Food addiction: process or substance disorder?

Dr. Vera Tarman, author of Food Junkies: The Truth about Food Addiction *joins us on Rebellion Dogs Radio # 10 to talk about eating and other process addictions*

INTRO: What do Maxwell House Coffee, Grape-Nuts cereal, Kool-Ade, Jello and Marlborough cigarettes all have in common? Well their formulas are engineered by chemists that all work for the same companies. Companies that continue to get sued over misleading us about the health issues of their cigarettes are now processing many of the foods we eat each day.

How about that; "Don't smoke, Suzzie, it's addictive and it will make you unhealthy," we say to our daughter as we pour her a bowl of yogurt that has more sugar than Honey-Nut Cheerios.

Have you ever heard of *bliss-point*? That's the term chemists that make processed foods call the perfect amount of salt, sugar and fat that will create craving in you for more, will play with your brain chemistry and be whispering to your addictive tendencies while at your next meeting, holding hands and reciting the Serenity Prayer.

Episode Ten of Rebellion Dogs Radio is please to invite Dr. Very Tarman to our show. Vera is Medical Director of Renascent Treatment Centres and she just authored a new book, *Food Junkies: The Truth About Food Addiction*. We talk about process addiction in general – sex, food, gambling etc. and discuss how and why eating disorders have divided the professionals.

Not long ago, buying yogurt or granola meant you were buying health-food. It's not so simple today. Food is engineered or designed to fight for stomach space against all the other consumer-goods companies. This episode of Rebellion Dogs Radio will help you get to know Dr. Vera better. Her experience with addiction might surprise you. If it's true that we are what we eat then we owe it to ourselves to better understand how the food industry is making *food junkies* out of us all.

REBELLION DOGS RADIO EPISODE 10 TRANSCRIPT: Dr. Vera Tarman, medical director of Renascent Treatment Centres[i] in Toronto Canada since 2006, has been working in the

field of addiction medicine since 1994. She has become a TV host and commentator and I'm hoping she'll soon become an avid podcaster, too.

Late in 2014 she had a book come out about her personal interest in addiction—food. Her book that I just finished reading is called, *Food Junkies: The Truth about Food Addiction*[ii].

You'll get to know Dr. Vera, shortly. In this show, we'll look at the broader topic of process addiction. Damian Thompson, in his book *The Fix: How Addiction is Taking Over Your World*, looks at how pervasive process and substance addiction is today, from iPhones to cupcakes to retail therapy. A self-identifying alcoholic himself, I have quoted Thompson in a previous blog. Damian Thompson has the skeptical journalist approach to addiction. He wonders how heroin addiction can be just like chronic alcoholism and how these can both be like a preoccupation with online pornography. If addiction is like being in love, then it's like a relationship—only an infatuation with a process or a substance that becomes the basis of our primary relationship, snubbing any human connection that comes between us and our fix.

In *The Fix*, Thompson shares from books in his own research shelf:

> "Perhaps the crucial feature of addiction is the progressive replacement of people by things. That deceptively simple statement is a brilliant insight, though I can't claim credit for it. It comes from Craig Nakken, author of the bestselling book called *The Addictive Personality*, who argues that addicts form primary relationships with objects and events, not with people.
>
> He writes: 'Normally, we manipulate objects for our own pleasure, to make life easier. Addicts slowly transfer this style of relating to objects of their interactions with people, treating them as one-dimensional objects to manipulate as well.'
>
> What begins as an attempt to find emotional fulfillment ends up turning in on itself. Why? Because the addict comes to judge other people simply in term of how useful they are in delivering a fix. And at some stage, everybody lets you down. Therefore the addict

> concludes that objects are more dependable than people. Objects have no wants or needs. 'In a relationship with an object the addict can always come first,' says Nakken."[iii]

Thompson goes on to describe how otherwise well adjusted people around him started behaving in just this way. Any of us who have been affected, maybe even traumatized by a betrayal of trust—sexual exploitation by a parent figure, feeling the brunt of an adult-rage-a-holism or suddenly losing a loved one—we start to consider how fallible the best intentioned humans in our life are and how much more dependable our rituals and substances can be to bring us bliss or oblivion.

"Bliss-point" is a term used in the food industry. When I interviewed our guest, Dr. Vera Taman a few weeks ago, she motivated me to pay attention to a book I had heard about, *Sugar Salt Fat: How the Food Giants Hooked Us*[iv] by Pulitzer Prize-winning investigative journalist, Michael Moss. He likens the food companies today to the tobacco companies of yesterday. They point to the consumer and download responsibility for obesity and other health problems while they use and manipulate science to sell the maximum amount of food to consumers. Moss learned the term "bliss-point," from food company chemists. *Sugar Salt Fat* starts with a story about a secret meeting of the world's largest processed food conglomerates to talk about obesity and other health problems that might come back to haunt them in the form of class action suits like tobacco companies are now facing.

Addiction is sometimes described like an allergy—an abnormal reaction to a normally harmless substance or for some of us, a process. Some addictions, behaviors that bring about harmful consequences can be stricken from our life. Heroin, cocaine, alcohol, we can live without these pleasures. But love, work, money and food we have to learn to get along with.

In Vera Taman's book she talks about her own experience with food addiction and recovery. She's not the only doctor to this, of course. Dr. Gabor Maté has worked with Vancouver East-side, skid-row intervenes drug users. He says if a doctor can be measured by how long his patients live then he's not very good. His patients die young from physical violence, opportunistic, infectious disease and drug overdose. This is the life and death of the drug addict. When speaking he asks his audience to re-frame their own attitude towards addiction. "Don't ask 'Why the addiction?'" he challenges. "Ask, 'Why the pain?" Without exception, his addict, delinquent and sex-trade patients are victims of child abuse or child neglect. Their addiction started as a coping mechanism for trauma and unmet needs. In the same way the Army

administers morphine to soldiers with Post-traumatic Stress Disorder; street addicts are self-medicating to achieve the same result.

Dr. Maté talks about his own compulsions/addictions, his workaholism and his obsessive/compulsive shopping habits. He shares his own story of being the small child of a Hungarian Jew during the rise Nazi invasion. He connects a distracted, distraught and overwhelmed mothering to his own feeling of being a burden; unwanted.

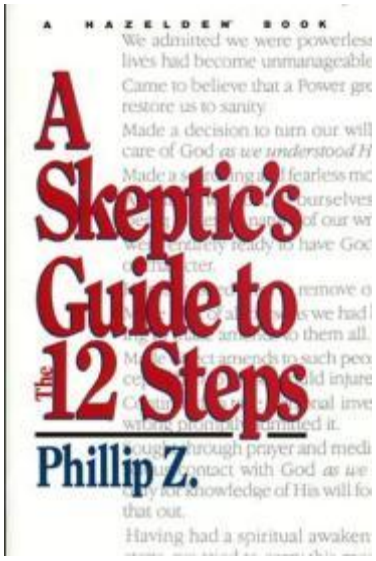
How does this play out for him as an adult professional in Vancouver, Canada? If he is going to be unwanted he's definitely going to be needed. He over-achieves professionally and as a absent, preoccupied father, he perpetuates the same environment for his own children that he himself suffered through. He publicly admits to leaving an expecting patient in labor to go to the music store to buy some Classical Music he was obsessed about. The hospital had to help the woman deliver the baby without him. Dr. Maté missed the birth of his patient's baby because he couldn't wait a day or few hours to get his CDs.[v]

Who can relate? Not showing up on time, not thinking our issue affects others: it rings a bell with me.

We all thrive from a sense of mastery. Everyone's sense of self is positively fed by doing well and being appreciated professionally. That's a normal reaction to a normal stimulus. Add unmet emotional needs to this cause and effect and an abnormal reaction comes from positive reinforcement at work. I bet that you know what I am talking about. For those of us with damage the buzz from a chocolate bar, a responsive lover or recognition from our community doesn't affect the psychologically damaged exactly the same way as it does, quote-unquote "normal" people. The initial rush gives us a temporary feeling of being important and mastering our

environment. Feelings are psychological and physical as well as emotionally. It can be intoxicating. It can create a need for more. More will never let us relive that first near perfect hit. More is always needed for diminishing returns. From feeling at one with the universe, we find ourselves trapped in a state of panic, secrecy and obsession and emotional isolation.

In the 1990 book, *A Skeptics Guide to the 12-Steps*, we find some common characteristics to Dr. Vera Tarman's book. Author Phillip Z. was a one-time clinical director for a family treatment program specializing in alcohol and other drug-related problems. He found himself with an eating disorder and his book is his atheists guide through the Overeaters Anonymous Twelve Step program. A few times I quote Psychologist Phillip Z in *Beyond Belief: Agnostic Musings for 12 Step Life.* Here is a quote from April 2. We see that Phillip Z shares another commonality with Vera Tarman, an affinity for a spiritual as well as a mental and physical component to eating disorders:



> "Unfortunately, we have come to depend on this quick solution, rather than experiencing and integrating many of the life's difficult challenges. As a consequence, we never fully matured. Abstinence is necessary for us, not just because of an allergy to alcohol or sugar, but because only when we begin to grow psychologically and spiritually. This is why coming to terms with my addiction must eventually involve spiritual work, the essence of which is the willingness to face, rather than avoid pain and suffering."

Philip Z's book draws on Junginan and transpersonal psychology as well as Eastern spirituality in his approach to overcoming addiction. These things, he sees are alive in 12 Step modality.

I was 2/3 of the way through Food Junkies when I attended the book launch of Food Junkies. No surprise I saw a a lot of friend from the 12 Step/12 Tradition community. Without ruining the punch line, I can tell you that from people I respect in 12 Step recovery, *Food Junkies* is an important missing link in the 21st century discussion of addiction and recovery. Let's go now to the busy office of Dr. Vera Tarman (pictured) in downtown Toronto:

JHC: Can you talk to us about what creates craving and how you differentiate between every-day overindulgence and addiction.

DrV: Let's work on the premises that the food industry already creates foods that are addictive. Foods are manufactured to be what David Kessler calls "hyper-palatable."[vi] There's another book by Michael Moss called *Salt Sugar Fat* where he writes about how the engineers in the food industry try to create what is called the bliss-point. That's the perfect amount of salt and sugar for chocolate or chips, etc. So it's intended to be addictive. Because of that, the line between normal eating, overeating and addiction is very muddy. We're talking about a toxic, addictive environment. If we were talking 100 years ago, this book wouldn't be needed. There might have been some who overeat but not enough to push it over edge. Everyone would be a smoker if we all smoked every day. But if the eternal environment only allowed you to do it every six months, say for a religious tradition, even the most addiction prone person won't become addicted. We live in an environment where you're expected to smoke or drink several times a day. We have the food engineers trying to design foods that are hyper-palatable, alluring; they are looking at how they can manipulate the neurochemistry. Let's look at that first and then look at the addictive mess-up—how we get re-wired.

We all have a *pleasure centre* in the non-thinking, mammalian part of our brain that we call the limbic system. The limbic system includes a three-part reward centre comprised of the ventral tegmental are, the key piece, the nucleus accumbens, and the front lobe. The nucleus accumbens, I teach to my students is the pleasure button. Everything that is pleasurable—normal or abnormal directly impacts it. So, if you wanted to remove pleasure, eliminate addiction just blast that out of existence.

JHC So people wouldn't eat for pleasure, they wouldn't run for pleasure…

DrV: No, they wouldn't do anything for pleasure. In fact, in the 1990s there was a drug—for food—that was manufactured and was relatively successful at reducing cravings but they took it off the market because people were killing themselves; the suicidality was too high. Why? It took away the joy and pleasure of normal life; who wants to live. You'll be thin, leave a beautiful corpse but it kind of defeats the purpose. So we have this nucleus accumbens. There are specific

neurochemicals that are involved in this process—the 'happy' ones that create pleasure—are serotonin, dopamine, and endorphins. Very simplistically, dopamine is the neurochemical that arouses curiosity and anticipation. It's what we all must have in order to want to get out of bed in the morning and know what to do next. 'What's going to happen,' 'what's in the paper,' 'what am I going to have for breakfast,' so you could say that a theory of depression is that there is a flattening, a blunting of the dopamine pathways. Dopamine is what we need to motivate ourselves, to want to know what's next. It's not the satisfaction one—it's the anticipation, the "I want." Any drug of abuse or activitity has to do with dopamine; it's the initiator.

Serotonin is a neurochemical that indirectly is impacted by normal behaviors. It has to do with satisfaction, contentment, what we consider as happy or grateful. Often people do stuff, with the motivator of dopamine because they want satisfaction in the end but they don't understand it's two separate pathways. Dopamine is the focus on the carrot. Serotonin is eating it but sometimes we crave and never get satisfaction. You can be constantly wanting, wanting, wanting (that's what drug use does) and never get what you want. That's why in recovery we have this making of a gratitude list. Go right to the satisfaction, forget the wanting. You can get there without wanting. And the other main neurochemical is endorphins. It takes away pain; it's the release of screaming or crying. It takes away pain physically or emotionally. If you hurt yourself, you get a flood of endorphins. It kind of takes away pain. We also get it other ways. It's the orgasmic release from sex. Also, painful as well as pleasant experiences—why do people do tattoos excessively, that kind of thing. It is very short-acting, just while we're in danger—that kind of thing.

What drugs do is they highjack the system by giving you an intense amount, quickly. You don't want the diluted normal; you want the heightened experience which is artificial. So the food industry is manipulating this very thing. 'How can we take normal foods and artificially make them more potent?' Like I always say, a Mars Bar is a drug because it's honey, it's sugar but not from the bark or the beehive, it's been taken out, it's been processed, concentrated and then put into a potent package called a Mars Bar.

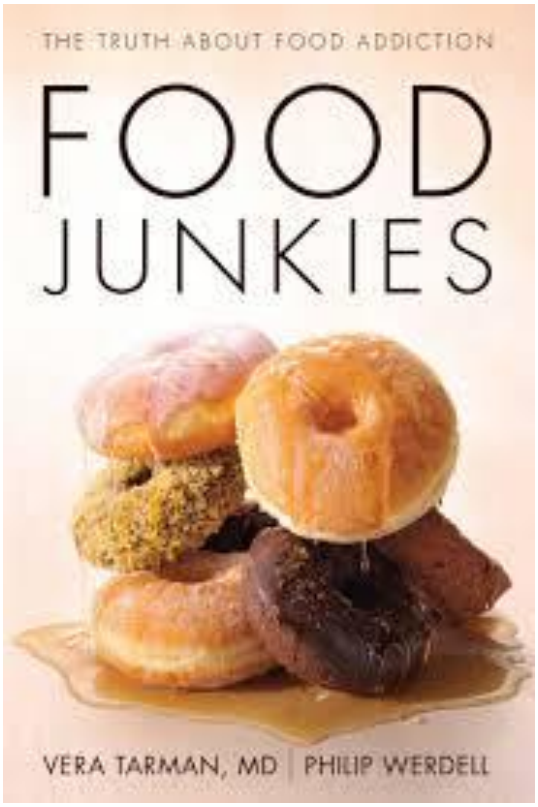
JHC: Even foods that used to be super healthy, once you could blindly buy yogurt and know it was healthy but now it might have more sugar than the Honey-Nut Cheerios.

DrV: Exactly and why is that? It's because that yogurt company is competing with all the other yogurt companies trying to get shelf-space and the only thing to do is to lure the unsuspecting or

even suspecting consumer; because it's happening in that part of the brain that is beyond intelligence so even for the person who knows I should buy this kind of yogurt, we say, 'Well, it's still yogurt.' We rationalize.

JHC: You expressed in your book that you're disappointed the Diagnostic Standards Manual (DSM-5) doesn't recognize food addiction—except for binge eating which is recognized as an eating disorder. But food addiction—no. What about other behaviors, other process addiction. Does the manual recognize sex or gambling or workaholism as an illness or disorder?

DrV: What happened with food addiction is proponents like myself—I wasn't actually there but colleagues of mine—went to the hearings to submitted all kinds of research and it wasn't outright rejected; they said, 'This is all very interesting but we need more. Binge Eating Disorder—they've been submitting papers for the last ten years now. We have thousands of studies that justify that this is a separate disorder. Come back in another five years when we do our revision and we'll see.' So it's really a question of not having enough research yet. We're making the argument that you have to start asking those questions and doing that kind of research and here's what happens. People keep getting redirected in the food/health industry. When someone comes in and says, 'Hey look; I have a problem with my eating.' They get referred to an eating disorder clinic and the clinic doesn't see it as addiction; it's a different paradigm. They'll look at you not as an addict but ask about a disorder. They'll ask, 'Are you anorexic; are you bulimic? Let's test you for Binge Eating Disorder.' You'll probably fulfill those criteria because many of them are the same as food addiction. But they're not looking at it as a paradigm *through the glasses*, as it were, of addiction. Now the people in the field—researchers and clinicians like myself are but we haven't managed to infiltrate into their ranks yet. So there's a bit of a paradigm class that's going on. It's still happening. We were disappointed with the DSM-5 because we weren't able to get that alternative perspective in. The problem with that is with



health insurance—you have to have a diagnosis to get insurance. Here in Canada, everyone has medical insurance but in the USA if there's no such thing as food addiction, you don't get the diagnosis and you don't have insurance to cover it. So what's going to happen in the States is that people will say, "Let's call this Binge Eating Disorder." We will treat food addiction as a sub-set of BED. They don't get exactly the treatment they need and it is just going to get messy.

JHC: The tail is wagging the dog then?

DrV: That's a perfect way to say it. If I can go back for a moment to a question you asked, 'How do you tell a food addict from someone whose just been *hooked* by the food industry.' Because I think we're all hooked. Even the person who's not a food addict, give them a spoon of *Häagen-Dazs* and they'll want the whole bowl. But the food addict will want three or four or five and as soon as you leave they'll go out and buy something else. That's where we feel food addiction fills the DSM-5 criteria for addiction: Do you lie about your food intake, do you hide your behavior, do you do all the addictive stuff we see with drugs and alcohol?

JHC: Are you ashamed, do you have remorse?

Dr.V: The shame, the lack of control—all of that. What makes a person a food addict as opposed to a 'non' is in the research; what makes an alcoholic an alcoholic and not a heavy drinker? There's probably a genetic issue, like a dopamine blunting response that you're born with. One of the things their looking at is a difference in dopamine-II receptors. There are other genetic variances as well. We've already identified these same characteristics in alcoholics, in food addicts. So there's a genetic piece. Also, I think, just like the more you smoke the more likelihood you are to become a smoker and the more you drink the more likely you are to become an alcoholic, similarly with food, the more we're exposed to this stuff, especially if you're already predisposed to really getting a bang from it—cause that's what happens to the addict: the more we are exposed to this stuff, the more susceptible we are to getting addicting. It's a continuum, and when you get past the point where all this behavior starts, that's when you can call someone an addict.

JHC: AA uses the John Hopkins "20-Questions" to self-diagnose for alcoholism. They are a combination of behavioral, emotional and intuitive questions. Is there the same thing for food-addicts?

Dr.V: Yes there is. My book has these things listed out. Just look up "20-Questions, Food Addiction" and the Food Addicts Anonymous. 20-Questions will come up. We now have a clinical scale. It's new; it's been peer approved, it's only been around a few years but they're starting to use it in research. It's called the Yale Food Addiction Inventory.

It's a big deal for us. It's a clinical tool we can all use to measure across many different samples and studies. Those questions are very much like the 20-Questions that 12-Step programs use.

JHC: There was always the comercial Weight Watchers and Jenny Craig and then there was Overeaters Anonymous. Now there's Food Addicts Anonymous, Eating Disorders Anonymous, Anorexics and Bulimics Anonymous …

DrV: There's GreySheeters Anonymous, too. I talk a little bit about the history of it in my book. I think it was the 1950s that OA started.

JHC: So, was it "a resentment and a coffee pot" that started the next meeting and then next—or maybe not coffee for some addicts…

DrV: There was a big split. It's almost an eating disorder paradigm. Some say get your emotional problems in order, do the Steps and the food will fall in line. Others said, 'Oh no, certain foods have to be cut out completely; you have to get rid of the chemical-irritant. 'I am allergic to sugar.' Or peanuts or whatever it is and you have to get rid of it, just like you have to do with alcohol, then you can do the program and stay clean. That kind of division just kept happening. Then there was the crowd that said, 'It's sugar but not flower'; another said, 'Flower, too.' One group says you have to measure your food—the next says, no, that's too rigid. It ended up being the treatment paradigms split the programs. It's unfortunate in one way because we don't have one solid fellowship like AA. In AA every group is anarchistic; they do things their own way but they are all part of the whole. We don't have it with food peer-to-peer groups. Some are writing their own books and not following the AA *Big Book* anymore. The good news is there is a great and substantial online presence in the eating 12-Step programs just as there is with AA and CA as well.

JHC: Like some of the other behavioral addictions. Like the sex and relationship programs; some are moralistic about certain behaviors and others are about self-diagnosing your problem and your bottom-line sobriety. There's SA, SAA, SLAA, Al-Anon, ACOA, Coda, and each has their own dogma. It seems the same idea is coming into play with the food thing.

Dr.V: Yeah, I think it's closest to sex because they have three or four strong programs.

JHC: I know a writing who is picking away at the disease-model for addiction. I'm not as fascinated with language—call it a disease, an allergy, a behavioral disorder—as a metaphor, disease works. I know it was said of Bill Wilson that he was more interested in alcoholics than in alcoholism—leave the qualifying and quantifying to the doctors and scientists, heredity, disease, whatever.

DrV: It like depression, you can say that depression is a disease—or not, it's clearly a disorder. It's a disorder that we can manipulate with neurochemistry but it's probably a lot more than that. I think alcohol and food is the same idea.

JHC: Now you do something not ever clinician does; you talk about your own experience, your own eating disorder.

DrV: Yes, that took me a long time to come to that place. I was quite happy to sit on this side of the desk and talk about addiction to the client, the patient. My own story is such that this is what has fueled my passion in this area, personally. It's my reason to get up in the morning. It's more than to work or make money; I am grateful that I have a message that I want to pass on. But still, I didn't have to tell my own story. However, people kept telling me that it's going to be more valuable to do so. It does worry me though. I continue to feel a bit uncomfortable because people—especially in the professional community—will discredit me. My reputation may be somewhat diminished. I guess, I don't know, I am still taking my chance there.

JHC: You're still agnostic about it all then?

DrV: Exactly, I've never been terribly comfortably with it but I am more and more willing to.

JHC: As a reader, I just warmed up to you in a way that I just don't when it's a clearly clinical description of the problem and solution. I read a lot of books. The personal stuff matters to the audience, although, I don't know what kind of audience you're trying to reach. On a peer-to-peer level you'll find some resistance but on a person to person basis this can only ingratiate people to you.

DrV: Good; that's what I'm hoping for. I hope you're right. I am willing to do it because of my passion.

JHC: But we'll see. It's not ready, aim, shoot; it's ready shoot, aim. I understand; you'll have to wait and see. Personally, I am nothing if I'm not ambivalent. I relate. And I really wanted to hear about that—how you were with revealing yourself like you've done. The OA membership survey tells us something about membership. In theirs survey 87% are women—almost converse to AA. There is a huge Caucasian base, while I am sure that food addiction isn't purely a Caucasian affliction. Is self-help a Caucasian reality, is it a culture thing? Why is there a disconnect?

DrV: That's a very interesting thing. There's a name of a book that I can't remember right now where they talk about the appreciation of disease in culture across different cultures. Anorexia, as an example isn't seen as a disease in Japan. It's something else—an entirely different thing. My publisher was going to a big book fair in Berlin and we thought, this is very topical right now—food addiction—in the states it's a big issue. But in Berlin they didn't care about it and we thought, 'how can that be?' but it really wasn't their issue there.

JHC: In the UK for instance there was blowback from the public when drinking was touted as a health problem. The people saw drinking as part of heritage—hardly a social problem. Don't mess with our heritage. So, don't be calling drinking an illness. Now, I don't know that it's systemic discrimination inside the fellowships so much as cultural differences. To some people, spilling our guts in front of total strangers, is perfectly okay and for some people, such things just aren't done.

DrV: Yes, it's an American thing, for sure. One thing you said was that the OA fellowship is women. I don't know if there has been a study done but it would be very interesting to make the distinction. In the general population—not the 12-Step population—men tend to pick up alcohol to relax, for their drug to self-medicate and woman turn to food. That might be why you have this strong instance of men in AA and women in OA. It's a cultural thing. Sure men will have an ice cream but they always have their beer, also. And for women, forget the beer, forget the sex, 'I just want the chocolates,' 'I just want the chips,' whatever.

JHC: And whether the reason for that is DNA, genetics or cultural, I guess it's unknown.

DrV: I would put my money on cultural. Years ago, if I was going to go where there was a lot of woman—and I'm sorry, this is going to sound sexist—I would wonder, 'What are they going to

be talking about—cooking or kids?' I didn't want to talk about either. And with men, it's football, it's sports or cars. Sorry listeners (lol), thankfully it's not like that now.

JHC: No, not as much. And the OA membership survey said that for over ½ of them, they recognize that they had an eating problem before the age of 16. It might not have shown to other people. They might not have been seeking help yet. But there it was. There's a drinking age, but there's no addictive food minimum age.

DrV: That's true. As you said that, it made me wonder about the boys (and their drinking). A lot of them talk about starting drinking at 12 but you're right, there's no eating age.

JHC: I talked to Dr. Tim Bilkey who specializes in ADHD. He said that with kids with ADHD, they have a 70% chance of developing a substance or process addiction. He sees smoking cigarettes as the gateway drug. He tells other doctors, 'Ask your 11-year-olds, do you smoke?' ask 13-year-olds, 'Are you sexually active?' The ones that are smoking, sexually active—those are your ADHD kids.

DrV: Yes, that's right.

JHC: Thumbs up on the book, by the way. Everyone should read it. Just like you can shake any family tree and a few drunks fall out of it, it's the same with eating disorders. There are food junkies in every family. Whether someone has a problem themselves, or not, we all know someone who is full of shame or remorse about their eating; the time is now and this is a good book.

Where's the best place for people to get your book?

DrV: Can I say one more thing before I tell you about that? I've done a lot of interviews now. I don't know how many times—maybe 2/3 of the time—after the mic is off, at the end of the intereview.they say, 'Have you got a meeting? Can I tell you about… (my sister), (my aunt) (me)? Where do I go, what can I do?' 'I have a problem…' I say 'Oh my God.' This is why I am okay about talking about this. It's bringing people out of the closet (or pantry) about their food addiction and I think, 'Wouldn't it be great if people started talking about it, because we could start helping each other.' Instead of say saying, 'You're trying to quit sugar? Oh come on, have some cake,' people might say, 'Okay, good; I'm trying to quit, too. Can you help me?'

Okay, so, where do you get the book. If you're in a large urban Canadian center, Chapters or Indigo will have it. Philip Werdel, who is the co-writer—he didn't actually write it but I used a

lot of his intellectual property—he's trying to get it in Barns & Noble in the States. But for sure you can get it on Amazon. You can get it on Kindle—it's dirt cheap on Kindle for a while. I just discovered that the other day. And on my own website www.addictionsuplugged.com you can get it as well.

JHC: Someone else you referred to in your book—Esther Helga Gudmundsdottir—they are doing some radical things in Iceland; can you tell people about that?

DrV: Where can you get help for food addiction now? Zip! Well there's a few places in the States that as well as alcohol and cocaine they also do food. And Phil Werdell also does a five-day out-patient retreat thing. But Esther Helga has actually got a center in Iceland for food addiction. She sees it as kind of a bridge place; 'Come here and we'll get you a food plan, we'll deal with the emotional part of it—because there's always an emotional component to food addiction. And within a period of a year I will link you up to the right 12-Step program—because you need something to help maintain sobriety.' What she's found is that a lot of people don't want to go off to the 12-Step stuff; they just want to stay within the groups that she's put together. Iceland is small and it's very innovative and the press is very open to what she has to say. I'm actually going there in a few weeks to talk to the press. She just has that magic ability to get that kind of exposure. It's a great social experiment that is going on there in Iceland with food addiction. It's very exciting.

JHC: Are doctors ready to help when someone says, "I'm a food addict; I'm concerned about my eating habbits"?

DrV: They're ready to hear it but what they're going to do is send you off to an eating disorder clinic. I did a talk to family doctors at a conference and they were really interested. But if I try to get the specialists involved, like I say, there's still that paradigm issue. The bariatric surgeons they are still installing the gastic bands and doing the gastric bypasses. There are still wanting to treat people with surgery and use a diet that is moderation based. They're not doing the food-addiction piece. So there's still a lot of work to do on that front. It's unfortunate but that's where we are.

JHC: People who are new to all this, when they read *Food Junkies*, will be moved by the first-hand accounts (case studies) and the shame and guilt, downward spiral and suffering that we know about with heroin and alcohol but isn't on everyone's radar with food. It will surprise a

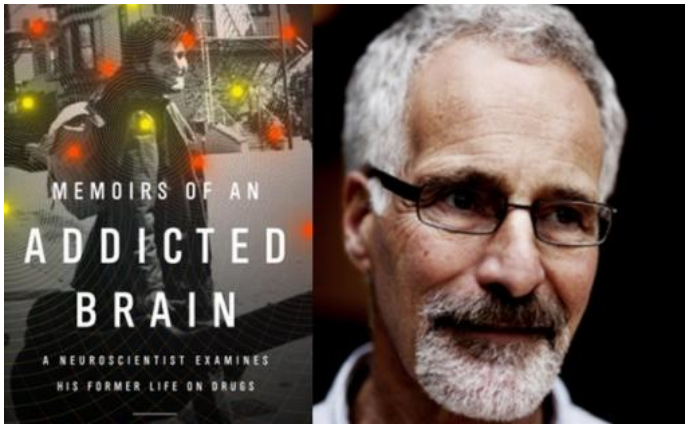
few people who think this is a simple matter of "Pull yourself up by your boot-straps; go jogging…"

DrV: Or 'Go on a diet."

JHC: Yeah. It's a great book and I hope everyone's talking about it a year from now.

DrV: I hope so too, and thank you for the opportunity to talk with you.

In *Food Junkies* as is the interview above, Vera talks about brain-chemistry and addiction.



Another addict/scientist who wrote about addiction and, as Vera did, made personal and scientific descriptions of the addict and addiction is Marc Lewis. Again, I've mentioned him in previous blogs as well.

Marc Lewis, in his *Memoirs of an Addicted Brain* chronicles the emotional and physical downward road of his own intravenous drug use. From the vantage point of a neuroscientist, Lewis gives us a rare, firsthand account of the brain chemistry causes and effects as well. Observe as he describes, not just the process of getting high—which he does with shocking candor in his book—but the process of longing to be high and loathing the obstacles in our way.

If the terminology is unfamiliar, focus instead on the emotional description of obsessive compulsiveness. In other words, if "striatal craving" or "amalgam consolidating, "doesn't paint a picture in your heard, the same message is getting through with terms like, "raw desire" and "incomplete soul" should ring a bell. At the point of this quote, we are over 150 pages into the book now so there are some scientific terms used that Marc Lewis previously defined.

> "Dopamine creates engagement with life's pleasures—both natural ones, like the taste of cheesecake, and unnatural ones, like the pulverizing fist of narcotic sedation. But when those pleasures are out of reach, when the goal is beyond your grasp, two things happen. First, if the goal remains attainable, anticipated by not yet present, dopamine flow gets

> stronger, energizing pursuit, turning orbito-striatal connections in the moment and entrenching those same connections over minutes and hours. In this way, orbitofrontal *value* is translated into *striatal* craving and with repetition, the value—craving amalgam consolidates into a lasting union, a dependency that drives away the competition, perhaps forever. When the object is just out of reach, that gush of dopamine feels like raw desire, a deep itch, the contradiction of an incomplete soul—whether the object of our desire is a girl or a drug. The second stage is when the goal is no longer anticipated, when you've given up. This stage brings the addict face to face with the world's other half: the not-so-good half. Because when the drugs (or booze, sex, or gambling) are nowhere to be found, when the horizon is empty of their promise, the humming motor of the OFC sputters to a halt. Orbitofrontal cells go dormant and dopamine just stops. Like a religious fundamentalist, the addict's brain has only two stable states: rapture and disinterest. Addictive drugs convert the brain to recognize only one face of God, to thrill to only one suitor. And without that purveyor of goodness, orbitofrontal neurons become underactive, sleepy, deadened."[vii]

So, if Marc Lewis' explanation of brain-firing during craving is hard to follow, I think every addict relates to being in a state of rapture or disinterest.

Vera talked about the DSM-5 and I went looking into how it dealt with process addiction. In the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Internet Gaming Disorder is identified in Section III as a condition warranting more clinical research and experience before it might be considered for inclusion in the main book as a formal disorder. Section III more than an Appendix. According to Psychiatric News, "Section III of *DSM-5* is where the revised manual is a "living document."

Vera talked about this as well. I like to always remember that we are part of continuum of care when it comes to addiction—we are always in flux and both findings and attitudes are in transition as we speak. So we are going to look at a process addiction through the lens of the DMS-5. But remember, there have always been more anecdotal ways of defining our own behavior. Vera mentioned a questionnaire in her book to assess ones own food addiction. Here's

a description of another process addiction—Sex and Love, as stated in the Sex & Love Addicts Anonymous literature called, "The Problem."

SLAA "The Problem"

> Many of us felt inadequate, unworthy, alone, and afraid. Our insides never matched what we saw on the outsides of others.
>
> Early on, we came to feel disconnected—from parents, from peers, from ourselves. We turned out with fantasy and masturbation. We plugged in by drinking in the pictures, the images, and pursuing the objects of our fantasies. We lusted and wanted to be lusted after.
>
> We became true addicts: sex with self, promiscuity, adultery, dependency relationships, and more fantasy. We got it through the eyes; we bought it, we sold it, we traded it, we gave it away. We were addicted to the intrigue, the tease, the forbidden. The only way we knew to be free of it was to do it. "Please connect with me and make me whole!" we cried with outstretched arms. Lusting after the Big Fix, we gave away our power to others.
>
> This produced guilt, self-hatred, remorse, emptiness, and pain, and we were driven ever inward, away from reality, away from love, lost inside ourselves.
>
> Our habit made true intimacy impossible. We could never know real union with another because we were addicted to the unreal. We went for the "chemistry," the connection that had the magic, because it by-passed intimacy and true union. Fantasy corrupted the real; lust killed love.
>
> First addicts, then love cripples, we took from others to fill up what was lacking in ourselves. Conning ourselves time and again that the next one would save us, we were really losing our lives.

Someone who identifies with some of that description of sex and love addiction might want to go to a few meetings, talk to a specialist or do some more reading. Here's a look at Gambling through the DSM-5 lens;

DSM-5 Diagnostic Criteria: Gambling Disorder

A. Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

    1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
    2. Is restless or irritable when attempting to cut down or stop gambling.
    3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
    4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
    5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
    6. After losing money gambling, often returns another day to get even ("chasing" one's losses).
    7. Lies to conceal the extent of involvement with gambling.
    8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
    9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

B. The gambling behavior is not better explained by a manic episode.

Specify if*:*

Episodic: Meeting diagnostic criteria at more than one time point, with symptoms subsiding between periods of gambling disorder for at least several months.

Persistent: Experiencing continuous symptoms, to meet diagnostic criteria for multiple years.

Specify if*:*

In early remission: After full criteria for gambling disorder were previously met, none

of the criteria for gambling disorder have been met for at least 3 months but for less than 12 months.

In sustained remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met during a period of 12 months or longer.

Specify current severity:

Mild: 4–5 criteria met.

Moderate: 6–7 criteria met.

Severe: 8–9 criteria met.[viii]

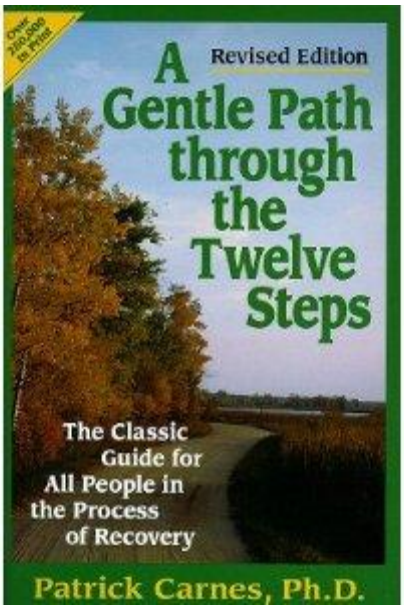
Dr. Stuart Gitlow is President of the American Society of Addiction Medicine blogged on January 2013 about the new DSM-5 in his post "When Will There Be Definitions and Terminology in Addiction Medicine?"

> "I've heard that it creates definitions for mild, moderate, and severe substance use disorders, something we've not had before and something I've never heard any of our members request. I can't see myself telling a patient that he has a 'moderate alcohol use disorder.' And I worry that an individual defined as having a 'mild' substance use disorder would not be able to gain access to treatments that would be available if he simply had a substance use disorder. What I've learned from patients is that addiction is something you either do or do not have. There's little middle ground. I've also heard that DSM-5 fails to correct the oversight of earlier editions that separate alcohol use disorders from other sedative use disorders. This means that by definition, individuals' alcohol use disorders are gone once they've switched from Bud to Xanax. They now have another disease state. And that is simply wrong.
>
> "But we've never said that formally. Isn't it time to do so? Isn't it time, now that we have our own Board and our own residencies and our very well established specialty of more than 50 years, to have our own set of terms and definitions?"[ix]

Another book on my recommended list is *The Gentle Path through the 12 Steps* by Patrick Carnes. Here's something Carnes says that really describes any addiction—process or substance:

> "Addicts and coaddicts live in the extremes. No middle ground exists. You as an addict are like a light switch that is either totally on or totally off. Life, however requires a rheostat, a switch mechanism in which there are various degrees of middle group. Mental health involves a disciplined balance that relies on self-limits and boundaries. Nowhere is that more evident than in the two core issues that all addicts (including coaddicts) face: intimacy and dependency."

We've heard already how addiction leads us away from healthy intimacy and dependency with people and we get our fix from stuff. Not only is our tendency towards opposite extremes important to confront as we confront Step One – the insanity and unmanageability of our lives, but we have to face these demons when we are rebuilding our lives, too. For those of us prone to extreme, Step Six and Seven are an invitation to replace chaos with rigidity. "Became entirely ready to have all our defects of character removed." Isn't that just a set up for over-controlling?



If any of you have heard me talk it's possible that you've heard me mock my own flawed track for recovery as I teeter-tottered from chaos to rigidity, never having musch time for the middle groups of life with some order and some spontaneity. "More is better," became a reflex for me – even in recovery. This was my analogy. Imagine having your bare foot in a bucket of ice. Put the other foot in a bucket of boiling water. On the average you'll be perfectly comfortable, right? Of course not! Nor is a life of binging and purging perfectly comfortable, be it on drinking, infatuation and objectifying or chocolate drizzled pecan pie or gambling, spending, food, debt, online gaming—you name it.

Sometimes an extreme is what's called for. When I quit drinking, moderation management wasn't an option for me. I'm an alcoholic. But if all you have is a hammer, everything looks like a nail and sometimes I applied this all-or-nothing attitude towards all of my indulgences. Sloth isn't the solution to workaholism. Isolation isn't a solution to sex or love addiction (or disorder

or imbalance or OCD if you prefer). This episode isn't about definitions or wording—important, I grant you, but a topic for another day.

The Gentle Path goes on to describe these extremes,

> "The chemical or experience becomes the trusted source of nurturing or a way to avoid pain or anxiety. All else is sacrificed or compromised. … In the grip of addiction or obsessive behavior, life becomes chaotic and crisis-filled. Addicts and coaddicts live in excess and on the edge. Because they do not complete things they have much unfinished business. They lack boundaries, so they often do not use good judgment. Others see them as irresponsible and lacking in common sense.
>
> The opposite excessive extreme is grounded in overcontrol. Sexual obsession, for example, can be expressed as either sexual addiction or compulsive abstinence. … An anorexic and a compulsive overeater are both obsessed with food. Overcontrol may be reflected in behaviors such as compulsive dieting and saving, extreme religiosity, phobic responses, panic attacks, and procrastination.
>
> For those with a strong need to control people, events or their emotions, life becomes rigid, empty ans sterile. Risks are to be avoided at all costs. The fear of beginning new projects or experimenting with new behaviors is sustained by harsh judgmental attitudes and perfectionism. Livng in deprivation may seem better than being out of control. But it is still an obsessive lifestyle that leads to loss of self. Recovering people can fall into a real trap if they switch from one extreme to the other and believe that the shift equals true change."[x]

So, *Food Junkies* by Dundurn Press: Rebellion Dogs Boosktore page can link you to the eBook or paperback. Or ask for it at your favorite bookstore. Thank you, Dr. Vera Tarman for being such an enthusiastic and generous guest. I hope we get to talk some more. For a list of all the books I've mentioned and links to some of the authors, visit RebellionDogsPublshing.com and look for Episode 10 on our Rebellious Radio page. We're going out with a song. This is one I wrote with my son, Jesse. It encapsulates relationship—to people and experience, the seemingly impossible balance of chaos and order, reacting and overreacting, intimacy and isolation. It's by the Chronicles, it's a driving song, it's called "Toronto to Miami."

Show notes for further exploration:

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[i] http://www.renascent.ca/

[ii] Tarman, Dr. Vera, *Food Junkies: The Truth About Food Addiction*, Toronto: Dundurn, 2014

[iii] Thompson, Damian, *The Fix: How Addiction is Taking Over Your World*, London: Harper Collins Publishers, 2012

[iv] Moss, Michael, *Salt Sugar Fat*, New York: Penguin Random House, 2014

[v] Maté, Gabor, Ted Talk, https://www.youtube.com/watch?v=66cYcSak6nE

[vi] Kessler, David A., *The End of Overeating: Talking Control of the Insatiable American Appetite*, New York: Rodale Books, 2009

vii Lewis, Marc, *Memoirs of an Addicted Brain.* Toronto: Double Day Canada, 2011 pp. 158 – 159

[viii] From the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (section 312.31)

ix http://www.asam.org/publications/president%27s-blog/asam-president%27s-blog/2013/01/27/when-will-there-be-definitions-and-terminology-in-addiction-medicine

[x] Carnes, Patrick, *A Gentle Path Through the Twelve Step*, Center City: Hazelden Foundation, 1993, pg. 8, 9.