Food Addiction Treatment

An Important Missing Piece in the Obesity Epidemic Puzzle

October 22, 2014, Lecture

Phil Werdell, M.A.

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Food Addiction Treatment
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DISCLOSURE

I used to be a doctor’s worst nightmare. At age 24, I was told by my physician that I would have a heart attack within ten years if I didn’t lose some of my 240 pounds and keep it off. He was right. At age 34, that’s exactly what happened. I had tried to lose weight both before and after the heart attack, but despite repeated attempts at dieting and years of therapy, I was unable to do this.

At age 42, a good friend, who was also a recovering alcoholic, said to me, "Phil, you eat like I used to drink." I didn't know what food addiction was, but it made some sense to me given my progressively out-of-control eating history. I found recovery six months later, with the support of other self-identified food addicts. I lost 80 pounds and kept it off from there on. I was then fortunate enough to pass on my experience in a food addiction treatment program at Glenbeigh Psychiatric Hospital, where I began as a case manager and ended as lead therapist and coordinator of professionals training. Once insurance companies ceased reimbursing addiction-model food treatment, I founded a business, ACORN Food Dependency Recovery Services. ACORN offered an alternative to inpatient food addiction treatment for people who did not require medical supervision. Since then, I founded the Food Addiction Institute, a non-profit organization committed to increasing awareness of the disease of food addiction, training professionals in food addiction treatment and developing innovative treatment programs and public policy. I have worked with over 4000 self-identified food addicts. I estimate that one third of these have been food-abstinent since treatment and maintaining healthy weight-loss, one third have had long periods of abstinence and weight loss after treatment, and the remaining third are in relapse.

This document contains both state-of-the-art treatment for food addiction in addition to citations and appendices supporting my presentation on the Treatment of Food Addiction at the first national Food Addiction conference at The University of Massachusetts Medical School, October 2014.
Introduction

We are just getting accustomed to the scientific consensus that sugar and other specific foods can create chemical dependency.¹ (See Appendices A, B.)

Dr. Nora Volkow, Director of the National Institute on Drug Abuse (NIDA), now says that the evidence for food as an addiction is overwhelming.² The American Society of Addiction Medicine (ASAM) includes food as one of the addictions in its new policy statement on addiction as a brain disease.³ The American Psychiatric Association (APA) declares in the DSM5 that many with eating disorders also present as having substance use disorders regarding food.⁴ The scientific material has been presented at most of the major medical associations and covered in the print, TV and digital media. Recently the science was summarized in the feature documentary film Fed Up.⁵

So, what do we know about treating food as a substance use disorder?

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³ www.asam.org, Public Policy Statement: Definition of Addiction, 2011. (See Appendix C.)


As with alcoholism and other drug addictions, it was the 12-Step fellowships, beginning with Overeaters Anonymous in 1960, who first established that there was a solution to food addiction.\(^6\) By 1990, there were approximately 100,000 members of OA, about half of the membership as of 2004 abstinent and maintaining a 50-pound average weight loss.\(^7\)

During the 1980s and 1990s, over a dozen U.S. hospitals developed residential treatment programs in the addiction model, i.e., Minnesota Model for alcoholism and drug addiction.\(^8\)

The university-based study of the in-patient food addiction program at Glenbeigh Psychiatric Hospital of Tampa found that outcomes were

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\(^{6}\) Rozanne, S., *Beyond Our Wildest Dreams: A History of Overeaters Anonymous as seen by a Co-Founder*, Overeaters Anonymous, Rio Rancho, NM, 1996. OA is a fellowship which includes many types of compulsive eaters—binge eaters, bulimics, anorexics and food addicts, often those with a history of all these diagnoses. While there are no attempts to study the proportion that were food addicted, there was, from the beginning, a faction inside the fellowship which self-assessed as food addicted and developed an addictive model of recovery which has continued within parts of OA to this day.

\(^{7}\) Overeaters Anonymous, "Membership Survey Report," Rio Rancho, NM, 2004. This is an internal survey, not the research of a neutral outside observer. The attendance at World Service Meetings confirms the total membership numbers were close to 100,000. Abstinence is not objectively or behaviorally defined. Percentage of abstinence and weight loss figures are all based on self-reports. The methodology of the survey was developed in consultation with faculty of the University of New Mexico. The percentages and numbers are similar to those found in a Ph.D. research thesis by Kriz, "The Efficacy of Overeaters Anonymous in Fostering Abstinence from Binge Eating Disorder and Bulimia," Virginia Polytechnic Institute, 2002. In this sample, 46% of members were abstinent.


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\(^{9}\) Carroll, "The Eating Disorder Inventory and Other Predictors of Successful Symptom Management in Bulimic and Obese Women Following an Inpatient Treatment Program Employing an Addictions Paradigm," PhD dissertation in the Department of Psychological and Social Foundations, University of South Florida, Tampa FL available through U-M-I, Ann Arbor, MI, 1993. Since food addiction was not yet scientifically established as a diagnosis, the food addiction treatment outcome research had to be done within a study the outcome measures. Glenbeigh of Tampa and all the major hospital-based primary treatment programs closed at the end of 1995 when private insurance companies arbitrarily stopped reimbursing for food addiction model treatment. More recently, an outcome study of a five-day residential workshop model using the protocols of the first week of food addiction treatment for those not needing medical supervision or hospitalization. Hillock, et al., "Survey of Outcomes in ACORN Primary Intensive (2006)" in Foushi et al., *Food Addiction Recovery: A New Model of Professional Support—the ACORN Primary Intensive*, Evergreen, Sarasota, FL, 2007. The results were similar—33% abstinent consistently for a year or more, 33% abstinent at the time of the survey but having one or more relapses, and the other 33% in relapse. This was a self-selected sample of 250 alumnae of the program from a mailing to all 1,500, not a random sample.
comparable to those of the best alcoholism and drug addiction rehabs: Two thirds were abstinent after five years, half of these with stable food abstinence and weight loss from the beginning.$^9$

This paper summarizes three levels of obesity complexity; defines the differences between physical obesity, psychological eating disorders, and chemical dependency on food, i.e., food addiction; presents the stages of progression in food addiction with recommended treatment; discusses five practices of food addiction treatment—getting the food right, understanding the disease, supporting rigorous honesty, challenging addictive denial, and deepening emotional and spiritual recovery; offers a vision of simple and short interventions regarding food addiction that general practitioners can do on a regular basis; and outlines a number of issues of diagnosis and treatment to pursue in more depth.
PART I

Food addiction and levels of obesity complexity

Until recently, most people in the U.S., including many health professionals, saw the issue of more people gaining more and more weight entirely as obesity. This paper suggests that there are different levels of complexity to the problem of obesity and that this problem is best understood and treated as three completely different but often coexisting diseases.*

**Obesity is a complex problem.**

Obesity is sometimes simplified to a medical condition in which a patient takes in *too many calories and not enough calories go out*; but it isn't so simple. A range of external factors contribute to the complexity of the problem: more palatable food, larger portions, sedentary jobs, and growing amounts of time sitting in front of the TV and the computer. (See Appendix E.)

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**Definitions:** There are many conflicting positions, both in scientific literature and in the general public, regarding the words defining the essential diseases involved in obesity. In Overeaters Anonymous (OA), all types of loss of control over food are called *compulsive eating.* In other 12-Step fellowships, there is a focus on anorexia, bulimia, and binge eating disorder; and there are several fellowships focused primarily on food addiction. Medically, the American Medical Association (AMA) has just acknowledged obesity as a diagnostic category, and the American Psychiatric Association (APA) brought forth binge eating disorder—in addition to bulimia and anorexia—as an eating disorder in the DSM-5. In the introduction to the eating disorder section in the DSM5, the APA observes that many eating disorders also present as substance use disorders with cravings and mental obsessions.

Some who see food addiction as real assume all issues of obesity and eating are addictions. Some treatment professionals argue that most eating disorders are addictive disorders. In this paper, we will refer to simple physical obesity as, "Normal Eaters with Obesity." We will call those with unresolved psychosocial trauma and lack of feeling skills, "Emotional Eaters with Eating Disorders;" and we will call those with chemical dependency on specific foods, "Food Addicts with a substance use disorder.

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10 Foushi and Werdell, eds., *ACORN Primary Intensive Manual*, ACORN Dependency Food Recovery Services, Sarasota, FL, revised 2014. (See Appendix E.)
finds that 33% of the U.S. population is obese, and another 33% is overweight.¹¹

Obesity becomes further complex when people start using food as a coping mechanism for dealing with stress and difficult feelings. This problem is particularly acute in rigid and/or chaotic families, when there is a history of substance abuse and where emotional trauma remains unresolved. A recent Harvard study found more than 5% of Americans have eating disorders at a clinical level.¹²

Obesity becomes almost intractable when people are also actively addicted to specific foods and the chemical dependency upon specific food substances has progressed to a critical level. This not only adds to the complexity of diagnosis, but also to treatment. Given that substance addiction involves loss of control, it also creates a medical situation in which the patient literally loses control, and there is a need for both unusually high levels of external support and progressively deeper internal healing.¹³

We are suggesting that the main thing that physicians and allied health professionals have to get right is that obesity, eating disorders and food as a chemical dependence are three very different medical problems, and they each need to be treated quite differently. When a person has all three, which is very common, they all must be treated, and the food addiction is primary.

¹¹ www.cdc.gov
¹² Hudson, James, "Lifetime Preferences of DSM 4 for Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder," Biological Psychiatry, Feb. 1, 2007. Based on data gleaned from NIMH-funded National Comorbidity Survey Replication (NCS-R), a nationally representative survey conducted between Feb., 2001, and Dec., 2003. The percentage of adults with binge eating disorder is almost twice that of adults with anorexia and bulimia combined. The study also found that people with eating disorders, regardless of the type, often have coexisting mood, anxiety, impulse control, or substance use disorders.
¹³ ASAM, op. cit.
When the problem is **only physical obesity**, the solution is **less calories in, more calories out, and support for lifestyle changes to maintain this**.\(^{14}\) There are many for whom the prescription of diet and exercise works: for example, 10-30% of dieters have substantial weight loss and maintain it for more than a year on their own or in programs like Weight Watchers.\(^{15}\) When a person needs to lose just a moderate amount of weight, the diet may take just several weeks. In cases of obesity, it could last a year or more.

If obesity is **complicated by an eating disorder**, the solution is **to deal with underlying irrational thoughts, difficult feelings and unresolved issues**.\(^{16}\) This usually means mindfulness training,\(^{17}\) developing feeling skills,\(^{18}\) Cognitive Behavioral Therapy (CBT)\(^{19}\) or other forms of talk therapy, and/or psychotropic medication. This could be a treatment of a few months or of many years—in addition to support for a healthy diet and exercise regime.

However, when obesity is **complicated by a substance use disorder with food**, the solution is similar to that of alcoholism and other drug addictions: **complete elimination of the toxic food(s), education about addiction as a brain disease, a community of support for rigorous honesty, challenging of food addiction denial, and healing damage to the emotions and spirit**.\(^{20}\) This is in addition to diet if the person is also overweight, and therapy if an emotional eater. Initial recovery can take


\(^{20}\) Werdell, Phil, "From the Front Lines: Treatment for Food Addiction," in Brownell & Gold, op. cit.
several months to a year, and in later stages, food addiction is a chronic disease that needs to be managed for life.
PART II

"Normal" Eaters with obesity, Emotional Eaters with eating disorders, and Food Addicts with chemical dependency

Chart I is a summary of information that I have found useful when introducing issues of food addiction to clients and their families. I also like to begin every presentation to physicians and health professionals with a review of this chart. It makes clear how I will be using terminology which is still used vaguely in the general public, and I think incorrectly used by some in the medical community.²¹

Chart 1

Normal Eater, Emotional Eater, Food Addict

<table>
<thead>
<tr>
<th>NORMAL EATER with Obesity</th>
<th>EMOTIONAL EATER with Eating Disorder</th>
<th>FOOD ADDICT Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>The problem is <strong>physical</strong>&lt;br&gt;• Weight</td>
<td>The problem is <strong>physical and mental-emotional</strong>:&lt;br&gt;• Binge eating, restricting, and/or purging over feelings&lt;br&gt;• Unresolved trauma&lt;br&gt;• And possibly weight (sometimes overweight and sometimes underweight)</td>
<td>The problem is <strong>physical, mental-emotional</strong> and <strong>spiritual</strong>:&lt;br&gt;• Physical craving (false starving)&lt;br&gt;• Mental obsession (false thinking)&lt;br&gt;• Self-will run riot (false self)&lt;br&gt;• And often trauma and weight</td>
</tr>
<tr>
<td>The solution is primarily <strong>physical</strong>:&lt;br&gt;• Medically approved diet&lt;br&gt;• Moderate exercise&lt;br&gt;• Support for eating, exercise and lifestyle change</td>
<td>The solution is mostly <strong>mental-emotional</strong>:&lt;br&gt;• Develop skills to cope with feelings other than with restricting, purging and bingeing&lt;br&gt;• Resolve past emotional trauma and irrational thinking (healing trauma) ... <strong>and physical</strong>:&lt;br&gt;• The same as for Normal Eaters (if needed)</td>
<td>The solution is essentially <strong>spiritual</strong>:&lt;br&gt;• Abstinence from binge foods and abusive eating behaviors&lt;br&gt;• Rigorous honesty about all thoughts and feelings&lt;br&gt;• A disciplined spiritual practice, e.g. The Twelve Steps ... <strong>and mental-emotional</strong> and <strong>physical</strong>:&lt;br&gt;• The same as for Normal &amp; Emotional Eaters (if needed)</td>
</tr>
<tr>
<td><strong>What works:</strong>&lt;br&gt;• Willpower (less calories in, more calories out)</td>
<td><strong>What works:</strong>&lt;br&gt;• Moderation (mindfulness training, challenging irrational thinking, resolving prior trauma)</td>
<td><strong>What works:</strong>&lt;br&gt;• Surrender (letting go of binge foods, not making recovery decisions alone, replacing food with something more important)</td>
</tr>
</tbody>
</table>

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"Normal" eaters with obesity.
Many overweight and even severely obese people are not food addicted. This can be seen by their ability to diet, lose weight, and keep it off for considerable periods of time, often over a decade. I call these overweight people "Normal Eaters."

I will begin with two "Normal Eaters" I know quite well as examples.

**Example #1: My father.** When he was about 50 years old, his doctor became very alarmed by his blood pressure and cholesterol readings, and told him that he needed to lose at least 50 pounds and keep it off or he could easily have a heart attack or stroke. My dad said, "What do I need to do?" The doctor gave him a pre-diabetic exchange diet. Dad gave it to my mother and said, "Can you please cook this way." When she said yes, he also asked her, "How can I eat this way when at work and in restaurants?"

Right there in about an hour, they figured out how he could follow this diet outside the home.

The outcome was that without any problem, my father ate this way for the last 25 years of his life. He lost the needed weight in less than a year and never had any interest in eating returning to his previous way of eating.

My observation was that he had no craving and no food obsession.

**Example #2: My ex-wife.** One day when we had been together about twelve years and I had been in recovery from food addiction for about five years, she came down to breakfast and said she had something really difficult to tell me. My first thought was that something had happened to one of the kids. This turned out not to be true. Her problem was, as she put it, "My clothes don't fit anymore."

While I was maintaining an 80-pound weight loss by treating myself as a food addict, she had gained about 15 or 20 pounds. My first thought was, "Ah, I'll have company on this journey, and we can go
to support meetings together." She had a different idea. She said, "I'm going to have to stop eating between meals, stop eating desserts, and stop having seconds."

Assuming she might be addicted, I thought, "Well, that's not likely to happen. I'll give her about a year." I didn't tell her what I was thinking, and that was good because she did give up eating between meals, gave up seconds, and gave up desserts. She lost her weight in a few months, her clothes fit, and for years she had no problem with food. She continued to eat foods that are addictive to me and to most food addicts, but she would often say that she didn't have cravings "like Phil used to have."

I now call these two members of my family "normal eaters" who were overweight or obese. As an academic, I like to see if there is evidence that this category exists out in the world with more objective data. My favorite study is the one that was done by Consumer Reports Magazine, in which over 7,000 readers registered their experiences with various programs in the diet industry. The results were that only 10-30% who participated in any of these programs lost weight and maintained the loss for a year.22

There are many studies of different dieting programs, most of which find that a majority of serious dieters conclude in general that no diet works.23 I look at the data from a different point of view, however. To me, 10-30% of those who diet in the weight loss business are able to lose weight and maintain it. Some of these need to continue in groups like Weight Watchers or return to them if their weight starts creeping up. But I consider all of these "successful dieters" as evidence that some people have not completely lost control over their food and their weight, even though they were overweight or obese at one time.

22 Consumer Reports, op. cit.
Emotional eaters with eating disorders.
I contrast this group of normal eaters with obesity with two other groups who have lost control or are in the process of progressively losing control. The first group represents almost 10% of the U.S. population. They have clinically diagnosable anorexia, bulimia, and/or binge-eating disorders. Besides exhibiting the characteristics in the DSM for their diagnosis, my experience is that they often do not have the attention skills necessary to quiet themselves and notice what's going on in their bodies; they don't have the emotional skills to deal with difficult feelings, particularly fear, anger, grief, and shame; and frequently they have unresolved prior trauma.

Basically, in common language, they are immature emotionally. More significant to the issue of this paper, they have found that binging, purging and restricting of specific "comfort foods" are a way to cope with their emotional inadequacies. They are what I have come to call "Emotional Eaters with Eating Disorders."

Example #3: My stepdaughter. While my own food addiction recovery was becoming more stable, my ex-wife and I observed that one of our daughters was becoming too thin. We talked to her about this, and she disagreed. She said that there were many different body types, and that hers, when she was exercising a lot, just happened to be particularly thin. She said she was eating healthily and had built up healthy muscle which made her appear thinner. We were not convinced and told her so.

The next year, when both of our daughters were home from college for Christmas, our other daughter had conversations with her sister, and she became concerned about how her sister was thinking about and talking about her body. On Christmas eve, she suggested that we do

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24 Hudson, op. cit.
25 APA, DSM 5, op. cit.
an intervention. Daughter #1 looked still thinner to us, and she was even more reactive to our feedback. We planned the intervention out for that evening.

Daughter #2, my wife and I all shared our growing concerns. Daughter #1 broke down and cried and said that she thought we may be right. I said that we would only continue paying for her graduate education if she identified an eating disorder therapist and worked with her until they both thought she didn’t need therapeutic support. She agreed.

The outcome was excellent. From this point on, everyone in the family was able to talk about issues of weight and body image and feelings. Daughter #1 continued in therapy for about 16 months, and her weight edged up to the low levels of normal.

Example #4: My mother. A different type of anorexic, my mother found that as a young woman, she couldn’t open a pack of Oreo cookies without eating a whole sleeve of them. Her solution was to "stop eating entirely." When pregnant with me, she reported cravings that could only be satisfied with binges on sugar, flour and fat. As a new mother, she stopped eating again and was hospitalized for several weeks for depression. (The associated anorexia was not diagnosed or treated.)

Throughout her adult life, she spent an inordinate amount of time thinking about food, and to control her eating, she became a mild health food fanatic. She didn’t really lose her preoccupation and rigidity about eating until late in life. This all changed when, at 76 years old, a therapist suggested addiction recovery, and she entered a 12-Step program.

I view my daughter as an early stage "classic" anorexic and my mother as middle stage "food addicted anorexic." Most research finds that a combination of talk therapy and medication work best in treating classic eating disorders. When emotional eaters are healed, they become more like normal eaters, are able to distinguish physical
hunger from emotional hunger, and eat any foods in moderation. In fact, one of the objectives of many eating disorder treatments is to be able to eat all foods, including sugar and other potentially addictive food substances, regularly and in moderation. My mother figured out that she had "anorexic tendencies" long before she got that she had also been addicted to specific foods.

As pointed out above, about 5% in the U.S. have a clinically diagnosable eating disorder: "Lifetime prevalence estimates of DSM-IV anorexia nervosa, bulimia nervosa, and binge eating disorder are .9%, 1.5%, and 3.5% among women, and .3% .5%, and 2.0% among men."  

Some studies show the incidence of eating disorders as higher, and there are many more Emotional Eaters at a subclinical level. When underlying issues in the eating disordered are addressed, they become more like Normal Eaters.

**Food addiction as a substance use disorder.**

As the APA’s DSM 5 now states that many with eating disorders also present with the characteristics of a substance use disorder; for example, physical cravings and mental obsession. Gerhard, one of the creators of the Yale Food Addiction Scale, has several studies of groups identified with the new Binge Eating Disorder; 37% to 59%—usually those most advanced in BED—showed up as having clinically diagnosable food addiction.

Food addiction is a completely different disease than obesity or a traditionally defined eating disorder. In food addiction, the

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26 Hudson, op. cit.
27 American Psychological Association, op. cit.
fundamental problem is not lack of understanding or will power, and it
is not social stress or unresolved trauma. In food addiction, the
problem is that some food substances, occasionally all foods in very
large volume, biochemically change the brain when ingested and create
a physical dependency.\(^{30}\)

As in alcoholism and other drug addictions, people who are food
addicted experience clinically significant neurochemical changes in the
brain after they ingest one or more highly addictive substances—e.g.,
sugar, excess fat, salt, flour, wheat.\(^{31}\) This has been shown via PET Scan
of food addicts' brain scans compared to those addicted to alcohol,
cocaine or heroin; they are remarkably similar.\(^{32}\) In treating food
addiction we often show a Doctor Vera Tarman film, "Food Addiction
Unplugged," in which she explains to patients in a residential drug and
alcohol treatment program the biochemistry of food addiction.
Basically, the receptors in the instinctual part of the brain become
weaker from their contact with addictive chemicals, and it takes a
stronger and more concentrated dose of those chemicals that addicted
them for those receptors to work. This damages more receptors, and
the problem gets worse.\(^{33}\) This is the essence of chemical dependence.

In chemical dependency, the person who is food addicted begins to
experience physical cravings, i.e., to want their addicted foods out of
proportion to normal hunger. As the addiction progresses, more parts
of the brain are damaged, and craving increases to a point where there
begins to be loss of control. Food cravings are the first subjective

\(^{30}\) Brownell and Gold, Chapter 66: "Food and Addiction" in *Food and Addiction, a Comprehensive Handbook*, op.cit.


\(^{33}\) Tarman, op. cit.
experience of addiction. I describe food cravings as a "false starving." The food addict cannot differentiate these cravings from normal hunger. It is a false starving because it seems to food addicts that they must eat or something horrible will happen.

The food cravings have negative consequences. Most commonly, overeating and bingeing result in weight gain. When food addicts try to control their eating so they can lose weight or so they won't get diabetes or heart disease, the disturbance at an instinctual level begins to overpower the conscious mind.

The food addict begins to have thoughts which rationalize overeating and which seem believable, even though they are untrue. This condition is commonly called "mental obsession." As Dr. Abraham Twerski writes in *Addictive Thinking: Understanding the Deception*, the experience of the mental obsession in food addiction resembles that of schizophrenics. As the addiction progresses, the food addict develops hallucinations, inappropriate moods, even a whole mindset in which the brain is distorted. The consciousness alternates between the healthy and the addictive parts of the brain.

What is important about this is that the food addict, like the alcoholic and the drug addict, is powerless when the addiction hijacks the mind. Therapies like CBT (Cognitive Behavioral Therapy) can help someone deal with irrational thoughts; but in addiction, the therapeutic correction is forgotten whenever the disease reactivates. At this point, psychological knowledge is of no help.

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In the clients with whom I work, there is a third phenomenon developed which I often call "distortion of will"; the desire to overeat overrides all healthy and rational thoughts about eating. Sometimes this is called a disease of the spirit, or a shame-based disease, where food addicts start to believe that their addictive mind is their true self. This is a level of powerlessness which is very common in late-stage alcoholism and drug addiction. It is also common in late-stage food addiction. In food addiction, they progressively cannot eat any of their addictive foods in moderation and soon cannot control any behaviors around food by force of reason or self will.

Neither dieting nor traditional talk therapy will help the food addict recover in the long term. The solution to physical craving is entire abstinence from addictive foods. The solution for the mental obsession is a practice of rigorous honesty in a community of support, commonly a 12-Step fellowship.\(^{37}\) (See Appendix F.)

It is important to be clear that the 12-Step fellowship model is not the only strategy for healing addiction, but it is the one most accessible, and it is free. For those needing long-term support, the cost of having professionals fill the roles of the 12-Step community of meetings and a sponsor is usually prohibitive. It is important to say that the 12-Step community defines spirituality as individual and highly personal. It can be experienced within any religious denomination or outside of religion entirely. (See Appendix F.)

There are about 100,000 currently working to treat their food addiction in one of the many 12-Step fellowships, and there are about a half

\(^{37}\) For those who have partially or fully developed an addictive mind, the solution is deeper, an actual personality change. In the 12-Step programs, this level of the disease is identified as spiritual, and the 12 Steps are a protocol for a spiritual healing experience which affects a change of personality.
dozen professional programs with decades of success in treating the most advanced and difficult cases, i.e., those where 12-Step participation is insufficient.

As with alcoholism and drug addiction, correct diagnosis and regular follow-up from primary doctors, dieticians and therapist can make a substantial difference. For those clinicians who are the main support in food addiction recovery, it is important 1) to put abstinence first and get the food plan right; 2) to create support for rigorous honesty about the food and about all thoughts and feelings; 3) to educate about addiction as a brain disease and about resources, like food related 12-Step fellowships, available for recovery support; 4) to challenge food addiction denial and help eliminate blocks and resistance to recovery; and, as there is stable food abstinence, 5) to work on underlying mental-emotional and spiritual problems caused by the disease.
PART III
Stages of Food Addiction Progression
and Recommendations for Treatment

Introduction

Food addiction is a progressive disease. It is important to diagnose the stages of progression in order to ascertain the correct treatment. Most people in the U.S. are not food addicted yet. Important stages include: pre-disease, early stage, middle stage, and late or final stage.
### Chart 2: Food Addiction—Progression and Recommended Actions

<table>
<thead>
<tr>
<th>Disease Stage</th>
<th>Recommended Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Disease</strong></td>
<td><strong>Prevention</strong></td>
</tr>
<tr>
<td>No sign of abnormal eating or reactions to specific foods. If no dependency or pathology develops, this stage will continue through the person's entire life.</td>
<td>Education about food addiction. Ongoing checks for signs of chemical dependency. Moderation in eating, especially commonly addictive foods, e.g., sugar, caffeine, excess fat, alcohol, drugs.</td>
</tr>
<tr>
<td><strong>Early Stage</strong></td>
<td><strong>Detox and Abstinence</strong></td>
</tr>
<tr>
<td>Problems with weight management, cycles of weight gain followed by dieting, weight loss, and weight gain again. Occasional binge eating on sugar, excess fat, or volume. Could be early-stage food addiction or a normal eater making unhealthy choices.</td>
<td>Identify addictive foods. Eliminate binge and trigger foods. Move through detoxification. This often seems extreme if negative consequences are not yet severe, an early stage of addictive denial.</td>
</tr>
<tr>
<td><strong>Middle Stage</strong></td>
<td><strong>Twelve-Step Group/Counselor</strong></td>
</tr>
<tr>
<td>Frequent binge eating and grazing. Purging or severe restriction may begin. Rationalizing before eating, guilt afterward. Could be advancing food addiction or emotional problem eater with a psychologically based eating disorder.</td>
<td>Participation in a food-related Twelve-Step program, e.g., Overeaters Anonymous, and/or work with a food addictions counselor. Assistance with addressing blocks to physical abstinence, especially denial. Develop feeling skills, resolve trauma.</td>
</tr>
<tr>
<td><strong>Late Stage</strong></td>
<td><strong>More Structure and Support</strong></td>
</tr>
<tr>
<td>Serious consequences from overeating—morbid obesity, Type II diabetes, chronic depression and/or spiritual disillusionment, and eating anyway. Food no longer provides comfort, escape, oblivion, etc. Loss of control, increasing tolerance.</td>
<td>Participation in a highly structured Twelve-Step program, e.g., Food Addicts in Recovery Anonymous, Compulsive Eaters Anonymous—HOW. Outpatient treatment and/or workshops such as those offered by ACORN. Abstinence as a spiritual path.</td>
</tr>
<tr>
<td><strong>Final Stage</strong></td>
<td><strong>Primary Inpatient or Residential Treatment</strong></td>
</tr>
<tr>
<td>Severe consequences—hospitalization for heart attacks, suicide attempts, lost jobs or inability to work, ruined relationships, treatment and/or intestinal surgery followed by relapse, housebound or confined to nursing homes.</td>
<td>Given the lack of any hospital-based inpatient treatment for food addiction, alternatives include Turning Point of Tampa, Milestones, Shades of Hope, ACORN's multi-year program. This is sometimes insufficient.</td>
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© copyright Phil Werdell, *Bariatric Surgery & Food Addiction: Preoperative Considerations, 2008*  Form A-113
1) Pre-Disease and Prevention

If there are no early signs of food addiction or reactions to commonly addictive foods, it is still important these days to give a patient information about the disease. Currently, 80% of the 600,000 processed foods contain some form of sugar\textsuperscript{38}; and if they also contain excess fat and salt, their addictive potential increases.\textsuperscript{39} Many people who were not born with a predisposition to addiction become food addicted just by eating too much sugar. I call it Type II food addiction.

| Example #5: Supersize Me. | In the movie “Supersize Me,” Morgan Spurlock, though not previously food addicted, shows signs of clinical substance use disorder—foggy mind, using food to deal with feelings, fatty liver, withdrawal, continued use despite strong medical advice to stop—after just two or three weeks on a McDonalds-exclusive diet.\textsuperscript{40} It takes Spurlock over a year to regain a healthy weight and regain balance about food after he stops the fast food regimen.\textsuperscript{41} |

Patients need education about food addiction. The movie “Fed up” is an excellent introduction to food addiction, though it does not deal with treatment.\textsuperscript{42} The University of Massachusetts School of Medicine has produced a one-page trifold which is a model handout for medical professionals and centers.\textsuperscript{43} They can also be pointed to basic books

\textsuperscript{39} Kessler, op. cit.
\textsuperscript{40} Spurlock, Morgan, \textit{Don’t Eat This Book: Fast Food and the Supersizing of America}, London: Penguin Group, 2005.
\textsuperscript{41} Ibid.
\textsuperscript{42} fedupthemovie.com, op. cit.
\textsuperscript{43} University of Massachusetts Medical School, Department of Psychiatry, ”Do You Have Concerns about Compulsive/Binge Eating or Food Addiction?” The original article describing normal eaters and food addicts is by Werdell, ”Food Addiction beyond Ordinary Eating Disorders,” in the \textit{Clinical Forum of the International Association of Eating Disorders}, 1994.
and websites if they are interested in a more in-depth look at the problem (see below).  

For the medical professional, it is a good idea to check up on the patient’s status at yearly visits for signs of emerging chemical dependency. Such a check should be as common as the basic weigh-in, blood pressure check and inquiry about smoking. (See Section V of this paper.) These patients should be informed of the most commonly addictive foods, e.g., sugar, fat, salt, flour, artificial sweeteners, caffeine, and, of course, alcohol. They should be cautioned to eat them only in moderation with an explanation that the average American already eats more than twice the recommended amount of sugar daily.

### Readings: Pre-Disease and Prevention

Kessler, *Your Food is Fooling You*

Michael Moss, *Salt, Sugar, Fat: How the Food Giants Hook Us*

Mary Hyman, *The Blood Sugar Solution*

### 2) Early-Stage Food Addiction, Detoxification and Abstinence

Early Stage food addiction usually shows up first with problems of weight management. If a person is overweight, or if he or she has already dieted more than once and gained back most of the weight lost or more, this could be a normal eater making unhealthy choices, but it also could be early-stage food addiction. Do they experience food binges? Are the foods they overeat the commonly addictive foods? Is

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their eating causing medical, social, economic or intimacy problems—
and they still do it? Do others in their family have chronic problems
with food, alcohol or drugs? These are basic screening questions for
food addiction. If there is a positive answer to any of them, it would be
good to have them take some form of self-assessment. (See Section V.)

The Yale Food Addiction Scale is a peer-reviewed assessment that can
be obtained online with instructions for evaluating it. There are a
number of other excellent assessment instruments: the self-
assessment question from Overeaters Anonymous (OA), Food Addicts
Anonymous (FAA), and Food Addicts in Recovery Anonymous (FA),
Compulsive Overeater Anonymous HOW (CEA-HOW) and Recovered
Food Addicts Anonymous, Inc. (RFA) are all good, as are those in some
of the major self-help books by Hollis, Sheppard, Katherine, Bernard,
Danosky, Illand, Tarman, and ACORN Food Dependency Recovery Services.
Check also the websites foodaddiction.com and foodaddictioninstitute.org.

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45 Gearhart, et al., Yale Food Addiction Scale. (See Appendices O, P.) Source:
http://www.yaleruddcenter.org/resources/upload/docs/what/addiction/FoodAddictionScale09.pdf, Yale Food
Addiction Assessment Instrument
46 http://www.overeatersanonymous.org
47 www.foodaddictsanonymous.org
48 http://www.foodaddicts.org
49 http://www.ceahow.org
50 http://www.RFAworldservice@aol.com
51 Hollis, Judi, Fat Is a Family Affair: How Food Obsessions Affect Relationships, 2nd ed., Center City, NH: Hazelden,
2003.
55 Danowski, Debbie, Why Can't I Stop Eating? Understanding and Overcoming Food Addiction, Center City, MN:
58 ACORN Food Dependency Recovery Services, foodaddiction.com. See also appendices in Werdel, Bariatric
Surgery and Food Addiction, op. cit.
59 Food Addiction Institute (FAI), foodaddictioninstitute.org.
If the assessment is positive, the first order of business is to identify trigger foods and eliminate them completely. Partial abstinence or moderation do not work with food addiction. This may seem extreme, but it is a fundamental difference for the treatment of food addiction compared to emotional eating or eating disorders. If someone were addicted to alcohol, cocaine or prescription drugs, you would not suggest “taper down.” The idea is to get the addictive substance out of your blood entirely.

There are complexities with food abstinence that do not arise with drugs and alcohol. What are their binge foods? What foods and eating behaviors trigger overeating? What type of thinking often leads to out-of-control eating? For the food addict, the first bite can trigger a binge, but the binge begins in the mind. This is where mindfulness training can be of most help with food addiction.

When one becomes completely detoxified from an addictive food substance, there are often withdrawal symptoms. They may be so mild they are almost unnoticed; but they can be quite severe, especially in the first week. Withdrawal may include agitation, moodiness, emotional lability, prolonged or heightened cravings, varied blood pressure, lethargy, insomnia, anxiety, hot and cold flashes, or defiance. Rationalizations for eating may become especially strong, and they can seem very reasonable to the food addict. Food addicts can often put down their binge foods on their own in the early stages of the disease,

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60 Werdell, Phil, "Proposal for a Food Addiction Treatment Track in the Impaired Physicians Alcohol and Drug Treatment Program at the University of Florida," Gainesville, FL: University of Florida Medical School, 2012. Link to this grand round lecture found on the website of the Food Addiction Institute, op. cit.


but negative consequences are often not yet severe enough to make a case for going through the deprivation of complete abstinence from addictive foods. This is another characteristic of the beginning of food addiction denial.\textsuperscript{64} Sooner or later, the disease will get worse.

<table>
<thead>
<tr>
<th>Readings: Early Stage</th>
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<tbody>
<tr>
<td>Nancy Appleton, \textit{Lick the Sugar Habit, Suicide by Sugar}</td>
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<tr>
<td>Nicole Avena, \textit{Why Diets Fail: Because You Are Eating Sugar}</td>
</tr>
<tr>
<td>Debbie Danowski, \textit{Why Can’t I Stop Eating?}</td>
</tr>
<tr>
<td>Pam Peeke, \textit{The Hunger Fix, the Three-Stage Detox and Recovery Plan for Overeating and Food Addiction}</td>
</tr>
<tr>
<td>Robert Pretlow, \textit{Overweight: What Kids Say}</td>
</tr>
<tr>
<td>Rick Warren, \textit{The Daniel Plan}</td>
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</table>

3) \textbf{Middle Stage Food Addiction and Getting Outside Help}

Signs that the food addiction has progressed include: persistent weight gain—even very gradual if it continues over time; Yo-Yo dieting; over-the-top fad diets; habitual grazing; more frequent binging and less time between diets; beginning of extreme restriction, purging or other bulimic behaviors; more rationalizations and guilt or shame after giving in to them; secondary medical consequences: high blood pressure, Type II diabetes, depression, high cholesterol, sleep apnea, anxiety, some cancers and dozens of “lesser” diseases can be seen as secondary to food addiction.\textsuperscript{65} If there has been a diagnosis with a prescription to lose weight and this advice is disregarded or impossible to do, this is a possible sign of advanced food addiction. Switching between

\textsuperscript{64} This initial stage of denial comes from even early-stage food addicts not being able to distinguish the difference between hunger and physical craving. (See section below on challenging denial.)

\textsuperscript{65} Appleton, \textit{Lick the Sugar Habit}, Santa Monica, CA: Avery/Penguin, 1996.
overeating and another addiction—e.g., smoking, shopping, alcohol, gambling, drugs, relationships, overwork, sex, computer abuse or over-helping—is also a possible sign of food addiction.

It is often difficult to distinguish between a psychologically-based binge eating disorder and a substance-caused chemical dependency on food. In both, there is compulsive overeating, obsessive thinking, inability to stop when trying to stop eating despite negative consequences. In anorexia nervosa, bulimia, and binge eating disorder, there can be conscious eating over feelings—even specific “comfort foods,” and psycho-social roots with unresolved trauma. Food addiction, on the other hand, is caused by the interaction of specific foods and the brain, a distortion of the hunger instinct such that physical cravings are thought to be hunger, obsessive thinking thought to be rational, the focus on addictive food and too much food in general, and eventually, behavior similar to that of substance dependency, e.g., dishonesty, impulsivity, acting against social norms, and violating one's own individual values. Many times the person has both an eating disorder and a substance use disorder regarding sugar or other specific foods.

In an eating disorder, the chemicals in food, especially certain foods, are used to “medicate” difficult feelings. In food addiction, specific foods—often similar to those which are used to cope with feelings—create a progressive chemical dependency. With an eating disorder, the goal is to learn to eat all foods in moderation. For food addiction,

66 APA, DSM-5, op. cit.
69 Cheren, et al., op. cit. It is suggested in this science review that mood disorders related to eating may be related to dysfunction in serotonin receptors in the brain, and an addiction regarding food may be related to dopamine receptors in the brain.
the recovery goal is substantial and sustained abstinence from the offending or toxic substances.

With eating disorders, it makes sense to try to understand the underlying reasons that one eats. With food addiction, understanding ultimately does not help: food addicts eat out of control because they are addicted, i.e., chemically dependent. In treating eating disorders, the strategy is to become more conscious of dysfunctional thoughts and behavior and to work through difficult feelings and issues—to take back power in your life. In treating food addiction, the strategy is to challenge denial of the disease’s biochemical power at an unconscious level—to accept one’s powerlessness in the situation and reach out for effective help. The eating-disordered person works to return to being a normal eater with a normal and fulfilling life. Food addicts work towards accepting that they will never be normal around food; but if they obtain and accept help to treat the addiction, they can have a rich and full life.

Eating disordered persons work to develop mental, emotional and spiritual skills and substantially heal prior unresolved trauma; then they are recovered. The food-addicted person begins by understanding his or her powerlessness and reaching out for help to friends, to family, to mutual support groups like food-related 12-Step fellowships, to spiritual or religious community, or to counselor-led recovery groups. For many, maintenance of recovery requires extended, even life-long, participation in such a support community. (See Appendix F.)

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70 Twerski, Addictive Thinking, op. cit.
Eating-disordered clients develop shame from prior abuse and lack of helpful emotional support, and they eat over their low self-esteem and discomfort with the guilt and shame. Food-addicted clients have lost control over their eating because of physical craving and mental obsession, and they develop shame because they falsely believe they should be able to control their eating by themselves. The first overeats to remove the pain because they are ashamed. The second overeats because they are addicts, and they develop shame because they are in denial about their food addiction.\textsuperscript{72}

A very serious problem in treatment of these food- and eating-related diseases is that many, if not most, of the more severe cases clearly have an eating disorder and a food addiction.\textsuperscript{73} They are also overweight or obese—or have been as a part of the history of their disease—so they are, so to speak, "triple winners." That means that the physical obesity, the psychological eating disorder, and the chemical dependency all need to be diagnosed properly with distinctive aspects of the treatment plan for each. Then, treatment is an art, and timing of various interventions makes an enormous difference. At the simplest level, if one is obese and eating disordered, long-term cures for the weight problem are seldom solved without dealing effectively with the emotional and thought disturbances first. More important to our discussion in this paper, if someone is obese and/or eating disordered and also food addicted, the substance use disorder is primary.\textsuperscript{74} Just as we would not offer an alcoholic therapy while they are still actively

\textsuperscript{72} Stark, op. cit.
\textsuperscript{73} ADA, DSM-5, p. 329, op. cit. This observation is confirmed by Werdell clinical work with over 4,000 clients at the Glenbeigh Psychiatric Hospital Tampa, Rader Institute of Washington, and ACORN Food Dependency Recovery Services.
\textsuperscript{74} It is beyond the scope of this paper to deal with the important issues of treating obesity, eating disorders, and food addiction when they all appear in the same person.
using, efforts to therapeutically deal with the underlying issues of a food addict will ultimately fail if the person is still actively eating his or her addictive foods.

**Readings: Middle Stage**

Alcoholics Anonymous, *The Story Of How Many Thousands Of Men And Women Have Recovered from Alcoholism*

Food Addicts in Recovery Anonymous, *Food Addicts in Recovery*

Judi Hollis, *Fat Is a Family Affair*

Ann Katherine, *Anatomy of a Food Addiction*

Gerald May, *Addiction and Grace: Love and Spirituality in the Healing of Addictions*

Overeaters Anonymous, *Overeaters Anonymous*

Overeaters Anonymous, *The Twelve Steps and Twelve Traditions of Overeaters Anonymous*

Kay Sheppard, *Food Addiction: The Body Knows, From the First Bite*

**Late Stage Food Addiction and the Need for More Structure and Support.**

Late stage food addicts often know that the food has beaten them. They may not use the name “food addiction," but they know that they are whipped. Even when they try as hard as they can, controlling their eating becomes impossible; there are times when the physical cravings are too powerful, and other times their thinking is so subtly out of control they cannot figure out why they all are eating again. They are
powerless over food, even though they have no idea that they are powerless.\textsuperscript{75}

There are times when the picture of a binge food on TV, the smell wafting from a bakery, or the persistence of a food fantasy is enough to send them over the edge into active food addiction. Late-stage food addicts can tell innumerable war stories of their eating, and it makes sense to them when someone talks about the addiction high-jacking their mind. \textsuperscript{76}

Often the consequences secondary to their food addiction have become quite severe, and they know that it is because of their overeating, or the eating at least makes it worse. Most often, they have periods where they keep getting fatter; those who are overweight start to become obese, and those who are obese become morbidly obese. Late-stage food addicts may continue to eat, even when knowing the negative effects on diet and health, e.g., continuing to consume large quantities of sugar when diabetic or continuing high-caloric intakes in spite of obesity-related illnesses. \textsuperscript{77}

Those who are still in the illusion of control because of their anorexia and bulimia start to isolate more, restrict more dangerously, purge more frequently and violently, develop malnutrition or gum or rectal disease. Some food-addicted anorexics die of their disease, often by

\textsuperscript{75} Note: Powerless over food does not mean that a food addict can never control his or her eating. If this were true, the food addict would never be able to diet at all; the food addict who purges or restricts would never be able to maintain a stylish weight—much less become dangerously underweight; the food addict who steals some grocery candy would never be able to get out of the store. No, loss of control is more subtle than this; it means the food addict does not know if this bite of food will or will not trigger an out-of-control reaction. Since the reactions can be strong and long when they come, recovering food addicts often learn that it does not make sense for them to try even a small deviation from their abstinence. There are countless cases where people were binging out of control in days, and frequently the person does not come back from the relapse for years.)

\textsuperscript{76} Brownell and Gold, op. cit.

\textsuperscript{77} Appleton, op. cit.
committing suicide.\(^78\) Some bulimics have a very high rate of suicide attempts. Even without these dangerous and dramatic acts and even for those who are not anorectic or bulimic, depression and/or spiritual disillusionment is common.\(^79\)

Some see later that they replaced worship of their childhood God with a worship of food and/or a food-addictive lifestyle. Eating disorder folks become hopeless and run to the food; food addicts run out of control, and this causes depression. Late-stage food addicts become deeply hopeless. In the caricature of the happy fat person, many late-stage food addicts are smiling on the outside, committed to making others feel better, even believing that this really is as good as life ever gets. But down deep, if pushed just a little, they admit that they live with an element of hopelessness all the time.\(^80\)

In late-stage addiction, food no longer produces the same high, no longer gives adequate comfort, no longer is an escape from the rest of life that works. For many, tolerance keep increasing, so it actually takes more sugar or other food drugs to get to a minimal state of oblivion, and this “relief” includes a constant knowing, "Jonesing," i.e., physically craving, for that perfect food fix. For some late-stage food addicts, when they hear a good explanation of their food addiction (for example, when they read the recovery text Alcoholics Anonymous, changing the words “alcohol" and “alcoholism" to “food" and “food addiction"), they jump into a food-related 12-Step program and surrender to doing everything asked, even that which they do not want

\(^78\) Anorexics and Bulimics Anonymous, Anorexics and Bulimics Anonymous, Alberta, Canada, 2002. The fellowship details its program of recovery for anorexics and bulims.


\(^80\) Ibid.
to do. It is such a great relief that they have a disease, but they are not the disease. Food addiction has so taken over their lives that they are willing to do anything to have the recovery they witness in the fellowships.

For some, a single food addiction professional and/or a 12-Step fellowship is insufficient support. Like alcoholics and other drug addicts who need 24/7 detox and treatment, many late-stage food addicts are in need of more professional help. When there were primary hospital-based treatment programs in the 1980s and 90s, this recovery resource was available to those with excellent insurance. This was only a drop in the bucket of late-stage food addicts, but we did learn that their in-patient programs were quite effective for those late-stage food addicts whose diseases were highly progressive.81

There are now a small number of non-hospital programs which carry on the U.S. tradition of addiction-model treatment for food: ACORN Food Dependency Recovery Services, Sarasota, FL; Milestones in Recovery, Miami, FL; Shades of Hope, Texas; COR, Minneapolis; Turning Point, Tampa, FL; Bitten-Jonsson Treatment Program, Sweden; and Esther Helga Guðmundsdóttir’s MFM Food Addiction Treatment Center, Iceland. There is a need for many more such programs, at least one in every community and at least one primary hospital-based treatment program in every state and major metropolitan area.82

81 Carroll, op. cit.
Readings: Late Stage
Brownell & Gold, Food and Addiction: A Comprehensive Handbook
Debbie Danowski, Locked Up for Eating Too Much
Foushi, et. al., Food Addiction Recovery: A New Model of Professional Support
Marty Lerner, Guide to Eating Disorder Recovery: Defining the Problem and Finding the Solution
Michael Prager, Fat Boy: Thin Man
Tennie McCarthy, Shades of Hope
Tarman & Werdell, Food Junkies: The Truth about Food Addiction
David Spero, Diabetes—Sugar-Coated Crisis: Who Gets It, Who Profits from It, How to Stop It
Abraham Twerski, Addictive Thinking: Understanding Self-Deception
Werdell, Bariatric Surgery and Food Addiction: Preoperative Considerations
Part IV

Five Practices of Food Addiction Treatment

A Guide for Health Professional Providing Primary and Ongoing Food Addiction Recovery Support

Food addicts often need information and support in five important areas: 1) what to do with the food, 2) understanding addiction as a brain disease, 3) developing rigorous honesty, 4) challenging food addiction denial, and usually later, 5) pursuing deeper emotional and spiritual healing.

Getting the Food Right.
As with alcoholism and other drug addictions, it is vital for a food addict to develop a workable definition of food abstinence. In its simplest terms, this means committing to a food plan which eliminates chronic binge foods, trigger foods and behaviors that lead to loss of control. The most common addictive food is sugar. Almost all food addicts need to abstain from added sugar—often in many hidden forms—to what often seems as a fairly radical degree in America today. (See Appendices G.) Other common binge foods include: excess fat, flour, salt, caffeine, alcohol and artificial sweeteners. (See Appendix H.) Some need to eliminate gluten or dairy or all grains. For example, Kay Sheppard's food plan and the fellowship Recovering Food Addicts, Inc., eliminate wheat from the food plan, and Greysheet Anonymous eliminates all grains.83

After toxic foods have been eliminated, there needs to be a food plan devised which is nutritionally balanced. For example, the Glenbeigh Psychiatric Hospital of Tampa had one such plan which was approved by the American Heart Association and the American Diabetes Association. (See Appendix I.) There are many variations, and sometimes the variations make a difference. So a food addict should consult with a dietician or medical professional who understands food addiction. One good source for individualizing a food plan is Theresa Wright's *Your Personal Food Plan.*

Food Addicts can often tell if a food is toxic if they think they cannot live without eating it or, at least, really do not want to give up that particular food, even if it causes negative consequences. Those who have problems of volume eating with most foods—and those needing a “black and white” way to define their early abstinence—frequently commit specific foods and the amounts of each for each meal and then weigh and measure. This is an increasingly common practice for those whose disease is further progressed. (See Appendix J.)

If one has just a food plan, this is often not sufficient for abstinence. It is just another diet. A diet without foods a person craves is likely to be more effective than one that includes them, but it still assumes that a food addict can control food substances to which they have become chemically dependent. So food addicts frequently need to find recovered people, or professionals who understand addiction recovery, who can give them support and to whom they are accountable. This could be family, friends, members of a spiritual or religious community,

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people at work, or recovering food addicts in one of the Twelve Step fellowships, i.e., a sponsor.

The basic process of support is as follows: 1) Tell someone exactly what you will and will not eat. 2) Brainstorm together ways to make this more likely. 3) Go to any length on your commitments. 4) Then come back and tell the truth about what happened. This is a way of being accountable to another person regarding your food abstinence. In the Twelve Step rooms, it is called committing food to a sponsor or surrendering your food. (See Appendix K.)

This committing of food to someone else is a major difference of food addiction recovery from alcoholism and other drug addictions. In early stages of food addiction, the commitment can often be very general, and once a week or month or even once a year. As the disease progresses, food addicts often need more structure and support, so they commit more specifically and more frequently. It isn't unusual for late-stage food addicts to commit their food specifically each day to a sponsor, one day at a time, for a very long time.

Understanding Addictive Disease.
According to the DSM 5, the characteristics of addiction include: physical craving, loss of control, tolerance, withdrawal, and dependency.\textsuperscript{86} As with alcoholism and other drug addictions, another major characteristic of food addiction is denial. The biochemical food substance not only distorts the hunger instinct, it also distorts the parts of the brain dealing with pleasure, well-being, memory and control.\textsuperscript{87} In each of these areas, food addicts who progress to a critical level

\textsuperscript{86} DSM-5, op. cit.
\textsuperscript{87} ASAM, op. cit.
cannot differentiate the true from the false. This is what is meant by being powerless over food and admitting that sometimes, not always, this creates substantial unmanageability. Food addiction makes mindfulness, talk therapies and medication only of secondary help. The first task of recovery is to eliminate the toxic food entirely and develop support beyond one’s self to deal with distorted addictive thinking. While not the only path for treatment, the food-related 12-Step fellowships are one of the most accessible sources of support. (See Appendix F.)

In its new (2011) science-based statement of addiction as a brain disease, the American Society of Addiction Medicine (ASAM), the professional organization of medical directors of chemical dependency rehabs, declared that science now sees food addiction as just like alcoholism and other drug addictions. In its DSM 5, the American Psychiatric Association (APA) found that many eating disorders present as substance use disorders. Further research shows that 37-59% of the cases—usually the most advanced cases—of Binge Eating Disorder are positive for food addiction on the Yale Food Addiction Scale. One idea for health professionals that seems to have a lot of merit is the new eating disorder diagnoses in the DSM 5, Binge Eating Disorder, and treating those also assessed for a substance use disorder in the addiction model, as well as a traditional eating disorder. A new

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88 Alcoholics Anonymous, op. cit.
89 ASAM, op. cit. (Public Policy Statement: Definition of addiction—Adopted by the ASAM Board of Directors April 19, 2011.)
90 APA, DSM-5, ”Feeding and Eating Disorders,” p. 329, op cit
protocol has been developed in Sweden which offers a path to rigorous diagnosis of food addiction.  

**Being Rigorously Honest.**

Rigorous honesty in food addiction recovery is difficult, but essential. Physicians and scientists have long known that the overweight and obese frequently cannot be trusted to tell the truth about their eating. The doctor or therapist taking on the primary professional role for an active food addict must assume that his or her client is not always telling the truth and is sometimes unable to do so.  

First of all, they may not know much about addictive disease; they have often been told by other health professionals—implicitly, if not explicitly—that they should be able to control their eating and weight by reason and willpower alone. This, of course, is not always true.  

Even more problematic, they may not be able to distinguish physical craving from true hunger, healthy thinking from mental obsessions rationalizing eating, and even be able to distinguish their experience of the disease from themselves. For example, "I have a disease; I am not the disease."  

Finally, the guilt and shame from not being able to control something as basic as eating and not knowing the truth—sometimes not even being able to discern the truth—adds further to their difficulty in being rigorously honest. (See Appendices L, M.)  

Eventually, when food addicts consciously try to control their weight or eating or limit their use of food, their disease of food addiction,

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92 See Jonsson, Bitten, "A New Diagnostic Tool for Food Addiction," First National Conference on Food Addiction, University of Massachusetts School of Medicine, Oct., 2014.  
93 Twerski, op. cit.
operating at an unconscious level, still fights for what it assumes it has to have. As the memory and control aspects of the brain weaken, the food addict starts to experience conscious thoughts that rationalize their eating. This phenomenon is so subtle and so strong that the food addict comes to believe completely in irrational or false thoughts.\textsuperscript{94} It is the addictive thinking that creates the need for middle and late-stage recovering food addicts to have other people with whom they can check out their thinking. Thus, joining a 12-Step group and working with a sponsor also supports a food addict to be more rigorously honest.

Many call the subtlest and most important work of being rigorously honest, spiritual. At the First International Conference on Food Addiction, Dr. Robert Lefebvre suggested that once the disease reaches a critical level, food addiction is a biochemical problem that causes a spiritual disease.\textsuperscript{95} This will likely never be proved by science, but there are tens of thousands of food addicts and other addicts in 12-Step recovery\textsuperscript{96} and in religious-based recovery, like Celebrate Recovery,\textsuperscript{97} who have recovered by considering that their problem is ultimately spiritual. This very important issue is beyond the scope of this paper.

The practical focus for supporting the rigorous honesty needed for food addiction recovery is telling secrets. In this situation, when someone might be powerless to always tell the truth, special support is needed for telling secrets. This support is often easier in a group than on a one-

\textsuperscript{94} Alcoholics Anonymous, op. cit; Twerski, op. cit.
\textsuperscript{96} Overeaters Anonymous, “We Are Not a Diet Club.” In the introduction to Overeaters Anonymous World Service Organization, Rio Rancho, NM, 1990.
\textsuperscript{97} Warren, et al., op. cit.
Having a patient check out a 12-Step group is often a good focus for initial work. Is the client willing to attend six or more meetings? What do they experience when listening to other food addicts in recovery? Are they able to participate themselves? Have they asked someone to be their sponsor? Do they have a food plan designed to help them be abstinent? Are they able to follow it? What difficult thoughts and feelings come up when trying to be abstinent? Have they read the Twelve Steps? What are their considerations about them? Have they actually tried to work the initial Steps with the help of a more experienced food addict? These are assignments for actions and reflection which can be exercises in honesty, challenging defiance, and helping break down initial denial. Doing 12-Step work with a sponsor is a way of supporting rigorous honesty over time. (See Appendix N.)

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Insert picture of steps
Challenging Food Addiction Denial.

Paradoxically, food addicts in early recovery cannot begin really challenging their denial until they are cleanly abstinent. For example, we remember that in Alcoholics Anonymous (AA), one puts down the drink and then starts working the Twelve Steps. Similarly in Narcotics Anonymous (NA), no one would ever expect someone to do subtle mental, emotional and spiritual work effectively while still on cocaine, heroin or prescription drugs. Biochemically, food addiction works in the same way. In food addiction recovery, the rule is you don’t try to get a right understanding in order to inform right action; rather, you take right action, and this leads you to right thinking. The first right action, as we have seen, is eliminating specific addictive foods. A second right action is often telling secrets.

Trying to be food abstinent for just one meal can give someone insight into whether or not he or she is addicted. A few days of abstinence, especially if there is substantial withdrawal, can give a lot more evidence. If this is done with a group of other food addicts getting abstinent, the learning is magnified. When a food addict is abstinent long enough for physical cravings to diminish—sometimes go away completely—this is really substantial experiential proof. There is nothing like 90 days or a year of back-to-back abstinence—and experiencing life without the foods you used to think you could not live without—to convince food addicts that they are chemically dependent and that food addiction recovery is a better path.  

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99 If food addicts cannot get physically abstinent on their own—or with the help of a therapist or 12-step program—the next option, as with alcoholism and drug addiction, is residential detoxification. (See workshops of ACORN Food Dependency Recovery Services, Sarasota, FL; Milestones in Recovery, Miami, FL; Shades of Hope, Texas; COR, Minneapolis; Turning Point, Tampa, FL; Bitten-Jonsson Treatment Program, Sweden; and Esther Helga Guðmundsdóttir’s MFM Food Addiction Treatment Center, Iceland.)

100 Hillock, et al., op. cit; Shivaram, op. cit.
For those whose are working a 12-Step program, it is often a surprise how much more deeply they begin to understand and accept their powerlessness over food after they are stably abstinent. This is called First-Step work. It might be done using the questions in the Overeaters Anonymous (OA) *Twelve Step Workbook*, doing an AWOL (A Way of Life—Step Study) in Food Addicts in Recovery (FA), or joining a Big Book Step Study meeting for food or all addictions. The workbooks can be used to pursue these emotional and spiritual issues whether or not one becomes a member of the fellowship. Again, though, it is often best to do recovery work as a part of a group. (See Appendix F.)

For many, even the support of 12-Step fellowships alone are not enough. After all, half of the first hundred members of AA had at least a week of hospital-based detox and treatment, and many stayed extensively at each other’s homes in early recovery. Today still, at least half of the members in most AA groups have done outpatient or residential treatment, often more than once. The work of treatment is mostly detoxification, education about the disease and doing more in-depth work challenging denial, i.e., First-Step work.103

There were dozens of such addiction model treatment programs for food in the l980s and 1990s, but private health insurance companies stopped reimbursing for this service, and now there are only a handful of food addiction treatment programs. I believe this is a major reason food addiction has gotten so out of control, and we need turn this around. Professional addiction model treatment is a primary place

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where critical-level alcoholics and drug addicts learn the skills of rigorous honesty and do work of challenging their own addictive denial. This level of treatment is needed on a broad scale for food addiction.

**Deepening Emotional and Spiritual Recovery.**

If food addicts admit they are powerless over food (Step One), then it is important that they look at and work for a relationship with someone, a support group or a spiritual connection, for help. Any and all of these are common in food addiction recovery. The most common "power greater than self" is another food addict already in recovery or a food addict professional. They have done what the active food addict was unable to do alone or they know how to support someone to get abstinence so they can best recover in an inter-dependent relationship. Working to eliminate resistance to such a process is important in the short and long term.

Again, the place where it is easiest to find other recovering food addicts is in the several food-related Twelve Step fellowships. Overeaters Anonymous (OA) is by far the oldest, largest and most diverse. There are movements within OA that are more structured and designed for later-stage food addicts—OA-HOW, OA-90 Days, OA Greysheet—and a lot of inspiring, long-time abstinence and recovery in the rest of the fellowship.\(^{105}\) Recently, some OAs have broken off to form whole new fellowships focused primarily on food addiction recovery: Food Addicts Anonymous (FAA), Compulsive Eaters Anonymous HOW (CEA-HOW), Food Addicts in Recovery Anonymous (FA) and Recovering Food Addicts Anonymous, Inc (RFA). There is also a new fellowship which offers

\(^{105}\) Many in Overeaters Anonymous do not see themselves as food addicted. Rather, they see themselves as only eating disordered or call themselves “compulsive eaters” with an emphasis on “psychologically compulsive.” So it is important for self-assessed or diagnosed food addicts going to OA to look for others who are following the addictive model and, of course, who are themselves physically abstinent and sober regarding food.
mutual support for anorexics and bulimics using the addiction model, Anorexics and Bulimics Anonymous (ABA).

All the Twelve Step fellowships are specifically non-religious; they call for a recovery of one’s personal relationship with Spirit, but they are open to all faiths, and plenty of the members are agnostic or atheistic. For those wanting a more religious based program, they can either attend their church in addition to a Twelve Step group (few have ever find significant conflict), or they can join Bible-based programs such as Overcomers Outreach, Inc., Christian Food Addicts in Recovery, or Celebrate Recovery.

Most food addicts eventually turn food into a false deity. Food is where they go for comfort, for companionship, for caretaking in the last resort. Though few call food their “god" or their higher power, this "false God" spiritual language fits their behavior and consciousness while active in the food. There is a need to replace the binging, the isolating, and the numbing out with something both physically healthier and more spiritually gratifying. This can be done by actually working the Twelve Steps or by any number of other therapeutic and spiritual paths. When we talk of recovering from food addiction, this is not just a matter of putting down excess food and maintaining a healthy weight; it is also recovering deeper, more nuanced, richer contact with yourself and others. It could be called "recovering the Higher Self."

Most food addicts have done their full share of damage to themselves and others—just like alcoholics and drug addicts. So there is a need for what the 12-Step programs call “some internal housekeeping" or “cleaning up one’s own side of the street." It is interesting to look at the principles involved in each of the Twelve Steps and compare them to
the issues identified in Erick Erickson’s stages of psychological development.¹⁰⁶

The comparison is excellent, and it shows the depth to which food addicts often need to grow emotionally and spiritually. It also reminds us again that 12-Step fellowships are not the only way for food addicts to heal, but just a healing network and community which has been specifically useful to those addicted to specific foods or volume eating in general.

Part V

A Vision of Doctors Using Minutes of Each Appointment Wisely to Intervene with Food Addiction

In the United States, food addiction is drastically under-diagnosed and frequently mistreated. This is a major reason efforts to deal with the obesity crisis continue to be so unsuccessful. The CDC still finds over two-thirds of adults are overweight, and one-third are obese. Children are still becoming overweight and obese at an increasing rate, boding greater problems for the future.\(^{107}\)

Here are possible strategies for primary doctors, dieticians and therapists to treat food addiction similarly to how they treat alcoholism and other drug addictions.

**Strategy 1: Become familiar with the research, and tell patients that food addiction is real.**

Now that there is overwhelming agreement in the scientific community that food addiction really does exist, the first order of business is for health professionals and their staffs to become sufficiently familiar with the new research that they can tell all their patients that the science is in: Food Addiction is real. They can provide printed material and refer people to food addiction professionals and 12-Step websites that food addiction is real, and this important scientific advance that could affect them significantly. Make printed material available and refer people to food addiction professionals and also Twelve Step websites. (Refer to Charts 1 and 2 in this paper: Normal Eater, Emotional Eater, Food

\(^{107}\)http://www.cdc.gov/obesity/data/adult.html; http://www.cdc.gov/healthyyouth/obesity/facts.htm. Even with “leveling off” of the numbers of Americans who are overweight and obese the last few years, the more dangerous type of obesity where there is an increase of inner-belly fat, is actually increasing. One possibility is that “Normal Eaters” or obese are losing weight, while those who are food addicted are still gaining more weight.
Addict; and Food Addiction—Progression and Recommended Actions; and Appendix O.)

**Strategy 2: Have a regular screening process built into each appointment—ask a question about food addiction.**

A simple screening process for food addiction could become as routine as checking for weight, blood pressure, drug and alcohol use, and smoking. Just as patients are asked about past and present smoking and use of alcohol at each visit now, they could also be asked about their eating: Do you sometimes eat more than you expect or want to eat? Do you have a recurring cycle of overeating and restricting, i.e., yoyo dieting? Do you think you might be addicted to food like sugar, flour, fat or salt?

The first time a physician inquires about food addiction, the nurse might have the patient fill out a simple screening like the S-UNSCOPE (See Appendix P.)

**Strategy 3: Provide more thorough assessment tests for those screening positive.**

The only peer review assessment instrument to date is the Yale Food Addiction Scale. It can be found online with instructions for interpretation. (See Appendix Q.) Two other types of assessments commonly used are: 1) the three ACORN assessments for normal eater, emotional eater, and food addict;¹⁰⁸ 2) the self-assessment instruments of the various 12-Step fellowships.¹⁰⁹

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¹⁰⁸ These are available in Werdell, *Bariatric Surgery and Food Addiction*, op. cit.
¹⁰⁹ See websites for these organizations, Appendix F.
Most self-help books on food addiction also have a set of assessment questions. The patient could do these assessments in the office or take them home. A nurse or technician could be responsible for evaluating the assessment and putting the results in the patient's chart.

*Once a patient has self-identified as a food addict, the following questions are always appropriate:* Have you attended a 12-Step fellowship? Do you have an abstinent food plan? Are you following it? Are you accountable to someone for your food and recovery work? Are you being rigorously honest with them? Do you need more support?

**Strategy 4: If the assessment for food addiction is positive, then they need a highly rigorous process for full diagnosis and treatment planning.**

If the assessment is positive, there should be a full diagnosis and treatment plan. I recommend using the new "ADDIS Sugar" Instrument developed in Sweden. Such a diagnosis looks at food addiction in great depth as characterized in the DSM 5. It is important for us to establish a very high standard for diagnosis and treatment planning. There are many who think they can learn this just by reading about it and become an instant expert. We would rather have people with experience in addiction recovery who are thoroughly trained.¹¹⁰

**Strategy 5: Develop a liaison for your patient to be a guide to food-related 12-Step fellowships and other free recovery support.**

While 12-Step approaches are not the only ones that deal with addiction, there are no other peer support groups for food that are as plentiful, easily accessible, and inexpensive. The recovery in food 12-

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¹¹⁰ Jonsson, op. cit.
Step programs is not as consistent as it is in Alcoholics Anonymous and Narcotics Anonymous because most members have not yet been afforded the opportunity for detoxification and/or treatment. Thus it is useful to identify a recovered food addict in the local community or a professional who can be a liaison for your patients referred to 12-Step groups.

**Strategy 6: Identify professional referrals with expertise and successful experience in working with food addiction.**

It is important to differentiate between dieticians, eating disorder therapists, and addiction counselors who understand food addiction and are successful with food addicted clients from those who do not have this experience or expertise. Many dieticians and eating disorder therapists were trained to suggest that their clients should learn to eat all foods in moderation, especially sugar and other binge foods. This does not work for the food addict. Also, most trained and certified drug and alcohol counselors were not taught about food addiction and often were taught that food addiction does not exist, or is not very consequential. In-service training is needed locally on a large scale.

**Strategy 7: Have recommendations for detoxification and treatment for those needing more than 12-Step support and individual professional counseling.**

The Food Addiction Institute has recommendations for programs which have addiction-model food treatment and which have a substantial successful track record working with food addicts. Unfortunately, since private insurance stopped reimbursing for most overweight adults needing addiction-model treatment, the number of such programs is limited.
Since ASAM (American Society for Addictive Medicine) accepted food addiction as a brain disease, many existing drug and alcohol programs are considering adding treatment for food addiction. The Food Addiction Institute is developing a model for a local community to maximize resources for food addicts.

**In conclusion**

In my clinical experience, the physicians and other health professionals who are most convinced that food addiction is a diagnosable disease and that there are really treatments which work are those who have experienced one of their own patients experience stable physical abstinence and full recovery physical, emotionally and spiritually. From their own experience with the patient, they know that neither diets alone nor talk therapy alone worked with this individual. However, when the patient began treating herself or himself in the food addiction paradigm, the results could be truly amazing.

What general practitioners usually do not see, even in the cases of their individual patients, is 1) how much work addiction recovery was for their patients, especially at the beginning; 2) how much specially assistance they needed from family and other supporters, often entirely free from 12 Step fellowships; and 3) the type of professional treatment, adapting the models for alcoholism and drug addiction treatment to food addiction, that many required when 12-Step fellowships were not enough. If I were to sum up the most important thing I have learned in watching thousands of middle- and late-stage food addicts lose weight and keep it off, resolve emotional issues created both from prior trauma and the addictive disease itself, and recovering—sometimes finding for the first time—an inner life and path
for service beyond their wildest dreams, I would say they could not do it alone: they often needed extraordinary support.

This is true regarding my own recovery from food addiction; I needed extraordinary support to recover. It was true of the fellow recovered food addicts who helped me, and it is true of the professional staff who have worked with me to run workshops all over the world for over two decades. When food addicts go to any length to be completely abstinent from their specific binge foods, are rigorously honest about their abstinence and recovery process one day at a time, and are open to healing not just physically and emotionally, but also mentally and spiritually, miracles happen.

In the medical field, we see such “miracles” all the time. Every time there is a heart transplant. Every time a several hundred pound person has successful bariatric surgery. Every time an Ebola patient survives. Every time a child is vaccinated and avoids any number of serious diseases. Every time a late stage chronic alcoholic or drug addict achieves and maintains sobriety. I am sure this can happen much more than it already is happening with all stages of food addiction if we in the medical community get behind learning and supporting what we have already found that works.

We need to screen and assess for food addiction as systematically as we do already for alcoholism, drug addiction and nicotine addiction. We need obesity specialists to include food addiction recovery as well as dieting and eating disorder counseling as a part of our medical strategy. We need to tell our clients and the world that the food-related 12 Step fellowships are as important to dealing with the obesity epidemic as AA is to the healing of the problem of alcohol abuse and
addiction. We need to develop a ladder of food addiction medical services in every community and health insurance reimbursement for all in need. We need primary hospital-based treatment again—in every state and major metropolitan area. We need epidemiological research and rigorous outcome studies of existing treatment as well as continuing basic scientific research. We need public health policies and strategies which prevent future food addiction, especially among children. We need to ________ the major food companies to create profitable ways to gradually but steadily decrease the number and amount of addictive foods in our grocery stores and restaurants. We need parents to learn about and align their families with all aspects of this extraordinary effort.

Food addicts, including as many as a third of those reading this paper, need extraordinary support in diagnosis and treatment. This is a large and essential, still mostly missing, piece of the solution to the obesity epidemic.
Part VI
Further Issues of Diagnosis and Treatment

We are at the end of this lecture, but we have only touched the surface. There is a longer, fully-referenced written version of this talk posted online at www.foodaddictioninstitute.org. But I would like to suggest some areas for further discussion:

1. How do we reach all physicians, dietitians and therapists with the new information on the science, diagnosis and treatment of food addiction?

2. How do we cooperate with food-related 12-Step fellowships, religion based support and other free services?

3. How do we develop a ladder of professional services for food addicts—screening, diagnosis, counseling and treatment—in every community?

4. How do we re-establish primary hospital-based research and treatment for food addiction in every state and major metropolitan area?

5. How do we create food addiction prevention programs, especially for parents and children, especially in the schools and public media?

6. How do all local institutions in a community—grocery stores, restaurants, schools, churches, weight loss businesses and gyms,
businesses, hospitals, police and military, prisons—to be more supportive to prevention of and recovery from food addiction?

7. How do we create laws locally, statewide and nationally regarding sugar and layered and other potentially addictive foods comparable to those for alcohol and drugs?

8. How do we encourage epidemiological research on prevalence and outcome research treatment of food addiction?

This Is Just A Beginning!
We have a lot of exciting work ahead of us.
APPENDICES
APPENDIX A

Evidence of food addiction from clinical experience

I- Thoughts on Clinical Experience

Let me first write from my clinical experience: 4000 plus self-assessed late stage food addicts who recovered from their out of control eating by treating it as a substance use disorder. As with alcoholism and other drug addictions, the food addiction recovery was not 100% for all clients, but all but a handful were detoxed from sugar and other binge foods in five days of residential treatment, and two studies (one of the Glenbeigh Psychiatric Hospital of Tampa's residential 40 day residential treatment and one of the ACORN Primary Intensive five-day residential workshop) which showed one-third completely abstinent one-to-five-years later and one-third abstinent at the time of the study but having had at least one relapse. All those who were abstinent had significant long-term weight loss - the popular measure and the standard for obesity, but "food abstinence" is a much higher standard. All these clients had been unsuccessful with numerous diets and years of therapy, many unsuccessful getting abstinence with OA or FA alone. OK - that is what I consider my own credentials and research on my work.

Dickson and Menzies agree that there is some form of addiction. they call it "eating addiction" which they say is a form of loss of control. Their argument is that this is a "process addiction" and not a substance use disorder. So what do I find from my own clinical work?

So, my first noticing about food addiction clients is that they all exhibited physical craving, and the physical craving diminished substantially or went away completely when sugar and other specific binge foods were removed completely. The cravings frequently returned if the person was not entirely abstinent from these foods. (More about the biochemistry of food cravings is detailed in the FAI science review paper on physical craving.)

Clinically, the next issue is withdrawal. When patients are taken off of sugar, flour and other binge foods, more than half have marked symptoms of detoxification: headaches, sleepiness, moodiness, inability to sleep, flue like symptoms, more intensive cravings and obsessions, etc. Some are ready to leave treatment against medical advice; those who do take back their binge foods within 24 hours.

There is also obvious tolerance in the case histories of clients with whom I have worked. All do "First Step" writing - personal stories of their powerlessness over food throughout their lives - and everyone shows a pattern of progressive use and progressive loss of control. If this were just loss of control, it might be attributed to eating in general, but there is an increased tolerance for specific food substances. Again, when these are taken out completely, there are not just less cravings but also more control.
Note: Gerhardt et al did a study of withdrawal in one of our residential food addiction workshops. Her Yale research team found that withdrawal was remarkably similar to withdrawal from alcohol and other drug addictions. The paper on this is written but not yet published.

Then, there is the issue in addiction treatment that clinically we call denial. There is little scientific research on this (I am working on some now), but it is probably the most demanding aspect of food addiction treatment. Our patients will often go to any length arguing that they do not need abstain from sugar and other binge foods - ordinary denial. They will often call very specific foods they eat out of control "comfort foods" and say they cannot do without them - psychological denial. Most to the point, they will forget that they binged, mistake the amount they ate, sometimes not remember overeating at all, and completely forget the consequences of overeating or taking the first bite of certain foods even after they had analyzed this rigorously in therapy - biochemical addictive denial.

Note: There is considerable brain scan research on animal and humans showing that there are distortions in the memory sections of the brain in out of control food consumers.

Finally, an important characteristic of addiction is that they are treatable. Here, as already mentioned, there is considerable evidence. Besides the studies of my own clinical practices, there is research on the outcomes in food-related 12 Step groups. Many within these organizations follow a specifically food addiction model, i.e, they assume suggest "abstinence from binge foods first". There are tens of thousands in OA, FA, GSA, FAA, CEA-HOW, RFA who have long term recovery by specifically following the food addiction model. Medicine is a pragmatic science: if there is a diagnosis and this results in healing outcomes, the diagnosis is presumed sufficient.

Note: There is both internal research (OA )and more objective studies of OA and clinical treatments from outside academics (Hillock, Carroll, Kriz, etc.) which finds about half the membership is abstinent and maintaining a weight loss of 50 pounds or more. They often do not separate the "emotional eaters" from the "food addicts", though it is clear that some in the samples are chemically dependent.

It does not seem like the article in Neuroscience and Biobehavioral Reviews by Dickson and Menzies deals with most of this evidence.

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APPENDIX B
Peer reviewed scientific studies of food addiction

There is **genetic research** evidence starting with Noble *et al*, "D2 Dopamine Receptor Gene and Obesity." *International Journal of Eating Disorders*, Volume 15, Number 3. April 1994. This finds that some obese and overeating adults who do not have symptoms of alcoholism or other drug addictions have the same D2 Dopamine gene marker as has been found for alcoholics and drug addicts. This is evidence that some out of control eaters have a food addiction, i.e., substance use disorder.

There is **brain imaging research on animals** summarized by Avena *et al*, "Evidence for Sugar Addiction: Behavioral and Neurochemical Effects of Intermittent, Excessive Sugar Intake" in *Neuroscience and Biobehavioral Reviews*, pp 20-29, 2008. All the types of animal tests for addiction characteristics used for alcoholism and other drug addiction were done for sugar, and the conclusion was "some animals can be addicted to sugar."

There is **brain imaging research on humans** summarized by Gold, "Eating Disorders, Overeating and Pathological Attachment to Food: Independent or Addictive Disorder?" in *The Journal of Addictive Diseases*, Volume 23, No. 3, 2004. The finding is that specific hyper-palatable foods can be addictive and should be given a substance use disorder diagnosis in the DSM of the American Psychiatric Association.

There is **biochemical research** summarized by Colantuoni, "Evidence That Intermittent Sugar Intake Causes Endogenous Opioid Dependence", *Obesity Research*, 2002. It is the ingestion of sugar that catalyzes the creation of endogenous opioids and bring out about a state of chemical dependency. This is not evidence for an "eating addiction", rather very specific evidence for food addiction.

There is controlled **behavioral research** by Drewnowski, "taste Response and Preferences for Sweet High-fat Foods: Evidence of Opioid Involvement", *Physical Behavior*, pp 371-9, No 51, 1992. This study showed that Naloxone, an opiate inhibitor, decreases the amount of sugar/flour/fat food eaten in contrast with a control group not given the drug. Naloxone is a medication used for opioid addiction, not process addiction.

**Biochemical pain research** has found that sugar, flour and other specific food foods stimulate serotonin in the brain to alleviate pain, and clinician Ann Katherine makes the case for this being another piece of the food addiction puzzle. In *Anatomy of Food addiction: the Brain Chemistry of Overeating*, Hazelden, 1996, takes early serotonin research and make a compelling case that humans can be addicted such pain relieving internal chemicals. The solution is to remove sugar, then flour, from the diet completely - a case for the problem being a food substance not the eating process.

There is **research on leptin**, human body chemical in every cell which plays a role in the regulation of satiation. Extremely low levels of leptin are found in some Prader Willi
Syndrome patients, many of whom lose control over their eating. " See Shapira et al, "Satiety Dysfunction in Prader Willi Syndrome Demonstrated by fMRI," Journal of Neurological and Neurosurgical Psychiatry, No 76, pp 262-69, 2005. Here is a case that could be called eating addiction; clinicians and 12 Step food addicts call it "volume addiction." Adult Prader Willi patients learn to control this problem by avoid visuals of food they don't want to eat and by weighing and measuring their portions, the same treatment used frequently by 12 Steppers who see themselves as food addicts. Treatment is successful when focusing on the portion control of food substances.

There is research on metabolic syndrome that shows sugar creates an insulin dysfunction and blood sugar imbalance. Summarized by Lustig in his U Tube lectures, then in Fat Chance: Beating the Odds Against Sugar, Processed Food, Obesity and Disease, 2012 this phenomenon well documented in the peer reviewed literature is created by sugar and other refined carbohydrates, not by the process of eating. In The Blood Sugar Solution, clinician Mark Hyman coins the term "diabesity" to show the addictive link between these foods and mild insulin resistance, to pre-diabetes, to full-blown Type 2 diabetes. His solution begin with a 10 day sugar fast, but attention to the process of eating.

Then, of course, there is the outcome research. The Overeaters Anonymous "Membership Survey Report", 2004, coached by faculty at the University of New Mexico School of Business found that 50% of a sample of the 60,000 plus 12 Step overeaters were abstinent and maintaining a 50 pound weight loss. Kriz in "The Efficacy of Overeaters Anonymous in Fostering Abstinence from Binge-Eating Disorder and Bulimia," Virginia Polytechnic Institute, 2002 found that 46% of her sample were abstinent, most often meaning free of sugar and other binge foods. Carroll, "The Eating Disorder Inventory and Other Predictors of Successful Symptom Management of Bulimic and Obese Women Following an Inpatient Treatment Program Employing the Addictive Paradigm," University of South Florida, 1993 shows that an abstinence based 12 Step approach was as effective for food addicts as the best chemical dependency treatment programs are for alcoholism and drug addiction. Hillock, et al, "Survey of Outcomes for a Residential Food Addiction Recovery Workshop," Promising Practice Conference, International Society of Food Addiction Professionals, January, 2009, showed that addiction model treatment was similarly successful when beginning with a five day sugar and binge food detox and pointing towards 12 Step support to continue this abstinence and do the underlying work. This success was based on a food addiction diagnosis and treatment, a very good reason to assume there is such a disease as food addiction.

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APPENDIX C

News Release
FOR IMMEDIATE REVIEW

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ASAM RELEASES NEW DEFINITION OF ADDICTION

Addiction Is a Chronic Brain Disease,
Not Just Bad Behaviors or Bad Choices

CHEVY CHASE, MD, August 15, 2011 – The American Society of Addiction Medicine (ASAM) has released a new definition of addiction highlighting that addiction is a chronic brain disorder and not simply a behavioral problem involving too much alcohol, drugs, gambling or sex. This the first time ASAM has taken an official position that addiction is not solely related to problematic substance use.

When people see compulsive and damaging behaviors in friends or family members—or public figures such as celebrities or politicians—they often focus only on the substance use or behaviors as the problem. However, these outward behaviors are actually manifestations of an underlying disease that involves various areas of the brain, according to the new definition by ASAM, the nation’s largest professional society of physicians dedicated to treating and preventing addiction.

“At its core, addiction isn’t just a social problem or a moral problem or a criminal problem. It’s a brain problem whose behaviors manifest in all these other areas,” said Dr. Michael Miller, past president of ASAM who oversaw the development of the new definition. “Many behaviors driven by addiction are real problems and sometimes criminal acts. But the disease is about brains, not drugs. It’s about underlying neurology, not outward actions.”

The new definition resulted from an intensive, four-year process with more than 80 experts actively working on it, including top addiction authorities, addiction medicine clinicians and leading neuroscience researchers from across the country. The full governing board of ASAM and chapter presidents from many states took part, and there was extensive dialogue with research and policy colleagues in both the private and public sectors.

The new definition also describes addiction as a primary disease, meaning that it’s not the result of other causes such as emotional or psychiatric problems. Addiction is also recognized as a chronic
disease, like cardiovascular disease or diabetes, so it must be treated, managed and monitored over a life-time.

Two decades of advancements in neurosciences convinced ASAM that addiction needed to be redefined by what’s going on in the brain. Research shows that the disease of addiction affects neurotransmission and interactions within reward circuitry of the brain, leading to addictive behaviors that supplant healthy behaviors, while memories of previous experiences with food, sex, alcohol and other drugs trigger craving and renewal of addictive behaviors. Meanwhile, brain circuitry that governs impulse control and judgment is also altered in this disease, resulting in the dysfunctional pursuit of rewards such as alcohol and other drugs. This area of the brain is still developing during teen-age years, which may be why early exposure to alcohol and drugs is related to greater likelihood of addiction later in life.

There is longstanding controversy over whether people with addiction have choice over anti-social and dangerous behaviors, said Dr. Raju Hajela, past president of the Canadian Society of Addiction Medicine and chair of the ASAM committee on the new definition. He stated that “the disease creates distortions in thinking, feelings and perceptions, which drive people to behave in ways that are not understandable to others around them. Simply put, addiction is not a choice. Addictive behaviors are a manifestation of the disease, not a cause.”

“Choice still plays an important role in getting help. While the neurobiology of choice may not be fully understood, a person with addiction must make choices for a healthier life in order to enter treatment and recovery. Because there is no pill which alone can cure addiction, choosing recovery over unhealthy behaviors is necessary,” Hajela said.

“Many chronic diseases require behavioral choices, such as people with heart disease choosing to eat healthier or begin exercising, in addition to medical or surgical interventions,” said Dr. Miller. “So, we have to stop moralizing, blaming, controlling or smirking at the person with the disease of addiction, and start creating opportunities for individuals and families to get help and providing assistance in choosing proper treatment.”

To read the full Definition of Addiction, visit:

Dr. Miller is past president of ASAM. Dr. Hajela is past president of the Canadian Society of Addiction Medicine and is a board member of ASAM. The American Society for Addiction Medicine is a professional society representing close to 3,000 physicians dedicated to increasing access and improving quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addictions.

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Appendix D

APA DSM-5: Feeding and Eating Disorders

Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Diagnostic criteria are provided for pica, rumination disorder, avoidant/restrictive food intake disorder anorexia nervosa, bulimia nervosa, and binge-eating disorder.

The diagnostic criteria for rumination disorder avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder result in a classification scheme that is mutually exclusive so that during a single episode, only one of these diagnoses can be assigned. The rationale for this approach is that, despite a number of common psychological and behavioral features, the disorders differ substantially in clinical course, outcome, and treatment needs. A diagnosis of pica, however, may be assigned in the presence of any other feeding and eating disorder.

Some individuals with disorders described in this chapter report eating-related symptoms resembling those typically endorsed by individuals with substance use disorders, such as craving and patterns of compulsive use. However, the relative contributions of shared and distinct factors in the development and perpetuation of eating and substance use disorders remain insufficiently understood.

Finally, obesity is not included in DSM-5 as a mental disorder. Obesity (excess body fat) results from the long-term excess of energy intake relative to energy expenditure. A range of genetic physiological, behavioral, and environmental factors that vary across individuals contributes to the development of obesity; thus, obesity is not considered a mental disorder. However, there are robust associations between obesity and a number of mental disorders (e.g., binge-eating disorder, depressive and bipolar disorders, schizophrenia). The side effects of some psychotropic medications contribute importantly to the development of obesity, and obesity may be a risk factor for the development of some mental disorders (e.g., depressive disorders).

Pica

Diagnostic Criteria

A. Persistent eating on nonnutritive, nonfood substances over a period of at least 1 month.
B. The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.
C. The eating behavior is not part of a culturally supported or socially normative practice.
D. If the eating behavior occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.
Appendix E

Pressures on Normal Eaters (contributing causes of obesity)

The following are some of the pressures in American society for Normal Eaters to 1) eat more or in an unhealthy manner, 2) exercise less (and not burn calories from physical exertion or keep metabolism active) and/or 3) to use food to deal with stress and non-nutritional needs. These pressures are in addiction to internal stressors from unresolved prior trauma which are the basis for the eating disorders of Problem Eaters. Further, these pressures are in addition to Food Addict’s unique bio-chemical predeliction towards food dependency. It often seems a wonder that more Normal Eaters are not becoming obese, and, of course, this may be exactly what is happening.

1) **Less physical exertion.** The economy of industrial countries has moved from a large majority of worker doing manual labor in agriculture and factories most of the day to a larger majority of workers doing office, sales and human service job with almost no manual labor.

2) **Labor Saving Devices:** In the homes, there has been a steady increase of “labor saving” devices

3) **TV:** The average use watching TV as “recreation” has increased from ½ hr per day in 195 to over 3 hours a day in fifty years: “Couch potatoes” (*check figures)

4) **Stress:** There has been a steady increase in the time worked on the job and out of the family: trend towards two earner families, speed up in work expectations

5) **Fast Food:** Less time to make meals and more reliance on restaurants, particular fast food restaurants

6) **More Sugar** in the diet: Increases use of sugar and sugar substitutes in the general population. Sweetness attracts people to eat more and sugar is an empty calories (saying nothing of addictive aspects for some people)

7) **Artificial Tastes:** The rise of the artificial taste business in which chemistry can make anything taste like anything and more seductive to eat “make cardboard taste delicious”

8) **Corporate Lobbying:** The food and sugar lobby is putting more and more money into advertising and into supporting health professionals who argue for sugar and other

9) **More Fat in the Diet:** Meat is being grown to have more fat – for taste and profit –

10) **Deceptive Advertising:** Fat free usually means adding sugar and sugar free usually means adding fat – merchandise to the weight conscious is “deceptive”
11) **Feminist issues/ Sexism**: The middle class ideal for a woman is to cook seductively and weigh less; women are increasing able to make it in middle level jobs and want the rewards: in America, going out for a meal is one of the rewards.

12) **US Food Surpluses**: The farmers of America keep growing a surplus of food, and the Depart of agriculture which represents them) and encourages food purchase – is also the Government agency that sets dietary criterion

13) **More Food on the Plate**: The average portions in restaurants are getting larger and larger

14) **More Advertising**: Advertising for food of food has been steady in creasing in quantity and quality = bombarded with images of food and often the food most likely to lead to obesity. (Also Advertising for the Diet Industry which does not take into account eating disorders and food addiction.)

15) **Under-education of Health Professionals**: It’s old news that most doctors are not educated about nutrition nor know much about helping patients with weight loss. (There is much evidence that some foods have addictive potential, but this is not formally acknowledged by the AMA, ADA, APA or ACA)

16) **The growth of Junk Food**: Fast food restaurants have made a menu that is way to heavy in sugar, flour, fat and caffeine i.e. “The American meal” When they try to serve healthier fare, customers often don’t but it

17) **Unintended Consequences**: School lunch programs have grown to subsidize meal which are carbohydrate and sugar heavy, and often kids refuse to eat healthy foods when made

18) **Affluence**: Until recently US family incomes have been steadily increasing and this has lead Americans to spend more on everything including groceries and going out to restaurants – this is considered by more and more “the good life”

19) **More Feminist issues**: Body image distortions are created by the fashion and advertising industry; most people can’t be healthy at weight of most models – when they try to eat less, they are hungry

20) **Sexism as it Affects Men/ Macho**: Men are often encourage to “eat more”, “drink a lot” and “be big” in order to be more manly.

21) **Family and Cultural Norms**: Cultural pressure to eat more or in less than healthy ways at “the holidays” and at ethnic family functions.

22) **Aggressive marketing**: When you walk through the grocery checkout line, the last thing you see is a plethora of “junk food,” and so-called convenience stores contain little else. They are the liquor store for people who might want to eat too fast, too much or unhealthy.
23) **Poverty and Oppression**: The additional pressure of life for all people who are poor or from other oppressed groups, including oppression of fat people.

Clearly, anyone who needs a “reason to eat” too much or in a manner that does not support optimum health does not have to look very hard in the United States and other highly developed capitalist societies. Even for those who do not have eating disorders and are not chemically dependent of food, it takes real work to eat moderately and healthy in America.
APPENDIX F
Food Related Twelve Step Fellowships

Anorexics and Bulimics Anonymous (ABA)
ABA
Main P.O. Box 125
Edmonton, Alberta, Canada T5J 2G9
www.anorexicsandbulimicsanonymousaba.com

Compulsive Eaters Anonymous-HOW (CEA-HOW)
5500 East Atherton St., Suite 227-B
Long Beach, CA 90815-4017
562-342-9344
www.ceahow.org

Eating Disorders Anonymous (EDA)
General Service Board of EDA, Inc.
Box 55876
Phoenix, AZ 85078-5876
www.eatingdisordersanonymous.org

Food Addicts Anonymous (FAA)
World Service Office
4623 Forest Hill Blvd., Suite 109-A
West Palm Beach, FL 33415-9120
561-967-3871
www.foodaddictsanonymous.org

Food Addicts in Recovery Anonymous (FA)
6 Pleasant St. #402
Malden, MA 02148
781-321-9118
www.foodaddicts.org
Greysheeters Anonymous (GSA)
GSAWS, Inc.
Prince Street Station
P.O. Box 630
New York, NY 10012
www.greysheet.org

Obsessive Eaters Anonymous (OEA)
P.O. Box 7555
Glenageary, Co. Dublin Ireland
353-[0]1-289-1599
www.obsessiveeatersanonymous.org

Overcomers Outreach (OO)
Box 922950
Silmar, CA 91392-2950
800-310-3001
www.overcomersoutreach.org
Note: Food-related difficulties are only some of the life problems this Christ-centered fellowship addresses.

Overeaters Anonymous (OA)*
Overeaters Anonymous/World Service Office
P.O. Box 44020
Rio Rancho, NM 87174-4020
505-891-2664
www.overeatersanonymous.org
*Note: This is the oldest, most diverse, and largest food-related fellowship.
**Note: There are at least two subgroups within OA that have a long history of supporting food addiction: 90-day meetings (Mass. Bay Intergroup, Box 1440, Arlington, MA 02474) and OA-HOW (oahow.org).

Recovery from Food Addiction, Inc.
P.O. Box 35543
Houston, TX 77235-5543
713-673-2848
www.RFAworldservice@aol.com
Food Addiction Treatment: An Important Piece of the Puzzle
Food Addiction Treatment: An Important Piece of the Puzzle, p. 74
ACORN Primary Intensive

Appendix H: Dosages of Medications and Levels of Food Dependency

<table>
<thead>
<tr>
<th>Psychotropic Drugs</th>
<th>Food Addictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the diagnosis is depression, for example, the first problem is to identify one anti-depressant medication from the possible – tricyclites, Prozac, Paxil, Effexor, etc. – that might help. Once one is selected, the next issue is to experiment to find an appropriate dose. As an example, if the medication being tried is Prozac, possible doses could be as in the ranges shown below.</td>
<td>If the assessment is food dependency then the first problem is to identify which food or foods – e.g. sugar, flour, caffeine, fat, wheat, volume, etc. – are addictive. Once this is known, the next issue is to identify the degree of sensitivity. For example, if one needs to eliminate sugars, there are levels of abstinence as in the ranges shown below.</td>
</tr>
<tr>
<td>20 milligrams per day</td>
<td>No “added sugar,” e.g. no sugar sprinkled on cereal</td>
</tr>
<tr>
<td>40 milligrams per day</td>
<td>No “sweets,” e.g. no desserts like ice cream or frosted cake</td>
</tr>
<tr>
<td>60 milligrams per day</td>
<td>No sugar in processed food, e.g. up to the 5th ingredient</td>
</tr>
<tr>
<td>80 milligrams per day</td>
<td>No sugar or “hidden sugars,” e.g. dextrose, barley malt, fructose – up to the 5th ingredient</td>
</tr>
<tr>
<td>100 milligrams per day</td>
<td>No sugars or hidden sugars or artificial sweeteners at all</td>
</tr>
<tr>
<td>120 milligrams per day</td>
<td>No sugar, hidden sugars or very sugary natural foods, e.g. dates, ripe bananas, etc.</td>
</tr>
</tbody>
</table>

If psychotropic medication can be seen as adding a micronutrient to balance brain chemistry, abstinence from food addiction can be understood as eliminating a psycho-active food to balance brain chemistry. In part it is science, and we will become better educated with further study. In part, it is an art, and recovering food addicts can often tell when someone else is food dependent – and perhaps what food plan might be appropriate for them – merely from their own experience of getting abstinent. Sometimes there is not yet an ideal food plan for a food addict – just as there are at times continuing and substantial problems finding appropriate psychiatric medication for people. Similarly, sometimes the suggestion of one food addict to another is limited because the abstinent food addict has only experienced one food plan that works for them.

Most important, however, is that if there is a particular food that a food addict needs to eliminate or a certain level of abstinence needed to make it unlikely that they will be triggered into physical carving, this is not a matter of choice. This is an issue of biochemistry, just like the issue of which psychological medications and doses will work – and which will not work – regarding other mental health problems caused by aspects of the brain which do not function normally. For food addicts, the idea that they can learn to “control foods in moderation” to which they have become chemically dependent simply never works in the long run. This is also a matter of bio-chemistry. The only real choice is for food addicts to accept that they have this disease and to abstain from the foods – and to the level of abstinence – which eliminates the triggering of the physical addictive process.

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APPENDIX I

Glenbeigh Hospital of Tampa
Suggested Food Plan, 1995

This is a pre-diabetic food plan that is free of sugar, flour, caffeine and alcohol.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BREAKFAST</strong></td>
<td><strong>LUNCH</strong></td>
<td><strong>METABOLIC</strong></td>
</tr>
<tr>
<td>8 oz. low-fat milk</td>
<td>3 oz. protein (men</td>
<td>8 oz. low-fat milk</td>
</tr>
<tr>
<td>or low-fat, sugar</td>
<td>get 4 oz. protein)</td>
<td>or low-fat fat,</td>
</tr>
<tr>
<td>free yogurt</td>
<td>½ cup starch</td>
<td>sugar free yogurt</td>
</tr>
<tr>
<td>1 fruit</td>
<td>1 cup cooked</td>
<td>1 fruit</td>
</tr>
<tr>
<td>1 oz. cereal</td>
<td>vegetable</td>
<td>1 fat</td>
</tr>
<tr>
<td>2 oz. protein</td>
<td>1 cup salad</td>
<td>1 oz. cereal</td>
</tr>
<tr>
<td></td>
<td>1 fat</td>
<td></td>
</tr>
</tbody>
</table>

Add 8 oz. decaffeinated, sugar-free beverage at each meal.

The process of recovery includes identifying and communicating any strong feelings that may arise while eating on this food plan.

**Note:** This is the A.C.O.R.N. food plan from Glenbeigh Psychiatric Hospital. A.C.O.R.N. stood for Addictive Concept for Overeaters Recovery Needs. Glenbeigh found that this food plan worked for 90 percent of its 15,000 patients during detoxification and treatment. For 10 percent of Glenbeigh patients, the dietitian made adjustments based upon medical need. Almost all patients required food plan adjustments as they approached goal weight.

ACORN Food Dependency Recovery Services does not have a food plan that it recommends. In its Primary Intensive, participants who have been stably abstinent on a specific food plan for 90 days or more are recommended to follow that food plan. Those who do not have a food plan can use the Glenbeigh/ACORN food plan until they consult with a doctor, dietitian or therapist.
APPENDIX J

Why A Weighed And Measured Food Plan?

1. A food and eating plan is “first things first.” Clearly alcoholics need to be sober to address the pain propelling them. The same holds true for the food addicted individual. Expecting someone who is still toxic to be able to process issues is unfair if not cruel. Abstinence on a food plan opens one up to new levels of feeling and insures that what is experienced is emotion and not reactive toxicity.

2. To clearly define what to eat and what not to eat is the beginning of honesty. After years of denial, distortion and deception as a result of the disease of compulsive eating, a food plan describes accurately what is eaten. Growing up in a family where lying was a means of survival can make being honest threatening in a very primitive way. Being truthful can begin in this prescribed area of life. Often the experience of honesty with food can be transferred to and flourish in other aspects of living.

3. There must be a definition of the: “first bite” – the initial step over the line from abstinence into compulsive eating. Not knowing what the “first bite” is may mean it has already been taken. The anorectic pull can also be highlighted immediately because the food is outlined precisely. For alcoholics and addicts, the first drink or joint or pill or line is easily discernible. The same clarity needs to be created about the “first bite,” whether it is one bite over or one bite under the line that has been drawn.

4. Designing and shaping a container for the food establishes boundaries on that which has been boundless. Compulsion and obsession with food run wildly out of control in an addicted individual’s life, flooding every aspect of existence with problems. Distinct edges, clear yes’s and no’s, provide a healing experience. New behavior in setting limits feels positive, healthy and esteem-giving.

5. “Eating with guilt” may be one of the simplest definitions of food dependency/eating disorders. A commitment to a defined eating plan can mean walking away without the punishing mental voices – the guilt, the worry, the anxiety. Every bit of food confronted during the day no longer provokes an agonizing decision. The decision has already been made. Gone is the constant, excruciating debate: Should I or shouldn’t I?

6. Serenity in relation to food is the ultimate goal. A food plan can be the vehicle for learning detachment. Food is eaten at regular intervals to meet physical needs. Three weighed and measured meals are eaten to promote optimum health and not in response to the emotional fluctuations of the day. A food plan becomes a way to disengage the food from the feelings.

7. A food plan affirms the physical nature of this disease. Food dependency is not a moral problem, nor is it a physical symptom of an underlying psychological disturbance. It is a complex physical/emotional/spiritual disease.

8. A weighed and measured food plan facilitates seeing the correlation between what food is taken into the body and what the body looks like. There is a cause and effect relationship. A food plan can put an end to the mystery that plagues many their whole lives about what food has to do with weight. An equation is set up: weight up = reduce food or weight below what is appropriate = add food. No myth or magic. Just measure.
9. An accurate reporting of what is eaten is a baseline from which to troubleshoot physical symptoms. The perpetual terminal vagueness about what is actually eaten is eliminated and the facts are evident. It is then possible to discover and uncover clues about what foods may or may not be appropriate for a particular individual’s biochemistry. Adjustments can be based on accurate nutritional information.

10. Being able to state honestly what is eaten also helps stop the devastating isolation of food dependency. Now there is an understandable and precise way to talk about food. If one is “only as sick as their secrets,” the need for secrets has vanished.

11. Perfectionism will get attention as an individual lives abstinently. A food plan measures the food precisely, accurately, scrupulously – perfectly – if you will, as the rest of life is surely imperfectly human. The past’s unrealistic expectations will bubble to the surface to be resolved.

12. A food plan can be the essential anchor, the constant when nothing else in a life of recovery is predictable or unchanging. It provides steady, stable ground on which to stand as the flow of feelings and experiences becomes more fluid. People, places, things and emotions will change while a food plan can be safe, dependable and consistent.

13. Food plans are also instrumental in learning to “let go.” Genuine recovery requires that the loss of friend food and the resulting grief (denial, anger, bargaining, depression, and acceptance) must be dealt with. A food plan delineates an end-point at each meal. It becomes more than good intentions: it is a plan, a statement, a decision, a commitment. A food plan pushes against whatever resistance to, and ambivalence about, change and surrender remains.

14. Detractors vehemently argue that a food plan fosters deprivation. Certainly the feeling of “there is never enough” is exacerbated – to be repeatedly challenged by a visceral experience of enough food at every abstinent meal. The sense of deprivation is not about food and never has been. Once food is no longer the focus of all needs, the insight can begin to dawn that what has been so painfully absent is nurturing, attention and love.

15. The food and eating rituals which are an integral part of the progression of food dependency are embarrassing, even bizarre and humiliating. Using a food plan, the obsession is replaced with healthy new behaviors. Where food has been truly out of control, a food plan is concrete and symbolic evidence of a new self-respect.

16. Diets are based on control: food plans are the demonstration of surrender. Diets rely on willpower: food plans necessitate a Higher Power. Acceptance of a Higher Power is followed by the recognition that that Power will not be showing up to fix breakfast! Food plans are the “footwork” – putting one foot in front of the other to take responsibility for recovery. Weighing and measuring becomes a spiritual discipline. Three times a day, weighing and measuring is a demonstration of an acceptance of personal powerlessness. It becomes the “chop wood, carry water” of food dependency.

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APPENDIX K

The Process of Food Addiction Abstinence:

SURRENDER

Common guidelines for committing your food in early recovery are:

1. Write down your food specifically before eating.

2. Read what you wrote to a peer sponsor.

3. Don’t change your commitment (except for an extreme health emergency)

4. Check back with your sponsor after you eat and be rigorously honest.

If you broke your commitment in any way, do an inventory—physically, mentally-emotionally and spiritually—and create a plan of surrender for the next meal/day.
The Dishonesty-Honesty Continuum

**Complete or Congenital Dishonesty**

The text or “Big Book” of Alcoholics Anonymous calls this “constitutionally incapable of being honest.” These are congenital liars who are often not even aware that they are not telling the truth.

**Unconscious Dishonesty**

Like psycho-therapeutic neurosis and psychosis, there is material which is at times unavailable to the conscious mind. In addiction, this is biochemical denial. Addicts in denial do not know what they do not know.

**Mean-Spirited Dishonesty**

This is knowing that a lie will hurt someone and doing it anyway. This is intentional and malevolent dishonesty even if being hurtful is just a part of the intention or a covert reason for the lie.

**Conscious Dishonesty**

This is a bold-faced lie, consciously knowing what you are saying is not truthful. Such a lie is almost always selfish and self-centered, and there is usually the expectation that you will not get caught or, if you do, it will be worth the price.

**Dishonesty by Omission**

Often called a white lie, this is often done with the thought that you don’t want someone else to get hurt. It is also the lie of the con person, showing attractive truth while hiding the deceptive underbelly.

**Cash Register Honesty**

This is telling the objective truth about objective matters. “You gave me too much change.” “I did not eat the foods that I committed.”

**Tough Love Honesty**

This is telling hard truths, often ones that the recipient might not want to hear, but being honest anyway with the intention of being helpful. This is not “brutal honesty” or saying whatever negative thoughts are on your mind regardless of the effect on others.

**Rigorous Honesty**

This is telling the complete truth, often about yourself, even though you are embarrassed and really do not want to reveal the information. It is being hard on yourself because this is the right thing to do — or because, if you are not this truthful, your abstinence is in danger.

**Perfect Honesty**

This is a level of honesty that is beyond the human capacity. It is the truth of God or of the spiritual realm unburdened by any human frailty. Though we may be instruments of this level of truth, we can never be perfectly certain that this is happening. As the book *Alcoholics Anonymous* puts it, “we are not saints.”
APPENDIX M

Levels of Telling on the Disease

Level I: In Denial:

I don’t have a problem.
It’s going to be different.
I’m not as bad as real food addicts.
I should be able to be like other people.
I can stop if I want to.
I can deal with this by myself.

Level II: Admitting

I do have a problem.
I’m different than a normal eater.
I’m not as bad as some others yet.
My way didn’t work.
I can’t stop. I’m powerless – out of control.
I need help.

Level III: Being Specific about the Food

I had a slip yesterday.
I didn’t eat exactly what I committed.
I ate sugar.
I binged on ice cream.
I ate a whole pint of Haagen-dazs Chocolate Chocolate Chip Ice Cream.
I ate out of control with my fingers.

Level IV: Being Specific about Feelings

Early that day I decided to put down ice cream for good. I felt happy, committed, determined, a little excited. . . . By the end of the day, I was shoveling down a pint of Haagen-dazs with my fingers while I was driving. I felt frantic, crazed, and numb. I had a headache from eating so much cold ice cream so fast, but I couldn’t stop. When it was gone, I wanted . . .

Level V: Being Specific about Being Powerless

. . . so when I went to throw it out, I had the thought, “Maybe I should save it in case I get a visitor who eats ice cream.” It didn’t feel like the best idea, but I said, “I can handle it.” I went to work and had a good day, except that my boss didn’t like a report I turned in at the end of the day. I was miffed, but didn’t say anything. When I got home I had the thought, “I’ll just have a look at the ice cream in the freezer.” I had a vague sense that this was not too good an idea, but I opened the freezer door anyway. Something subtly shifted inside me. I just stood there enjoying the coolness from the freezer coming at me. I was almost mesmerized by the picture of the ice cream in a dish on the package. I had the thought, “Well, I could have just a little.” I took the container out, opened it, and stuck my finger in it. It was very hard. I had to dig to get out a chunk, and I just crammed it into my mouth. It tasted sweet, delicious, but only for a moment as I swallowed it still whole and hard. I already had my fingers digging out more ice cream, thinking of the next night before the second was finished. I felt crazed, out of control, like an animal. . . .
## APPENDIX N

### Twelve-Step Work and Telling Secrets

<table>
<thead>
<tr>
<th>12 Steps for Food Addicts</th>
<th>Areas of Possible Dishonesty &amp; Secrets</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We admitted we were powerless over food—that our lives had become unmanageable.</td>
<td>Do you want to be honest? Have you lied about food? What are all your specific food secrets? Does this make your life unmanageable?</td>
</tr>
<tr>
<td>2. Came to believe that a Power greater than ourselves could restore us to sanity.</td>
<td>What is your current idea of a Higher Power? Does it help with your food? Can you imagine a Higher Power and a relationship to it that could?</td>
</tr>
<tr>
<td>3. Made a decision to turn our will and our lives over to the care of God as we understood God.</td>
<td>Are you willing to try relying on someone else, a group, a principle or a new Higher Power, to see if it works for you?</td>
</tr>
<tr>
<td>4. Made a searching and fearless moral inventory of ourselves.</td>
<td>What are your resentments, fears and problems in relationships? Do you blame them on others? What is your own part in each?</td>
</tr>
<tr>
<td>5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.</td>
<td>Can you be honest about the details of Step 4 with someone else, yourself and God as you understand God? especially how you were selfish, dishonest, self-seeking and afraid?</td>
</tr>
<tr>
<td>6. Were entirely ready to have God remove all these defects of character.</td>
<td>Are you willing to have a Power beyond yourself remove your defects? What are the payoffs for keeping them? What would you be like without them?</td>
</tr>
<tr>
<td>7. Humbly asked Him to remove our shortcomings.</td>
<td>Are you willing to ask a Power greater than yourself to remove your shortcomings? to keep asking again if you take them back?</td>
</tr>
<tr>
<td>8. Made a list of all persons we had harmed, and became willing to make amends to them all.</td>
<td>Who are all the people, places and things that you have hurt in your life?</td>
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<td></td>
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<td>---</td>
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</tr>
<tr>
<td>9. Made direct amends to such people whenever possible, except when to do so would injure them or others.</td>
<td>Are you willing to apologize face to face? willing to make the situation right?</td>
</tr>
<tr>
<td>10. Continued to take personal inventory, and when we were wrong, promptly admitted it.</td>
<td>Are you willing to continue this inventory and amends process the rest of your life? Admit when you are wrong? Correct all the wrongs?</td>
</tr>
<tr>
<td>11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry it out.</td>
<td>How, if at all, do you consciously relate to a Higher Power of your choosing on a daily basis now? Are you willing to ask for &quot;God's will&quot; and nothing else?</td>
</tr>
<tr>
<td>12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to food addicts and to practice these principles in all our affairs.</td>
<td>Are you willing to try and help other food addicts as you have been helped on an ongoing basis? Are you willing to live all your life by the principles in the Twelve Steps?</td>
</tr>
</tbody>
</table>
APPENDIX O

**Take Control of Your Eating**

**Here are some tips:**

1. Seek help. Talk to your doctor or mental health clinician about your concerns and available options.
2. Find a support group of people that will provide encouragement and guidance.
3. Make a list of foods you commonly binge on and the frequency of bingeing.
4. Keep a journal to know what feelings or circumstances act as triggers that make you want to reach for food.
5. Make a list of healthier ways to soothe yourself, for example, go for a walk, breathing exercises.
6. Don't skip meals or ignore true hunger signals.
7. Keep trigger foods away from your home and work.
8. Consider eliminating from your diet white flour, processed sugar, and bad fats (saturated and trans fats).

**Consequences of Food Addiction**

Consequences may include:

- Frequently continuing to overeat past the point of feeling comfortably full and often feeling unable to stop eating.
- Feelings of guilt or shame after eating.
- Isolating from others when eating.
- Lying to self or others about eating behaviors.
- Eating food that isn’t healthy.
- Emotional or physical withdrawal symptoms when stopping or reducing specific types of foods.
- Diseased or difficult functioning due to behaviors related to eating.

**Am I ready to make lifestyle changes?**

When thinking about your eating habits, ask yourself the following questions:

- Is changing my eating behaviors important to me?
- Do I need help or support to change my eating behaviors?
APPENDIX P
S-UNSCOPE, Screening for Sugar Addiction

Screening for sugars*, alcohol and drugs: Sugars can be any carbohydrate such as pasta, bread, sweets, cookies, soda, ice cream, junk, etc.

1. U = Unplanned Use
"In the past year, have you ever eaten sweets* more than you meant to?" Or:
"Have you spent more time eating and using sweets* than you intended to?"
YES       NO

2. N = Neglected
"Have you ever neglected some of your usual daily responsibilities because of using sweets* and/or overeating?"
YES       NO

3. C = Cut Down
"Have you felt that you wanted or needed to cut down on eating/sweets* in the last year?:
YES       NO

4. O = Objected
"Has anyone objected to your overeating sweets*?" Or: "Has your family, a friend, or anyone else ever told you they objected to your eating habits?"
YES       NO

5. P = Preoccupied
"Have you ever found yourself preoccupied with wanting sweets*? Or: "Have you found yourself thinking a lot about sweets/food*?"
YES       NO

6. E = Emotional Discomfort
"Have you ever used sweets/food* to relieve emotional discomfort, such as fatigue, sadness, anger, tiredness or boredom, etc.?"
YES       NO

With four or more YES to sweets/overeating/food*, the risk to be addicted is very high. I recommend doing a diagnostic interview to know for sure.

Key to interpret:
0-1 YES.................. Indicates Social Use
2-3 YES.................. Indicates Abuse/Harmful Use
4 or more YES........ Indicates Addiction
### APPENDIX Q

#### Food Addiction Scale

This survey asks about your eating habits in the past year. People sometimes have difficulty controlling their intake of certain foods such as:

- Sweets like ice cream, chocolate, doughnuts, cookies, cake, candy, ice cream
- Salty foods like chips, pretzels, and crackers
- Fast food, such as hamburgers, cheeseburgers, pizza, and French fries
- High-calorie drinks like soda, sports drinks, and smoothies

When the following questions ask about "CERAIN FOODS," please think of ANY food similar to those listed in the food group or ANY OTHER foods you have had a problem with in the past year.

<table>
<thead>
<tr>
<th>IN THE PAST 12 MONTHS</th>
<th>Never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I find that when I start eating certain foods, I end up eating much more than planned</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I find myself continuing to consume certain foods even though I say I am no longer hungry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I feel physically ill</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I feel a lot of time thinking about certain foods or craving them</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I find myself continuing to consume certain foods even though I say I am no longer hungry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I feel a lot of time thinking about certain foods or craving them</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I find that when certain foods are not available, I feel out of my control</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I feel a lot of time thinking about certain foods or craving them</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

9. There have been times when I have consumed certain foods so often or in such large quantities that I spent time feeling with negative feelings from the food and eating it instead of engaging in other activities.

10. I have been eaten when I avoided professional or social situations where I thought I would be more likely to consume certain foods.

11. I have been unable to control the amount of food I eat when I am eating with others.

12. I have been unable to control my eating when I am in a social situation.

13. I have been unable to control my eating when I am not hungry.

14. I have been unable to control my eating when I am not hungry.

15. I have been unable to control my eating when I am not hungry.

16. I have been unable to control my eating when I am not hungry.
IN THE PAST 12 MONTHS:

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td>My food consumption has caused significant psychological problems such as depression, anxiety, self-loathing, or guilt.</td>
<td>0</td>
</tr>
<tr>
<td>18.</td>
<td>My food consumption has caused significant physical problems or made a physical problem worse.</td>
<td>0</td>
</tr>
<tr>
<td>19.</td>
<td>I kept consuming the same types of food or the same amount of food even though I was having emotional and/or physical problems.</td>
<td>0</td>
</tr>
<tr>
<td>20.</td>
<td>Over time, I have found that I need to eat more and more to get the feeling I want, such as reduced negative emotions or increased pleasure.</td>
<td>0</td>
</tr>
<tr>
<td>21.</td>
<td>I have found that eating the same amount of food does not reduce my negative emotions or increase pleasurable feelings the way it used to.</td>
<td>0</td>
</tr>
<tr>
<td>22.</td>
<td>I want to cut down or stop eating certain kinds of food.</td>
<td>0</td>
</tr>
<tr>
<td>23.</td>
<td>I have tried to cut down or stop eating certain kinds of food.</td>
<td>0</td>
</tr>
<tr>
<td>24.</td>
<td>I have been successful at cutting down or not eating these kinds of food</td>
<td>0</td>
</tr>
</tbody>
</table>

25. How many times in the past year did you try to cut down or stop eating certain foods altogether?

<table>
<thead>
<tr>
<th></th>
<th>1 time</th>
<th>2 times</th>
<th>3 times</th>
<th>4 times</th>
<th>5 or more times</th>
</tr>
</thead>
</table>

26. Please circle ALL of the following foods you have problems with:

| Food           | Ice cream | Chocolate | Apples | Doughnuts | Broccoli | Cookies | Cake | Candy | White Bread | Rolls | Lettuce | Pasta | Strawberries | Rice | Crackers | Chips | Pretzels | French Fries | Carrots | Steak | Bananas | Bacon | Hamburgers | Cheese burgers | Pizza | Soda Pop | None of the above |
|----------------|-----------|-----------|--------|-----------|----------|---------|------|-------|-------------|-------|----------|-------|--------------|------|----------|-------|----------|--------------|--------|-------|----------|-------|------------|----------------|-------|---------|-----------|--------|-------------|----------------|-------|---------|-----------|

27. Please list any other foods that you have problems with that were not previously listed:
APPENDIX R

Instruction Sheet for the Yale Food Addiction Scale

(Gearhardt, Corbin, & Brownell, 2008)
Contact Information: ashley.gearhardt@yale.edu

The Yale Food Addiction Scale is a measure that has been developed to identify those who are most likely to be exhibiting markers of substance dependence with the consumption of high fat/high sugar foods.

Development

The scale questions fall under specific criteria that resemble the symptoms for substance dependence as stated in the Diagnostic and Statistical Manual of Mental Disorders IV-R and operationalized in the Structured Clinical Interview for DSM Disorders.

1) Substance taken in larger amount and for longer period than intended
   Questions #1, #2, #3

2) Persistent desire or repeated unsuccessful attempt to quit
   Questions #4, #22, #24, #25

3) Much time/activity to obtain, use, recover
   Questions #5, #6, #7

4) Important social, occupational, or recreational activities given up or reduced
   Questions #8, #9, #10, #11

5) Use continues despite knowledge of adverse consequences (e.g., failure to fulfill role obligation, use when physically hazardous
   Question #19

6) Tolerance (marked increase in amount; marked decrease in effect
   Questions #20, #21

7) Characteristic withdrawal symptoms; substance taken to relieve withdrawal
   Questions #12, #13, #14

8) Use causes clinically significant impairment
   Questions #15, #16
Cut-offs

Cut-offs were developed for the continuous questions by examining scatterplots of the answers compared to Binge Eating scores, EAT-26 scores, and BMI.

0 = question not significantly met, 1 = question criteria is met

The following questions are scored 0 = (0), 1 = (1): #19, #20, #21, #22
The following question is scored 0 = (1), 1 = (0): #24
The following questions are scored 0 = (0 thru 1), 1 = (2 thru 4): #8, #10, #11
The following questions are scored 0 = (0 thru 2), 1 = (3 & 4): #3, #5, #7, #9, #12, #13, #14, #15, #16
The following questions are scored 0 = (0 thru 3), 1 = (4): #1, #2, #4, #6, #25
The following questions are NOT scored, but are primers for other questions: #17, #18, #23
Questions #26 & #27 provide information on foods that participants have trouble controlling

SCORING

After computing cut-offs, sum up the questions under each substance dependence criterion (e.g. Tolerance, Withdrawal, Clinical Significance, etc.). If the score for the criterion is ≥ 1, then the criterion has been met and is scored as 1. If the score = 0, then the criteria has not been met.

Example:
Tolerance: (#20 =1) + (#21 = 0) = 1, Criterion Met
Withdrawal (#12 =0) + (#13 = 0) + (#14 = 0) = 0, Criterion Not Met
Given up (#8 =1) + (#9 = 0) + (#10 =1) + (#11 = 1) = 3, Criterion Met and scored as 1

To score the continuous version of the scale, which resembles a symptom count without diagnosis, add up all of the scores for each of the criterion (e.g. Tolerance, Withdrawal, Use Despite Negative Consequence). Do NOT add clinical significance to the score. This should range from 0 to 7 (0 symptoms to 7 symptoms.)

To score the dichotomous version, which resembles a diagnosis of substance dependence, compute a variable in which clinical significance must = 1, and the symptom count must be ≥ 3. This should be either a 0 or 1 score (no diagnosis or diagnosis criteria met.)

Norms
Diagnosis of Food Dependence – 11.6%
Median Symptom Count Score – 1.0
Withdrawal – 16.3%
Tolerance – 13.5%
Continued Use Despite Problems – 28.3%
Important Activities Given Up – 10.3%
Large Amounts of Time Spent – 24.0%
Loss of Control – 21.7%
Have Tried Unsuccessfully to Cut Down or Worried About Cutting Down – 71.3%
Clinically Significant Impairment - 14%