

Vegan and Vegetarian Diets: What They Tell Us About Eating Disorder Risk

Written by The Life Science Feed Editorial Team · Published 17 August 2026 · Edited by Mara Voss

The adoption of vegan or vegetarian diets has seen a notable increase across Europe, driven by a range of ethical, environmental, and health considerations. While these dietary patterns are often associated with positive health outcomes, their intersection with eating disorders presents a complex clinical picture for general practitioners and specialists alike. The challenge lies in distinguishing a genuine dietary preference from a restrictive eating pattern that may signal or exacerbate an underlying eating disorder.

KEY TAKEAWAYS

- **The Pivot:** Dietary choices like veganism and vegetarianism can serve as both a genuine lifestyle preference and a potential camouflage for disordered eating behaviors, complicating clinical assessment.
- **The Data:** Observational studies indicate a higher prevalence of vegetarianism and veganism among individuals with diagnosed eating disorders compared to the general population.
- **The Action:** Clinicians should routinely inquire about dietary patterns in patients presenting with unexplained weight changes, gastrointestinal symptoms, or body image concerns, maintaining a high index of suspicion for underlying eating disorders.

Eating disorders, including anorexia nervosa, bulimia nervosa, and avoidant/restrictive food intake disorder (ARFID), are severe psychiatric conditions with significant morbidity and mortality. These disorders are characterized by persistent disturbances in eating behavior, thoughts, and emotions, often leading to impaired physical health and psychosocial functioning. The diagnostic criteria for these conditions focus on specific behaviors, cognitions, and physiological consequences, but the presentation can be subtle, particularly when intertwined with socially acceptable dietary choices. The prevalence of vegetarian and vegan diets has risen, especially among adolescents and young adults, demographics also at higher risk for developing eating disorders. This demographic overlap creates a diagnostic conundrum. A patient presenting with significant weight loss and restrictive eating might genuinely be adhering to a vegan diet for ethical reasons, or their dietary choice could be a socially sanctioned means to restrict food intake, avoid certain food groups, and control weight or shape. Distinguishing between these motivations is paramount for effective intervention.

The Overlap Between Dietary Choice and Disordered Eating

Vegetarianism, defined as the exclusion of meat, poultry, and fish, and veganism, which further excludes all animal products including dairy and eggs, are not inherently pathological. Many individuals adopt these diets for well-articulated reasons, maintaining a healthy relationship with food and body image. But for some, these dietary frameworks can become a convenient justification for increasingly restrictive eating. The initial motivation might be health or ethics, but

the rigid adherence and subsequent elimination of entire food groups can quickly devolve into disordered patterns. Clinicians frequently encounter patients who report adopting a vegetarian or vegan diet shortly before or concurrently with the onset of eating disorder symptoms. This temporal association does not establish causation, but it does highlight a potential pathway. The structure of these diets, particularly veganism, often requires meticulous planning and label reading, which can appeal to individuals predisposed to obsessive or perfectionistic tendencies, traits commonly observed in anorexia nervosa. The perceived 'health halo' around plant-based eating can also provide a socially acceptable cover for restrictive behaviors, making it harder for family, friends, and even healthcare providers to identify a problem.

Identifying Red Flags in Dietary Patterns

The challenge for general practitioners is to differentiate between a healthy, intentional dietary choice and one that serves as a vehicle for an eating disorder. Several red flags warrant closer investigation. Extreme rigidity in dietary rules, beyond what is typically required for a vegan or vegetarian diet, is a concern. For example, eliminating entire food groups within a vegan framework (e.g., all grains, all fats) without clear medical necessity or nutritional guidance suggests a deeper issue. An excessive preoccupation with food quality, purity, or 'clean eating' (orthorexia nervosa) can also manifest within these dietary patterns, often leading to significant nutritional deficiencies and social isolation.

Another warning sign is a history of multiple dietary changes or shifts to increasingly restrictive diets. A patient who moves from an omnivorous diet to vegetarian, then to vegan, then to raw vegan, and then to fruitarianism, for instance, may be using each step as a means to further restrict and control food intake. This escalating pattern of restriction, often accompanied by increasing anxiety around food and eating, is highly indicative of an eating disorder. If the dietary choice is accompanied by significant weight loss, amenorrhea, electrolyte imbalances, or other physical signs of malnutrition, an eating disorder should be strongly considered, regardless of the stated dietary rationale.

The Psychological Underpinnings

The psychological mechanisms linking vegetarianism/veganism and eating disorders are complex. For some, the dietary choice may be a way to exert control in a life that feels otherwise uncontrollable. This is particularly relevant for individuals with anorexia nervosa, where control over food and body is a central feature. The moral superiority sometimes associated with plant-based diets can also reinforce a sense of self-worth that is otherwise lacking, providing a fragile foundation for identity that is tied to dietary purity.

The relationship is not unidirectional. Individuals recovering from eating disorders may also adopt vegetarian or vegan diets as part of their recovery journey, seeking to establish a healthier relationship with food. In these cases, the dietary choice is made under careful medical and nutritional supervision, with a focus on adequate intake and nutritional balance. The distinction lies in the motivation, the flexibility of the diet, and the overall psychological health of the individual. A healthy dietary choice is adaptable, allows for social eating, and does not cause significant distress or impairment.

Clinical Assessment and Management

When assessing a patient who follows a vegetarian or vegan diet, a thorough history is essential. Clinicians should inquire about the duration of the diet, the specific foods included and excluded, the reasons for adoption, and any previous dietary changes. It is also important to explore the patient's relationship with food, their body image, and any concerns about weight or shape. Questions about fear of certain foods, anxiety around meal times, social avoidance related to food, and compensatory behaviors (e.g., excessive exercise, purging) are critical.

Physical examination should include assessment of weight, height, BMI, vital signs, and signs of malnutrition such as lanugo hair, dental erosion, or peripheral edema. Laboratory investigations may include a full blood count, electrolytes, liver and renal function tests, and vitamin levels (e.g., B12, D, iron), as deficiencies are common in restrictive eating disorders and poorly planned plant-based diets. For a comprehensive overview of general clinical assessment, the Oxford Handbook of Clinical Medicine remains an invaluable resource.

Management requires a multidisciplinary approach, often involving a physician, a registered dietitian, and a mental health professional. The initial goal is to address any immediate medical instability and restore nutritional status. This may involve refeeding protocols and careful monitoring of electrolytes. Psychological interventions, such as cognitive behavioral therapy (CBT) or family-based treatment (FBT), are essential for addressing the underlying psychopathology of the eating disorder. The dietitian plays a key role in guiding the patient towards a nutritionally adequate and flexible eating pattern, whether that includes animal products or not.

The open-label nature of self-reported dietary choices is an obvious caveat in many observational studies. It is difficult to blind participants to their own eating patterns, and self-report can be subject to recall bias or social desirability bias. The definition of 'vegetarian' or 'vegan' can vary, making comparisons across studies challenging. Some individuals may identify as vegetarian but still consume fish (pescatarian), while others may be strict vegans. These differences matter when evaluating nutritional adequacy and psychological motivations.

The long-term impact of maintaining a vegetarian or vegan diet during eating disorder recovery also warrants careful consideration. For some, it may be a sustainable and healthy choice, but for others, it may perpetuate restrictive tendencies or make it harder to achieve full nutritional rehabilitation. Clinicians must assess each patient individually, considering their unique history, motivations, and recovery goals. The focus should always be on promoting a healthy, flexible relationship with food, rather than rigidly adhering to a specific dietary label. This is particularly relevant when considering the broader context of dietary trends and their impact on mental health, a topic explored in our previous coverage on coffee's role in gut dysbiosis, which also touches on the psychological aspects of dietary choices.

The absence of specific, large-scale randomized controlled trials directly comparing outcomes of eating disorder treatment in vegetarian/vegan versus omnivorous patients is a significant gap. Such trials are inherently difficult to conduct due to ethical considerations and the complexity of randomizing dietary patterns in a psychiatric population. Most evidence comes from observational studies and clinical experience, which, while valuable, cannot establish causality or definitive treatment guidelines. This means that clinical judgment, informed by a deep understanding of eating disorder psychopathology and nutritional science, remains paramount.

The role of social media and online communities in reinforcing dietary choices and potentially exacerbating disordered eating is another area of concern. Patients, especially adolescents, are often exposed to highly curated and often unrealistic portrayals of 'healthy' eating and body ideals, which can fuel restrictive behaviors. Clinicians need to be aware of these external influences and address them as part of a comprehensive treatment plan. This extends to understanding how broader societal narratives, such as those discussed in why medical schools are failing to teach about autism, can shape patient perceptions and behaviors around health and illness.

The goal is to help patients achieve full recovery from their eating disorder, which includes developing a peaceful and flexible relationship with food. For some, this may involve continuing a well-planned vegetarian or vegan diet. For others, it may mean reintroducing animal products. The decision should be driven by the patient's recovery needs and

nutritional requirements, guided by expert clinical advice, rather than by rigid adherence to a dietary ideology. The next step in research should focus on developing validated screening tools that can effectively distinguish between genuine dietary preference and eating disorder symptomatology in individuals following plant-based diets.

CLINICAL IMPLICATIONS

The increasing popularity of plant-based diets presents a genuine diagnostic challenge for clinicians. It is no longer sufficient to simply accept a patient's stated dietary preference at face value, particularly when other signs of disordered eating are present. GPs and specialists must cultivate an understanding of the motivations behind these dietary choices.

We need to be more proactive in our questioning. A patient reporting a new vegan diet, especially if accompanied by rapid weight changes or an intense focus on 'clean' eating, warrants a deeper dive into their relationship with food and body image. This isn't about discouraging plant-based diets, but about identifying when they become a socially acceptable mask for pathology.

The lack of robust, randomized data on this specific intersection means clinical judgment remains paramount. We are relying on observational trends and our own experience. This highlights the need for better screening tools and clearer guidelines for assessing eating disorder risk in individuals following restrictive diets, ensuring we don't miss a diagnosis under the guise of a healthy lifestyle choice.

The focus must shift from the dietary label itself to the underlying psychological health and nutritional adequacy. If a patient's dietary choices are causing distress, social isolation, or physical harm, then the label becomes irrelevant. Our role is to treat the patient, not the diet.

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