A History of Food Addiction Treatment

While food addicts in 12 Step fellowships receive all of their help free of charge, there are many food addicts who need more help than they can acquire in Overeaters Anonymous and the other groups. These food addicts seek out professional help, and this is often very difficult to find.

This article offers a number of specific suggestions regarding dieticians, workshops and residential rehabs that food addicts have rated highly. It also gives some very practical guidelines for identifying local doctors, dieticians, and therapists who understand – or at least are sympathetic to – food dependency recovery. Finally, there are suggestions for informing health professional about the latest findings about addiction to food and, as a last resort, how to work with those who are still openly hostile to the “disease” concept of food addiction. First, a little history of food addiction treatment over the last two decades will help put this information in context.

The primary reason it is difficult to find good professional help is that the American Medical Association (AMA), the American Dietetic Association (ADA) and the American Psychological Association (APA) have not yet recognized food addiction as a disease. The AMA and ADA recognize obesity – the physical aspect of being overweight. The APA recognizes anorexia and bulimia – and is looking at binge eating as a possible mental health disease; these are considered psychological trauma based illness. At this point in time, they seem to be treating the symptoms of those diagnoses, rather than primary causes. Food addiction – i.e. chemical dependency on a specific food, several foods or volume of food in general – is an entirely different disease. Thus, when a person is obese or has an eating disorder and is food addicted, medical professionals cannot legally diagnose the problem nor be effectively reimbursed for treatment by a patient’s health insurance company. This really discourages health professionals from taking food addiction seriously.

There are a number of secondary reasons for the current paucity of good professional treatment for food addiction: Chemical dependency on food is not taught well, if at all, in most medical schools, licensure for dieticians or psychology graduate programs, so doctors, dietician and therapists are almost always uninformed if not misinformed about food addiction. Most major eating disorder treatment programs moved from an addiction model to the psycho-therapeutic model during the 1990s when health insurance programs

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1 This was the case for the first decades of serious work on alcoholism and drug addiction after the founding of Alcoholics Anonymous. AA was founded in 1935, and the “Doctor’s Opinion” by William Silkworth M.D. was first published in the book Alcoholics Anonymous in 1937, but the AMA did not officially recognize alcoholism as a disease until 1956, and in 1980, the APA developed a “substance abuse” diagnosis that did not specifically identify alcohol.
moved towards not funding treatment of adult compulsive overeaters. Much of the training of counselors and medical professionals in the treatment of alcoholism and drug addiction comes in the residential treatment centers of which there are thousands, but currently there is not one hospital based primary treatment program for food addiction in the United States or the entire world.

The first serious residential treatment center for compulsive over eating using the addict concept of food addiction was the Rader Institute in California. William Rader, M.D. had been the chief psychiatrist for the chemical dependency treatment programs of the U.S, Navy. Judy Hollis, Ph.D., a therapist working with Dr. Rader in a private chemical dependency treatment program, discovered that she herself had all the characteristics of alcoholism, but her “drug of choice” was food! Dr. Hollis and Dr. Rader both thought that a treatment regime similar to the one which was successful in treating alcoholism would also work for those who were powerless over food. Out of this insight, Dr. Rader created a national chain of in-patient treatment programs for compulsive overeaters, and Dr. Hollis later created her own treatment program for food addiction.

Soon after this, a group of the founders of the Overeaters Anonymous HOW (OA HOW) program collaborated with the Naples Research and Counseling Center (later renamed the Willows) to create a similar program for food addiction next to the Center’s long-established program for alcoholism treatment. Many of the original counselors who were food addicts in recovery moved to the Glenbeigh Hospital in Tampa, and this became one of the best residential treatment programs for food addiction in the world. Soon there were dozens of other hospitals and addiction treatment programs around the country that were treating food addiction as a chemical dependency.

What were the essentials of a residential primary treatment program for food addiction? Essentially, it was adapted from the successful chemical dependency treatment programs for alcohol and drug addiction often called the “Minnesota Model.”

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<thead>
<tr>
<th>Minnesota Model</th>
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<td>Week I</td>
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<td>The first priority is the elimination and detoxification of alcohol and other drugs.</td>
<td>The first priority is the elimination of detoxification of sugar and other addictive food and drugs.</td>
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| A thorough multidisciplinary assessment including: self-assessment, doctor’s exam, psychological testing, psychiatric diagnosis, social assessment, and “peer” | A thorough multi-disciplinary assessment including: self assessment, doctor’s exam, psychological testing, psychiatric diagnosis, dietician’s food history, social

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2 Judy Hollis, Fat is a Family Affair, Hazeldon, 1985, Center City, Minnesota.
3 Glenbeigh Hospital went on to become accredited as a Psychiatric Hospital, but is no longer in existence.
4 Beside the dozen of Rader units and the Willow, there were a chain of eating disorder residential treatment centers using the addiction model connected to Horizon Hospitals.
assessment by sober alcoholic who then becomes the client’s case manager. assessment, and “peer” assessment by an abstinent food addict who then becomes the case manager.

Start going to AA/NA meetings daily find a sponsor, and begin reading alcoholism recovery. Start going to OA\(^5\)/AA meetings daily, start committing food daily to sponsor, And begin reading alcoholism and food addiction recovery literature.

Week II

Begin going to daily lectures and group, start writing story of powerlessness over alcoholism/drugs (First Step), listen to other members’ read their completed First Steps. Begin going to daily lecture and groups, start writing story of powerlessness over food (First Step), listen to other members’ Food First Steps.

Continue going to AA/NA meetings daily. Psychiatric consult on dual diagnoses. Continue committing food to OA sponsor, going to OA/AA meetings daily. Group work focuses on rigorous food abstinence. Dietician consult if there are problems.

Week III

Begin body image workshops and trauma groups. Continue committing food abstinence, going to 12 Step meetings, daily lectures and groups.

Work on abstinence, unresolved trauma issues, and bring parts of First Step to process group. Keep listening to completed food First Steps and work on one’s own.

Week III

Finish and present First Step to the client community and recovered counselors. Continue lectures and 12 Step meetings Finish and present food First Step to client community and recovering food addicted counselors. Continue lectures, trauma groups and 12 Step meetings.

Do First Step over if necessary. Go on to Steps 2 and 3 - finding a Higher Power of

\(^5\) Overeater’s Anonymous (OA) is the largest and most diverse food-related 12 Step organization. If there is none locally, the treatment center would use recovering food addict staff to have a meeting of OA or one of the other food related 12 Step fellowships: e.g., Food Addicts Anonymous (FAA) Compulsive Eaters Anonymous-HOW, (CEA-HOW) or Food Addicts in Recovery Anonymous (FA)
one’s own understanding. Possibly start 4th Step moral inventory.

one’s own understanding. Possibly start 4th Step or a new First Step of a second addiction-e.g relationship or work addiction or codependency.

Week V

Present rewritten food First step or new First Step of secondary addiction. Share 4th step inventories with a recovered counselor or sponsor.

Continue committing food, attending 12 Step meetings and lectures. Start being a peer food sponsor for those coming into treatment.

Week IV

Prepare and agree to an after care plan which puts 1) sobriety as first priority, 2) commits to 90 AA/NA meetings in 90 days, 3) doing the rest of the Steps with a sponsor, 4) weekly meetings with a therapist or recovery support group, and 5) individualized goals.

Prepare and agree to an aftercare plan which puts 1) food abstinence first, 2) commits to 90 OA/AA meetings in 90 days, 3) doing the remaining Steps with a sponsor, 4) weekly recovery or therapy group, and 5) individualized goals.

There are two major differences between chemical dependency residential treatment programs for alcohol/drugs and a residential treatment program for food addiction. It is not just the substitution of specific addictive food(s) for alcohol and drugs but also the longer time needed, because addictive eating usually begins earlier than using alcohol or street drugs. The second difference is the additional focus on helping food addicts to identify body image issues and resolve prior trauma, as well as the work of developing a process of committing food daily to a peer sponsor and working on any problems this brings up.

During the 1990’s, all of the primary residential treatment programs for food addiction were either closed or shifted to the psycho-dynamic model of treatment. It was a great loss. The epidemic of obesity and eating disorders was underway, and an effective approach to treating many of the most difficult cases – those who were food addicted and whose disease was quite progressed – became almost impossible to find. By 2000, the rule – with a few important exceptions – was that an adult, overweight food addict could simply not get health insurance coverage for eating disorder treatment and no food addict could be diagnosed for chemical dependency. Only those who were anorexic or bulimic,
quite young, dangerously suicidal and/or needing medication seemed to be health insurance qualified for treatment for their eating disorder. A diagnosis of Binge-Eating Disorder, though by then an “experimental category” for the purposes of research, would seldom be approved for insurance reimbursement. No one, even if clearly chemically dependent on food(s), could be diagnosed as food addicted.6

This was, and is, a very significant problem. There are critical differences between psychologically based eating disorders (basically eating over difficult feelings) and chemical dependency on food (basically an abnormal reaction to some foods as a drug.)

Many people have both an eating disorder and a food addiction, but during treatment it is not seen as important to treat the addiction first. Someone would never assume that an alcoholic or drug addict could do effective therapy if they were still drinking or using drugs, but that is the model today.

There was a devastating effect upon professional treatment of food addiction when most health insurance money was withdrawn for food dependency treatment. With all the residential treatment centers who could deal with the most difficult cases closed, the health system did its best to find another diagnosis or treatment path. Many were diagnosed as having Major Depression, but if their depression was caused by their food addiction, this usually meant moving towards permanent medication and no real effective way to direct them towards healthy eating. Out-patient treatment programs shifted their focus to more psychological approaches; this meant medication, behavior modification, and talk therapy, but these also have not been very successful in working with food addiction.

This also created an indirect problem: professionals were no longer being trained to work with food addiction in a treatment center that took food addiction seriously. A very large proportion of the counselors for other addictive disorders come from the ranks of people who have recovered from alcoholism or drug addiction and then became front line counselors in chemical dependency treatment centers. Without such hospital based treatment centers for food addiction, there was no place for recovering food addicts to receive professional training, and no place for non-addicted counselors and other health professionals to see and learn about food addiction treatment.7

Like with alcoholism and other drug addiction, food addiction must be treated with the elimination of offending drug foods. Finally, under the pressure of no diagnosis for food

6 A key member of the committee formally suggested the “experimental” diagnosis category of Binge-Eating Disorder for the American Psychiatric Association’s Diagnostic Manual, wrote more than one book on the subject and specifically argued that there was no such thing as addiction to food. See Christopher Fairburn, MD, Eating Disorders and Obesity, Binge Eating, Overcoming Binge Eating, Guilford Press, 1995, New York.

7 It is very common for doctors, dietician and therapists to have the assumption from their professional training that there is no such thing as food addiction. However, when they take case histories, then watch the process of people going through effective treatment for food addiction, they change their minds. One good example of this is a dietician at Turning Point of Tampa’s eating disorder and food addiction program, Lori Harold, RD,
addiction, individual practitioners – doctors, dieticians, psychologists, therapists, and other counselors - tried to treat everyone this way, i.e., by focusing entirely on behavior modification and work on “underlying issues”. It worked for many – those who were not food addicted or whose food dependency was still at an early stage, but it did not work at all for those who were chemically dependent. Health professionals came to believe their own diagnosis, and explicitly or implicitly, food addicts were blamed for not being able to recover like others with trauma-based eating disorders were able to do.  

While eating disorder treatment almost always works with the client on eating all foods moderately, food addiction treatment worked towards abstinence from offending drug foods.

Eating disordered people work to identify and resolve issues so that they could return to being normal healthy eaters; At one time, and hopefully again, food addicted people can be encouraged to develop support with other recovering food addicts and to build a whole new life style minus the addictive foods.

So, how have the food-addicted found professionals who understand, accept and have experience successfully treating food addiction? The most common way has been to ask a food addict in recovery (often identified at a meeting of Overeaters Anonymous or one of the other food-related 12 Step fellowships) for a suggestion about a health professional who has been respectful and helpful to them. Another way is to contact one of the treatment alternatives which have been created by those who worked at Glenbeigh and other food addition treatment centers of the 1980’s and 1990’s. These include residential programs such as Milestones in Miami, Florida, Turning Point of Tampa, Florida, The Willow in Naples, Florida, PROMIS in England, Turning Point of Washington (Pittsburgh, PA) and the Caron Foundation. All of these centers require personal payment in order to receive treatment, often tens of thousands of dollars.

The one I know best is the one I helped found, ACORN Food Dependency Recovery Services, a non-residential model. More information about services can be found here.

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8 It is very common in ACORN for people to come in who were in eating disorder therapy and using OA but could not get abstinent. They put sugar, flour, alcohol and any other major binge foods down, spend five days going through detoxification, and their cravings and obsessions for food are eliminated or lessened to the point they are able to start eating without compulsion.