The Disease of Processed Food Addiction:
Aka – Peínamania

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1. A Parallel to Dipsomania

A plethora of information exists on the origins of alcoholism, with evidence of fermented or alcoholic beverages dating as far back as the early Egyptian civilization and around 7000 B.C. China. In fact, the Bible posits alcohol as a gift from God that makes life more joyous, however, warns against the dangers of 'over-indulgence' leading to drunkenness and immoral and unethical behaviour – sins (Foundation for a drug free World, n.d.).

Understandably, the beginnings of addiction pathology are entwined with the global and increasing need for answers to the many questions relating to why certain individuals appear unable to control their intake of alcohol and other substances (Raymond, 2019, p. 2).

The term "dipsomania" is a historical nomenclature of the pathology involving an uncontrollable craving for alcohol, and continues to be significant in promoting a disease theory of chronic inebriety. The etymology of dipsomania comes from the Greek word *dipso* meaning 'thirst', whilst the etymology of *mania* transpires from the Greek and Latin words denoting madness, frenzy, mad passion, fury and insanity, with derivatives referring to the qualities and states of one's mental cognitions. Joined together, the Greek term *dipsomania* delineates an addiction to alcohol (online Etymology dictionary, n.d.). Thus, an individual presenting with dipsomania is diagnosed as a dipsomaniac.

In parallel, the etymology of Peína in Greek translates to English as hunger, synonymous with craving, longing, yearning, eagerness, of desire, fervency, appetite, and greediness. Peína combined with the etymology of mania is peínamania, which refers to an uncontrollable hunger for processed food, delineating addiction to processed food (Raymond, 2019). Hence, I have coined the nomenclature for an individual with the symptomatology of processed food addiction as having the diagnosis of peínamania or a peínamaniac, congruent with dipsomania and dipsomaniac.

The purpose of this paper is to introduce the nomenclature of peínamania and peínamaniac – neologisms which I have pioneered by combining the Greek word for hunger, Peína, and the existing word mania.[1] In my view, it is a much needed term to differentiate processed food addiction from simply food addiction (which has a myriad of connotations). The clinical term peínamania for the disease of processed food addiction fills this void when it comes to the minority of individuals never being able to ingest processed food without sparking off a craving for more (see Raymond, 2019). This paper covers the Etiology of peínamania and uses the term peínamania interchangeably with processed food addiction throughout.

Etiology of Peínamania There is a principle which is a bar against all information,
which is proof against all arguments and which cannot fail
to keep a man in everlasting ignorance – that principle is
contempt prior to investigation.

Herbert Spencer (Alcoholics Anonymous, 1976).

[1] The word "peínamania" does not currently exist in online searches or dictionaries.

As a practitioner[2] clinically treating patients presenting with processed food addiction, and as a team, we present clinical and practical experience and insights for a disease of addiction that has hitherto been misunderstood as a chronic behavioural and cognitive disorder. Attempts to challenge the notion that addiction to processed food is a phenomenon analogous to alcoholism and not a 'behavioural or cognitive' disorder is typically met with misunderstanding and dismissal. The majority of people eating excessive amounts of processed food are processed food abusers, much like the majority of those who drink alcohol to excess are alcohol abusers, who can be treated using more conventional approaches such as Self-Help groups, individual therapies (e.g., Cognitive Behaviour Therapy, motivational enhancement therapy) and marital and family therapy (McKay, Hiller-Sturmhöfel, 2011). However, for a small proportion of these people, processed food consumption is an addiction.

There are numerous labels depicting processed food addiction or 'food' disorders, which are more in line with substance use disorders, although perhaps not the disease of addiction. The disease of peínamania is a unitary, non-communicable disease of addiction that stands alone, albeit, poorly understood by medicine, the myriad of health domains, therapeutic communities, religion, politics and society at large; although we acknowledge as yet, it has not been systematically studied like other chronic illnesses (not without lack of trying). Hence, for a minority, it is impossible for these individuals to control and enjoy their intake of processed food.

2. Differences between food abuser/over-consumption and peínamania Many people want to consume processed food without experiencing the primary symptom of weight gain - the number of diets and control methods, including exercise, naturopathy regimes,

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psychodynamic therapies, hypnosis, and weight loss surgery, that individuals, families, and communities partake in demonstrate this. However, for most people they have a choice to ingest processed food or not and are able to moderate or stop as they so desire. For those who have this choice, ingesting processed food is not a dominant factor in their lives and if the normal eater earnestly wishes to stop ingesting processed foods, they can and do. Conversely, over-consumption of processed food is different from processed food addiction, thus there is a particular class of ingesters (i.e., processed food addicts or peínamaniacs), who at a certain point in their ingesting career, experience a 'change' — this is to say they are overpowered by a mental obsession to ingest processed food, which then sparks off a physical allergy of the body that forces the individual to continue on ingesting beyond their mental control (Raymond, 2020; Raymond, 2021).

In the late 20th and early 21st Century, in particular, medical and health professionals have largely viewed *processed* food addiction and disordered eating as a symptom of an underlying psychiatric condition. It is a view that implies an individual suffering from processed food addiction can and will regain self-control over their increasing ingestion of processed food if such underlying problems were resolved. This perception that processed food addiction can be treated with conventional or popular methods such as dieting and exercise ignores the fact that peínamania is highly individual.

Symptomatology of Peínamania

The symptomatology of peínamania has specific and definite manifestations in all such cases. The peínamaniac (processed food addict) exhibits high anxiety which could be classed in the 21st century as Panic Disorder or Generalized Anxiety Disorder (GAD), with a predisposition for either euphoria (especially when the obsession to ingest kicks in to get the next bite) or depression (one of the many withdrawal symptoms following the binge), which

could also fall under a myriad of diagnoses in the DSM 5 (e.g., major depressive disorder, bipolar disorder). On the other hand, and contrary to the progressive nature of addiction, many individuals (for whom the phenomenon of craving is not present) can and do overindulge on processed food, however, they do not suffer the same debilitating reactions as the processed food addict.

Raymond (2019, p. 2) reports 'an addict may be classed as many things: weak-willed, gluttonous, stubborn, belligerent, and arrogant, on the other hand, sweet, nice and innocent, as if butter wouldn't melt in her mouth. But she will ingest processed food, not because she can, but because she is compelled to, which appears to be a supreme global paradox. Usually, when the peínamaniac (processed food addict) is "on a diet," just as an alcoholic (dipsomaniac) goes "on the wagon", she feels in control – until the uncontrollable obsession to ingest (drink) strikes and the craving (allergy) to binge (drink) rears up again.'

As peínamania progresses and reaches the point where it breaks outside the family, she herself observes what is transparent to all – when she ingests even a morsal of processed food she experiences an effect which is disproportionate to the amount ingested and different to what she used to be able to do. Moreover, it is not at all unusual, in fact, it is the rule for her to declare, "All through my teenage years and before I had children, processed food never affected me like this; I could keep my *weight* manageable" (Raymond, 2019, p. 23). Unfortunately, since the early-stage processed food addict appears asymptomatic, the logical but wholly erroneous notion persists that processed food addiction begins only when the ingester suffers from ingesting and exhibits a progressive decline in physical functioning, including the hallmarks of addiction - increased withdrawal symptomatology (depression, anxiety, stress, decreased tolerance for processed food); a complete shift in personality, and or an increasing inability to control her consumption of processed food. Unfortunately, the medical professions regard peínamania (under the banner of simply food addiction, food

abuse or misuse) coupled with a 'behavioural disorder label' as a chronic condition with detrimental outcomes, but within the voluntary control of the patient.

During endless periods of dieting (trying to control their intake of processed food), the *patient* develops an increased sense of fear, coupled with depression and what appears to be absent-mindedness, with an increased lack of 'disinterest' in former activities. As months and years go by, the processed food addict's cognitions and actions continue to be affected more and more, and the processed food addict heads towards a myriad of secondary complications such as cardiac disease, hypertension and type 2 diabetes (see Raymond, 2019, for further vignettes of processed food addiction – peínamania).

As an increasing awareness of the disease of peínamania (processed food addiction) transpires, an even greater burden of responsibility will be placed on the health professionals. The view that processed food addiction is a vice or a moral dilemma, rather than a disease, can be in part attributed to its relatively limited research focus. This orientation arises perhaps because data regarding processed food addiction have not been linked or investigated with the same fervency attached to other maladies that are no more serious and yet evoke more empathy, compassion and sympathy.

Symptoms of processed food addiction – peínamania – encompass *whole-body symptoms* (e.g., weight gain, isolation, insomnia, headaches, craving); *behavioural symptoms* (e.g., restlessness, agitation, self-destructive behaviour, no restraint); *mood symptoms* (e.g., discontent, guilt, low self-esteem, loneliness, boredom, self-pity, depressed, manic, euphoria, hedonistic, delirium or fear, depression, anxiety, stress, panic attacks); *secondary complications* (e.g., weight gain, diabetes, cardiac disease, some cancers), plus *Gastrointestinal symptoms* (e.g., constipation, irritable bowel syndrome, haemorrhoids, diverticular disease, vomiting). Also common among patients presenting with peínamania is the removal of their gall bladder, poly cystic ovarian syndrome (PCOS), restless leg

syndrome, infertility problems, gall bladder problems, obsession with weight, itchiness of the skin, as well as having a history of an insistent desire to ingest processed food even when not desired.

The majority of these symptoms overlap with the symptomatology of disordered eating, for example, binge eating disorder (BED), compulsive overeating, Bulimia nervosa and *food* addiction. In fact, this is the foundation and principal reason for pioneering the nomenclature of peínamania. In a previous paper I have stated,

'*In terms of research implications with regard to furthering the knowledge base in this topic area, developments in current understanding as well as application have been compromised by the inconsistent use of terms to describe addiction in the context of uncontrolled food consumption and addictive behaviours related to the ingestion of high calorie foods. We encourage future discussions in the 'PFA' domain to reach better agreement on this universal term for the construct of food and addiction.'* (Raymond, Kannis-Dymand & Lovell 2017, p. 99).

Unfortunately, very little has changed since 2017, with still a major emphasis on BED, disordered eating and simply *food* addiction. To reiterate, the value and contribution of this article is to facilitate a more coherent approach to the study and conceptualisation of peínamania (not to take away the importance of the professionals treating those individuals diagnosed with eating disorders). However, we are making a clear distinction between a disease and a disorder. In other words, separating processed food addiction as a malady from what the medical and health professionals have largely viewed as a symptom of an underlying psychiatric condition.

3. Conclusion

In this paper, we highlighted the multitude of labels currently used to describe excessive consumption of processed food, which we believe have hindered understanding and research on the distinctive nature of processed food addiction. We have, therefore, argued for a new term to clearly distinguish between disordered eating and an addiction to processed food. Specifically, we put forward "peínamania" and "peínamaniac" to denote processed food addiction and a processed food addict, respectively – in parallel to "dipsomania" and "dipsomaniac", which are used in relation to alcohol addiction. We have also described the defining characteristics of processed food addiction, recognising that many of its symptoms overlap with disordered eating and other mental health disorders. The capacity to accurately identify processed food addiction will help pave the way for increased recognition and understanding of this disease, and support future research and practice on its diagnosis and treatment.

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