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For many people recovering from an eating disorder, a registered dietitian is an integral part of the treatment team. It is important that this dietitian specializes in (and has experience with) treating eating disorders. They must also be willing to work with the rest of the treatment team and be a good fit for you. Dietitians have advanced training in nutrition. They use this training to help clients improve their health and wellness through food. Working with a registered dietitian can help people recover from an eating disorder in several different ways. The first is by providing factual information. This is important because almost two-thirds of eating disorder treatment manuals contain information not supported by evidence. A registered dietitian can help you sift through what is true about food and what isn't. It's also not uncommon for someone with an eating disorder to be malnourished. Working with a registered dietitian can help correct nutritional deficiencies created from consuming too little food (such as with anorexia nervosa) or from purging food consumed before the nutrients are absorbed (like with bulimia). A registered dietitian also helps people with eating disorders by assisting with: Menu creation: A registered dietitian can create a personalized meal plan to help you achieve a healthier weight or to begin to include challenging foods in your diet. Whether seeing a dietitian in an inpatient or outpatient setting, eating disorder treatment sometimes involves sitting down for meals and eating alongside them to work directly with the issues you face. Nutritional counseling: A registered dietitian can educate you about the nutrients your body needs and why, also advising how much someone of your size, age, and sex needs to consume to be healthy. They can also teach you how to recognize physical cues of hunger and satiety. Weight monitoring: The registered dietitian may be the treatment team member tasked with monitoring your weight. This type of tracking can help verify that the treatment you're receiving is working, while a lack of progress may be a sign that your eating disorder treatment may need to be modified for a better response. A registered dietitian's job duties can include educating you about food and nutrition, creating personalized meal plans to help you meet your health-related goals and correct any existing nutritional deficiencies, and monitoring your weight to help track your progress. With all the different titles for a dietitian, it can be confusing to know the difference. Here are a few of the most common, along with what they mean: Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN): An RD or RDN is someone who has been credentialed through the Commission on Dietetic Registration. To earn this title, the professional needs at least a bachelor's degree and must have completed an internship. In 2024, the educational requirement for RD and RDN designations will increase to a master's degree.Licensed Dietitian (LD): A licensed dietitian is someone who is licensed to practice in their state. The requirements for licensure vary from one state to the next but can include having an advanced degree, getting a certain amount of experience (under supervision), and passing a licensing exam.Nutritionist or Nutrition Specialist: Credentials and requirements can vary quite a bit under the nutritionist title, with some people in this role having formal education and experience while others may lack in one or both of these areas.Certified Nutrition Specialist (CNS): Someone with a CNS title has a master's degree or higher, has supervised experience in this role, and has passed an exam administered by the Board for Certification of Nutrition Specialists. Many states accept this designation for licensing purposes. Registered dietitians have advanced education and training, whereas nutritionist is a general term with many variations in training by those who use the title. To put it simply, every dietitian is a nutritionist but not every nutritionist is a dietitian. Here are a few of the differences between dietitians versus nutritionists. Dietitian Typically must have advanced education and training Meets the requirements needed to qualify for licensing in states that require it Qualified to work in specialized settings, such as hospitals and academic institutions Nutritionist May be able to practice without formal education or training May not meet the requirements needed for licensure in states that require it May not have the requirements needed to work in specialized settings There are many ways to find a licensed or registered dietitian. Because it is important to find someone who specializes in eating disorders and will work with your treatment team, a referral from your therapist or another member of your team is one of the best ways to find a dietitian with this experience. If your insurance plan covers visits with a dietitian, checking with your provider can help you find a registered dietitian who is in-network. The International Association of Eating Disorder Professionals (IAEDP) also provides a member search that you can use to find a dietitian in your area who specializes in eating disorders. Other factors to consider when choosing a registered dietitian include whether they are experienced with your specific eating disorder and your level of comfortability when discussing your unique condition and concerns. Being able to talk with your dietitian openly is important to eating disorder recovery. Frequently Asked Questions A nutritionist provides education and guidance for eating in a way that supports optimal health. This can include offering advice on which foods or supplements to consume. A nutritionist can also help address and change unhealthy eating habits. To work as a dietitian, you generally need a bachelor's degree (or higher) in dietetics, nutrition, or a related field. You will also likely be required to obtain experience under the supervision of a registered dietitian, such as through an internship. Check with your state to learn the requirements needed to provide services as a dietitian. A dietitian must typically have formal education and experience to qualify for this title. Conversely, the requirements to work as a nutritionist can vary by state. Additionally, specialized settings such as hospitals and educational institutions often require certification or licensure as a dietitian to work in this type of role. Hay P, Chinn D, Forbes D, Madden S, Newton R, Sugenor L, et al. Royal Australian and new Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Aust N Z J Psychiatry. 2014;48(11):977–1008.Article Google Scholar National Institute for Health and Care Excellence. Eating Disorders: Recognition and treatment [NG69]. National Institute for Health and Care Excellence; 2017. Google Scholar Heruc G, Hurst K, Casey A, Fleming K, Freeman J, Fursland A, et al. ANZAED eating disorder treatment principles and general clinical practice and training standards. J Eat Disord. G, Hart S, Stiles G, Fleming K, Casey A, Sutherland F, et al. ANZAED practice and training standards for dietitians providing eating disorder treatment. J Eat Disord. J, Le Grange D. Treatment manual for anorexia nervosa. 2nd ed. United States: The Guildford Press; 2015. Google Scholar Fairburn CG. Cognitive behavior therapy and eating disorders. New York: Guilford Press; 2008. Google Scholar McMaster CM, Wade T, Franklin J, Hart S. A review of treatment manuals for adults with an eating disorder: nutrition content and consistency with current dietetic evidence. Eat Weight Disord. 2020. C, Wade T, Franklin J, Hart S. Development of consensus-based guidelines for outpatient dietetic treatment of eating disorders: a Delphi study. Int J Eat Disord. 2020;53:1480–95. CG, Cooper Z, Shafran R. Cognitive behaviour therapy for eating disorders: a “transdiagnostic” theory and treatment. Behav Res Ther. 2003;41(5):509–28.Article Google Scholar Khan M, Hui K, McCauley SM. What is a registered dietitian nutritionist’s role in addressing malnutrition? J Acad Nutr Diet. 2018;118(9):1804.Article Google Scholar Calugi S, Chignola E, El Ghoch M, Dalle GR. Starvation symptoms in patients with anorexia nervosa: a longitudinal study. Eat Disord. 2018;26(6):523–37.Article Google Scholar Gentile MG, Manna GM, Ciceri R, Rodeschini E. Efficacy of inpatient treatment in severely malnourished anorexia nervosa patients. Eat Weight Disord. 2008;13(4):191–7.Article Google Scholar Tapsell L, Hickman I. Evidence based practice guidelines for the nutritional management of malnutrition in adult patients across the continuum of care. Nutr Diet. 2009;66:S1–S34.Article Google Scholar Whitelaw M, Lee KJ, Gilbertson H, Sawyer SM. Predictors of complications in anorexia nervosa and atypical anorexia nervosa: degree of underweight or extent and recency of weight loss? J Adolesc Health. 2018;63(6):717–23.Article Google Scholar Costin C, Schubert GG. 8 keys to recovery from an eating disorder. New York, United States: WW Norton & Co; 2012. Google Scholar Treasure J, Russell G. The case for early intervention in anorexia nervosa: theoretical exploration of maintaining factors. Br J Psychiatry. 2011;199(1):5–7.Article Google Scholar As a library, NLM provides access to scientific literature. Inclusion in an NLM database does not imply endorsement of, or agreement with, the contents by NLM or the National Institutes of Health. Learn more: PMC Disclaimer | PMC Copyright Notice . Author manuscript; available in PMC: 2018 Oct 1. Dietitians are trained to identify optimal food choices for clients based on medical state and lifestyle. Orthorexia nervosa (ON) is a proposed disorder related to obsessions about eating healthfully; eating disorders (ED) are serious mental illnesses with symptoms related to eating, body image, and self-esteem. Both ON and EDs are more common amongst dietitians than the general population. This study examined the prevalence of ON and EDs in dietitians in the United States and, amongst this sample, assessed whether the presence of ON symptoms related to symptoms of EDs, including weight, shape, eating, and restraint. A cross-sectional design compared responses for participants after dividing into three groups: those scoring at-risk for ON, those with a current or past ED, and a comparison group. A sample of 2,500 registered dietitians were invited to complete surveys electronically; 636 responses were received. Scores on the ORTO-15 and Eating Disorder Examination Questionnaire (EDE-Q) determined prevalence of ON and EDs. Differences in these measures, and body mass index (BMI) were compared in the three groups. Analysis of Variance (ANOVA) and Chi-square analyses compared the groups. For the entire sample, scores on the ORTO-15 suggested 49.5% were at risk for ON, and scores on the EDE-Q suggested 12.9% were at risk for an ED, with 8.2% of dietitians self-disclosing treatment for an ED. Both the group disclosing ED treatment and the group at risk for ON had a lower mean BMI, lower scores on the ORTO-15 and higher scores on the EDE-Q and all its subscales than the comparison group. Clarifying the relationship between ON and EDs is warranted, as ON symptoms appear to be associated not only with disturbances in eating but also with elevated shape and weight concerns.Keywords: orthorexia nervosa, eating disorders, dietitians, prevalence, clinicians Orthorexia nervosa (ON) is a term defined as the “fixation on righteous eating” coined in 1997 by Steven Bratman, MD.1 ON is characterized by obsessive thoughts about food, self-punishment with fasts or over-exercise, restrictive eating behaviors, and a belief that one’s self-esteem is based on dietary choices. Individuals that develop ON may initiate a quest for a healthier lifestyle but then dysfunctional, compulsive beliefs about food emerge that then impair health, work, and social functioning.2,3 As ON is not yet an established psychiatric diagnosis, the specific constellation of psychiatric symptoms necessary to separate lifestyle choices related to eating healthfully (not ON) from pathological behaviors and obsessions surrounding eating healthfully (potential for ON) are not fully established.2,3 In contrast to ON, eating disorders (ED) have established diagnostic criteria that include dysfunctional feeding behaviors, cognitive problems related to self-esteem and body-image, and body weight is significantly low (for anorexia nervosa only).4 Individuals with ON appear to share traits for both EDs as well as obsessive-compulsive disorder.5,6 Dunn and Bratman proposed diagnostic criteria for ON as an obsessional preoccupation with healthy foods paired with impairment of physical or mental health because of the obsession, and the lack of a different mental illness, an established medical problem, or religious belief leading to the behaviors.3 Based on those proposed criteria, individuals with ON deny a desire for and lack the weight loss characteristic of anorexia nervosa. However, the relationship between ON and EDs have not been determined; this study sought to address this gap in the literature by examining whether symptoms of ON were related to symptoms of EDs in a population of registered dietitians. A better understanding of the relationship between ON and EDs may help to reduce risk of EDs and to improve treatments for ON. EDs have substantial medical complications, with anorexia nervosa showing the highest mortality rate of any psychiatric illness.7–9 If risk for ON is related to risk for EDs, utilization of interventions that reduce the development of EDs amongst individuals at high risk for ON may reduce incidence of EDs. Additionally, effective treatments for EDs exist, with evidence supporting medications, family therapy, and cognitive behavioral therapy.10–12 Currently, there is little evidence to support specific treatments or interventions for ON.13 Thinking about food choices is a large part of both the work of a dietitian as well as part of the pathology of ON and EDs. An increased prevalence of EDs has been reported amongst dietitians.14–20 More recently, ON has also been observed to be more common in dietitians than the general population, although there have been no studies of this in the United States.21–23 Because both ON and EDs are common in dietitians, this population was selected to consider whether these problems are related. There were two major study goals. First, determination of the prevalence of risk for ON and EDs amongst a sample of dietitians was motivated by a desire to consider how work as a dietitian might impact food behaviors and cognitions in the United States. Using the same population, a second objective was to determine if the different types of symptoms common in EDs, including restraint, eating concerns, shape concerns, and weight concerns, were also present in ON. Clarification of the relationship between these illnesses may help in the treatment and prevention of both ON and EDs. Together, these questions construct a framework connecting professional work as a dietitian with the individual mental health of these clinicians. The Institutional Review Board at UT Southwestern Medical Center approved this study. The Commission on Dietetic Registration provided a random sample of 2,500 email addresses of registered dietitians from throughout the United States. Each dietitian received an emailed invitation to participate through Mail Chimp, which provided a de-identified link to a survey in Google Forms. Participation demonstrated consent; identifying information was not collected. Dietitians currently pregnant, breastfeeding, or unable to read English were excluded. Participation was voluntary, and participants were not compensated for their participation. Participants reported if they had obtained any type of treatment for a current or previous ED (selecting from anorexia nervosa, bulimia nervosa, binge-eating disorder, and eating disorder not otherwise specified), how long they had been a dietitian, provided self-reports for both current height and weight, as well as their low and high weights as adults, age, and dietary constraints (selecting from no dietary restrictions, low fat, low carbohydrate, gluten-free, vegetarian, vegan, paleo, mediterranean). The ORTO-15 is a validated, 15 item questionnaire designed to determine risk of ON.24 A high risk of ON is seen as a score below 40 with higher scores (maximum of 60 points) indicative of normal eating behavior.5,24 Questions included on the ORTO-15 consider the impact of eating beliefs in terms of health (e.g., Are you willing to spend more money to have healthier food?), ruminative behaviors (Does the thought of food worry you for more than three hours a day?), and self-esteem (Do you think that the conviction to eat only healthy food increases self-esteem?). The Eating Disorder Examination Questionnaire (EDE-Q) includes 28 items that measures eating disordered cognitions and behaviors occurring over the past 28 days, providing a Global score and 4 sub-scales (Eating Concern:e.g., Has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in?), Shape Concern:Has your shape influenced how you think about yourself as a person?), Weight Concern:Have you had a strong desire to lose weight?), and Dietary Restraint:Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?).25 Increased ED behavior is indicated with higher scores, with a score above 2.5 considered a sensitive and specific threshold to identify clinically-relevant symptoms of an ED amongst non-clinical samples.26,27 The percentage of participants scoring below 40 on the ORTO-15 were reported as at high risk for ON and the percentage of participants scoring above 2.5 on the EDE-Q were reported as at high risk for an ED. The participants were then divided into three groups: D-ED (dietitians reporting current or past treatment for an ED), D-ON (dietitians with a score less than 40 on ORTO-15), and D-HC (dietitians in healthy comparison group, with a score greater than or equal to 40 on ORTO-15 and no self-report of ED treatment). Analysis of Variance (ANOVA), followed by Bonferroni-corrected pairwise comparisons, and Chi-square analyses comparing the groups were completed in IBM Statistical Package for Social Sciences (SPSS, v.23).28 A Mann Whitney U test was conducted when Levene’s test assumption of equal variances of the populations were not equal. Results of parametric comparisons among the study groups were reported as no differences were observed with the non-parametric test. Weight or height was missing for five participants; these subjects were excluded for the body mass index analyses. As there were only 21 male participants (9 in the D-HC, 12 in the D-ON, and 0 in the D-ED groups), all analyses were repeated without the men, but there were no significant differences. There were 684 participants that responded, but 48 were excluded for pregnancy, breastfeeding or unable to read English, resulting in a total of 636 dietitians (615 women and 21 men) that completed the questionnaires. For the primary aim, prevalence of risk for ON amongst all dietitians, 49.5% scored at a high risk of ON, with the mean ORTO-15 score for all participants at 39.3 ± 3.6 points, and a range of 23–49. Amongst all dietitians, 12.9% of the entire group scored at the high risk for an ED, with the mean EDE-Q test score for all participants 1.21 ± 1.0 with a range of 0 – 4.62. Based on the grouping criteria (Table 1), 8.2%of participants were in the D-ED group (reported treatment for ED), 44.6% were in the D-ON group (ORTO-15 less than 40), and 47.2% remained in the D-HC group (no treatment for ED and ORTO-15 greater than or equal to 40). Within the D-ED group, twenty-nine women reported receiving treatment for anorexia nervosa, sixteen for bulimia nervosa, fifteen for an eating disorder not otherwise specified and eleven for binge-eating disorder. The D-ON and D-ED groups reported more dietary restrictions than the D-HC group, but there were no group differences related to gender, ethnicity, race or clinical experience. Characteristics of 636 dieticians responding to an online survey assessing the prevalence and effects of orthorexia nervosa and eating disorders in dieticians D-HCa(n = 300) D-ONa(n = 284) D-EDa(n = 52) Statistical Comparisonsb n (%) n (%) n (%) X2 p Gender 2.62 0.27 Female 291 (97.0) 272 (95.8) 52 (100) Male 9 (3.0) 12 (4.2) 0 (0.0) Ethnicity/Race 13.96 0.30 Caucasian 265 (88.9) 251 (89.0) 50 (96.2) Hispanic 14 (4.7) 10 (3.5) 0 (0.0) Asian 7 (2.3) 14 (5.0) 1 (1.9) African American 7 (2.3) 5 (1.8) 0 (0.0) Other 5 (1.7) 1 (0.4) 1 (1.9) Years as RD 11.65 0.17 0–5 years 54 (18.0) 73 (25.7) 14 (26.9) 6–10 years 34 (11.3) 27 (9.5) 4 (7.7) 11–20 years 69 (23.0) 64 (22.5) 15 (28.8) 21–30 years 67 (22.3) 69 (24.3) 12 (23.1) >30 years 76 (25.3) 51 (18.0) 7 (13.5) Dietary Restrictions 54.80