



A qualitative study of overweight and obese Australians' views of food addiction



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ABSTRACT

The concept of food addiction is increasingly used in the academic literature and popular media to explain some forms of overweight and obesity. However, there is limited evidence on how this term is understood by and impacts overweight and obese individuals. This qualitative study investigated the views of overweight and obese individuals on food addiction, and its likely impact upon stigma, treatment-seeking, and support for public policies to reduce overeating. Semi-structured interviews were conducted with 23 overweight and obese individuals ($M_{age} = 38$, $M_{BMI} = 33$, 74% female) and analysed thematically. The concept of food addiction was consistent with many participants' personal experiences, and was accompanied by high perceptions of control and personal responsibility. Some participants believed "sugar" or "fat" addiction to be more accurate. Others were reluctant to be described as an "addict" owing to perceived negative connotations and the belief that it would increase self-stigma. Food addiction was seen as a motivator for seeking psychological services, but not pharmaceutical or surgical treatments. In light of food addiction being perceived as plausible and relevant, participants supported targeted public health policies (e.g., taxes, regulations for junk food container sizes) but did not believe these would affect their own purchasing or consumption behaviours. Education for interpreting food labels and reducing the costs of healthy foods were endorsed, leading to positive changes in food-related behaviours. This research suggests discretionary use of the food addiction label in a supportive and educational manner to minimise stigma while encouraging treatment-seeking.

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1. Introduction

The prevalence of overweight and obesity is increasing globally

Abbreviations: BMI, Body Mass Index kg/m²; GPs, General Practitioners; YFAS, Yale Food Addiction Scale; yo, Years old.

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and is expected to affect 2.16 billion people by 2030 (Kelly, Yang, Chen, Reynolds, & He, 2008). Associated health costs have reached AU\$21 billion per year in Australia (Colagiuri et al., 2010). In the United States of America (USA), annual costs are expected to increase by up to USA\$66 billion/year by 2030 (Wang, McPherson, Marsh, Gortmaker, & Brown, 2011). Despite the growing prevalence of excess weight, there are currently insufficient effective long term treatments for obesity (Dixon, Logue, & Komesaroff, 2013; Fisher & Schauer, 2002; Whiting et al., 2013). Weight loss interventions, such as lifestyle (e.g. diet and exercise) and pharmacological treatments, are only modestly effective (Manning, Pucci, & Finer, 2014), while bariatric surgery is only suitable for a small

percentage of individuals with severe or complex obesity (Dixon et al., 2013). Unfortunately, for most obese and overweight individuals, the initial weight loss from these treatments is often followed by weight regain (Anderson, Konz, Frederich, & Wood, 2001). A number of leading obesity and addiction researchers have argued that some forms of obesity may be best understood as a consequence of, and treated as, an addiction to food (Avena, 2010; Gearhardt, Grilo, Dileone, Brownell, & Potenza, 2011; Volkow, Wang, Tomasi, & Baler, 2013). They argue that food addiction may explain the poor effectiveness of weight loss interventions and subsequent weight gain. The concept of food addiction (hereafter 'food addiction') has generated significant research and media interest (Gameau, 2015; Garth, 2014; Kontominas, 2015; Medaris Miller, 2015), but little is known about the impact that describing obesity as a food addiction would have on overweight or obese individuals.

The self-reported consumption of certain refined foods, such as those high in sugars and fats, by some obese individuals resembles the diagnostic criteria for drug addiction, including impaired control over consumption, greater than intended use, tolerance, and the development of a withdrawal-like syndrome following attempts to cut down (Avena, Bocarsly, Hoebel, & Gold, 2011; Davis et al., 2011; Ifland et al., 2009; Meule & Gearhardt, 2014b). There are also neurobiological similarities between drug addiction and models of obesity. The chronic consumption of refined foods produces changes in the reward pathway of the brain that are also observed in animal models of drug addiction (Avena, 2010; Epstein & Shaham, 2010; Ziauddeen & Fletcher, 2013). Laboratory studies have also shown that when given the choice, rodents will preferentially consume high calorie foods that lead to weight gain (Epstein & Shaham, 2010; Ziauddeen & Fletcher, 2013), a pattern of eating that continues even in the face of aversive stimuli (Epstein & Shaham, 2010), similar to behaviours seen in drug addiction.

These animal studies are consistent with neuroscience research in overweight or obese humans (Smith & Robbins, 2013; Ziauddeen & Fletcher, 2013). Brain studies in obese humans reveal structural and functional changes in executive functioning and decision-making similar to those seen in addicted individuals (Frascella, Potenza, Brown, & Childress, 2010). There are also comparable cognitive impairments in these two populations, such as impaired executive functioning, attention (Bechara, 2005; Fitzpatrick, Gilbert, & Serpell, 2013; Frascella et al., 2010), impaired inhibitory control (Barry, Clarke, & Petry, 2009; Gearhardt et al., 2011), and impaired reward processing, that likely contributes to chronic overeating (Smith & Robbins, 2013).

The validity and utility of the concept of food addiction, however, remains controversial (Carter et al., 2016; Davis et al., 2011; Gearhardt et al., 2011; Ziauddeen & Fletcher, 2013; Ziauddeen, Farooqi, & Fletcher, 2012). Supporters of the concept of food addiction claim that its adoption by clinicians and policy makers will result in better treatments and improved policy outcomes (Gearhardt et al., 2011; Volkow & O'Brien, 2007; Volkow, Wang, & Baler, 2011). They argue that a food addiction explanation may reduce the significant self-blame associated with being overweight by providing biological accounts that view the disorder as intrinsic rather than simply a poor choice (Pearl & Lebowitz, 2014). Proponents hope that the food addiction model of overweight and obesity will also reduce societal stigma (Latner, Puhl, Murakami, & O'Brien, 2014) and the discrimination experienced by overweight people (Gearhardt, Bragg, et al., 2012; Puhl & Heuer, 2009), both of which are significant barriers to treatment-seeking (McFarling, D'Angelo, Drain, Gibbs, & Rae Olmsted, 2011; Pescosolido et al., 2010). Some advocates argue that these changes will increase public support for population-level policies directed at reducing overeating, such as taxing and regulating the sale of energy dense

foods (Gearhardt et al., 2011; Pearl & Lebowitz, 2014). At present there is little public support for these measures (Lee et al., 2013), despite significant evidence of their effectiveness in reducing the use of other addictive commodities, most notably tobacco (Hall & Carter, 2013; Oliver & Lee, 2005).

Critics argue that treating obesity as a food addiction may have a number of potential negative consequences. Rather than reducing stigma, food addiction may in fact increase stigmatisation, as has occurred following neurobiological explanations of drug addiction (Pescosolido et al., 2010; Stice, Figlewicz, Gosnell, Levine, & Pratt, 2013). Increased stigmatisation may subsequently encourage emotionally-driven, maladaptive overeating (Gianini, White, & Masheb, 2013). Such "fixed" biological attributions may also erode individuals' self-confidence and belief in their ability to lose weight (Burnette, 2010; Pearl & Lebowitz, 2014), reducing the perceived importance of healthy eating (Hoyt, Burnette, & Auster-Gussman, 2014). By framing obesity as a "brain disorder" the food addiction hypothesis may foster overreliance upon individual medical interventions (Hardman et al., 2015). Similar medical explanations of obesity in the 1950s inadvertently increased stigma and undermined population-wide policies (Rasmussen, 2012, 2015) and created a surge in membership of weight-loss groups that failed to have a significant impact on obesity (Parr, 2014). The suggestion that food addiction is an individual flaw may further undermine support for population wide policies such as those that change the food environment by regulating portion sizes and the cost or availability of energy dense foods (Pearl & Lebowitz, 2014). The public may view these as ineffective if they are not seen to address what is understood to be a neurobiological addiction (Iselin & Addis, 2003).

Despite the competing predictions about the likely clinical and social consequences of the use of food addiction as a diagnostic category, there has been very little research on the views of those most directly affected by the concept, namely overweight and obese individuals. The present study employed a qualitative research methodology to examine the perspectives and attitudes of overweight and obese individuals. Specifically, it aimed to examine: (a) attitudes towards the concept of food addiction; (b) whether food addiction explanations of obesity affect discrimination, control, and responsibility; (c) how the use of the concept of food addiction influences treatment-seeking behaviour, particularly medical interventions; and (d) possible uses for the food addiction concept in improving public health and addressing overeating.

2. Method

One-on-one semi-structured interviews were conducted with 23 individuals over 18 years of age with self-reported Body Mass Index (BMI) > 25. Participants were recruited to explore differences in the way that individuals view the concept of food addiction across a range of weight ranges. The participants were recruited from: (a) an obesity clinic that specialised in surgical treatments (among other treatments), and (b) an online advertisement through Monash University accessible to the public. We employed a purposive sampling approach to recruitment (Sarantakos, 2005) to ensure that the sample included individuals of both sexes and various ages, with a broad range of weight-loss experiences, including self-managed or no assisted weight-loss attempts, as well as those in clinical treatment (including for bariatric surgery). It became apparent during the piloting of the interview that people with different weight-loss experiences viewed their weight differently and held different attitudes towards treatment. Participants were provided with a gift card in recognition of their travel and time. Ethics approval was obtained from the Monash University Human Research Ethics Committee.

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