The Disease of Processed Food Addiction:
Treating the Cause not the Symptoms…
A perspective

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The disease of processed food addiction continues to suffer from a world of misunderstanding, ignorance, and denial by individuals whose reactions are in direct contrast to that of a processed food addict. As a result, those with the responsibility of diagnosis typically try to treat the symptoms rather than the cause.

Processed food addiction appears to be one of the basic causes of diseases such as obesity, diabetes, hypertension, cardiac disease and mental health illnesses with research demonstrating strong correlations between processed food addiction, obesity, type 2 diabetes, and psychological distress (Raymond, Kannis-Dymand, & Lovell, 2017). However, the medical and health professionals perceive these diseases as the primary illness which disparages the viewpoint that there is another cause to such illnesses.

Generally, the 'professional' does not look at the disease of processed food addiction, but instead, treats the secondary disease process such as obesity which is a cardinal symptom of processed food addiction. (Raymond, Kannis-Dymand, & Lovell, 2016).) The time, expenditure, research and differing notions to illicit other causes of such chronic illnesses continues to allude society. Contempt prior to investigation maybe at play.

The probability of exploring a root cause to these secondary diseases is challenging as very little is known about the disease of processed food addiction as it has been overlapped with other disordered eating diagnoses. Trying to control what one ingests, is analogous to trying to control an alcoholics drinking which is absurd if that person suffers from the disease of alcoholism. History reiterates time and again many and varied approaches in treating the symptoms of alcoholism by trying to control ones drinking of liquor including; religious approaches, psychiatric treatments, drug substitution, harm reduction strategies, psychoanalytical practices, to name but a few (Raymond, Lovell, & Hsueh-Chih Lai, 2020). For those cases who suffered from the physical allergy and a mental obsession associated with alcoholism, the result was always nil. This is similar in today's society for processed food addiction. For centuries society has also been trying to find the next 'cure' or 'quick

fix'. There is no cure for the disease of addiction—it can only be treated (like other chronic diseases).

In the medical and health services today, the focus is on trying to control what the processed food addict is ingesting (for e.g., by implementing diets, food plans, exercise) that is the healthcare practitioner is laboriously working on the symptoms and the secondary illnesses whilst disregarding the disease of addiction—processed food addiction. The general signs and symptoms of *addiction* such as craving the processed food coupled with no willpower to stop ingesting in spite of having to meet lifestyle commitments (work and family responsibilities – life becoming more and more unmanageable), tolerance (needing more and more processed food to get the chased after effect) and withdrawal (depression, anxiety and stress symptomology), (American Psychiatric Association, 2000) are ignored.

Let's take for example a typical case where a patient presents with symptoms of pneumonia. The clinician treats the pneumonia, observes the temperature subsiding as the patient leaves the practice or hospital and then informs them to return immediately if any further complications arise. The clinician *does not* treat the high temperature (the symptom) and then send the patient home telling them now that their fever is down, watch that 'pneumonia' (primary illness).

Regrettably, this is what I observe globally is happening with those individuals presenting with ingesting (processed food addiction). The clinician takes care of the symptoms of the secondary disease are taken care of telling the patient, "Your weight is normal, now watch that ingesting."

The same can be said for someone suffering from chronic depression, anxiety, and or stress. A person grieving for the loss of a parent, for example, may start going to several take-a-way joints for breakfast as she is sad, bereft, and lonely, and because ingesting processed food abates some of those emotions. If the individual does not have the predisposition of processed food addiction, she will be able to moderate and control her ingesting of processed food as time heals the psychological injuries, enabling her to cope with her emotions. She will also be able to come off medications that have helped her over this time of grief.

However, for a processed food addict, they *will not* under any circumstance be able to control their ingesting and use of processed food to cope with life. The key points to focus on here is that the *non*-processed food addict does not experience a physical need to ingest more and more often; *non*-processed food addicts do not experience a mental obsession coupled with a physical allergy to ingest more and more often, and they do not experience the withdrawal symptoms that increase in severity as they continue to ingest. Non- processed

food addicts never experience the need to ingest to relieve the physical and mental anguish of not ingesting. Not ingesting, in other words, is the more comfortable choice for the non-processed food addict, but the more agonizing choice for the processed food addict.

The biggest hindrance in society today for an addiction diagnosis to be made is the challenges associated with recognising the early stages of this malady as they are so subtle and easily confused with normal reactions to processed food. There appears to be no observable physical or psychological dysfunction. Just like the non-processed food addict, the processed food addict does not have any reason to complain. She may go on and off diets like her peers, try the latest exercises, smoke, or overindulge (binge) on a Friday night or weekend, but she does not suffer abnormally when she ingests or after she ceases to ingest. Hence, she is perceived to be 'just like' her peers and family. She puts on weight when she binges, but so do her non-processed food addict peers. She enjoys ingesting and looks forward to her Saturday dinner parties that go on all night, but this is no different to her friends.

Because there appears to be no symptomology of the disease in the early stages, the logical but erroneous belief persists that processed food addiction begins only when the processed food addict suffers from some deterioration in physical functioning, such as severe withdrawal symptoms, changes in character, or demonstrates definite signs of her inability to control or moderate her ingesting of processed food. But until these visible symptoms appear, most people assume processed food addicts and non-processed food addicts experience the same physical reactions to processed food.

As the disease of processed food addiction progresses, her symptomology exacerbates to include twisted, dramatised and illogical thoughts, emotions and actions. The processed food addict lives in a dichotomous world of thinking and feeling – either extremely happy or severely depressed, loving or cold-hearted, angry or serene, in a state of heightened anxiety and stress or life is blissful and under control. They also live in a polarised world of actions – either flat out or full stop, 110% effort or none at all, on a diet or off a diet, bingeing or starving (Raymond, 2019). Unfortunately, these symptoms are, in far too many cases, misconceived as the causes of the processed food addict's uncontrollable ingesting, rather than the actual consequences of the physiological allergy and mental obsession that the processed food addict has no control over.

In the diagnosis, treatment, and recovery from any chronic disease, it is crucial that the cause of the symptoms be investigated – ruling out secondary symptoms. In the future (sooner rather than later), I believe those in the addiction arena will become more and more

aware of the 21st Century phenomenon known as processed food addiction investigating more in this area as they come to know and understand this malady in all of its many and varied facets.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Raymond, K-L., Kannis-Dymand, L., & Lovell, G. P. (2016). A graduated food addiction classification approach significantly differentiates obesity among people with type 2 diabetes. *Journal of Health Psychology, 1-10,* doi: 10.1177/1359105316672096

Raymond, K-L., Kannis-Dymand, L., & Lovell, G. P. (2017). A Graduated Food Addiction Classifications Approach Significantly Differentiates Depression, Anxiety and Stress among People with Type 2 Diabetes. Diabetes Research and Clinical Practice. 132, 95-101 http://dx.doi.org/10.1016/j.diabres.2017.07.028

Raymond K-L (2019) *Processed food addict: Is this me?* Australia: KLWR publications. URL: https://www.amazon.com.au/dp/B081TSBV27

Raymond, K-L., Lovell, G. P., & Hsueh-chih Lai, S. (2020). Alcoholism–History repeats: Processed food addiction, a 21st Century Phenomenon. K-L A: Brisbane Australia. Retrieved from: https://addictionology.com.au/publications/