

Food addiction a step closer to formal diagnostic status—or not?

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Food addiction is not yet recognised as a mental disorder but certain obese individuals clearly display addictive-like behaviour towards food. To achieve a formal diagnostic status, 'food addiction' requires a stronger evidence base to support the claim that certain ingredients have addictive properties identical to addictive drugs of abuse. This topic is up for debate in the session, 'Binge eating obesity is a food addiction'.

This year's fifth edition of the DSM (Diagnostic and Statistical Manual of Mental Disorders) recognises 'binge eating disorder' (BED) as distinct from Anorexia nervosa and Bulimia nervosa, but it remains debatable whether BED is underpinned by an [addiction](#) disorder and should be prevented and treated like other addictive disorders.

The new category 'Substance related and addictive disorders' in DSM-5 combines the DSM-IV categories of substance abuse and [substance dependence](#) into a single disorder measured on a continuum from mild to severe. Importantly, the term 'dependence' is not used anymore in DSM-5, because most people link dependence with addiction when, in fact, dependence can be a normal body response to a substance.

Speaking at the 26th ECNP Congress Professor Suzanne Dickson, neuroscientist from the Institute of Neuroscience and Physiology, Sahlgrenska Academy at the University of Gothenburg, Sweden, said, "the introduction of 'addictive disorders' allows classification of behavioural addiction for the first time, for example with pathological gambling, but this does not apply to [food addiction](#). Although there

might be neurobiological and clinical overlaps between 'addictive-like' overeating and substance related and [addictive disorders](#), a major difference is that is that food consumption, unlike alcohol, cocaine, or gambling or internet gaming behaviours, is necessary for survival."

"A subgroup of obese patients indeed show 'addictive-like' properties with regard to overeating, such as loss of control," continued Professor Dickson, "but this does not automatically mean they are addicted."

According to some studies, at least 10-15% of obese individuals suffer from BED. However, BED also occurs in people that are normal weight. The term 'food addiction' has been coined by the popular press and by many sufferers as a reasonable explanation for their predicament. Studies exploring the brains of obese patients that score highly for food addiction on the Yale Food Addiction Scale show that certain areas known to be involved in reward and addiction have an altered response to both images of appetising foods and even to the taste of food.

However, more evidence is needed to support inclusion of food addiction as a diagnostic category. Professor Dickson said: "This evidence itself is insufficient to support the idea that food addiction is a mental disorder. We do not have a clinical syndrome of food addiction so far, and it is very important to establish the validity of a condition before putting it forward for inclusion in the DSM."

She pointed out that the trend to recognise behaviours as addictions is a major step forward and will help avoid stigmatising people that exhibit these behaviours. "This development is critical because behavioural obsessions that are not pathological can potentially be medicalised, and thus receive a formal diagnosis, in which they reflect an excessive, but non-pathologic, engagement. However, it will be important to avoid over-diagnosing disorders, reflecting the inflationary trend in the lay public to label various behaviours as 'addiction'."

Adding his opinion to the debate about the status of food addiction as a diagnosis, psychiatrist, Dr Hisham Ziauddeen, from the Wellcome Trust-MRC Institute of Metabolic Science, Addenbrooke's Hospital, Cambridge, questions the model of food addiction, in the session entitled, 'Binge eating obesity is a food addiction'.

"While the idea of food addiction is intuitively very appealing, there is actually little evidence so far to suggest that it actually exists in humans," said Dr Ziauddeen. "It is a very important idea to explore, but it is essential that we have sufficient research to conclusively support it before we hurry to recognise it as a genuine condition and start thinking of ways to tackle and treat it."

He noted that the best evidence for food addiction at present comes from animal models but there are important caveats to be borne in mind when looking at the animal evidence. Further, the evidence for differences in brain responses to images of food in lean and obese individuals is very inconsistent and does not currently support the idea of food addiction.

Addressing the broader concerns of how a formal diagnosis of 'food addiction' might present challenging issues for health care policy, Dr Ashley Gearheardt, Assistant Professor of Clinical Psychology, University of Michigan, US, discussed which regulatory steps would be suitable and practical.

"The idea that certain foods might be able to trigger an addictive process in vulnerable individuals is a hotly debated topic. If 'food addiction' exists, it may alter the way we think about the role of the brain in obesity, which might open up development of novel pharmaceutical treatments. Policy successes and failures from the addiction field might also guide approaches to this worldwide public health crisis."

Provided by European College of Neuropsychopharmacology

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