Food Addiction Institute

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Charles P. O'Brien, M.D.
Chair, Substance Use Disorder Committee, DSM-5
American Psychiatric Association
Washington, D.C.

Dear Dr. O'Brien,

Thank you for your response to our request to add food addiction as a Substance Use Disorder in the DSM-5. It is good to hear that you see this as a valid and important policy direction. We agree that it is important to learn more about the underlying science, particularly regarding the biochemical differences between Binge Eating Disorder and food addiction as a Substance Use Disorder, but **we request you continue to consider putting food addiction as an experimental diagnostic category in the back of the book as was done with Binge Eating Disorder in the DSM-4R. We continue to support moving Binge Eating Disorder from the back of the book as an experimental designation to a formal diagnosis as an Eating Disorder.**

Clinically, there is a simple and effective way to identify possible food addicts. If repeated attempts to diet have not been successful and if several years of therapy for an eating disorder have resulted in increased weight, overeating and/or bingeing, if no other current diagnoses offer reason for this loss of control, and if there are signs of major characteristics of chemical dependency regarding food(s), then an experimental diagnosis of food addiction would make sense. There are currently a very large number of obese and/or eating disordered adults who qualify as food addicted by this method, possible several million.

Of course, this would not identify all food addicts. It would leave out those who were not overweight or obese. It would leave out early stage food addicts who could temporarily gain control over their eating by diet and exercise. It would leave out even some middle stage food addicts whose eating disorder was more advanced than their chemical dependency, who made progress on their underlying psycho-social problems through CBT, mindfulness and/or medication, and who gained a measure of control over their weight through this treatment. However, this elimination method does leave most of the late and final stage food addicts for experimental treatment by psychiatrists or other medical practitioners regarding a possible substance use disorder with one or more specific foods.

In fact, most food addicts who have been treated outside the APA's categories of diagnosis, most often on a fee for service basis without insurance reimbursement, follow this pattern. I will just speak of the 4000 plus late stage food addicts with whom I have worked since 1986. A vast majority had seriously tried at least a half dozen diets – and not been able to achieve and maintain a healthy weight loss. A vast majority had been in therapy for three or more years, a substantial minority have done residential treatment for an eating disorder.

Moreover, about one third of these clients responded to food addiction treatment immediately, and another third made substantial progress over time. Medicine has always been a pragmatic science; if the treatment for a disease is successful, it is the strongest of reasons for considering the diagnosis to be valid. (Hillock, 2009). There are many diseases which have been diagnosed and treated before we knew the full underlying biochemistry, e.g. many cancers. I personally know dozens of health professionals specializing in food addiction treatment who report similar results. This says nothing of the tens of thousands of self-assessed food addicts who are recovering successfully in the food-related 12 Step fellowships or by such things as vegan lifestyle.

Thus, **there could be major strides in the experimental treatment of food as a substance use disorder before we have a rigorous understanding of the underlying bio-chemical difference between binge eating disorder and food addiction.**

It is worth mentioning that, if the diagnosis of food addiction is delayed because of gaps in our understanding about the differences between binge eating disorder and chemical dependency on food, this is just as convincing an argument not to designate Binge Eating Disorder as a formal diagnosis in the DSM-5 or to leave it as an experimental diagnosis while adding food as a Substance Use Disorder as an equally important experimental diagnosis. If food addiction is disallowed for this reason and Binge Eating Disorder confirmed as an official mental health diagnosis, it could be argued that the APA was not following the science on both matters in the same way.

As we have indicated above, we do not suggest this choice. **There is every reason to include Binge Eating Disorder as a full diagnostic category and to add food as a Substance Use Disorder as experimental.** We have considered this matter and offer the follow arguments for this approach:

- As you cite in your recent letter, since Binge Eating Disorder was presented as an experimental diagnosis in the DSM 4R, there have been over 1000 peer reviewed articles examining its use. **BED is often a useful diagnosis leading to successful treatment.** There was a recognition of this among clinicians long before. This is reason enough to move BED to standing as a formal diagnosis.

- For some time there has also been research evidence that **some with the clinical symptoms of a substance use disorder regarding food are have been successfully treated using the addictive model** (Carroll, 1993). Clinicians have consistently reported this in large numbers at the International Association of Eating Disorder Professionals. This is reason enough to establish food as an experimental SUD.

- The professional book establishing the background for Binge Eating Disorder as a diagnosis included a chapter arguing that there was not *yet* scientific basis for claiming specific food(s) could be addictive (Fairburn, 1994) and soon after this, private health insurance reimbursement for treatment of the obese using the

addictive model was stopped. Dozens of food addiction treatment programs closed, hundreds of professionals stopped treating food addiction, and thousands have told their clients that there is no such thing as food addiction**. Fifteen years later, there is an abundance of scientific evidence that some foods can be addictive to some people.** (Cheren, 2009; Volkow, 2010). Asserting this evidence in the DSM-5 would correct a major misconception among many psychiatrists and other health professionals and encourage experimentation with a diagnosis of food addiction.

- **There is an important difference in the treatment of obesity alone, eating disorders alone, and chemical dependency alone.** Obesity alone can be successfully treated through motivation, diet, exercise and change of life style. Eating disorders alone can be successfully treated by therapy, e.g. CBT, mindfulness training and medication. Chemical dependency on food(s) alone can be treated successfully through abstinence, detoxification, education, challenging denial and working through underlying emotional and spiritual issues. The later treatment is so out of favor with current professionals, there is a need to positively assert that it should be tried when it is possible that someone is food addicted.

- It is likely **that a large number of those with binge eating disorder are also addicted to specific food(s) and vice versa.** Common sense evidence includes data on Overeaters Anonymous (OA, 2004). While physical abstinence from "binge foods" is the suggested treatment (i.e. addiction model treatment), over eighty percent of members report that they were physically, emotionally and/or sexually abused, thus candidates for treatment of a psycho-social disease (i.e., an eating disorder.). It may be difficult to find clients who have only binge eating disorder or only food addiction; middle and late stage people where the symptoms are clearest often have both diseases. This argues for experimentally treating both diseases.

- More basic, until we can be sure in a more scientific way who is food addicted, we cannot do the most scientific research on underlying biochemical pathology or outcomes for treatment. Currently, the **most effective manner of identifying food addicts is by working backwards; if food addiction treatment, e.g. abstinence and challenging denial, works, then they probably were/are chemically dependent.** We need such cases to be able to verify assessment instruments, much more to develop cohorts of food addicts for controlled experimentation. This argues that we need to have psychiatrists and other professionals treating possible food addicts in an experimental way to do the research comparing them to binge eating disorder clients.

We hope this thinking will be shared with the Eating Disorder and Substance Abuse Committees. We hope you will agree. If not, we would deeply appreciate hearing your reasoning so that we can include them in our own professional and scientific dialogue.

Besides the clinical and scientific reasons, there is an underlying social urgency**. Binge Eating Disorder and food and a Substance Use Disorder are important – and likely large scale –**

factors in what we have come to call the obesity epidemic. There is a common sense argument that the reason that decades of public health policies to encourage overweight people to diet and exercise have not worked is that this strategy assumes that few have lost control regarding their eating and food due to eating disorders or food addiction; this is probably not the case. The rise of obesity has been proportional to the increase of sugars and artificial sweeteners into the commercial food supply. If, as many scientists now theorize, suggests (Kessler, 2009), a large portion of the population is slowly but surely becoming addicted to these substances, we need large scale experimentation. **One modest beginning would be for the APA in its DSM-5 to suggest that psychiatrists in the United States and around the world experiment with a diagnosis of food addiction.**

The American Society of Addiction Medicine (ASAM) has recently formulated a new policy declaring addiction a "brain disease." They explicitly include food as an important substance of abuse (ASAM, 2011). ASAM members are physicians and psychiatrists who are the experts in addiction, directors of thousands of substance abuse programs and board certified specialists in addictionology. We are concerned that, due to the nearly two decades in which there have been no hospital based primary treatment programs for food addiction, the experience in treating food in the addiction model is dangerously thin. Soon these chemical dependency treatment programs and substance abuse counselors will be experimenting with food addiction diagnosis and treatment again. We request that the APA also take a leadership role in this effort.

Thank you for your consideration.

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cc: Timothy Walsh, M.D., Chair Eating Disorder Committee DSM-5
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