



Self-perceived food addiction: Prevalence, predictors, and prognosis



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ABSTRACT

Food addiction is controversial within the scientific community. However many lay people consider themselves addicted to certain foods. We assessed the prevalence and characteristics of self-perceived “food addiction” and its relationship to a diagnostic measure of “clinical food addiction” in two samples: (1) 658 university students, and (2) 614 adults from an international online crowdsourcing platform. Participants indicated whether they considered themselves to be addicted to food, and then completed the Yale Food Addiction Scale, measures of eating behavior, body image, and explicit and internalized weight stigma. Participants in the community sample additionally completed measures of impulsivity, food cravings, binge eating, and depressive symptomatology. Follow-up data were collected from a subset of 305 students (mean follow-up 280 ± 30 days). Self-perceived “food addiction” was prevalent, and was associated with elevated levels of problematic eating behavior, body image concerns, and psychopathology compared with “non-addicts”, although individuals who also received a positive “diagnosis” on the Yale Food Addiction Scale experienced the most severe symptoms. A clear continuum was evident for all measures despite no differences in body mass index between the three groups. Multinomial logistic regression analyses indicated that perceived lack of self-control around food was the main factor distinguishing between those who did and did not consider themselves addicted to food, whereas severity of food cravings and depressive symptoms were the main discriminating variables between self-classifiers and those receiving a positive “diagnosis” on the Yale Food Addiction Scale. Self-perceived “food addiction” was moderately stable across time, but did not appear predictive of worsening eating pathology. Self-classification as a “food addict” may be of use in identifying individuals in need of assistance with food misuse, loss-of-control eating, and body image issues.

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1. Introduction

The concept of “food addiction” has attracted great interest within the scientific community, particularly in terms of implications for public policy on obesity prevention and management (Gearhardt, Grilo, DiLeone, Brownell, & Potenza, 2011). The Yale Food Addiction Scale (YFAS) was developed to identify individuals exhibiting addictive-like behaviours with respect to foods, and is based on the DSM-IV-TR criteria for diagnosis of substance dependence (Gearhardt, Corbin, & Brownell, 2009). These criteria identify seven potential symptoms of addiction syndromes, namely: taking the substance in larger amounts or over a longer period than intended; persistent desire or unsuccessful attempts to

reduce or stop use; continued use of the substance despite negative consequences; excessive time or money spent obtaining the substance; important social, occupational, or leisure activities reduced because of use of the substance; withdrawal symptoms when the substance is discontinued; and requiring larger amounts of the substance to achieve the same effects, i.e. tolerance. Endorsement of three or more of these criteria in the previous year, along with clinically significant distress or impairment, is required to receive a positive “diagnosis” (YFAS+). Based on these criteria, the prevalence of “food addiction” in student and non-clinical populations is generally between approximately 5% and 15%,¹ although significantly higher rates have been observed in obese or eating disorder samples (for a review, see Pursey, Stanwell, Gearhardt, Collins, & Burrows, 2014).

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¹ One study in a student sample reported much higher rates of YFAS+ diagnoses (24%; Murphy, Stojek, & MacKillop, 2014).

Positive diagnosis on the YFAS has been linked to a range of other problem eating behaviors, including binge eating, emotional eating, elevated food cravings, impaired self-control around food, night eating syndrome, and eating disorder psychopathology in both community and clinical samples, with similar findings reported when using the a continuous symptom score, i.e. the number of symptoms endorsed (Burmeister, Hinman, Koball, Hoffmann, & Carels, 2013; Davis et al., 2011; Gearhardt et al., 2009; Koball et al., 2016; Meule, Hermann, & Kübler, 2015; Nolan & Geliebter, 2016). Scores on the YFAS have also been associated with depression, anxiety, and attentional deficit hyperactivity disorder, weight and shape concern, and reduced quality of life (Brunault et al., 2016; Burmeister et al., 2013; Davis et al., 2011; Eichen, Lent, Goldbacher, & Foster, 2013; Koball et al., 2016; Meule, Lutz, Vögele, & Kübler, 2012). However, the existence of “food addiction” remains highly contentious among the scientific community, with some authors questioning whether the mechanisms underlying “food addiction” are equivalent to those seen in more traditional substance use disorders (Long, Blundell, & Finlayson, 2015; Ziauddeen, Farooqi, & Fletcher, 2012).

In contrast, the concept of “food addiction” is widely accepted within the lay population. In a series of studies in students and staff of a UK university, only 6 of 364 recruited participants did not believe in the existence of “food addiction” (Ruddock et al., 2016; Ruddock, Dickson, Field, & Hardman, 2015). A qualitative study in a low-income, ethnically diverse US sample also found the concept of “food addiction” was almost universally accepted (Malika, Hayman, Miller, Lee, & Lumeng, 2015), supporting the generalizability of these findings.

2. Lay conceptualization of “food addiction”

Few studies have explored what the concept of “food addiction” means to those who self-diagnose as such and to the lay population in general. Hetherington and MacDiarmid (1993) reported that self-confessed “chocolate addicts” scored highly on items that would map onto DSM-IV criteria for substance dependence. However, when asked what made them feel they were addicted to chocolate, 76% responded that it was their inability to control consumption. No other criteria were widely endorsed. More recently, an online qualitative study reported that understanding of “food addiction” was similar in those who did and did not consider themselves to be addicted to food, with the most frequently mentioned characteristics being reward-driven eating, preoccupation with food, and a perceived lack of self-control around food (Ruddock et al., 2015). This result suggests that lay understanding of the term “food addiction” may be driven predominantly by perceptions of control around food, or eating self-efficacy. However, other characteristics emerging from qualitative studies include non-physiological eating, e.g. in the absence of hunger, frequent and uncontrollable food cravings, usually for specific, energy-dense foods, eating despite negative health consequences, and devoting time and effort to obtain the craved food (Malika et al., 2015; Ruddock et al., 2015), which are similar to the conceptualization of substance use disorders used in clinical diagnosis, particularly since the addition of “cravings” to the diagnostic criteria in the DSM-5 (American Psychiatric Association, 2013).

3. Prevalence of self-perceived food addiction

Limited evidence from studies of lay appreciation of “food addiction” suggests that self-perceived food addiction (SPFA) is more prevalent than food addiction measured using the YFAS (Corwin & Grigson, 2009). A website poll of overweight adolescents provided a definition of addiction as “feeling driven to a behaviour

even though the person knows that it will damage her/his health or social life”. Based on this description, approximately one-third of the participants believed they were addicted to food (Pretlow, 2011). In contrast, another study simply asked children and adolescents, “Do you think you are addicted to food?” Approximately one-third of the sample answered positively to this question (Merlo, Klingman, Malasanos, & Silverstein, 2009). However, this item was placed at the end of the questionnaire following a number of questions based on DSM-IV criteria for substance dependence, which may have influenced responses. Consequently, these studies might not have fully captured self-attribution of food addiction. Nevertheless, the previously cited study by Ruddock et al. (2015) reported a similar proportion of adults (29%) self-classified as food addicted, and this number was unaffected by the *a priori* presence or absence of a definition of “food addiction”.

4. Characterization of SPFA

Although SPFA appears to be prevalent in the general population, little is known about the characteristics of this “condition”, whether particular constructs can uniquely predict SPFA, or what distinguishes it from YFAS-diagnosed food addiction. It has been suggested that SPFA is not reflective of any addictive-like processes but rather may be a way in which individuals with low eating self-efficacy can explain, to themselves and others, their “failure” to control their intake, whilst attributing the problem to a biological mechanism rather than a personal weakness (Rogers & Smit, 2000).

Some support for the attribution hypothesis comes from an experimental study that randomly allocated 60 students to either a condition in which they read a sham newspaper article explaining that “food addiction” was “real” or one in which they were told that it was a myth, and, in effect, an excuse for lack of self-control (Hardman et al., 2015). Students were then asked if they thought they were addicted to foods. Subsequently, students in the “myth” condition were less likely to self-classify as food addicts than students in the “real” condition, although over a quarter nevertheless did so (27% versus 57%, respectively). The authors concluded that SPFA is simply a convenient external attribution to explain “problematic” eating behavior, whose use is abrogated by receiving disaffirming information about the existence of the construct. However, an alternative explanation is that participants may be unwilling to admit to a researcher that they may have a condition that they have just been told does not exist; this possibility is supported by the fact that the manipulation check regarding the belief that foods can be addictive indicated only neutrality rather than disagreement in the “myth” group, consistent with demand characteristics or embarrassment as much as with success of the manipulation.

Whether SPFA is indeed simply an attribution response to dysregulated eating behaviors or a construct that is related to YFAS-diagnosed food addiction, it is likely to be characterized by a range of cognitions and behaviors associated with disordered eating that distinguish it from the experience of individuals who do not self-classify as food addicted. Nevertheless, we would expect these cognitions and behaviors to be less severe than those reported by YFAS+ individuals, who, by definition, experience clinically significant distress or impairment associated with their condition.

4.1. Eating cognitions and behaviors

In terms of eating behavior, self-perceived food addicts are likely to report more dietary restraint, less reliance on internal signals to trigger eating, more eating in response to affective or situational cues, and lower eating self-efficacy, that is, low perceived self-

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