>
<td>2,621</td>
<td>White</td>
<td>USA</td>
<td>82 minutes</td>
<td>6/19/18</td>
</tr>
<tr>
<td>ONIG-03</td>
<td>Erica</td>
<td>21</td>
<td>Female</td>
<td>In recovery</td>
<td>2,668</td>
<td>White</td>
<td>USA</td>
<td>60 minutes</td>
<td>6/19/18</td>
</tr>
<tr>
<td>ONIG-04</td>
<td>Luna</td>
<td>29</td>
<td>Female</td>
<td>In recovery</td>
<td>336</td>
<td>White</td>
<td>Canada</td>
<td>78 minutes</td>
<td>6/25/18</td>
</tr>
<tr>
<td>ONIG-05</td>
<td>Leah</td>
<td>34</td>
<td>Female</td>
<td>Coach</td>
<td>11,400</td>
<td>White</td>
<td>Canada</td>
<td>62 minutes</td>
<td>6/26/18</td>
</tr>
<tr>
<td>ONIG-06</td>
<td>Marion</td>
<td>28</td>
<td>Female</td>
<td>In recovery</td>
<td>685</td>
<td>White</td>
<td>USA</td>
<td>63 minutes</td>
<td>6/27/18</td>
</tr>
<tr>
<td>ONIG-07</td>
<td>Natalie</td>
<td>25</td>
<td>Female</td>
<td>Coach</td>
<td>994</td>
<td>White</td>
<td>USA</td>
<td>49 minutes</td>
<td>7/18/18</td>
</tr>
<tr>
<td>ONIG-08</td>
<td>Emilia</td>
<td>32</td>
<td>Female</td>
<td>Coach</td>
<td>3,024</td>
<td>White</td>
<td>Estonia</td>
<td>52 minutes</td>
<td>7/22/18</td>
</tr>
<tr>
<td>ONIG-09</td>
<td>Liam</td>
<td>18</td>
<td>Male</td>
<td>In recovery</td>
<td>249</td>
<td>White</td>
<td>USA</td>
<td>60 minutes</td>
<td>7/22/18</td>
</tr>
<tr>
<td>ONIG-10</td>
<td>Eva</td>
<td>31</td>
<td>Female</td>
<td>Coach</td>
<td>370</td>
<td>White</td>
<td>USA</td>
<td>42 minutes</td>
<td>7/23/18</td>
</tr>
<tr>
<td>ONIG-11</td>
<td>Agnes</td>
<td>21</td>
<td>Female</td>
<td>In recovery</td>
<td>550</td>
<td>White</td>
<td>Germany</td>
<td>61 minutes</td>
<td>7/29/18</td>
</tr>
<tr>
<td>ONIG-12</td>
<td>Rachel</td>
<td>32</td>
<td>Female</td>
<td>In recovery</td>
<td>139</td>
<td>White</td>
<td>USA</td>
<td>60 minutes</td>
<td>7/30/18</td>
</tr>
<tr>
<td>ONIG-13</td>
<td>Andrea</td>
<td>27</td>
<td>Female</td>
<td>In recovery</td>
<td>42</td>
<td>White</td>
<td>USA</td>
<td>85 minutes</td>
<td>7/31/18</td>
</tr>
<tr>
<td>ONIG-14</td>
<td>Nora</td>
<td>28</td>
<td>Female</td>
<td>Coach</td>
<td>622</td>
<td>White</td>
<td>USA</td>
<td>68 minutes</td>
<td>8/2/18</td>
</tr>
<tr>
<td>ONIG-15</td>
<td>Audrey</td>
<td>28</td>
<td>Female</td>
<td>In recovery</td>
<td>589</td>
<td>White</td>
<td>USA</td>
<td>59 minutes</td>
<td>8/2/18</td>
</tr>
<tr>
<td>ONIG-16</td>
<td>Helen</td>
<td>34</td>
<td>Female</td>
<td>Coach</td>
<td>396</td>
<td>White</td>
<td>USA</td>
<td>73 minutes</td>
<td>8/3/18</td>
</tr>
<tr>
<td>ONIG-17</td>
<td>Danielle</td>
<td>26</td>
<td>Female</td>
<td>Motivator</td>
<td>2,705</td>
<td>White</td>
<td>USA</td>
<td>67 minutes</td>
<td>8/4/18</td>
</tr>
<tr>
<td>ONIG-18</td>
<td>Isabella</td>
<td>31</td>
<td>Female</td>
<td>Coach</td>
<td>31,000</td>
<td>White</td>
<td>USA</td>
<td>NA</td>
<td>8/7/18</td>
</tr>
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<td>47</td>
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<td>119</td>
<td>White</td>
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<td>64 minutes</td>
<td>8/8/18</td>
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<td>28</td>
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<td>Coach</td>
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<td>31</td>
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<td>316</td>
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<td>62 minutes</td>
<td>8/10/18</td>
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<td>Gender</td>
<td>Occupation</td>
<td>Interview Duration</td>
<td>Country</td>
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<td>Canada</td>
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<td>Professional</td>
<td>9/6/18</td>
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<td>52 minutes</td>
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*Note. Articles without interview duration were answered to in written form.*