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Addicted to food: food as a drug

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Addicted to food : food as a drug

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When considering the variety of substances on which individuals can become addicted, food is usually not a drug that comes to mind. Some may argue food addiction is not a real disease and food cannot be considered a drug. For people who suffer from food addictions, all exercise and diet plans offer is a fix for the symptom (weight gain) and not a solution to the problem: food addiction. The definition of food addiction can get blurry; the foods that are addictive are specific; the treatment for people with food addiction is not readily available; and the success rate for treatment can be hit-or-miss. However, by offering a better understanding of how food can affect the brain, body and our mood, one can better understand the connection between food as a drug and other addictive substances that create dependence. The following information covers a variety of topics that factor into food addiction including biogenetic causes, physical and cultural considerations, signs and symptoms, treatment, and implications for the practitioners working in the field of mental health.
Addicted to Food: Food as a Drug

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Abstract

When considering the variety of substances on which individuals can become addicted, food is usually not a drug that comes to mind. Some may argue food addiction is not a real disease and food cannot be considered a drug. For people who suffer from food addictions, all exercise and diet plans offer is a fix for the symptom (weight gain) and not a solution to the problem: food addiction. The definition of food addiction can get blurry; the foods that are addictive are specific; the treatment for people with food addiction is not readily available; and the success rate for treatment can be hit-or-miss. However, by offering a better understanding of how food can affect the brain, body and our mood, one can better understand the connection between food as a drug and other addictive substances that create dependence. The following information covers a variety of topics that factor into food addiction including biogenetic causes, physical and cultural considerations, signs and symptoms, treatment and implications for the practitioners working in the field of mental health.
Addicted to Food: Food as a Drug

When thinking about individuals who struggle with substance dependence or addiction, one may automatically assume these persons are abusing alcohol, using illicit drugs or misusing prescription medication. It is true, alcohol and some prescription medications and other drugs such as cocaine or methamphetamine are some of the most common substances that create dependence and addiction for the individuals that use them. However, one drug that is commonly abused is becoming a greater problem for more and more U.S. Americans. Almost every single person in the United States uses it daily. What’s tricky about this drug is: it is not really a drug until its use interferes with normal, everyday functioning for the individual abusing it. Food may not be a “drug” that automatically comes to mind when thinking about what substances addicts use, but food is a very real drug for many people who suffer from the disease of addiction.

Some may argue food addiction is not a real disease and food cannot be considered a drug. Our society can be quick to blame the person suffering from the addiction frequently labeling him or her as weak-willed or lazy. If you look around a bookstore, an entire section of hundreds of books can offer any person advice on diets, weight loss solutions and exercise programs. For people who suffer from food addictions, all these books and programs offer is fix for the symptom (weight gain) and not a solution to the problem: food addiction. The definition of food addiction can get blurry; the foods that are addictive are specific; the treatment for people with food addiction is not readily available; and the success rate for treatment can be hit-or-miss. However, by offering a better understanding of how food can affect the brain, body and our mood, one can better understand the connection between food as a drug and other addictive substances that
create dependence. By better understanding inappropriate and unhealthy eating behaviors, one can better understand the link to other addictive behaviors.

The following information gives definitions of food addiction, possible causes and prevalence. Cultural considerations as well as signs and symptoms of food addiction are also addressed. Application for counselors includes information regarding treatments, theories and interventions, medications, and client potential for relapse. In gaining these understandings a network for treatment can continue to evolve to better treat the problem of food addiction as opposed to the symptom of weight gain.

Addiction

Markers for addiction are usually a compulsive need for a substance paired with its chronic use that has created dependence in the brain and body. According to the DSM IV T-R (2000), substance dependence is a maladaptive pattern of substance use, which leads to impairment or distress that is clinically significant. “Addiction is a process of self-medicating a distressed brain in chemical imbalance” (Noble et al. 1999, p.1520). It is characterized by the need for increased amounts of the substance to achieve the desired high. According to Sheppard (1993), the signs of addiction are: obsession, compulsion, denial, tolerance, withdrawal syndrome and craving. Sheppard goes on to suggest individuals addicted to food show all of these signs of addiction. In addition to these signs, food addicts also suffer from distorted body image.

Food Addiction

Biogenetic causes:

Sheppard (2000) outlines the biogenetic condition that is food addiction and agrees with multiple research findings. Noble, et al (1999) discusses food addiction as an
inherited trait "just like blue eyes and blond hair" (p. 1520). His research primarily focuses on A1: a dopamine receptor pleasure gene that has been linked to alcohol and cocaine abuse. Individuals who carry the rare A1 gene have fewer dopamine receptors than individuals who carry the more common A2 gene. Since dopamine "is responsible for the sensation of pleasure and reward" (Sheppard, 2000, p. 33), those individuals carrying the A1 frequently end up using substances such as drugs, alcohol or food to "satisfy the deficit" (p. 34).

According to Danowski & Lazaro (2000), food addiction involves "the compulsive pursuit of a mood change by engaging in repeated episodes of binge eating despite adverse consequences." Thus, a food addict is a person who engages continually in these repeated episodes of binge eating with no regard for the multiple side effects. Food addicts are not addicted to all foods. One would be hard pressed to find an individual who was addicted to a healthy food like broccoli. Certain foods or food substances (such as sugar) can affect any person's mood. People who are pre-disposed to food addiction most likely have a higher sensitivity to the foods that are mood-altering (Somer & Snyderman, 1999). These people may consume more trigger foods in order to achieve a temporary high, or they may crave and consume more fats and carbohydrates to seek out the mellowing affect these foods have on individuals.

In essence, when a food addict consumes a large amount of refined carbohydrates, the brain suddenly becomes drunk with dopamine, serotonin and norepinephrine, three feel-good neurotransmitters. As a result, after consuming the trigger food, the addict begins feeling the effects of the brain's own painkillers and tranquilizers because of the dramatic increase in serotonin released (Eller, 2006). The high one can achieve from
food is rapid after consumption, but this quick rush eventually creates a neurotransmitter deficiency in the brain. “In addiction, it’s feast or famine” (Sheppard, 2000). During this famine, the part of brain that is responsible for emotions and survival is most affected. This part of the brain, known as the hypothalamus gets so out of balance during the famine, mood and cravings become out of control. For the addict, depression and strong cravings usually set in and can persist for over 24 hours at time if the symptoms are not relieved and the brain is not put back into balance by another binge of the trigger food. As the feast and famine cycle continues in the brain, individuals find they need more and more of the drug to achieve balance, thus the compulsive need and chronic use of food becomes clinically significant enough to labeled as an addiction.

Eating disorders such as binge eating and bulimia nervosa have criteria that show signs and symptoms that are identical to those for food addiction. As previously mentioned, the actual term “food addiction” is not used in the DSM IV-TR as an identifiable eating disorder. However, research and experts suggest the diagnostic criteria of recurrent episodes of binge eating (an area considered in the next DSM), feeling relating to lack of control during a binge, engaging two or more binge episodes per week for three months or more, and demonstrating over concern with body shape and weight are some of the same criteria for both bulimia and food addiction (Sheppard, 1993). Other dually related criteria include inconspicuous and secret eating, rapid eating, purging, fasting, and exercising.

*Thoughts and other behaviors.*

In the early stages of food addiction, a preoccupation with food is usually present. “A food addict sees life in relationship to the next opportunity to eat” (Sheppard, 2000).
Frequently, the food addict will spend hours talking about or thinking food. During this early stage, other people may notice this preoccupation with food and comment on it. Thus, the addict may begin sneaking food and experiencing feelings of denial, guilt, dishonesty and fear (Koenig, 2005). As the addiction grows, the behavior of sneaking food may grow into stealing food or stealing money to buy food. “All addictions command the addict to get and ingest the addictive substance...food addicts are not different from those who are hooked on other drugs” (Sheppard, 1993, p.175).

Early on in the disease of food addiction, addicts may find themselves feeling uncomfortable in situations where food is not readily available. If food addicts cannot manipulate the situation to assure the availability of food, they most likely will avoid the situation and possibly isolate in order to binge uninterrupted (Stoltz & Ross, 1986). When isolation begins, the addiction begins to grow more rapidly as addicts begin feeling concerned about weight and feeling self-hatred (1986).

For most addicts, addiction is not addiction until there is a loss of control. As food addiction worsens, the addict begins to lose control over the amount of food consumed and over behavior. Life becomes increasingly unmanageable (Sheppard, 1993). During this time, addicts engage fully in self-deception as well as deception of others. The food addict may buy food for others and end up eating it all, eat only a little bit at a party but later binge at home, blame missing food or sweets on children, hide wrappers, eat frozen baked goods, or eat all the leftovers while cleaning up. Excuses are always made for the huge amounts of food consumed. “Overeating is blamed on boredom, nervousness, family problems, medical problems and the old standby...you would eat too if you had (a job, kids, husband, schedule, mother, father, sister, brother.
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teacher) like mine!” (p.85). In essence, these excuses are really just ways to help addicts make sense of and normalize their own addiction. As weight gain ensues, so do more excuses related to metabolism problems or other medical reasons the addict is gaining weight. In reality, it is simply a sign the addiction is truly at an unmanageable state.

The depression connection.

Kay Sheppard (1993) refers to the repeated failure of controlling binging as the final stages of food addiction. During this time, addicts attempt and fail at many weight loss programs still not realizing the problem is not weight gain, but rather food addiction. Not surprisingly, symptoms of depression begin to disrupt the life of the addict.

According to Grimm (2007), family, friends and other pursuits of interests are usually the first to suffer loss of interest by addicts. Not unlike individuals addicted to drugs and alcohol, the addict usually begins having problems as work and with family. The act of living on a daily basis becomes too much of a task and requires too much energy and makes it difficult for addicts to get out of bed of a morning (2007).

As mental health declines, so does the physical and moral health of food addicts (Sheppard, 2000). Addicts often experience chronic disturbances of mood “involving depression, low energy and fatigue, low self-esteem, poor concentration, anxiety, difficulty making decisions and feelings of hopelessness” (Sheppard, 1993, p.32). By nature of the disease, addicts have neglected good nutrition practices, which increased problems with health and create chronic irritation and depression (Somer & Snyderman, 1999).

To complete the true final stages of food addiction, food addicts turn to food as their main source of security. For the food addicts, ingesting food creates emotional and
physical sensations (Sheppard, 1993). Panic soon sets in for addicts, as they are completely overwhelmed with the obsession and compulsion to eat until the addict accepts defeat.

**Prevalence**

Even though it is common for a food addict to possess a strong desire to be thin, the addict’s obsession with food creates a problem with constant eating, which results in weight gain (Sheppard, 1993). There is a genetic component to both addiction and obesity (Eller, 2006). Because many people who suffer from food addiction attempt to treat the symptom of weight gain as opposed to treating the problem of addiction (Danowski & Lazaro, 2000), it is difficult to give even an approximate number of how many U.S. Americans suffer from food addiction. However, the statistics of individuals in this country who are overweight to obese may be helpful in understanding the prevalence of food addiction.

**Obesity**

Obesity is considered to be a general medical condition and is not listed in the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition-revised* “because obesity has not been clearly linked with a psychological or behavioral syndrome” (Danowski & Lazaro, 2000, p. 56). What research is suggesting is that obesity is one of the side effects, or symptoms of the behavioral and psychological syndrome of food addiction.

According to the *Johns Hopkins Family Health Book* (1999), men are considered obese when 25 percent of total body weight is accounted for by fat, and women are considered obese 30 percent of body weight is fat. According to the Center of Disease
Control and Prevention (2008), an adult who has a body mass index, or BMI, between 25 and 29.9 is considered overweight. Any adult with a BMI 30 or higher is considered obese. (When calculating an individual’s BMI, his or her height and weight are both taken into consideration.)

For the past 25 years, the obesity rate in the United States has been steadily climbing. In the last three years, obesity rates have leveled off, but are still considered high. Over 30 percent of adults, or nearly one-third of the population, over the age of 20 are considered obese. This statistic means: currently, more than 72 million people in this country are obese (National Center for Health Statistics, 2007). It would be unreasonable to suggest each person in the U.S. who falls into the category of obesity also falls into the category of being a food addict. However, it does give researchers a frame of reference as to how many people struggle with the most debilitating side effect of food addiction.

*Cultural and gender considerations for obesity.*

The Center for Health Statistics (2007) noted the following in regard to ethnic-race disparities regarding obesity prevalence rates in the United States for women:

“Approximately 53 percent of non-Hispanic black women and 51 percent of Mexican-American women age 40-59 were obese compared with about 39 percent of non-Hispanic white women of the same age. Among women 60 and older, 61 percent of non-Hispanic black women were obese compared with 37 percent of Mexican-American women and 32 percent of non-Hispanic white women” (p.2).

Among these three groups (non-Hispanic black individuals, Mexican-Americans, and non-Hispanic white individuals), the prevalence of obesity in men had few
discrepancies. 67 percent of non-Hispanic black males, aged 20 and older feel into the category of overweight to obese, while Mexican-American and Non-Hispanic white males both fell into the 70-72 percent range (National Institute of Diabetes and Kidney Diseases, 2007).

Currently, there is no generally accepted definition for obesity that differs from the term overweight for children and adolescents. However, as of 2004 in the United States, approximately 17 percent of children aged 6 to 19 were considered overweight (National Institute of Diabetes and Kidney Diseases, 2007).

Much focus remains on the prevalence of obesity in North America, but according to the World Health Organization, much of the world seems to be following our lead. “More than 1.2 billion people in the world are now officially classified as overweight” (Worldpress.org, 2004).

Obesity: Implications for health.

“Obesity is associated with about 112,000 deaths a year in the U.S. By some estimates, annual medical spending on overweight and obese patients constitutes 9.1 percent of U.S. health expenditures” (Grimm, 2007, p.27).

When individuals meet criteria for being overweight and obese, they are putting themselves at greater risk for a gamete of medical risk factors. Due to the excess weight on the body, joint discomfort and osteoarthritis are common as well as problems with sleeping or breathing. Other medical complications may not be as obvious to the individual, such as high blood pressure, high cholesterol, and coronary heart disease. People who are overweight to obese are also putting themselves at greater risk for
diabetes and certain types of cancers (National Institute of Diabetes and Kidney Diseases, 2007).

Obesity has also more recently been linked to hormonal irregularities, which can lead to fertility complications for both men and women and a presence of excess body or facial hair. Obesity can also cause stress incontinence, increase prevalence of depression and other mental illnesses, create increased surgical risks, and increase mortality rates (National Institute of Diabetes and Kidney Diseases, 2007). In essence, as individuals' weights increase, the medical risk and complications compound. The good news: if overweight or obese individuals can lose weight and eventually maintain a healthier weight, many of the medical complications associated with weight gain can subside (Johns Hopkins University, 1999). Unfortunately for food addicts, loosing weight and maintaining a healthy weight is only part of the battle they are fighting.

The brain's connection to obesity and addiction

According to Eller (2006), “The brains of obese people and drug addicts look strikingly similar” (p.172). Eller explained a brain-based research study in which the results suggested individuals who were obese did indeed have few dopamine receptors in their brains compared to people who were thin to average weight. In fact, the more obese the individual studied was, the few dopamine receptors in the brain. Similar to individuals with food addiction, in the brain of an individual addicted to drugs, the stronger the addiction, the fewer dopamine receptors found.

Physical considerations.

As previously mentioned, researchers suggest one of the contributing factors to food addiction is closely related to the chemical imbalances in the brain. More recently,
conclusions drawn about causes of food addiction are also in relation to what is happening not just in the addict's brain, but also his body and the environment in which he or she lives. Somer & Snyderman (1999) compiled two books that further explored the effects of food on the mind and body as well as examined the yeast in our bodies and how varying levels of yeast can affect cravings for certain foods, especially carbohydrates.

*Candida albicans* is certain amount of yeast that every normal person has in his or her body. When there is an overgrowth of this yeast, cravings for sugar can become overpowering (Somer & Snyderman, 1999). To assume that every person in this country has experienced a yeast overgrowth and found themselves craving something sweet is not unreasonable. The causes for this yeast abundance are most commonly attributed to emotional and physical stressors, fluctuating levels of hormones, ingesting sugars, feeling sick or run-down, and long-term use of antibiotics. In essence, the more sugar you eat, the more sugar you crave (Danowski & Lazaro, 2000).

Cultural considerations.

The predisposition and genetic factors of food addiction, coupled with increased yeast cycles in the body make it easier to see how individuals can become dependent on what would seem to be a harmless drug. For those who are physically and mentally predisposed to this problem, our society certainly does an excellent job at metaphorically and literally feeding the food addict's addiction. “Addictive ways of acting and thinking are actually reinforced by many aspects of our culture” (Weil & Winifred, 1983, p. 145). Most Americans associate happy times or celebration with food. In order to socialize with others, many celebrate by going out to dinner. Even in time of sadness, individuals
recollect back to the times when given ice cream, or milk and cookies to soothe aching
soles (Koenig, 2005). With such a strong emotional connection individuals have
developed with food, it is no wonder food addicts struggle.

In addiction to the emotional connection often associated with food, we have been
a nation of excess and encourage one another to take advantage of that excess. Our fast
food nation offers the American people over-portioned, high-fat meals at low prices that
most can attain without leaving the comfort of their own cars. Fast food especially
appeals to an addict’s cravings for sugar, carbohydrates and fats (Roth, 1991).

Food Addiction: Signs and Symptoms

As with all addictions, the signs and symptoms eventually become too difficult
for the addict to hide. The same is true for food addiction. One of the obvious symptoms
of food addiction is weight gain. However, weight gain alone is not a hard-marker for
food addiction. Even without research support, it is fair to say most U.S. Americans have
experienced a small to significant weight gain at some point in their lives. Experiencing
a weight gain does not immediately constitute an addiction.

According to Danowski and Lazaro (2000), it is important for individuals to
recognize familial addictive patterns. Many may think because there is an absence of
drug or alcohol abuse in the family, there is an absence of addiction altogether. Other
addictive patterns may show up in behaviors, such a compulsive gambling or shopping,
frequent promiscuous sexual behavior, problems with over-exercising, binge eating or
other eating disorders, even witnessing family members who schedule their lives around
sporting events, or those who seem to jump from one abusive relationship to the next.
These examples, and many more are addictions that are presenting concerns in today’s society.

Recognizing the signs.

Once one recognizes the familial pattern of addiction, he or she may be more apt to accept the possibility of predisposition to addiction. Sheppard offers a self-diagnostic checklist that may be helpful in recognizing signs and symptoms of food addiction and offers the questions for self-diagnosis that can be found in Appendix A.

Treatment

The arguments documented here are geared toward informing the reader about the possibility of food possessing addictive qualities. Many skeptics do not believe in this possibility citing their reasoning as individuals’ lifestyle choice. These skeptics tend to ignore the brain-based research, as well as behavioral research. Whether or not food is drug, the fact of the matter is, people who struggle with overeating, weight, body image and obsession and compulsion related to food can not just change their lifestyle overnight. Just as addicts can rarely overcome their addictions without help, the same holds true for people to appear to be addicted to food.

Theories and Interventions

Grim (2007) suggested the treatment course for persons addicted to food as a mixture of counseling, exercise, and healthy eating habits: a very simple and understated overview for the life-long process of recovery. Although there are many places to seek support and treatment for eating disorders such as binge eating, anorexia and bulimia, it is difficult to find a treatment center that solely treats food addiction without relating directly to one of the above-mentioned eating disorders. Since food addiction is not
listed in the *DSM IV-TR*, it may make sense not to create treatment programs for an addiction that has not been made *real* on paper. However, since most of the symptoms for food addiction are paralleled to bulimia nervosa (Webbe & Clontz, 1989), it makes sense that bulimia treatment can also prove successful for individuals who suffer from food addiction.


Koenig (2005) stresses the importance of understanding “normal eating”. This approaches teaches the individual to learn to recognize the difference between hunger and cravings. As the individual learns to differentiate between the two, he or she learns to feed the body *and mind* food that it needs to satisfy hunger as opposed to binging on foods that perpetuate cravings.

Along with learning normal eating patterns, Danowki and Lazaro (2000) help food addicts understand foods that trigger cravings. In addition, they stress the importance of overcoming depression and low self-esteem by utilizing rational thinking, positive self-talk, external motivators, and relationship building skills.

*Medications.*

Medication can also be a useful tool in aiding the recovery process for people suffering from bulimia. Just like food addiction, many people with bulimia struggle with symptoms of depressions. The Food and Drug Administration have approved one
antidepressant, Prozac, for the treatment of bulimia. This medication can aid in decreasing the number of binges as well the desire to purge in people with moderate to severe bulimia (NEDA, 2007).

Medications such as Prozac, Zoloft, Paxil, which are approved for depression and obsessive compulsive disorder may help a person with bulimia have less depressed feelings, as well as be less obsessed with food and weight. The same kind of treatment may be beneficial for those struggling with food addiction (NEDA, 2007). At appropriate doses, antidepressants have been found to decrease the strength of urges to binge for some individuals they increase the serotonin in the brain: one of the feel good receptors from which food addicts continually seek their highs. Individuals who respond well to these medications have reported less carbohydrate cravings, which is a key trigger substance for individuals suffering from food addiction. Naltrexone is another group of medicines, which works on the opiate system in the pleasure center of the brain. This medication is also used to help recovering alcoholics (2007).

A therapeutic, educational approach, combined with appropriate medications can be extremely useful in treating eating disorders, including food addiction. With continued education and support, one can overcome these maladaptive behaviors, but relapse is always a possibility.

Relapse

Relapse is a part of recovery and is usually true of individuals who struggle with drug use, alcohol abuse, gambling, eating disorders and more. One of the most frustrating things for most addicts is always keeping the addiction at bay. Approaches in
therapy help teach the recovering addict to recognize dangerous situations and utilize coping skills to help the addict avoid relapse (Danowski & Lazaro, 2000).

“Relapse occurs when the individual becomes complacent or overly confident, resulting in the process of decompensating in recovery. This involves the performance of increasingly more disease-related behaviors and fewer recovery-related tasks, until recovery is so weakened it can no longer withstand the power of the disease” (Sheppard, 2000, p. 258). In order to continue with recovery, it is important to be aware of relapse so it can be confronted at its weakest point as opposed to waiting until the addict is at his or her weakest point, and relapse has already won: “...recovering people cannot achieve perfect recovery. everyone who is in recovery is also in some sort of stage of relapse” (p. 258). In other words, it would be difficult to find an individual who is healing from this disorder who has never had a setback (relapse) and therefore is susceptible to relapse at some point during recovery.

Implications for Mental Health Practitioners

It is possible the validity of the term food addiction may continue to be debated for years to come. However, brain-based research coupled with current knowledge of eating disorders makes it vital for mental health practitioners to at least have background knowledge regarding addictive eating patterns.

Many clients present with body image concerns as well as other issues surrounding the topic of food. It is the mental health practitioner’s responsibility to be open to the possibility of food addiction, understand the signs and symptoms, and educate their clients, and make appropriate referrals as necessary. Frequently food addicts, especially those in earlier stages of the disease, complain of weight gain as their main
concern. If the counselor attempts to work with the client on the issue of weight gain alone, the counselor and client will both find their efforts to be futile. As with any presenting issue, the counselor is responsible to helping the client explore the issue to its fullest, providing unbiased support along the way.

When working with a client who presents with complaints of weight gain, it is important to discuss all possibilities that may be contributing to this problem. The practitioner needs to take the time to explore eating habits, ask the client if they have a food or substance they consider a weakness or they can’t say no to, and further explore eating patterns related to the food. In the early stages of food addiction, some individuals are unaware of the possible problem (Koenig, 2005), so as practitioners, it is vital that we can identify food addiction as a potential problem before the client gets to a stage when they are out of control.

Other interventions such as medication and therapy can continue to be helpful to individuals struggling with food addiction. Because there is frequently a lot of shame associated with individuals who suffer from addiction, group therapy can be extremely helpful. Some therapists may even recommend 12 step-type programs for eating disorders, or even suggest AA as a helpful treatment method. This can provide the client with a support system that aids in taking away isolation and feelings of shame (Sheppard, 1993).

What may be one of the most important implications for a counselor with regard to food addiction is a true background knowledge and understanding of general addiction. If a therapist can look at food addiction as a disease, and understand that relapse most
likely will be a part of recovery, the therapist is better apt to treat the client with the
unconditional positive regard he or she needs to recover from addiction.

*Summary*

People who suffer from addiction usually have some sort of genetic
predisposition, causing them to be more susceptible to familial patterns of addiction. The
most obvious and prevalent types of addiction are from the use of drugs and alcohol.
Other addictions include gambling, shopping, or even over exercising. The concept of
food addiction has been studied in-depth in the past 20 years, though most journal articles
tend to focus on diagnoses that can currently be found in the DSM-IV TR. Not only is
their a strong connect between bulimia and food addiction, but brain based research also
proves the deficit of dopamine in the brain is the same in both food addicts and drug
addicts.

Metaphorically speaking, one of the largest symptoms of food addiction is weight
gain and the potential of obesity. More than 72 million U.S. Americans are considered
obese and by default, considered to have some sort of problem with food. When food
addicts, doctors and therapists alike attempt to treat the symptom of weight gain, they
most likely will find only short-term successes since the problem (food addiction) is not
being addressed. Treatment programs for food addicts are available in the form of
individual therapy, self-help, and eating disorder treatment centers.

Food addiction should be treated as a life-long illness and therefore the addict
must always be aware of the possibility of relapse. Relapse prevention programs used for
drug and alcohol abuse can be just as effective for food addicts. In these programs,
addicts are taught to recognize signs of relapse and learn to use coping skills and support systems to help them avoid falling back into addictive patterns.

Mental health practitioners need to be aware of the signs and symptoms of food addiction and other maladaptive eating patterns. Through examination of family history, empathetic therapy, appropriate education for the client, and appropriate referrals, mental health practitioners can play a vital role in the recovery of individuals suffering from addiction to food.
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References


Appendix A

Questions for Self-Diagnosis of Food Addiction

1. Has anyone ever told you that you have a problem with food?
2. Do you think food is a problem for you?
3. Do you eat large amounts of high calorie food in a short period of time?
4. Do you eat to overcome shyness?
5. Do you eat when you are disappointed, tense, or anxious?
6. Can you stop eating with a struggle after one or two sweets?
7. Has your eating ever interfered with any part of your life?
8. Has being overweight ever affected any part of your life?
9. Do you weigh yourself once, twice or more per day?
10. Do you eat more than you planned to eat?
11. Have you hidden food so that you would have it for yourself?
12. Have you felt angry when someone ate the food you saved for yourself?
13. Do you worry that you can't control how much you eat?
14. Have you ever felt frantic about your size, shape, or weight?
15. How many of these weight loss methods have you tried in the past?
   a. Self-induced vomiting
   b. Laxatives
   c. Diuretics
   d. Fasting
   e. Compulsive exercise
   f. Amphetamines
   g. Cocaine
   h. Over-the-counter diet pills, gums and caramels
   i. Sorbitol (for laxative effect)
   j. Chewing and spitting food
   k. Acupuncture, acupressure
   l. Hypnosis
   m. Urine shots
   n. Special food and drink supplements
   o. Weight loss programs: how many? How often?
16. Have you ever felt so ashamed of the amount of food you eat that you hide your eating?
17. Have you ever been so upset about the way you eat, that you wished you would die?
18. Do you overeat more than twice per week?
19. Do you invent plans in order to be alone to eat?
20. Do you seek out companions who eat the way you do?