

Food and Sex Addiction: Helping the Clinician Recognize and Treat the Interaction

CYNTHIA A. POWER

Life Enrichment Services, Inc., Wheaton, Illinois, USA

Of the several categories of process addiction—gambling, food, Internet, compulsive shopping, addictive athleticism, workaholism, and sex—two pertain directly to the very existence and continuation of human life, food and sex. Yet very little literature can be found on the recognition and treatment of these two vital processes when they become interactively addictive. This article addresses the need for clinicians to become aware of when food and sex addiction is interacting in a client's life and the need to have some specific methods with which to treat this co-occurring disorder. Definitions of six forms of eating disorders are given, ten types of sexual addictions are listed, and techniques for breaking through client denial and increasing client motivation for recovery are provided. Bibliotherapy recommendations and Internet resources are identified to additionally assist the clinician in treating the food and sex co-addicted client.

There was a time, in the not too distant past, when the Monday morning staffing of all the cases that came in over the weekend occurred in two separate rooms. Staff in room one were assigned all the mental health issue cases; those in room two took care of the drug and alcohol intakes. The fields of mental health and addictions were changed, however, when the truth of dual diagnoses was recognized and embraced. By the late 1990s the existence of multiple diagnoses and even multiple addictions was accepted. The lexicon of co-existing and comorbid quickly expanded to include co-existing pathologies (Amico, 1997), polysubstance dependencies (American Psychiatric Association [APA], 2000), and cross addictions (Johnson, 1999). In 1994 a significant revolution in treatment emerged (Carnes, Murray, &

Address correspondence to Cynthia A. Power, MA, LCPC, CSAT, Life Enrichment Services, Inc., 2238 Appleby Drive, Wheaton, IL 60187. E-mail: Cynthiapower@aol.com

Charpentier, 2004, p. 31) when Patrick Carnes introduced his model of addiction interaction. Not only do addictions co-exist, they also interact. It is true that each addiction can be treated separately. The fact that they interact, reinforce, and become part of one another, however, makes them a powerful package, which, as Carnes so forcefully argues, needs to be treated as an interaction disorder. A major relapse factor is the failure to recognize and treat companion addictions that are part of the addictive process. (Carnes, Murray, & Charpentier, 2004).

As a clinician treating eating disorders since 1979 and working with sex addicts since 1986, this author has been especially interested in applying the addiction interaction model to that population of clients suffering from both food and sex addictions. A review of the literature reveals a multitude of articles on food addiction and a proliferation of research and articles on sex addiction, but a veritable dearth of material on the interaction and/or treatment of these two specifically co-existing disorders. What little was found is encouraging. One was by Schneider and Irons (1997), entitled "Treatment of Gambling, Eating and Sex Addictions." Carnes (1989) noted that significant parallels exist between sex addiction and eating disorders, and indicated the two disorders can co-exist within a person or between a married couple. Also found were two books that devoted a few pages to the subject: *No Stones* by Marnie Ferree (2002) and *Women, Sex and Addiction* by Charlotte Kasl (1989). A large study of 9,313 male and female college students has just recently been completed, looking at the interactive relationship of drugs, sex, and love from the perspective of dependency/addiction (Eisenman, Dantzker, & Ellis, 2004).

When Carnes did his landmark study of 1,000 inpatient sex addicts, 38% reported also having eating disorders (Carnes, 1991). Kasl, in her work with women, describes sex and alcohol (or drugs) being the most common addiction ritualized together, "with sex and food running a close second" (Kasl, 1989, p. 171). This article, then, is an added attempt to remedy the lack of published information on the interaction of food and sex addiction, to encourage needed research with this population and especially to alert clinicians, working with sex addicts, to recognize the too commonly overlooked or minimized parallels and interactions of food and sex addictions.

FOOD AND SEX AS ADDICTIONS

Readers of this Journal will be very familiar with recognizing, understanding, and treating excessive and compulsive sexual thoughts and behaviors as sex addictions. The concept is gaining wider recognition in the non-professional world also, with Cybersex titles on store magazine covers and whole sit-com shows devoted to sex addiction themes or characters. The same cannot be said for the eating disorder field, where controversy, strong divisions,

and debates continue over whether food and eating problems are illnesses, disorders, compulsions, or addictions. For a lucid description of the addiction model of eating disorders, along with clarification of how the OA (Overeaters Anonymous) 12-Step Program handles the concept of abstinence while having the client continue to eat, the reader is referred to the insightful chapter, "Understanding and Diagnosing Eating Disorders" in the *Handbook of Addiction Disorders* (Garner & Gerborg, 2004). Should the reader also wish for a more specific explanation of food as an addiction, Anne Katherine's *Anatomy of a Food Addiction* is fast becoming a classic on this matter (Katherine, 1991). For the purposes of this article, food addiction and eating disorders as an addictive process are posited as clinical realities.

This author identifies eating disorders as both substance and process addictions. Some clients evidence addictions to specific foods such as sugar, chocolate, or starches. Addictive features, such as loss of control, preoccupation with a food or foods, secrecy and lies around the food or eating habits, and continuation of the behaviors despite adverse consequences are readily seen. Some clients even manifest addictions to brand names or to a certain ritual of preparing a given food. In the absence of that brand or the inability to prepare a food in a specific way, withdrawal symptoms of anxiety, distress, and/or depression are marked. For some other clients, disordered eating is truly a process addiction, in which food (whether eaten or refused, binged or abstained) is mood altering. Angry clients need to chomp, chew, or masticate hard, chewy substances, no amount of cottage cheese will do it. Depressed clients reach, most subconsciously, for sugars and caffeine and other foods that stimulate. Loneliness is often artificially assuaged with bulky, fill-up-the-stomach foods. Total restriction of intake, as in anorexic clients, can also serve to alter moods, reduce anxiety, or provide a false sense of power.

Carnes, in his Gentle Path Press video entitled "Addiction Interaction Disorders: Understanding Multiple Addictions" (1999), and again in the co-authored chapter from the *Handbook of Addiction Disorders*, "Addiction Interaction Disorders" (Carnes et al., 2004), gives the example of Catherine who alternates between her food and sex addictions. He so clearly describes the alternating addiction cycle as Catherine goes from promiscuity and being food anorexic to compulsively overeating and being sexually anorexic, over and over again, through three marriages. Her 100-pound weight changes were most obvious and hard to deny.

Helping Clients See the Interaction

For many clients, the food-sex interaction is initially less recognizable, by either the therapist or the client, and needs to be ferreted out by effective questioning. Besides the basic questions, inherent in any thorough intake process, concerning the presenting problem(s) that brings a client to the therapeutic situation, questions need also be asked, such as:

"Do you ever skip meals to pursue sexual activities?"

"Do you have an urge to eat something when you experience a sexual frustration?"

"How many times have you used food to obtain sex?" (Our culture has not been helpful here. Many a young girl has been taught the fairly manipulative adage, "The way to a man's heart is through his stomach" and many a young man has learned, "Take her to a nice restaurant and you can have her for dessert.")

"Do you recognize how food and sex is combined or interacts in any way in your life?"

"How much does your sense of being attractive or desirable depend on your size, weight, or appearance?"

"Do you find your self losing weight at the beginning of a relationship? Or gaining weight as the relationship continues?"

Answering questions such as these is often eye opening to the client, who, may for the first time, begin to see the interaction of his or her food and sex addiction. Being creative with questions, the effectively probing clinician can uncover a lot of addiction interaction information in just the initial interview.

Helping Specific Client Types

Clients also present on the spectrum from denial to full awareness of their food-sex interactions. In the author's experience, five different situations commonly occur:

Client A comes in, already aware of his or her food and sex addiction, wanting help to address both issues simultaneously. Of course, this level of motivation is every clinician's dream. The author has found *A Gentle Path Through the Twelve Steps: The Classic Guide for All People in the Process of Recovery* (Carnes, 1993) to be exceptionally suitable for treating addiction interaction disorders. Food and sex are necessary for the procreation and survival of the human race; total abstinence is not an appropriate goal in treatment of either of these addictions. Doing homework that directs both human needs towards moderation and health (healthy sexuality, healthy eating) certainly facilitates the therapeutic process. Exercises from *A Gentle Path* provides such homework. The *Facing the Shadows* workbook (Carnes, 2001) likewise offers numerous exercises suitable for use with the food and sex addict. Often with merely a one-word addition pertaining to food, exercise, purging, or bingeing, a sexual addiction exercise is transformed into a food and sex addiction exercise. "Sobriety Challenges," "The Personal Crazyness Index," "The Letter to Yourself," and the "Arousal Template" sections of *Facing the Shadows* are favored recovery tools used by the author for treating the food-sex interaction disorder.

Case example. Having been in four different treatment centers for eating disorders between the ages of 15 and 27, Nurse Kari knew the tools of the trade. She could secretly binge and purge with the best of them while maintaining her same weight so no one would be the wiser.

It wasn't until she married, at the age of 28, that things began to change. Lacking her former privacy to continue the secret bulimia, feeling conjugal pressure to enjoy a glass or two of wine each night, and struggling with some of the requirements of sexual intimacy, Kari's life began a downward spiral. Fearing the "empty" calories of their nightly wine and her now limited opportunity to purge her supper, Kari began to restrict her food intake. Wine on an empty stomach soon became her "liquid supper." Such a "meal" often made her too drowsy for sex. By their first anniversary, Kari was both food and sex anorexic.

She came for therapy the week before her second wedding anniversary, keenly aware that her health and the longevity of the marriage was at stake unless she got help for her dual restriction problem. Already motivated for change, Kari was heartened to learn that deprivation was one extreme of the continuum of addiction and that "acting-in" (restricting) was as treatable as "acting-out" (addiction). In therapy, Kari recognized her bulimia in adolescence was her initial "flawed solution" to earlier incest experiences. Marital sexual intimacy resurrected many of her unresolved sexual issues. When, however, she was unable to continue her secret binge/purge pattern as a coping mechanism, she swung, pendulum fashion, to food and sex anorexia.

With addiction interaction disorder being explained to her, a food-sex outpatient recovery program was developed. Kari participated in an eating disorder support group, stopped all alcohol use, did healing work on incest issues, read abundantly on sexual anorexia, utilized the services of a nutritionist, and completed selected exercises from *Facing the Shadow* (Cames, 2001) workbook. Marital therapy also was initiated. When last seen, the couple was happily preparing to leave for a Recovering Couples Weekend Retreat.

Client B admits both problems exist but only wants to work on one of them at a time. The willingness to address both is there; the understanding of the addiction interaction is not yet present.

Case example. Doug and Dwight were not related. They did, however, share several things in common. They attended the same SA meetings, were married with adult age children, had recently turned 50, enjoyed a middle class lifestyle and were each at least 100 pounds overweight. Doug was a compulsive overeater and Dwight alternated between binge eating disorder (BED) and bulimia. Both admitted to being out of control with pornography, masturbation, anonymous sex—and food. Doug wanted help with his sexual addiction in order to save his marriage and be able to return home, Dwight wanted help with his sexual addiction because of intense religious conflicts resulting from his acting out and also to save

his marriage. Neither of them wanted to address their co-existing eating disorder at the same time.

With each client a strong sexual addiction recovery program was initiated, with the promise from the therapist to periodically return to the eating disorder issue. This promise was fulfilled in a variety of ways over a two year period: the viewing of the 17 minute segment of Carnes' (1999) video on Addiction Interaction Disorder; adapting the Arousal Template exercise, from *Facing the Shadow* (Carnes, 2001) workbook, to include food and sex, revisiting the Triad periodically. The Triad is (1) honesty-of-the-moment (am I really hungry? Am I hungry in my head or heart or stomach?), (2) healthy boundaries (when I eat, portion sizes, speed of eating, places I eat, etc.), (3) self-care (nutritional choices, body care, exercise, affirming self-talk).

When Doug reached his 18 month mark of sexual addiction sobriety, he was ready to directly put energy into his eating disorder recovery. One year later, he was 42 pounds lighter and still sexually sober.

When Dwight reached his three year sexual sobriety mark, he had also reached one year sobriety for his compulsive spending. His spending compulsion had only surfaced after he had begun his sexual addiction recovery in earnest. Buoyed up by his sex and spending recovery, Dwight became willing to finally address his eating issues. Forty nine months after his first appointment for sex addiction recovery therapy, Dwight felt like a new man, grateful for his sex and spending recovery and continuing to lose weight with his healthy, non-compulsive eating program.

Client C specifically wants help with an eating disorder/addiction but does not want to even admit to any possibility of a sex addiction being present. Example: the woman wanting help to stop her out of control binge/purge food pattern (pocket book and health being affected) but wants to retain her day job as a lingerie model for men's luncheons and her night-time job at a Gentleman's Club.

Case example: Cyndie said she was shocked and embarrassed when her dentist asked her if she vomited very often. Cyndie had always prided herself on her image, her good looks, her seeming to be just a cut above the rest. When her dentist explained that the large amount of lost enamel on her teeth, at her fairly young age of 22, most likely came from stomach acids, it was all Cyndie could do to not burst into tears. His question disturbed her for days. Then she had to face the severity of her out-of-control binge/purge eating: even her teeth were being affected.

At the same time, Cyndie feared getting help for her eating disorder because she feared recovery would mean weight gain. If purging could ruin her teeth, then weight gain could ruin her job. She was a lingerie model for men's luncheons and worked some evenings at a Gentlemen's Club nearby. She delighted in exhibiting her body, in enticing and teasing men, in making "big bucks from big boys." Nonetheless, she thought she'd

give getting help for her eating disorder a try. After all, she thought she could always quit therapy.

The therapist chose to go in the client's door, supporting her attempt to face and overcome her eating disorder. By session three, however, the therapist introduced the topics of addiction interaction disorder and sex addiction. Cyndie initially did not want to even talk about this being a possibility in her life. The therapist reassured Cyndie that not all lingerie models are sex addicts nor are all employees of Gentlemen's Clubs sex addicts. Some are, however, so an evaluation would be in order, especially when one of the signs of addiction is continuation of a behavior in spite of it being harmful to the person. In the addiction interaction disorder model, Cyndie's binge/purge food pattern, to keep her weight down and her body more sexually attractive to the male clientele, was destroying the enamel on her teeth. Cyndie then agreed to a sex addiction evaluation. She also quite thoroughly completed the "How Do You See Yourself?" exercise (See Table 1). Her own answers spurred her into taking a leave of absence from her modeling job and her Gentlemen's Club work, beginning an eating disorder program, and initiating a new job search. After six weeks, her binge/purge pattern was significantly reduced and she had only gained five pounds. Unsuccessful with a job search that provided a salary anywhere near what she could make at the Gentlemen's Club, she returned to that venue. Cyndie continued her eating disorder recovery for two more months, reducing her purging by 90% and then dropped out of therapy.

TABLE 1 How Do You See Yourself?

Here is a list of some of the most common behavioral and attitudinal correlates that seem to appear over and over again in the addictive process. On another sheet of paper, write out an example of how you see each of the characteristics manifested in your life when it comes to your use of food and/or sex.

- denial, self-deception around food and/or sex
 - faulty, delusional belief system
 - low self-worth, façade of bravado
 - preoccupation with food or sex
 - secretive, double life
 - grandiosity
 - guilt, shame
 - loss of control and freedom of choice
 - excessive dependence on or preoccupation with food or any sexual behavior
 - isolation and struggle with relationships and intimacy
 - mood swings
 - perfectionism
 - broken promises and poor follow through
 - refusal to take responsibility for consequences of negative attitudes and behavior
 - blaming of others for irresponsible behaviors
 - irrational fears
 - withdrawal and loneliness
 - inability to identify and express feelings
 - excessive anger, resentment, criticalness, rage
 - feelings of despair
-

Client D requests assistance for a sexual addiction problem but either doesn't care about any food addiction or denies any food issue. An example would be the cybersex addict who couldn't care less about his weight or appearance but wants therapy for sex addiction because he lost his job. That he's gained 35 lbs. since his job ended is inconsequential.

Case example: Jimmy was shocked when the police appeared at his door, demanding to see his computer. He was charged on the spot with possession of child pornography, was told he'd better get a lawyer, and his computer and all files were taken away. Instead of going out to celebrate his 35th birthday, he made an appointment with a sex addiction therapist. Therapy initially focused on crisis intervention for suicide ideation, facing the whole court process, and losing his job due to his felony conviction.

Jimmy is now complying with all the requirements of his long probation. His Cybersex recovery program consists of two meetings a week (one SA; one, a Church-based recovery group), Step work with his Sponsor, and twice monthly sessions with his therapist where they use the *Cybersex Unbooked* workbook by Delmonico et al. (2001).

While he reports he has been "pudgy" most of his life, he has gained weight since he lost his job. In the course of therapy, his eating patterns have been explored: he has watched the Addiction Interaction Disorder video he admits to both emotionally eating and to periodic binge-eating episodes. Jimmy, however, remains unmotivated to address his food issues. "I get it, about my food being a 'flawed solution,' too, for lots of my feelings and needs. Just like I used to do with the kiddie porn. It's just that I don't want to deal with my food thing. Stoppin' porn's enough."

Client E experiences another addiction developing as recovery from the first identified addiction progresses. One example is of a male client, working a successful recovery from his binge eating disorder and losing 42 pounds in the process, finding insatiable urges developing for cybersex, escort services, and "pick-ups" in his eating disorder support group.

Case example: At age 47, Jean had just returned from another missionary assignment in the Middle East. She came to her first appointment ashamed and guilt ridden. There were certain things that a missionary, a person of God, just doesn't do: smoking and playing with oneself being examples. She was both smoking and masturbating, with some frequency, but always in secret and always with shame. Even seeing another person smoke aroused her. In addiction interaction language, she had fused nicotine and masturbation: they had become as one united addiction for her.

Over a two-year period of using the recovery guidebook, *A Gentle Path through the 12 Steps* (Carnes, 1993), daily Scripture readings and journaling, exercises from *Facing the Shadow* (Carnes, 2001) workbook, a church support group, Zoloft for depression and Welbutrin to aid in nicotine cessation, Jean was able to reach her desired goal: freedom from both masturbation and nicotine.

It was, however, about 18 months into her recovery program, that Jean became aware of her "sweet tooth." Initially, she brushed off these sugar cravings as a temporary reaction/compensation for stopping smoking. As she began to put on noticeable weight, with eating she kept a secret from her therapist, too, she wanted to explore the whole area of perimenopause and menopause as a possible explanation for her size changes. That exploration was done and then the therapist proposed re-visiting the concept of addiction interaction disorder. Jean was able to recognize that she had indeed stopped the fused nicotine-masturbation pattern but had switched to sugar and binge-eating to alter her moods. By her big 5-0 birthday, Jean was working a strong OA program and remained nicotine and masturbation free.

For Clients B and E, the author has found it most helpful to initially address the addiction presented and establish a solid client-therapist relationship. Soon, however, the concept of Addiction Interaction Disorder is introduced. The last 17 minutes of the Gentle Path video by Carnes (1999), called "Addiction Interaction Disorders," is viewed, delineating the ten signs or types of addiction interaction, followed by a therapist-led possible application to the client's life. In Carnes' more recent writing (Carnes, Murray, & Charpentier, 2004) he has identified 11 Addiction Interaction Dimensions and discusses them at length in Chapter Two of the *Handbook of Addictive Disorders*. For the reader's convenience, the 11 dimensions in which addictions are impacted or in some way related to one another are simply listed here:

- Cross tolerance
- Withdrawal mediation
- Replacement
- Alternating addiction cycles
- Masking
- Ritualizing
- Intensification
- Numbing
- Disinhibiting
- Combining
- Inhibiting

Grasping the concept of addiction interaction disorder has motivated several clients to work on their food and sex addiction simultaneously and has even helped them identify additional addictions in themselves.

Motivating Clients C and D to work on food and sex addictions simultaneously has been much more challenging. Identifying consequences of the "neglected" addiction has been moderately motivating. The author has

TABLE 2 Twelve-Step Resources

Sex Addicts Anonymous	www.scxaa.org
Sex and Love Addicts Anonymous	www.slaafws.org
Sexaholics Anonymous	www.sa.org
S-Anon	www.sanon.org
Sexual Compulsives	www.sca-recovery.org
Overeaters Anonymous	www.oa.org
Association of Anorexia Nervosa and Associated Disorders (ANAD)	www.ANAD.org
Eating Disorders Referral and Information Center (edreferral)	www.edreferral.com

devised a worksheet as a take-home exercise (Table 1) to help clients break-through denial and become motivated to follow the addiction interaction recovery model.

Requesting C and D type clients to attend three 12-Step meetings of the addiction or "flawed solution" they are wanting to avoid has proven very motivational. Client resistance to attending the meetings seems to lessen when they are given the power to go in order to help themselves "rule out" as well as "rule in" an addiction: Local 12-Step meeting lists are provided to the client. When clients relocate or travel out of state for periods of time, a national list is provided to them for easy access to finding meeting places and support groups (Table 2).

Overcoming Denial

The term "flawed solution," to describe the addiction processes, has also served to remove much shame and guilt and open clients up to looking at the possibility of the interactive process. Once they grasp that they are truly trying to solve some core issues in their lives, that they are not truly bad and unworthy persons, that the solution(s) they have chosen to solve their core issues are "flawed" because the solutions are creating more problems, the clients appear to become more positively solution oriented. It is not that they are bad people; their solution is extremely defective and new solutions need to be found. This "change" attitude is bedrock to recovery.

Often times, ignorance is at the bottom of resistance and denial. It is important, then, that presenting clients know the six basic types of eating disorders and the ten basic forms of sexually acting out.

Everyone knows the term alcoholic does not apply only to the skid row bum stumbling down a street curb. Alcoholics also run Fortune 500 Companies. In like manner, clients need to know that eating disorders encompass more than the starving gymnast or the dozen-donuts-for-breakfast 400 pounder. Also, sex addiction encompasses much more than the sexual predator snatching children from the playground or the Third World country multi-millionaire, made successful from his sex slave selling.

Giving Information

In session, each of Carnes' (1991) now familiar ten behavior types are examined to see which may have occurred or are occurring in a client's life:

- fantasy
- voyeurism (including cyberporn)
- exhibitionism
- seductive role sex
- intrusive sex
- anonymous sex
- trading sex
- paying for sex
- pain exchange
- exploitive sex

Likewise, in session, the author discusses six commonly recognized forms of eating disorders. Sometimes a client has stopped one form, taken on another, or finds himself or herself with characteristics transitioning between forms of eating disorders. Clarifying the type helps the client with "name it, tame it" attitudes for recovery motivation. For the majority of clients the following simplified definitions have proven sufficient:

Anorexia: excessive weight loss and self-starvation, body weight is 15% below minimally normal for height and age, intense fear of becoming fat or of even gaining weight; distorted body image; loss of menstrual cycle for at least three consecutive months in females. Two subtypes exist: restricting type and binge eating/purging type

Bulimia: a pattern of eating large amounts of food in a short period of time, with a sense of being out of control, and then purging through vomiting, exercise, diuretics, laxatives or fasting. Two subtypes exist: purging and non-purging types

Binge-Eating Disorder (BED): similar to Bulimia except the binge eater does not purge in any fashion, and has fewer episodes per week of eating excessive amounts of food than does the Bulimic.

Compulsive Overeating: while very similar to BED, the compulsive overeater can have longer periods where there is no significant amounts of bingeing occurring but where the eating is continual, hungry or not.

Bulimarexia: persons who move between the diagnostic categories of anorexia and bulimia at different points of time; not to be confused by the bulimic who binges three days straight and often starves for three days, as a purge. In the Bulimarexic, discrete diagnostic categories of eating disorders occur for months at a time before alternating to another or opposite form of eating disorder.

Insulin-Hidden Eating Disorder: Some diabetics (the word "some" is important here) discover that they can lose weight rapidly if they reduce their insulin—a form of purging unique to this population. Scarily, some insulin-dependent persons take near-fatal risks by reducing their insulin to dangerously low levels to lose weight. Other eating disorder patterns

also can be identified. Alternating periods of restricting and binge eating can interfere with normal pancreatic functioning leaving the pancreas dormant during periods of restriction and then challenged to respond during a binge. Careful questioning of the diabetic client by the clinician is required to discern whether or not there is a hidden eating disorder.

Should a client wish a more extensive description of the forms of eating disorders, the *DSM-IV-TR* (APA, 2000) can be used to delineate diagnostic features, associated features, prevalence, differential diagnoses, and specific criteria of anorexia nervosa, bulimia nervosa, and binge-eating disorder as well as to explicate examples of Eating Disorders Not Otherwise Specified, also known as EDNOS. It is important that clients see the EDNOS category to be as significant as any of the other eating disorder categories. Erroneously, some clients see EDNOS as a "watered-down" form of eating disorders. The truth is, an anorexic still having her menses (an EDNOS example) can be as gravely stricken as an anorexic with amenorrhea for more than three months (APA, 2000).

Additionally, bibliotherapy can be extremely helpful in having clients understand any form of eating disorder, disordered eating, or food addiction pattern they may have. The Gürze Eating Disorder Resource Catalogue remains a pre-eminent resource for clinicians, clients, and family members alike, is updated annually and is provided free of charge (1-800-756-7533 or www.bulimia.com) (Gurze, 2005). Bulimarexia is not well written on yet. A significant contribution, however, is *Bulimarexia: The Binge/Purge Cycle* (Boskind-White & White, 1983). For the clinician wanting further information on research studies concerning diabetes and eating disorders, contacting the American Diabetic Association will prove most beneficial (1-800-342-2383 or www.diabetes.org).

Another form of eating disorder/addiction is getting press lately, though little research on it can be found by this author. Going by the name of "Bigorexia" it is being seen as the "opposite of Anorexia" or "reverse Anorexia," found typically in body-building circles and also known as muscle dysmorphia. Here the individuals are overly worried that they are too small and men and women alike will go to all lengths to increase muscle mass. With this population, body image, eating disorders, the need for sexual attractiveness, and preoccupation with weight and acceptable appearance can prove to be fertile breeding grounds for a food-sex addiction. Even though the research appears to be almost non-existent, the clinician treating addiction interaction disorder should be apprised of this now-named condition. An AOL or a Google search will yield dozens of sites discussing both Bigorexia and muscle dysmorphia. It is recommended that the interested clinician, desiring a specific site, type in *Bigorexia—Eating Disorders Center* on the search line, then scroll down to the Healthy Place Communities' very informative article on Bigorexia.

Obesity is not looked on as an addiction; rather it is seen as a genetically influenced, medical problem or illness. Obesity is operationally defined using body mass index (BMI), which is a measure of body weight adjusted for height and calculated using this formula:

$$\text{BMI} = \frac{\text{Weight (lbs)} \times 703}{\text{Height (in)}^2}$$

or

$$\text{BMI} = \frac{\text{Weight (kg)}}{\text{Height (m)}^2}$$

Medical morbidity associated with abdominal or central obesity is further associated with a metabolic syndrome with specific serum parameters. What is important to the clinician, who is working with an obese person suffering with a sex addiction, is to be aware that eating disorders also can be embedded within the eating patterns of a person of size. Not all obese persons have eating disorders; some, however, do manifest binge eating disorder (BED) and bulimia nervosa (BN), particularly the non-purging subtype. So questioning of eating habits and patterns remain important when seeing obese clients.

There is yet another helpful and important concept, for the treating clinician to communicate, and the recovering client to understand, concerning the interaction of food and sex addiction. This is the role of neurotransmitters and the circuitry of the brain. Clients can make thoughtful connections after (1) being given a brief description of how much new knowledge about the brain's reward system the current advanced brain scan technology has given us, (2) understanding that a reward is a reward for the brain regardless of whether it comes from a substance, chemical, or experience, (3) realizing that the brain can be "hijacked" by addictions that reward survival-enhancing behaviors such as eating and sex. Additionally, clients evidence a reduction in the amount of crippling shame that so often attends the acknowledgment of addictions once they have some understanding that their "flawed solution" is just not impaired judgment on their part, it is also faulty circuitry. Clients have been heard to spontaneously verbalize such insights as:

"Now I understand why I get so depressed and anxious before I binge and feel such a pleasant 'after glow' when I'm done ... I love it, until the guilt and remorse comes back "

"Aha! It's the same turn-on I used to get from my chocolate binges and other 'gastronomical treats' .. now I'm getting the same high from sex and affairs. No wonder it feels just as good "

"I want to get that 'neurotransmitter high' but without the potato chips, porn videos and all that sneaking away from my wife's eye."

Understanding that the brain circuitry works on a dopamine-mediated reward system, and that their addictions are flawed attempts to experience that reward, helps motivate clients to seek other, healthier rewards, which, of course, is a large component of recovery. The client no longer has to switch addictions, mask one addiction with another, alternate addictions or engage in any other of the multiple forms of addiction interaction. Identifying significant sources of natural highs and healthy reward-producing activities then becomes a major focus of therapy.

Sometimes in the course of therapy, the question arises, "What is the reward in sexual anorexia or in food anorexia?" when deprivation is all that is seen. Initially, it may be somewhat difficult to grasp, but the deprivation is the reward. The deprivation state or acting-in, is one end of the same continuum, with addiction, or acting-out, being the other end or the extreme (Carnes, 1997; Ferree, 2002). Many a client has shared with the author the high she has felt with avoiding sex (if she suffered from sexual anorexia) or avoiding food (if she suffered from fear of fat or fear of weight gain), not unlike the auto-erotic asphyxiation client who experiences a tremendous orgasm when depriving self of oxygen. For the food or sex anorexic, the high of avoiding the dreaded object, food or sex, is indeed rewarding.

CONCLUSION

Compulsive overeaters do not have to give up food to be healthy; sex addicts do not have to give up sex to be healthy. Neither do food anorexics have to give in to food to be healthy any more than sexual anorexics have to become promiscuous. The goal is healthy sex and true intimacy; the goal is learning how to eat in a healthy and balanced manner. When it comes to food and sex, extremes are to be avoided as are any of the forms of addiction interactions. The client often needs an informed clinician, familiar with the addiction interactive processes such as alternating, masking, fusing, and switching, who can help the client achieve balance and sobriety with these two life forces: food and sex.

The past decade has seen greater emphasis put on the need to treat multiple and interacting addictions in order to more effectively prevent relapse. What has been lacking, however, are guidelines for recognizing and ideas for treating the two addictions in which the total abstinence model cannot be applied. This article is intended to start a bridge between a client need and clinical attention to that need. Definitions were listed for clinicians who may not be as familiar with eating disorders as they are with types of sexual addiction. Questions to help identify possible food-sex interaction disorders were suggested. A number of practical treatment exercises and resources were presented to assist the clinician once the food-sex interaction has been identified.

Surely, further research is needed to more clearly delineate the role of neurotransmitters and brain circuitry in the initiation, detection, and maintenance of addictions, especially the process addictions and particularly the food and sex addictions. Problems and issues ensuing from switching, alternating, or masking food and sex addictions needs further empirical study, as well as establishing and evaluating specific treatment strategies. Ferree (2002) and Carnes (1989, 1997) address the binge and purge parallels of eating disorders and sexual addiction activities, and illustrate how eating extremes (bulimia, anorexia) and sexual extremes (sex addiction, sexual anorexia) become interchangeable and interactive. This author is most grateful for their contributions in clarifying a process seen so frequently in the office setting, the co-existence and interaction of these two forms of over-consuming and under-consuming. Yet, it remains the fervent hope of this author that concerted research be now directed towards identifying the ways all ten types of sexual addiction behaviors and all six types of eating disorders interact.

This article predominantly serves three purposes: (1) a call to recognize the too commonly overlooked or minimized parallels and interactions of food and sex addiction, (2) an encouragement for more needed research with this population, and (3) an initial offering of specific treatment techniques and additional resources.

REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Amico, J. (1997). Assessing sexual compulsivity/addiction in clinically dependent gay men. *Sexual Addiction & Compulsivity: Journal of Treatment and Prevention*, 4, 291-297.
- Boskind-White, M., & White, W. C. (1983). *Bulimarexia: The binge/purge cycle*. New York: W. W. Norton.
- Carnes, P. J. (1993). *A gentle path through the Twelve Steps: The classic guide for all people in the process of recovery* (rev. ed). Center City, MN: Hazelden.
- Carnes, P. J. (1991). *Don't call it love: Recovery from sexual addiction*. New York: Bantam.
- Carnes, P. J. (1989). *Contrary to love: Helping the sexual addict*. Minneapolis, MN: CompCare.
- Carnes, P. J. (1997). *Sexual anorexia: Overcoming sexual self-hatred*. Center City, MN: Hazelden.
- Carnes, P. J. (1999). *Addiction Interaction Disorder: Understanding Multiple Addictions* [video]. Wickenburg, AZ: Gentle Path.
- Carnes, P. J. (2001). *Facing the shadow: Starting sexual and relationship recovery*. Wickenburg, AZ: Gentle Path.
- Carnes, P. J., Murray, R. E., & Charpentier, L. (2004). Addiction interaction disorder. In R. H. Coombs (Ed.), *The handbook of addictive disorders: A practical guide to diagnosis and treatment* (pp. 31-59). Hoboken, NJ: John Wiley & Sons.

- Delmonico, D. L., Griffin, E., & Moriarty, J. (2001). *Cybersex unbooked: A workbook for breaking free of compulsive online sexual behavior*. Wickenburg, AZ: Gentle Path.
- Risnman, R., Dantzer, M. J., & Ellis, L. (2004). Self-ratings of dependency/addiction regarding drugs, sex, love and food: Male and female college students. *Sexual Addiction & Compulsivity Journal of Treatment and Prevention*, 11(3), 115-127.
- Ferree, M. C. (2002). *No stones: Women redeemed from sexual shame*. Fairfax, VA: Xulon.
- Garner, D. M., & Gerborg, A. (2004). Understanding and diagnosing eating disorders. In R. H. Coombs (Ed.), *The handbook of addictive disorders. A practical guide to diagnosis and treatment* (pp. 275-311). Hoboken, NJ: John Wiley & Sons.
- Gurze Books (2005). *The Gurze 2005 eating disorders resource catalogue*. Carlsbad, CA: Author.
- Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (April 2005). Monitoring the Future: National Results on Adolescent Drug Use. University of Michigan and National Institute on Drug Abuse. 05-5726.
- Johnson, M. (1999). *Cross-addiction: The hidden risk of multiple addictions*. New York: Rosen.
- Kasl, C. D. (1989). *Women, sex and addiction: A search for love and power*. New York: Harper & Row.
- Katherine, A. (1991). *Anatomy of a food addiction: The brain chemistry of overeating*. Park Ridge, IL: Fireside/Parkside. [Order direct from the Gurze Eating Disorder Resource Catalogue: www.bulimia.com]
- Schneider, J. P., & Irons, R. R. (1997). Treatment of gambling, eating and sex addictions. In N. S. Miller, M. S. Gold, & D. E. Smith (Eds.), *Manual of therapeutics for addictions* (pp. 225-245). New York: Wiley-Liss.