A Qualitative Study of Binge Eating and Obesity From an Addiction Perspective

Claire Curtis \textsuperscript{a} \& Caroline Davis \textsuperscript{a}

\textsuperscript{a} Department of Kinesiology and Health Sciences, York University, Toronto, Ontario, Canada

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A Qualitative Study of Binge Eating and Obesity From an Addiction Perspective

CLAIRE CURTIS and CAROLINE DAVIS
Department of Kinesiology and Health Sciences, York University, Toronto, Ontario, Canada

The purpose of this study was to explore how obese women with and without binge eating disorder (BED) experience overeating in relation to the DSM-5 symptoms of addiction. Findings from this study demonstrate that food addiction can occur in obese individuals with and without BED. It is important that health care professionals identify individuals who may require a specific treatment approach that incorporates techniques used in the treatment of addictions.

INTRODUCTION

There have been various attempts to explain why some people chronically overeat and seem unable to restrain their food intake. One explanation relates directly to the markedly “toxic,” and dramatically changed, food environment in recent years (Horgen & Brownell, 2002). The likelihood of a pattern of excessive consumption developing is greatly increased in the current marketplace with its superfluity, and ready availability, of highly processed, and hyper-palatable foods—particularly those rich in sugar, fat, and salt—compared to previous generations (Gearhardt, Davis, Kushner, & Brownell, 2011).

A growing body of clinical and neurobiological evidence has shown how persistent overeating can lead, in vulnerable individuals, to a pattern of compulsive behaviour similar to that seen in drug abuse and other addiction disorders (Davis & Carter, 2009; Gold, Graham, Cocores, & Nixon, 2009; Volkow & O’Brien, 2007; Wise, 2006). Proponents of the view that
food can be addictive base their arguments on a compelling body of animal research (Avena, Gold, Kroll, & Gold, 2012; Avena & Hoebel, 2003; Avena, Rada, & Hoebel, 2008; Colantuoni et al., 2002; Johnson & Kenny, 2010). Notwithstanding the robust evidence of sugar/fat dependence in rodents, there are few parallel findings in human research. Notable exceptions have identified brain areas responsive to both food and drug cravings (Pelchat, 2009). Other researchers have recently advanced the field by developing a measure operationalizing “food addiction” using the *Diagnostic and Statistical Manual-IV-TR* (DSM-IV-TR; American Psychiatric Association [APA], 2000) diagnostic criteria for substance dependence (Gearhardt, Corbin, & Brownell, 2009).

Our group published the first case-control study using the *Yale Food Addiction Scale* (YFAS) diagnostic criteria in obese adults (Davis et al., 2011). The results provided good evidence that food addiction is an identifiable clinical syndrome with psychiatric co-morbidities and a psycho-behavioural profile remarkably similar to conventional drug-abuse disorders. We also found that 50% of those who met criteria for “food addiction” were co-morbid for binge eating disorder (BED), providing preliminary evidence that while food addiction overlaps with this disorder, it is a clinically distinct syndrome. Gearhardt and her colleagues (2012) also found a similar proportion of YFAS food addiction in obese patients with BED.

While these studies have contributed to the much-needed human support for the concept of food addiction, the research is still preliminary and largely quantitative. Few studies have taken a qualitative approach to understanding whether addictive tendencies towards food resemble the characteristics of other addiction disorders. One important contribution (Cassin & von Ronson, 2007), was based on structured telephone interviews, showing that 92% of women with BED met the *DSM-IV-TR* criteria for substance dependence when the word “food” was substituted for “drug” in the interview questions. Ifland et al. (2009) also reported that adults attending an education class on the deleterious effects of sugars and starches strongly endorsed features of substance abuse such as progressive use over time, withdrawal symptoms, and tolerance. Other qualitative studies conducted with Overeaters Anonymous confirmed that participants endorsed addiction symptoms, and used words such as “physically addicted,” “hangover,” “withdrawal,” “craving,” “drug of choice,” and “abstinence” (Ronel & Libman, 2003; Russell-Mayhew, von Ranson, & Masson, 2010). Further qualitative support for food addiction can be found in the language of chronic dieters when describing their weight-loss failures (Green, Larkin, & Sullivan, 2009), and from compulsive overeaters recruited from a weight-loss program (Lyons, 1998), many of whom attributed their struggle with food to an addictive process in which thoughts of food are constantly present, and eating becomes compulsive in spite of clear negative consequences.
Diagnostic and Statistical Manual—5 (DSM-5)

The recently published DSM-5 has a new category entitled “Addiction and Related Disorders” (APA, 2013), which includes both substance use disorders (SUD) and non-substance addictions. In addition, the list of clinical symptoms indicating substance dependence has increased from seven in the DSM-IV to 11 in the DSM-5, and includes additional features such as failure to fulfill role obligations, use in physically hazardous situations, continued use despite interpersonal problems, and craving or a strong desire or urge to use the substance. The latter also will require fewer endorsements of symptoms (two instead of three) in a 1 year period.

With the release of these new guidelines, it is timely to examine whether food addiction is a reasonable diagnosis for some cases of overeating based on these revised criteria, especially since all previous studies have operationalized food addiction according to the DSM-IV-TR standards.

The primary aim of the present study was to explore how obese women with and without BED experience overeating in relation to DSM-5 symptoms of addiction. It is anticipated that themes generated from this study will inspire future research, and will inform more personalized care for those who struggle with overeating. For instance, some may respond well to treatment strategies derived from the management of other addiction disorders. We employed a qualitative approach to provide valuable insight into the subjective experiences of those who chronically overeat.

METHODS

Participants

Twelve obese women with BED and 12 without BED took part in the study. The two groups were matched closely for BMI (BED $\bar{x} = 36.74$, $SD = 6.3$; Non-BED $\bar{x} = 38.07$, $SD = 5.3$) and age (BED $\bar{x} = 32.25$, $SD = 5.4$; Non-BED $\bar{x} = 34.33$, $SD = 7.5$) and therefore did not differ significantly on either variable ($p = .582$ and $p = .443$ respectively). Nor was there a different ethnic composition between the two groups (% Caucasian BED 83% vs. 67% non-BED, $p = .670$). Finally, 33% of the BED sample were cigarette smokers compared to the non-BED group who were all non-smokers ($p = .100$).

All participants were required to be fluent in English and free of a former diagnosis of anorexia or bulimia nervosa. Exclusion criteria included any serious medical conditions, pregnancy within the previous 6 months, and a current diagnosis of any psychotic disorder or substance abuse. They were recruited from posters placed at universities, local hospitals, and other public institutions soliciting volunteers who were “overeaters and overweight.” Advertisements were also placed in local newspapers and online sites. The
procedures employed in this study were carried out in accordance with the Declaration of Helsinki.

Procedure

As an initial screening procedure, a short telephone interview was carried out to confirm basic eligibility. On the day of the interview, informed consent was obtained, and all relevant demographic information acquired in a face-to-face interview. A structured clinical interview was carried out by a trained PhD student to confirm BED status. Height and weight were measured with the participant standing in stocking feet and wearing light indoor clothing.

A diagnosis of BED was given to participants who met the criteria provided in the main body of the *DSM-IV* where BED is defined as: “recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of bulimia nervosa” (APA, 2013, p. 550). This definition was operationalized in the following way. Participants had to report at least weekly objective binge episodes over the previous 3 months, but over this period they must not have vomited, fasted, or taken laxatives or diuretics as a means of controlling their shape or weight.

Semi-Structured Interview

All interviews followed a guided in-depth semi-structured format and were conducted by the first author. Two slightly different schedules were employed depending on eating disorder status. Interviews for the BED participants focused on the experience of “binge eating” for the BED group (version 1) and “overeating” for the others (version 2). Questions were based on the *DSM-IV* criteria for BED. For example, one question for the BED participants stated: “You have said you feel a lack of control over eating, can you tell me about this?” Whereas the version for the non-BED group was worded: read, “Do you feel a lack of control over your eating?” In addition to exploring how or whether the participants experienced these criteria, they were also asked whether they felt “addicted to food,” and to elaborate on the reasons for their answer. Interviews lasted between 45 and 90 minutes and were audio-taped (with signed permission) and transcribed verbatim. At the conclusion of the interview, all participants were paid a small stipend to cover their time and transportation costs.

The sample size was determined according to the recommendations of Glaser and Strauss (1967) regarding saturation where the collection of new data does not shed any further light on the issue under investigation. The authors considered the sample large enough to assure that most of the perceptions that might be important were uncovered, but at the same time not so large that data became repetitive and, eventually, superfluous.
Data Analysis

Data were analyzed using thematic analysis procedures described by Braun and Clarke (2006). As such, each transcript was carefully examined to identify whether the data it contained (i.e., words, sentences, paragraphs) fit within our *a priori* themes—the 11 *DSM-5* symptom criteria for a SUD or additional themes that emerged from the data. Once all relevant data from all transcripts had been organized into themes, the data within each theme were compared and contrasted, focusing on the similarities and differences between the two groups in relation to these themes (for example, extent of endorsement, language used, and meaning assigned). Data analysis was carried out by the first author, while a second examiner provided an audit of the analysis. There was 95% agreement between assessors on allocation and interpretation of the data. The remaining 5% consisted of purely semantic differences, which upon examination, the examiners agreed held the same overarching interpretation.

RESULTS AND DISCUSSION

This section focuses on how the two study groups were similar, in terms of endorsement of *DSM-5* criteria, as well as providing a discussion of the criteria that differentiated the two groups.

Both groups of women endorsed *DSM-5* SUD criteria (in relation to food) in their narratives; however, there were visible qualitative differences in how the women experienced these symptoms. Overall, the BED group described their overeating as an addictive process to a greater degree than their non-bingeing counterparts, as indicated by endorsing a greater number and frequency of the 11 *DSM-5* symptoms (see Table 1).

*DSM-5* Criteria Endorsement Common to Both Groups

While both groups endorsed criteria 6 and 7 with virtually the same frequency, there were clear differences in the quality of their reported experiences.

*Criterion 6: The substance is often taken in larger amounts or over a longer period of time.* Both groups spoke of eating a greater quantity of food than was originally intended—not surprisingly, since all participants were substantially overweight. The BED participants focused on the uncontrollable aspect of binge eating. For example, one individual described: “You start eating one and then ... and then, you are like, I am just going to have a couple ... then you realize the entire bag is gone. ... I did not mean to have the entire bag.”

While many binge episodes were unplanned, the women also described times when the event was intentionally premeditated, and these planned
TABLE 1 Number of Participants Endorsing DSM-5 Substance Use Disorder Criteria

<table>
<thead>
<tr>
<th>DSM-5 diagnostic criteria</th>
<th>BED group (N = 12)</th>
<th>Non-BED group (N = 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Failure to fulfil major role obligations</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. Use in situations which it is physically hazardous</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Use despite persistent or recurrent social or interpersonal problems</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4. Tolerance</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>5. Withdrawal</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. Taken in larger amounts or over a longer time</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>7. Persistent desire or unsuccessful attempts to cut down</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>8. Great deal of time spent engaged in the activity</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>9. Activities given up/reduced</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>10. Continued use despite persistent or recurrent physical or psychological problems</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>11. Cravings</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Meet full criteria for SUD: endorsement of two symptoms plus significant impairment/distress within a 12-month period</td>
<td>12</td>
<td>5</td>
</tr>
</tbody>
</table>

binges inevitably resulted in the eating episode extending over a longer period of time than was initially intended.

The non-BED women were distinctive in that they consumed more food than was originally intended but this was primarily due to consuming larger portion sizes and frequent snacking throughout the day saying: “I was almost eating my way throughout the day”; “I’m randomly snacking all day”; “I would say my snacking would be out of control.”

Criterion 7: There is a persistent desire or unsuccessful efforts to cut down or control the substance use. Both groups of women expressed the desire to reduce their food intake. When talking about their binges, the BED women gave the impression that binge eating was part of their intrinsic make-up, and therefore not realistic for them to stop it. They knew rationally they should discontinue bingeing, but emotionally they were unable to saying: “I want to stop, I know I should stop. But you just can’t.”

The BED women also spoke about various strategies they used to control their binges. The most frequently cited was restricting trigger foods in their diet. This was achieved either by avoiding situations where they may come into contact with these foods and/or not bringing these foods into their homes. While this may seem like a simple ploy, it clearly required a considerable amount of cognitive control. One BED participant talked about the lengths she would go to avoid her favourite foods: “I am trying to manipulate my mind . . . when I drive up to the drive-through . . . I think to myself, ‘Oh, did they just wipe their bum?’ I just try to gross myself out, so that I will not go there.”
Another way of restricting these foods was by substituting “healthier options” for them: “I know that some point later today I am going to want some junk food, so let me go find the sugar-free chocolate covered almonds that they sell in the diabetic aisle of the drugstore.”

The non-BED women also described their efforts to reduce food consumption (i.e., restricting certain foods, skipping meals, following diet plans, fasting until the evening) were largely unsuccessful in the long-term: “I wasn’t able to do it long enough, it gets to that point because I realized, well, I like cake, and I’m not wanting to give it up”; “So I needed some pleasure, some comfort . . . I didn’t have the strength to keep going without it.”

**Criterion 11: Craving or a strong desire or urge to use a specific substance.** This symptom was frequently endorsed by the BED group, but by fewer non-BED counterparts. Participants used a variety of words to endorse this criterion: “craving”; “urge”; “desire”; “constant thought”; “a voice in my head”; “almost uncontrollable”; and “a nagging feeling.” One BED participant described it as: “a thing in my brain. . . . It does not go away until it’s satisfied.” Some women drew an analogy to other forms of substance abuse saying their food cravings felt: “like how an alcoholic or a drug addict would feel.”

These “cravings” followed a similar pattern in both groups. They started with a triggering event such as restricting the foods they really enjoyed, seeing appetizing foods in advertisements and commercials, smelling food, time of day, or eating particular foods.

Once a craving is initiated, participants described how they were: “impossible to ignore”; “pretty much constant”; “I think about it, think about it, think about it . . .” One woman articulated what the experience was like for her: “I saw a chocolate cake [in the store], and I was like ‘That looks really good.’ . . . I thought I should buy the cake . . . then I was like ‘No, not going to do it.’ For two weeks, I did nothing but think of that cake . . . finally I bought it. I was like, I will just have a little piece, and I ate the whole thing in two days.”

Other participants were unable to resist their cravings: “I cannot wait”; “I just have to do it”; “It is so intense that I want it right now”; “It’s the only way to have that peacefulness [to give in to it]”; “I would not be able to function, unless it [the craving] was quieted.”

For both groups, the cravings were “desperate”; “obsessive”; and “relentless.” One explanation for these over-powering sentiments could be a lower-than-normal tolerance of distress in many obese women: “I usually don’t let it get that far [to the point where I’m stressed or uncomfortable]”; “I probably don’t let it get to the point of discomfort . . . I probably just satisfy it too quickly for it to build up to that level.”

Low distress tolerance has been associated with a number of addiction disorders including alcoholism and drug abuse (Brown, Lejuez, Kahler, &
where the
substance is frequently used to ease/detract from aversive emotional states, including cravings. A recent study also found that distress tolerance was inversely correlated with emotional eating, external eating, and eating on impulse (Kozak & Fought, 2011). This may suggest that low distress tolerance underlies both food and substance addiction and they share common psychobiological mechanisms.

There also was discussion among the participants of how they tried to avoid acting on their cravings such as taking a shower, eating a “healthier” option, or not bringing craved foods into their house. Most often these avoidance strategies were only effective in the short term and typically resulted in the eventual consumption of their craved food. Since cravings occurred on a regular basis, the women felt it took a great deal of mental effort to “fight” them and that there were certain times when they were more likely to “suck” to them, for example, if they were hungry, tired, premenstrual, or feeling emotional. Overall, the descriptions of food cravings for both groups shared similar qualitative dimensions—that is, a preoccupation with the food; feelings of loss of control; and improved mood once they had consumed it.

**DSM-5 Criteria That Differentiated BED From Non-BED Women**

The BED group also strongly endorsed criterion 10, unlike their obese counterparts.

*Criterion 10: The substance use is continued despite knowledge of having persistent or recurrent physical or psychological problems that are likely to have been caused or exacerbated by the substance.*

BED participants talked about the negative short- and long-term consequences of their binge-eating behaviour including the physical symptoms during and immediately following a binge such as nausea, stomach-aches, bloating, heart-burn, indigestion, and dry-heaving. Some explained how they would literally eat so much that they “hurt” or “feel very ill.” One woman longed to be able to throw up after her binges to help her feel better but said: “I just cannot do that. Vomiting is a really gross . . . after binge eating . . . it would be better if I was bulimic, if I could just get rid of it. I can say it, but I cannot do it.”

The women described how these physical symptoms would build to a point where they caused the binge to cease, and then what ensued were negative emotional states and feeling: “ashamed”; “guilty”; “disgusted”; “despicable”; and “angry.” It was often mentioned that the women would question themselves immediately post-binge about why they binge ate. It appeared as though, for many, an internal mental battle arose, with one voice defending the decision and another expressing that they did not want to continue to do this. “It was a battle with myself, but it was almost like there was two of me there.” These deleterious responses to the binge, described as
“beating myself up” [about engaging in this behaviour], frequently led to the consumption of more food to “ease” the psychological discomfort described.

In addition to these short-term physical and psychological adverse consequences, binge eating was also maintained in the face of longer-term negative outcomes such as excess body weight and the associated health risks. Repeated bingeing over time, combined with no compensatory weight control behaviours to counteract their overconsumption, invariably leads to weight gain. Participants explained some of the reasons they continued to binge despite these costs: “But, it is totally worth the chocolate—like the enjoyment of it—so I do not care”; “It happens to me [physical symptoms], but it does not stop me from eating it”; “Then ten minutes later, I feel fine and then I do not worry about it ever again, until the next time.”

Implications for “Diagnosing” Food Addiction

Except for one person in the non-BED group, all participants in our study met two or more criteria for a substance-use diagnosis (with food as the substance) as specified in the DSM-5. The APA has suggested that the seriousness of the disorder can be determined by the number of symptoms endorsed. For example: two or three symptoms are described as “moderate,” while greater than four reflects a “severe” condition. Although the BED participants, as a group, appear to be more severely addicted since they endorsed more symptoms than their non-binging counterparts (51 vs. 31: see Table 1), a DSM-5 diagnosis of SUD, also requires evidence of “clinically significant impairment and distress.” The testimonials indicate that all the BED participants satisfied this criterion as they had reported marked distress related to their binge eating episodes. As a consequence, all members of the BED group met the DSM-5 criteria for a SUD when “food” represented the “substance.” It is important to note, however, that none of these participants were actively seeking treatment for their eating disorder—a factor which may suggest less distress and impairment than would be found in treatment-seeking women with BED. On the other hand, in the two recent co-morbidity studies examining the prevalence of YFAS-diagnosed “food addiction” in BED, similar percentages were found whether the participants were treatment-naïve and recruited from the community (Davis et al., 2011), or they were recruited from a treatment facility (Gearhardt et al., 2012).

Determining whether women in the non-BED group were experiencing significant signs of impairment/distress was more challenging given the vague guidelines in the DSM and the absence of precisely defined

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1 These estimates are likely to be conservative as the women were not asked directly about SUD criteria. In order to reduce demand characteristics, the questions in the interview were based on the participants’ experiences of binge eating/overeating. Addiction symptoms were noted only if they were mentioned spontaneously by the women.
markers. Previous research has suggested that distress and impairment are not universal concomitants of obesity (Mitchell, Devlin, de Zwaan, Crow, & Peterson, 2008), and that these emotions vary considerably among individuals with a high BMI (Heinberg, Thompson, & Matzon, 2001). For many of the non-BED women in our sample, their overeating and obesity were not affecting their daily functioning adversely. They were also not experiencing clinically significant distress. However, those that did endorse this criterion reported pronounced food cravings—a state they found particularly distressing. Interestingly, the craving criterion is a new symptom for SUDs in the DSM-5 and was not included in previous versions of the DSM. This study suggests that craving is an experiential phenomenon in cases of uncontrolled overeating.

Subjective Endorsement of Food Addiction

As demonstrated, a large proportion of our sample appears to have addictive tendencies towards food, based loosely on the DSM-5 criteria for SUD. However, when the women were asked directly whether they felt “addicted to food” some were resistant to calling it an addiction: “I don’t know if it is an addiction, I would have to think about that; “That to me is pathetic. So I do not like to admit that”; “I do not want to excuse my behaviour by calling it an addiction.”

Others were confused: “I would not call it an addiction but it very well could be an addiction”; “There are certainly elements of what I know of addiction . . . appear in my relationship with food. But, I do not know if that is a true addiction. It is a little bit confusing.”

Part of the ambivalence stemmed from whether some foods have the potential for abuse: “Can anyone really be addicted to food? It doesn’t make sense”; “I do not really know how I can ever phrase it being addicted to food, because you need food to keep living.”

There were also misconceptions about what it meant to be “addicted”: “I don’t feel I am addicted because somebody who is addicted does it anytime, anyplace, anywhere, all the time”; “You do not feel compelled to eat sugar like an alcoholic would be compelled to drink alcohol because I can go part of my days without getting it.”

Of those who said they were “not addicted,” all acknowledged they had a “problematic” relationship with food: “I know I can’t control myself at times but I don’t think I’m addicted to it,” and instead of labelling it an addiction, many preferred to call it a “food problem” or a “bad habit.”

The women who felt they were “addicted” to food tended to base their decision on the similarities between their eating and other addictive behaviours: “You have addictions to sometimes fill a void, to make yourself better, um, I used food, and some people used drugs, some people sex.”
When probed about which features of their eating most resembled characteristics of other addictions, loss-of-control over their eating behaviours was most prominent. Particularly the feeling of not wanting to engage in the behaviour but then not having the control to stop doing it: “It is always a fight. Always a conflict every day. I know it is happening. I know the outcome, but I cannot stop it”; “It almost came to a point last year where I thought, maybe if I just do something to go to jail—they feed me there. It got to the extreme.”

When the participants were asked about whether they thought that some foods are addictive substances or whether the act of eating is a potentially addictive behaviour, their responses focused mostly on the food. All those who self-identified as “addicted” to food emphasised that it was only highly palatable “junk” to which they felt dependent. The sweet foods they craved the most included candy, chocolate, cookies, brownies, ice cream, and cakes. Given that many of these foods are also high fat, it may not be sugar alone that is driving their addictive feelings, but especially when it occurs in combination with fat. “It does usually involve sweets. Sweets trigger it for me. . . . anything sweet—I do not have an off switch—it is just fill, fill, fill”; “Once the idea is in my head to have something sweet, once that has been planted, then I am done.”

They also spoke about a “high” they would get from sugary foods and how the taste of sugar set them up for wanting more: “If I could not taste sweet things or if I had to inject myself with sugar to have it, I would be willing to guess that I would not have a problem.”

Many participants (a larger percentage in the BED group) also felt compelled to eat salt: “I am addicted to the salt”; “Yes it is more the salt that I crave”; “My perfect scenario is a sweet, salt combo—M&Ms and popcorn.”

CONCLUSIONS

The results of this study suggest that obese women with BED are more likely to meet criteria for a food addiction based on the revised criteria for SUD in the DMS-5. This conclusion converges with previous research using DSM-IV diagnostic standards (Cassin & von Ranson, 2007). On the other hand, studies using the YFAS have found a substantially lower incidence of food addiction in those with BED (Davis et al., 2011; Gearhardt et al., 2012). Therefore, future research should compare the self-report YFAS with a DSM-based clinical interview to establish the accordance rate of these two assessment tools. This will better establish the salient clinical characteristics of the food-addiction construct. Findings from this and other studies (Davis et al., 2011; Gearhardt et al., 2012) also demonstrate that addictive tendencies towards food do not only characterise BED but can occur in other individuals who struggle with overeating.
More research is needed, however, to examine the clinical course of this condition, identify relevant aetiological factors that give rise to its development, and determine whether unique biological mechanisms differentiate this syndrome from other forms of overeating and obesity. This study validates the view that not all foods are perceived as problematic in terms of their ability to induce cravings and/or feelings of “addiction.” Our findings are consistent with other literature suggesting that highly palatable foods (i.e., those high in sugar, fat, salt) are more likely to induce an “addictive” response given their impact on the brain’s dopamine system (Gearhardt et al., 2011).

It will also be important to determine whether food addiction predicts poorer outcome following treatment (e.g., weight-loss surgery). This knowledge will aid health care professionals in identifying individuals who may require a specific treatment approach that incorporates techniques successfully used in the treatment of other addiction disorders. Additionally, if the concept of food addiction becomes accepted and recognised as a clinical condition, it will be interesting to observe whether this impacts individuals’ views on their eating patterns and subsequent need for treatment. It is also important for future studies to examine whether there are gender or cultural differences in food-addiction symptomology given the exclusion of males and predominance of White participants in this study.

Some strengths of this study include the use of standardized clinical interviews to determine BED diagnosis and the use of multiple raters for data analysis. The findings unite research using quantitative methodology showing a considerable overlap between BED and food addiction, while also showing they are not the same construct. Furthermore, this study adds a greater depth to understanding how obese individuals with and without BED experience food addiction symptomology in their everyday lives.

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