New Jersey Alcohol/Drug Resource Center & Clearinghouse

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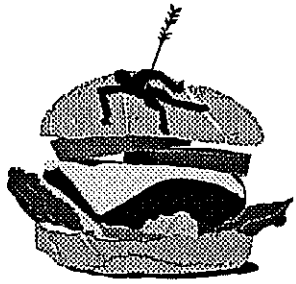

FACTS ON:
Food Addiction

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Eating is a fundamental activity of life. Health requires nourishment, and every cell of the body is constantly replacing itself. For most Americans this process occurs naturally and healthfully, but for some people distortion influences eating behavior and eating disorders, including food addiction, result. Food addiction is defined as *the chronic, habitual or periodic consumption or restriction of food to the point that it injures health or interferes with social, economic, or emotional functioning on a continual basis.* It causes obesity, anorexia (self-starvation), and bulimia (bingeing and purging). The most common form of food addiction is compulsive overeating. In many cases, symptoms such as high blood pressure, diabetes, or arthritis are treated at great expense with poor outcomes, while the primary disorder, food addiction, goes undetected.

Historically, the term "eating disorders" was used to encompass anorexia *and* bulimia. Binge eating was not considered a DSM III* diagnosable disorder until 1994. The concept of food addiction, as it is used here, differs from the concept of eating disorders because the addiction dynamic is considered causal. A disorder may occur independent of an addiction. This is determined by deciding whether loss of control over food intake is the precipitating factor. If, for example, the motivation for the disorder is fear of fat, and this fear translates into uncontrolled limitation of food intake, then food addiction is said to be present.

Cross-prevalence of food addiction with alcohol and drug addiction is high. One-third of food addicts are addicted to alcohol or other drugs, and one-third of cocaine addicts are anorexic or bulimic. These proportions reflect several times the rate of these disorders in the general population

Like alcohol and drug addiction, food addiction is primary, chronic, progressive, and, if left untreated, fatal. It is primary because, in most cases, this illness should be addressed first; it is chronic in that the majority relapse. As many as ninety-five percent of dieters gain back more weight than they lost within two years of dieting. The severity of the illness progresses over time and may become life-threatening if untreated. Food-addicted persons are preoccupied with food, experience loss of control with respect to the use of food and behave in ways which are harmful to themselves. Anorexics starve, bulimics get rid of the food, and compulsive overeaters retain it. All of these conditions are dangerous.

One theoretical model of food addiction is based on the principle that quickly-metabolized carbohydrates trigger a craving for more carbohydrates, establishing an addictive cycle. Specific substances include sugar, flour, caffeine, or anything eaten in volume. Sugar, for example, takes zero time to metabolize. The body uses it quickly and immediately calls for more. Flour takes a little longer to metabolize but is also quickly turned into sugar. Caffeine increases adrenaline, causing an overproduction of insulin, which sets up a craving mechanism. Anything eaten in volume is stored as fat, and when the body uses this material it is turned into glycogen, then glucose, setting up the craving mechanism again. After a detoxification period physiological cravings will disappear if these substances are removed from a food plan.

Addicted and non-addicted persons have different responses to addictive substances. With alcohol and other drug addictions, as well as with other conditions, genetic predisposition conspires with environmental stressors to establish susceptibility to addictive illnesses. According to this theory, addicted persons suffer from a chronically low level of the neurotransmitter *serotonin* that may be caused by genetic predisposition, trauma, depression, or other causes. When the addicted person ingests an addictive substance, a "neurotransmitter flooding" response occurs. Receptor sites are left empty, and this emptiness triggers craving. When a non-addicted person uses the same substances, neurotransmitters are engaged, but the flooding does not occur. Without the empty receptor sites craving is absent, and continued use of the substance is not necessary. This is why a non-addicted person can leave a cookie half-eaten, while a person with a food addiction could never imagine such an act.

During the 70s the Hazelden model of alcoholism treatment was applied to all mood-altering chemicals, and during the 80s the DSM-III* was revised to reflect the concept of psychoactive substance abuse. Clinicians began to apply traditional chemical dependency treatment methods to the problem of food addiction. Heritage, Glenbeigh and The Willough were the first three chemical dependency programs in the U.S. to add residential food addiction treatment components.

In 1970, 35 years after Alcoholics Anonymous (AA) was founded, Roxanne, a compulsive overeater, applied the principles of AA to eating problems and Overeaters Anonymous (OA) was born. Today over 100,000 people attend meetings for mutual aid and support in recovery from food addiction. Food Addicts Anonymous (FAA) was established in the late 80s as an offshoot of OA. FAA has developed a management protocol for physical abstinence and recovery, and has established abstinence guidelines and specific eating plan suggestions. Members suggest that attendance at weight loss programs is harmful to recovery, however, since such programs have an effect similar to that of suggesting controlled

drinking to an active alcoholic. Most dieters alternate periods of control with periods of unrestrained eating, and, because food addiction is characterized by loss of control over eating, the advice to just eat less is very much like telling an alcoholic or other drug addicted person to "just say no."

Denial is a hallmark of addiction, and food addicts usually have to fail more than one test of OA's "Twenty Questions" before they believe their relationship to food is addictive. Denial of food addiction is especially pervasive, since overeating is as socially acceptable in American culture as motherhood and apple pie. It is extremely difficult for even the most committed twelve-step member in stable, long-term recovery from alcohol and other drug addiction to believe that obesity is a result of addiction to food. Many simply believe that their addictive behavior is under control, and that eating a bag of chocolate-covered raisins can hardly be considered a lack of spiritual centeredness. This polarization of mind and body is another form of denial and another way of maintaining an addiction

Symptoms of this chronic disease state may include obesity, metabolic, gastrointestinal, and endocrine problems, heart disease, joint, and pulmonary diseases, and other serious medical conditions. While most of the circulatory, cardiovascular and other medical problems associated with obesity are entirely reversible with weight loss, without long-term food addiction support and treatment most of those who lose weight frequently regain it within two years.

Food addiction also has emotional and spiritual dimensions. Emotional dimensions may include loss of self-esteem, anxiety, and an emotional "roller coaster" ranging from hysteria to depression, and often including suicidal thoughts. Spiritual dimensions may include hopelessness, the perception of a "void" in one's life, and an absence of faith and trust in one's self or others. Addiction suppresses the ability to ask for, give, or receive help, and isolation is the result.

The effects of food addiction are pervasive: One in ten female college students suffers from an eating disorder, and children as young as fourth graders have reported dieting. Advertisements normalize binge eating and glamorize the image of being underweight. Persons who are obese experience discrimination in housing, health care, and employment. The social ostracism that obese children endure is frequently a cause of depression and an increased craving for food. Every obese person is a potential diabetic, and many serious medical problems also accompany anorexia and bulimia. After suicide, anorexia is the leading cause of death for persons with a diagnosable mental illness.

Professional inpatient and outpatient treatment for eating disorders and food addiction is available through traditional mental health and some addiction treatment facilities. Mutual aid and self-help for food addiction is available by calling the Intergroup Office of Overeaters Anonymous for the names and locations of local meetings. Education on eating disorders and food addiction is available from Hazelden, the U.S. Department of Health and Human Services, and the Rutgers University Center of Alcohol Studies.

The field of alcohol and drug treatment offers experience and skills useful to recovery from food addiction. Food addiction is a treatable illness, and many people enjoy long years of successful recovery from anorexia, bulimia, and compulsive overeating. If you or someone you know has a problem with food, contact Overeaters Anonymous, request a copy of the "Twenty Questions" pamphlet, and attend some meetings.

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Suggestions for Further Reading

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†The mailing address of Overeaters Anonymous is: P.O. Box 92870, Los Angeles, CA 90009.