

FACING ADDICTION WITH HOPE AND  
UNDERSTANDING

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# **When Healthy Becomes Harmful: Understanding Behavioral Addictions in Eating and Exercise, and What Families Need to Know**

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# **When Healthy Becomes Harmful: Understanding Behavioral Addictions in Eating and Exercise, and What Families Need to Know**

There is a particular cruelty in watching someone you love destroy themselves in the name of health. The parent who watches their teenager weigh every gram of food before eating it. The spouse who sees their partner disappear to the gym at 5 a.m., then again at noon, then again after dinner — driven not by joy or vitality but by something that looks disturbingly like compulsion. The family member who cannot name what they are witnessing because it does not fit the language they have been given. It is not anorexia, exactly. It is not bulimia. It looks, from the outside, almost virtuous. And that invisibility is part of what makes it so dangerous.

Recent research is beginning to name what many families have long sensed but struggled to articulate: that obsessive preoccupation with "healthy" eating and compulsive exercise can constitute genuine behavioral addictions — and that distinguishing them from more widely recognized eating disorders is not merely an academic exercise, but a clinical and human necessity.

## **\*\*The Problem of Looking Healthy\*\***

A 2026 study published in *BMC Psychiatry* set out to investigate whether Orthorexia Nervosa (ON) and Exercise Addiction (EA) could be meaningfully differentiated from disordered eating through the lens of body image and self-esteem. Orthorexia Nervosa is defined as the obsessive preoccupation with healthy eating — not an obsession with eating *less*, but with eating *purely*, *correctly*, *righteously*. Exercise Addiction, meanwhile, describes a behavioral addiction to

exercise characterized not by love of movement but by loss of control over it. The study's researchers hypothesized that "ON profiles would be characterized by stronger health orientation, EA profiles by greater fitness orientation, and disordered eating profiles by heightened preoccupation with overweight, appearance concerns, and lower self-esteem" (Wachten 2026).

What makes this research so important for families is what it implies about recognition. If orthorexia is driven by health orientation and exercise addiction by fitness orientation — rather than by the more familiar preoccupations with thinness and appearance — then families may be watching a loved one suffer without any of the usual warning signs they have been taught to look for. There is no dramatic weight loss. There is no obvious distress about body size. There is, instead, a person who seems deeply committed to wellness. And commitment to wellness, in our culture, is praised. It is rewarded. It is photographed and shared and liked.

The researchers applied a latent profile analysis — a statistical method that groups individuals by patterns of shared characteristics — specifically to "ascertain whether latent profiles can be identified that support the independence of ON and EA from disordered eating" (Wachten 2026). This methodology matters because it moves beyond symptom checklists and asks a deeper question: do these conditions form their own distinct psychological constellations? The answer has profound implications for how families understand what they are dealing with, and how clinicians respond.

### **\*\*A Culture That Confuses Virtue and Compulsion\*\***

We live in a moment of extraordinary nutritional moralism. Foods are "clean" or "dirty." Exercise is "earned" or "skipped." Bodies are "disciplined" or "undisciplined." In this cultural context, the line between genuine health-seeking and compulsive behavior is not merely blurry — it

is actively obscured by a language that assigns moral value to restriction and effort. For families trying to evaluate whether a loved one's behavior has crossed a line, this creates genuine confusion.

The Mayo Clinic has addressed related terrain in discussing anxiety and eating issues in children, noting in a 2026 question-and-answer piece that anxiety and disordered eating frequently co-occur and that the presentation in younger people can be particularly difficult for families to parse (Mayo Clinic 2026). A child or teenager who refuses certain foods, who becomes distressed when their routine is disrupted, who exercises with an intensity that seems disconnected from pleasure — these behaviors exist on a spectrum, and families often do not know where concern becomes alarm.

This is not a failure of parental attention. It is a failure of cultural and clinical vocabulary. When the Wachten study frames Orthorexia Nervosa and Exercise Addiction as "controversially discussed as potential mental disorders," it is acknowledging something important: that even the professional community has not fully settled on how to name and categorize these experiences (Wachten 2026). If experts are uncertain, families cannot be expected to be certain. What families need is not a diagnostic manual — it is permission to take their observations seriously, and access to people who can help them interpret what they are seeing.

### **\*\*Self-Esteem, Body Image, and the Architecture of Suffering\*\***

The Wachten study's focus on self-esteem and multidimensional body image is particularly revealing for family-centered understanding. Body image, as the researchers use the term, is not simply how someone sees themselves in a mirror. It is multidimensional — encompassing how people feel about their bodies' function, health, fitness, and appearance, and how those perceptions interact with their sense of worth.

The hypothesis that disordered eating profiles would be characterized by "lower self-esteem" while orthorexia profiles would reflect health

orientation raises a quietly radical question: Can someone with genuinely high self-esteem develop a behavioral addiction? Or does the obsessive quality of orthorexia eventually erode the self-esteem it appears to serve? These are not idle questions for families. They speak to the difference between telling a loved one "you seem confident" and recognizing that confidence in one's dietary purity can coexist with, or even mask, profound psychological distress.

For families who have watched a loved one move through the healthcare system without receiving adequate help — or who have been told their concern is overblown because their family member "seems healthy" — this research offers something important: a framework for understanding that behavioral addiction does not always look like rock bottom. Sometimes it looks like discipline. Sometimes it looks like dedication. And sometimes it looks, from the outside, like everything is fine.

#### **\*\*What Families Are Actually Navigating\*\***

Consider the practical reality of a family living with someone in the grip of orthorexia or exercise addiction. Mealtimes become minefields. Social events built around food — birthdays, holidays, ordinary dinners — become sites of conflict or avoidance. The family member with the addiction may experience genuine distress when their routines are disrupted, and may explain that distress in language that sounds completely rational: "I just care about my health." "I don't want to put that in my body." "I need to get my workout in."

From the inside of the addiction, these explanations are true. That is what makes behavioral addictions to "healthy" behaviors so particularly difficult for families. The person suffering is not hiding their behavior behind lies. They are telling the truth as they experience it — and that truth has been organized around a set of beliefs that are, on the surface, culturally endorsed. The family's reality — that something is wrong, that this person is suffering, that the rigidity and compulsion are causing

harm — can feel impossible to articulate without sounding like an attack on health itself.

This is where the research framework becomes practically important. The Wachten study's effort to establish that ON and EA can be distinguished from disordered eating through distinct psychological profiles is not just scientifically interesting — it is the beginning of a language that families can use. When we can say, "This is not about vanity or fear of weight gain — this is about a compulsive relationship with health and fitness as value systems," we open a different kind of conversation. One that does not feel like criticism. One that might actually reach someone.

**\*\*Facing It With Hope and Understanding\*\***

The thesis of this organization — that facing addiction with hope and understanding, rather than judgment, shame, or confrontation, is the only morally defensible approach — finds particular resonance in the context of behavioral addictions like orthorexia and exercise addiction. Shame-based intervention is always counterproductive, but it is especially so here, because the person suffering has organized their sense of self around behaviors that feel inherently praiseworthy. To attack those behaviors without understanding their psychological function is to attack the person's identity — and to do so in a cultural context where everyone else is applauding them.

Hope-based approaches begin with recognition. They begin with families learning to name what they see — not to diagnose, but to take their own observations seriously. They continue with compassionate engagement: conversations that approach the suffering person with curiosity rather than alarm, that ask questions rather than issue ultimatums, that communicate love alongside concern. And they require professional support that is equipped to distinguish between different presentations — support that recognizes, as the Wachten research urges, that "the

unclear distinction between these conditions and disordered eating" is a genuine clinical challenge, not a family's failure of perception (Wachten 2026).

Families do not need to be certain that what they are seeing is a diagnosable condition before they are permitted to ask for help. What they need is an environment — in clinical practice, in cultural conversation, in their own homes — where asking is possible. Where the language exists. Where someone will listen.

The research is still catching up to what many families already know: that you can lose someone to health. That compulsion does not always announce itself with destruction. And that understanding — patient, informed, compassionate understanding — is both the most difficult and the most necessary thing we can offer the people we love.

## Works Cited

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