

THE TRUTH ABOUT

FOOD ADDICTION

When “everything in moderation” does not feel moderate

The short answer Some people experience a recurring pattern of craving, preoccupation and loss of control around certain foods. Researchers call this addictive-like eating or proposed ultra-processed food addiction. The suffering is real, although food addiction is not yet a standalone diagnosis and treatment science is still developing.

Why This Matters

Food addiction is not only about eating a food and then wanting more. For some people, the struggle begins long before the first bite—and it may continue even when the food is never eaten.

A person may spend significant time thinking about a particular food, planning when they can have it, making deals with themselves, trying to justify buying it or repeatedly talking themselves out of it. They may know from experience that the food is difficult to stop eating, yet still hear the persuasive thought: Maybe this time will be different.

Even when a person follows a structured eating plan, food can continue to occupy substantial mental space. They may count the hours until the next meal, question whether they are truly hungry, or struggle to tolerate anxiety, loneliness, stress or other emotions without turning to food.

This relentless negotiation can be exhausting. The goal is not simply to achieve greater control over eating. It is to understand what keeps the cycle active, develop other ways to respond to hunger and emotion, and gradually create more freedom and peace around food.

Learning Objectives

- ☐ Describe food addiction as an emerging, debated clinical construct.
- ☐ Distinguish ordinary food thoughts from distressing food noise and loss of control.
- ☐ Recognize overlap with binge-eating disorders without treating them as identical.
- ☐ Compare moderation, harm reduction, structured eating and abstinence.
- ☐ Identify when individualized medical, nutrition or mental-health support matters.

Start With Your Experience

Have you ever felt that a food became mentally louder when you thought about it, knew where to get it or began eating it?

What Does “Food Addiction” Mean?

Food addiction is the proposed idea that some people may respond to particular foods—especially highly rewarding ultra-processed foods—with symptoms resembling substance-use disorders. These may include intense craving, consuming more than intended, unsuccessful efforts to cut down, continued use despite harm and clinically meaningful distress or impairment.

Important distinction: Food addiction is not currently a standalone diagnosis in the DSM-5-TR or ICD-11. Binge-eating disorder and bulimia nervosa are recognized diagnoses. A person may have addictive-like eating with or without an eating disorder, and careful assessment matters.

How Is It Studied?

The Yale Food Addiction Scale 2.0 applies substance-use-style criteria to eating and is the most widely used research measure. It does not prove that a particular ingredient is addictive, and a questionnaire should not replace clinical assessment. It helps researchers identify a reproducible pattern of symptoms and impairment.

What Is Food Noise?

Food noise is a newer term for persistent food-related thoughts that feel unwanted, intrusive or distressing and may interfere with daily life. It is more than enjoying food, noticing hunger or planning a meal. Food noise can accompany addictive-like eating, but it can also occur with dieting, inadequate intake, binge-eating symptoms, stress or other conditions. It is a symptom description—not proof of addiction.

Look closer: How much space do food decisions occupy in your mind? Does the thought pass after eating, or become more demanding?

Kathryn’s Reflection

For most of my career as a registered dietitian, I heard—and taught—the familiar message that all foods can fit and that everything is acceptable in moderation. I understood the intention: food should not be surrounded by guilt, shame or moral judgment. But privately, that message never fully matched my own experience.

There have always been certain foods that do not feel moderate to me. Sometimes the cycle begins before I take the first bite. Simply thinking about the food, seeing it or knowing where I could get it can activate an exhausting internal debate: Will I buy it? Am I going near that store? Can I pass it without stopping? If I get it, when will I eat it? How much? Will I be able to stop? Should I promise myself I will start again tomorrow? If I do begin eating it, the first serving may intensify rather than settle the desire.

For me, greater structure and clearer boundaries have brought relief. When the decision has already been made, I do not have to fight the same battle repeatedly. This is my experience, not a prescription for everyone. But experiences like mine deserve a place in the conversation—especially for people who were taught that difficulty moderating was simply a failure of willpower.

Take a Closer Look

When one can feel like too many—even before the first bite

Sometimes eating a particular food activates a powerful desire to continue. At other times, the struggle begins before the food is purchased or eaten. A person may already know that keeping or eating that food often leads to feeling out of control, yet find themselves caught in an exhausting internal negotiation.

The person may repeatedly decide to buy it, not buy it, eat it or avoid it—sometimes reversing the decision several times. Even when they ultimately choose not to eat the food, the bargaining, rationalizing and effort required to talk themselves into or out of it can consume enormous mental energy.

This is not simply a matter of liking food or lacking willpower. For some people, the preoccupation and internal battle are themselves part of the problem. Recognizing the entire cycle—anticipation, bargaining, eating, loss of control and aftermath—can replace blame with curiosity and help identify the level of structure, boundaries and support that brings greater peace.

A boundary is not a moral judgment. A food can be morally neutral and still be personally destabilizing. Choosing not to keep or eat it can be an act of self-knowledge rather than punishment.

What Might Be Driving the Pattern?

- Powerful combinations of refined carbohydrate, fat and sodium.
- Rapid eating, concentrated calories and textures requiring little chewing.
- Learned associations with comfort, relief, reward or celebration.
- Hunger and under-fuelling that amplify attention to food.
- Stress, sleep loss, trauma, mood, medication and individual vulnerability.
- An environment designed for visibility, convenience and repeated purchase.

No single mechanism explains every person. Biology, learning, emotion, environment and food characteristics may interact.

What Does Treatment Research Show?

Treatment evidence is young. A randomized trial found that four sessions combining motivational interviewing and cognitive behavioural therapy reduced food-addiction, loss-of-control and binge-eating symptom scores more than a waitlist, although food cravings and reported binge episodes did not improve more than the control condition.

Several structured, low-carbohydrate or abstinence-oriented programs have reported promising improvements. These include Toward Health, Liberate and the MFM community program. A 2022 evaluation by Jen Unwin, Clarissa Kennedy, Molly Painschab and colleagues followed 103 self-referred adults in online programs combining an individualized, low-carbohydrate real-food plan with education, psychosocial support and relapse planning. Food-addiction symptoms and mental well-being improved after the program. A 2025 report found sustained improvements among responding participants at six and twelve months.

These findings support targeted abstinence and structured eating as legitimate options for some people, but they do not prove that this approach is necessary or best for everyone. The programs were not randomized, had no comparison group and could not separate the effects of the food plan from education, community, psychological support or participant motivation. Several authors also had fee-paying clients in this area.

Evidence check: Promising is not the same as proven. Early findings justify better trials—not a universal prescription.

Moderation, Harm Reduction or Abstinence?

The appropriate goal may exist on a continuum. It should reduce distress and loss of control while preserving adequate nourishment, flexibility where possible and social and psychological well-being.

Flexible awareness: Notice patterns and make intentional choices without fixed exclusions.

Supportive structure: Use regular meals, planned options and a calmer home environment to reduce repeated decisions.

Harm reduction: Reduce frequency, portions or exposure to foods linked with loss of control.

Targeted abstinence: Avoid specific personally destabilizing foods while maintaining a varied, adequate diet.

Higher-support recovery: Combine defined boundaries with medical care, therapy, dietetic support, coaching or peer community.

Severe or expanding restriction, nutritional inadequacy, purging, significant binge eating, rapidly changing weight or intense fear around food requires assessment by a clinician with eating-disorder competence.

A Lapse Is Information, Not Failure

A lapse does not erase learning or prove that a person lacks commitment. It may show that a boundary remains useful, a situation needs planning, hunger became too strong, emotional support was missing or the approach itself needs adjustment. Compassion and accountability can exist together.

Kathryn's Perspective: Looking Ahead

I wonder whether food-addiction care will eventually be understood as a continuum rather than a single plan for everyone. Some people may need awareness and flexible boundaries. Others may benefit from reducing exposure, changing the home environment or planning meals. For someone whose thoughts about, access to or first taste of a food reliably begins craving, preoccupation and loss of control, abstinence from that personally triggering food may be the most compassionate boundary.

The appropriate level of support may change over time. What matters is not whether someone can follow a universal rule called moderation. What matters is whether the approach provides adequate nourishment, improves health, reduces mental distress and helps that person live more freely.

My hope: Future care will recognize that there is no single right approach for everyone. Some people may find freedom in greater flexibility, while others may find freedom in clear boundaries around foods that create persistent thoughts, internal bargaining or loss of control. Both deserve to be heard, supported and treated without shame.

Questions to Help You Look Closer

- ☐ Are there foods that become mentally ‘louder’ when I think about, see or begin eating them?
- ☐ Can knowing where the food is available begin an internal debate about whether I will buy or eat it?
- ☐ Does the first serving satisfy the desire—or make the desire feel stronger?
- ☐ How much time and mental energy do I spend bargaining with myself about this food?
- ☐ Does having the food nearby—or knowing I could easily get it—change how much I think about it?
- ☐ Am I physically hungry, seeking emotional relief or experiencing both?
- ☐ Am I eating adequately and regularly, or could physical deprivation be intensifying the pull?
- ☐ What does this food provide for me—comfort, relief, safety, reward, escape or companionship?
- ☐ Would flexibility around this food create freedom, or would a clearer boundary bring greater peace?
- ☐ What support could help me explore this pattern with curiosity and without shame?

Quick Summary

- Addictive-like eating is measurable and can cause significant distress, but food addiction is not yet a standalone diagnosis.
- Food noise describes intrusive, unwanted food thoughts; it can occur within several different patterns.
- Food addiction and binge-eating disorders overlap but are not necessarily identical.
- Moderation is not a moral achievement, and abstinence is not automatically punishment.
- Treatment should be individualized, nutritionally adequate and attentive to eating-disorder risk.
- The evidence for abstinence-oriented programs is promising but preliminary.

Bottom line: Before asking, ‘Why can’t I control myself?’ look closer at the whole pattern: the food, physical hunger, emotions, thoughts, learned associations, surroundings and the internal bargaining that may begin long before the first bite. Understanding what the food provides—and what happens before, during and after eating—can help reveal which boundaries and supports might bring greater peace.

Questions I Still Have

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Educational draft. This resource provides general information and does not replace individualized medical, mental-health or nutrition care.