Punti chiave
1. Le cause dell’Obesità e dell’Uso di Sostanze Psicoative sono complesse e specifiche per ciascun individuo.
2. Si apre la discussione se l’Obesità potrebbe essere considerata un disordine mentale che induce ad utilizzare criteri diagnostici simili a quelli impiegati per le Dipendenze.
3. Il nucleo focale del costrutturato diagnostico e le ricerche neuro-biologiche e psichiatriche si interfacciano con le Dipendenze che caratterizzano alcuni individui Obesi e con Disturbi Alimentari.
4. Le più recenti ricerche suggeriscono che esistono comunalità neuro-biologiche tra Obesità, Binge Eating e Dipendenze. E’ il Binge Eating una vera “Dipendenza”?
5. In aggiunta esistono comunalità comportamentali tra due condizioni: Obesità e Dipendenze sono associate a perdita di controllo per il cibo o per sostanze psicoattive e a “craving” (intenso desiderio di assumere una sostanza quale risultato di restrizione o di abuso in associazione con stato di malessere).
6. Le opzioni terapeutiche per l’Obesità hanno incominciato a tenere in considerazione queste informazioni per formulare Interventi Farmacologici e Psicoterapie Comportamentali che possono dare migliori risultati per la perdita di peso e per ridurre la frequenza del Binge Eating.
7. Le Terapie Farmacologiche nel campo delle Dipendenze possono dare informazioni per il trattamento dell’Obesità e viceversa?
8. Il management tradizionale del peso interferire positivamente o negativamente con il Disturbo Alimentare e con la Dipendenza da sostanze?
9. Il Sovrappeso e l’Obesità possono servire come fattori di protezione contro lo sviluppo dell’uso di sostanze considerando le comuni vie neurobiologiche operative?
10. La YFAS: Yale Food Addiction Scale: uno strumento da “italianizzare”

Programma
10.00-10.30 Accoglienza
10.30-11.00 1° Parte: La Clinica
Melchionda: Moderazione
11.00-11.30 Degli Esposti L, Tarrini G, Zanetti C: Analisi clinica ed epicrisi di un caso paradigmatico
11.30-12.00 Pasquali R: Il Reward Neuroendocrino
12.00-12.30 Cuzzolaro M: Implicazioni psichiatriche: Differenziale tra Binge Eating seguito o non da “purging”
12.30-13.00 Bonfà F: Il dropout: Esiste una relazione con i Disturbi Alimentari?
13.00-13.30 Pausa
13.30-14.00 2° Parte: La Terapia
Nizzoli U: Implicazioni della rete clinica integrata: Lo stato attuale di funzionamento
14.00-14.30 Giuntoli G: Implicazioni Psicologiche e Psico-terapeutiche
14.30-15.00 Mannato E: Implicazioni Farmacologiche
15.00-15.30 Interventi Preordinati
15.30-16.30 Dibattito Finale

Intervento Preordinato sul tema di 10 righe (carattere Courier 8) equivalente a 5’ e da inserire nel programma finale

Cognome e Nome
Obesity and Its Relationship to Addictions: Is Overeating a Form of Addictive Behavior?

VanBuskirk Katherine A, Marc N. Potenza

The Treatment of Obesity and Its Co-occurrence with Substance Use Disorders


1. Obesity and binge eating disorder are detrimental health conditions that are associated with lower qualities of life.

2. Individuals with obesity often face societal discrimination and frequently experience related medical disorders such as diabetes, hypertension, and hyperlipidemia.

3. Current research suggests neurobiological similarities between obesity, binge eating disorder, and substance dependence.

4. In addition, behavioral similarities link the two conditions: obese and substance dependent individuals often report similar features such as loss of control towards food or substances, respectively, and cravings.

5. Treatment options for obesity have begun to use this information to formulate pharmacological and therapeutic interventions that may provide greater results for weight loss and decreased binge frequency. Similarly, treatment approaches to substance addictions should consider aspects of weight management.

6. Findings from research and treatment studies are presented with the aim of reviewing the current literature of obesity within the context of an addiction framework and providing information on empirically supported approaches to the treatment of co-occurring obesity and substance addiction.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835148/

Eating Disorders Obesity and Addiction

Wilson G. Terence

Eat. Disorders Rev. 18 (2010) 341–351

1. An addiction model of both eating disorders and obesity has received increasing attention in the popular and scientific literature.

2. The addiction is viewed as a brain disease that must be directly targeted if treatment is to succeed.

3. Evident from laboratory feeding studies epidemiology genetic and familial research psychopathological mechanisms and treatment outcome research on cognitive behaviour therapy (CBT) is inconsistent with the clinical validity or utility of the addiction model of eating disorders.

4. Neurobiological research has shown commonalities in brain reward processes between obesity and substance abuse disorders.

5. Yet emphasis on apparent similarities overlooks important differences between obesity and drug addiction.

6. Interest in obesity as a brain disease should not detract from public health focus on the ‘toxic food environment’ that is arguably responsible for the obesity epidemic and related nutrition-based chronic disease.

http://onlinelibrary.wiley.com/store/10.1002/erv.1048/asset/1048_ftp.pdf?v=1&t=h6w42e8a&s=732108ce15fab8a069f37e9ccdf05d8c3814504c89

Obesity and Its Relationship to Addictions: Is Overeating a Form of Addictive Behavior?

Barry Danielle et al


1. This paper discusses similarities between obesity and addictive disorders, including common personality characteristics, disruptive behavior syndromes, and brain mechanisms.

2. Although there are important differences between overeating and other addictive behaviors, an addiction model of overeating may effectively inform prevention and treatment of obesity.

3. The conceptual model of substance addictions has begun to change, however, with an increasing emphasis on the behavior of substance use rather than the chemical properties of the substances themselves.

4. It is also becoming clear that repetitive engagement in many behaviors can lead to physiological changes in the brain similar to those observed in drug dependent individuаle.

5. According to recent models, addiction is a syndrome that can be expressed through a variety of specific behaviors. Overeating may be one of those behaviors.

6. First, we address whether obesity/overeating should be considered a psychiatric disorder with similar diagnostic criteria to substance use disorders.

7. We then discuss the implications of epidemiological and clinical studies showing positive and negative associations between obesity and substance use disorders in the general population.

8. Next we explore underlying characteristics and potential brain mechanisms associated with both overeating and addictions and point out important differences between overeating and addictions to drugs and alcohol. Finally, we discuss implications of an addictions model of overeating to prevention and treatment of obesity.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2910406/?tool=pubmed

Temporal relationships between overweight and obesity and DSM-IV substance use, mood, and anxiety disorders: results from a prospective study, the National Epidemiologic Survey on Alcohol and Related Conditions.


1. Nationally representative findings on the prospective relationships between overweight and obesity and DSM-IV substance use, mood, and anxiety disorders.

2. The main outcome measures were the incidence of DSM-IV substance use, mood, and anxiety disorders and changes in body mass index status during the 3-year follow-up period.

3. Overweight and obese women were at increased risk for incident major depressive disorder during the follow-up period.

4. Overweight men and obese men were at decreased risk of incident drug abuse and alcohol dependence.

5. Obese women had a decreased risk of incident alcohol abuse and drug dependence.

6. Men with drug dependence and women with specific phobia had a decreased risk of becoming overweight or...
obese.

7. Increased risk of major depressive disorder among overweight and obese women could be attributed to stigma and greater body dissatisfaction among women in Western cultures.

8. Overweight and obesity may serve as protective factors against developing incident substance use disorders possibly due to shared neural functions in the brain underlying addictions to numerous substances.

9. Results are discussed in terms of their clinical implications including the need to update treatment guidelines for the management of overweight obesity and major depressive disorder.


---

Taylor Valerie H et al.
The obesity epidemic: the role of addiction.

CMAJ, 2010, 182: 327-328

1. Although the cause of obesity is multifaceted, it is clear that chronic overconsumption plays a fundamental role.

2. When this type of overeating becomes compulsive and out of control, it is often classified as a “food addiction,” a label that has caused much clinical and scientific controversy.

3. The concept of addiction is complex, and the delineation of its defining characteristics has fostered considerable debate. Despite a lack of consensus, researchers nevertheless agree that the process involves a compulsive pattern of use, even in the face of negative health and social consequences. ____

4. ____ Interestingly, there is considerable overlap among the medications shown to interfere with food and drug abuse in animal models, and similar behavioural interventions – motivational interviewing, cognitive behavioural therapy and – step programs – are used in the treatment of both conditions.

5. The current “blame” mentality that is often applied to individuals with obesity needs to be reexamined.

6. Although medicine may not yet accept compulsive overeating as an addiction, we cannot ignore evidence highlighting the role played by biologic vulnerability and environmental triggers.

7. To do so would represent a clinical disservice.


---

Meule Adrien, Andrea Kübler
The Translation of Substance Dependence Criteria to Food-Related Behaviors: Different Views and Interpretations

Front Psychiatry. 2012; 3: 64.

1. The concept of food addiction proposes that there are similarities – both neurobiological and behavioral – between obesity (or overeating) and substance dependence and suggests that hyperpalatable foods could have an addiction potential.

2. One of the most highlighted arguments is that DSM-IV substance dependence criteria also apply to overeating provided they are modified with references to binge eating.

3. A reward deficiency syndrome is also considered reflected by a downregulation of striatal D2-receptor availability and concurrent hypersensitivity to palatable food-cues in obese individuals.

4. Ziauddeen et al. recently presented a critical evaluation of this food addiction model of obesity and overeating.

5. Some key conclusions are that a vast majority of obese individuals would not show a convincing behavioral or neurobiological profile that resembles addiction and that the evidence for an overlap with addiction would be inconsistent and weak even when the food addiction model would be refined to obese individuals with binge eating disorder (BED).

6. Specifically, the authors conclude that “food addiction may prevail in non-obese and not-yet-obese individuals” and that “obesity, particularly when assessed solely cross-sectionally by body-mass index, will be an unsatisfactory phenotype for food addiction.


---

Davis Caroline et al

Evidence that ‘food addiction’ is a valid phenotype of obesity

1. There is growing evidence of ‘food addiction’ (FA) in sugar- and fat-bingeing animals.

2. The purpose of this study was to investigate the legitimacy of this disorder in the human condition.

3. It was also our intention to extend the validation of the Yale Food Addiction Scale (YFAS) – the first tool developed to identify individuals with addictive tendencies towards food. Using a sample of obese adults (aged 25–45 years), and a case-control methodology, we focused our assessments on three domains relevant to the characterization of conventional substance-dependence disorders: clinical comorbidities, psychological risk factors, abnormal motivation for the addictive substance.

4. Results were strongly supportive of the FA construct and validation of the YFAS. Those who met the diagnostic criteria for FA had a significantly greater co-morbidity with Binge Eating Disorder, depression, and attention-deficit/hyperactivity disorder compared to their age- and weight-equivalent counterparts. Those with FA were also more impulsive and displayed greater emotional reactivity than obese controls.

5. They also displayed greater food cravings and the tendency to ‘self-soothe’ with food.

6. These findings advance the quest to identify clinically relevant subtypes of obesity that may possess different vulnerabilities to environmental risk factors, and thereby could inform more personalized treatment approaches for those who struggle with overeating and weight gain.

Highlights

1. Validation for the Yale Food Addiction Scale to identify those with addictive tendencies to food.

2. Obese food addicts show higher comorbidity with binge eating, depression and ADHD than controls.

3. Food addicts are more impulsive and show more addictive personality traits than controls.

4. Our findings have demonstrated strong parallels between food and substance abuse.


---

Degli Esposti L, Tarrini G, Zanetti C, Melchionda N

Seminario Multi-Professionale SISDCA E-RM DAO.USP
L’intervento si soffermerà sull’importanza semioologica del fenomeno binge eating e, insieme, sulle implicazioni psichiatriche: diagnostica, terapeutica e farmacologica, dell’attività ingestiva patologica e delle sue concomitanze nel quadro del disturbo bulimico nervoso. L’intervento si svolgerà in un contesto teorico-clinico, con un approccio di tipo semoologico e un’edificante analisi di casi pratici. 

Cuzzolaro M: Implicazioni psichiatriche: Differenziale tra Binge Eating seguito o non da “purging” 

1. Binge eating: sintomo trasversale, suoi legami con il disaggio del corpo e le dipendenze patologiche. 
2. L’incontro tra l’overeating, il bulimia nervosa e lo sviluppo delle patologie malnutrizione, la quale si manifesta con un’alimentazione impropriamente alimentare. 
3. Saranno discusse, in particolare, quattro temi, alla luce della letteratura più recente: rapporti fra Binge eating e obesità, BED e immagine del corpo, BED e food addiction, BED e chirurgia bariatrica. 

Umberg EN et al. 
From disordered eating to addiction: the “food drug” in bulimia nervosa. 

1. The high prevalence of substance abuse in individuals with bulimia nervosa (BN) and the pervasive symptom substitution in many types of drug addiction suggest that a number of substances-including food-can impair an individual’s self-control, even in the presence of negative consequences. 
2. Nonetheless, the neurobiological similarities between BN and drug addiction are not clearly established. This review explores how the specific eating patterns seen in BN (binge eating and obesity, purging, with intermittent dietary restriction) are particularly addictive and differentiate BN from other eating disorders and obesity. 
3. A number of peripheral and central biological aberrations seen in BN may result in altered reward sensitivity in these individuals, particularly through effects on the dopaminergic system. 
4. Neurobiological findings support the notion that BN is an addictive disorder, which has treatment implications for therapy and pharmacological manipulations. 

Berridge KC. 
‘Liking’ and ‘wanting’ food rewards: brain substrates and roles in eating disorders. 

1. What brain reward systems mediate motivational ‘wanting’ and hedonic ‘liking’ for food rewards? 
2. And what roles do those systems play in eating disorders? This article surveys recent findings regarding brain mechanisms of hedonic ‘liking’, such as the existence of cubic-millimeter hedonic hotspots in nucleus accumbens and ventral pallidum for opioid amplification of sensory pleasure. 
3. It also considers brain ‘wanting’ or incentive salience systems important to appetite, such as mesolimbic dopamine systems and opioid motivation circuits that extend beyond the hedonic hotspots. 
4. Finally, it considers some potential ways in which ‘wanting’ and ‘liking’ might relate to eating disorders. 

1. Food Reward: A composite process that contains ‘liking’ (hedonic impact), ‘wanting’ (incentive motivation), a learning (associations and predictions) as major components. 
2. ‘Liking’ (with quotation marks): An objective hedonic reaction detected in behavior or neural signals, and generated chiefly by subcortical brain systems. 
3. ‘Wanting’ (without quotation marks): The everyday sense of the word as a subjective conscious feeling of pleasurable niceness. 
4. ‘Wanting’ (with quotation marks): Incentive salience, or motivation for reward typically triggered by reward-related cues. 
5. Wanting (without quotation marks): A conscious, cognitive desire for a declarative goal in the ordinary sense of the word wanting. 
6. ‘Wanting’ without ‘liking’: A mechanism of drug addiction that leads to compulsive levels of ‘wanting’ for drugs. 

Bonfà F, Cabrini S, Avanzi M, Bettinardi O, Spotti R, Uber E. 
Eat Weight Disord. 2008 13(2):81-6. 

Treatment dropout in drug-addicted women: are eating disorders implicated? 

1. A high prevalence of eating disorders among drug-addicted female patients has been noted, and it could be associated to psychopathological underlying factors. 
2. Our aim was to assess eating disorder traits in women approaching a residential program for drug addiction. 
3. We hypothesized that these traits would correlate to more general psychopathological factors, and would influence treatment relapse. 
4. A sample of 204 substance dependent women attending a residential treatment was screened for psychopathological indices, and follow-up data were obtained at the end of the treatment. 
5. Clients had a high risk for eating disorders (15%), and lifetime prevalence was even higher (20%). 
6. Disordered eating was associated to psychopathological distress, in particular harm avoidance resulted significantly lower, evoking higher unresponsiveness to danger. 
7. Drug addiction treatment outcome is associated to completion of defined programs, and eating disorder was a key covariar in determining treatment relapse or success. 
8. Clinicians should be aware of this potential comorbidity, and concurrent treatments should be attempted, in order to prevent symptomatic shifting. 

Psychological Treatments for Binge Eating Disorder

1. The two specialty psychological therapies of CBT and IPT remain the treatments of choice for the full range of BED patients, particularly those with high levels of specific eating disorder psychopathology such as overvaluation of body shape and weight.
2. They produce the greatest degree of remission from binge eating as well as improvement in specific eating disorder psychopathology and associated general psychopathology such as depression.
3. The CBT protocol evaluated in the research summarized above was the original manual from Fairburn and colleagues.
4. Fairburn has subsequently developed a more elaborate and sophisticated form of treatment, namely, enhanced CBT (CBT-E) for eating disorders.
5. Initial research suggests that CBT-E may be more effective than the earlier version with bulimia nervosa and Eating Disorder Not Otherwise Specified patients.
6. CBT-E has yet to be evaluated for the treatment of BED, although it would currently be the recommended form of CBT.
7. Of relevance in this regard is that the so-called broad form of the new protocol includes 3 optional treatment modules that could be used to address more complex psychopathology in BED patients.
8. One of the modules targeted at interpersonal difficulties is IPT, as described earlier in this charter.

Psychological Treatments for Binge Eating Disorder

1. Binge eating disorder (BED) is the most prevalent eating disorder in adults, and individuals with BED report greater general and specific psychopathology than non-eating disordered individuals.
2. The current paper reviews research on psychological treatments for BED, including the rationale and empirical support for cognitive behavioral therapy (CBT), interpersonal psychotherapy (IPT), dialectical behavior therapy (DBT), behavioral weight loss (BWL), and other treatments warranting further study.
3. Research supports the effectiveness of CBT and IPT for the treatment of BED, particularly for those with higher eating disorder and general psychopathology.
4. Guided self-help CBT has shown efficacy for BED without additional pathology.
5. DBT has shown some promise as a treatment for BED, but requires further study to determine its long-term efficacy.
6. Predictors and moderators of treatment response, such as weight and shape concerns, are highlighted and a stepped-care model proposed.
7. Future directions include expanding the adoption of efficacious treatments in clinical practice, testing adapted treatments in diverse samples (e.g., minorities and youth), improving treatment outcomes for nonresponders, and developing efficient and cost-effective stepped-care models.
Manzano E: Implicazioni Farmacologiche

Review and meta-analysis of pharmacotherapy for binge-eating disorder.

1. This study evaluated available controlled treatment studies to determine utility of pharmacotherapy for binge-eating disorder (BED).
2. The authors identified randomized placebo-controlled trials testing pharmacotherapy-only treatments and controlled trials testing pharmacotherapy with psychotherapy treatments.
3. Meta-analysis was performed on placebo-controlled trials with data for attrition, remission, and weight loss.
4. Qualitative review was performed on remaining controlled treatment literature.
5. A total of 33 studies were considered of which 14 studies with a total of 1,279 patients were included in the meta-analysis of pharmacotherapy-only treatment and 8 studies with a total of 683 patients were included in the qualitative review of pharmacotherapy combined with psychotherapy interventions.
6. No evidence suggested significant differences between medication and placebo for attrition.
7. Evidence suggested that pharmacological treatments have a clinically significant advantage over placebo for achieving short-term remission from binge eating (48.7% vs. 28.5%) and for weight loss, although weight losses are not substantial.
8. No data exist to allow evaluation of longer-term effects of pharmacotherapy-only treatment for BED.
9. Combining medications with psychotherapy interventions failed to significantly enhance binge outcomes, although specific medications (orlistat, topiramate) enhanced weight losses achieved with cognitive behavioral therapy and behavioral weight loss.
10. In summary, BED patients can be advised that certain pharmacotherapies may enhance likelihood of stopping binge eating short term, but that longer-term effects are unknown.
11. Although some weight loss may occur, it is unlikely to be substantial with available medications.
12. Combining medications with cognitive or behavioral treatments is unlikely to enhance binge outcomes, but specific

http://www.nature.com/oby/journal/v16/n9/full/oby2008333a.html