

**SISDCA-DAO: Società Italiana di Studio dei Disturbi del Comportamento Alimentare
Disturbi-Alimentari-Obesità
Sezione Interregionale Emilia-Romagna-Marche**

**Seminario Multi-Professionale DAO-USP: Il Vaso di Pandora.
Interazioni tra Disturbi-Alimentari-Obesità e Uso di Sostanze Psico-Attive
Un messaggio per il Servizio Sanitario Nazionale
1° Annuncio**

**Ordine dei Medici - Via Zaccherini Alvisi 4E, Bologna
19 Ottobre 2012 10.00-17.00**

Punti chiave

1. Le **cause dei Disturbi Alimentari DAO** (Anoressia, Bulimia, Binge Eating, Binge Drinking, Obesità-BED) e dell'Uso (Abuso) di Sostanze Psico-attive (USP), lecite e illecite, sono spesso associate e complesse.
2. Si apre la discussione se l'Obesità possa essere considerata un **Disturbo Alimentare e/o un Disordine Mentale**. Il fatto che il Binge Eating, sempre associato all'Obesità di un certo livello, è entrato senza discussione nel DSM-V fa ritenere che l'Obesità è, sebbene in parte, un Disturbo Alimentare e quindi un Disturbo mentale. Si concretizza quindi il razionale dell'acronimo DAO.
3. Le più recenti ricerche dimostrano la presenza di una comunaltà delle **vie neuro-biologiche e degli atteggiamenti comportamentali**. Queste causalità sono operative nei DAO (Obesità, Binge Eating-Drinking e Dipendenze da sostanze psico-attive lecite e illecite): non si deve quindi sottovalutare che va consolidandosi sempre di più il modello della "Food Addiction: glucosio e palatabilità".
4. Il nucleo focale del **costrutto diagnostico** fa capo a ricerche neuro-biologiche e psicologico-psichiatriche e fenomenologiche che si interfacciano con le Dipendenze da Sostanze, lecite e illecite, e che caratterizzano l'Obesità e i Disturbi Alimentari, dove Binge Eating, Binge Drinking e "Craving" sono dominanti. E' necessario pertanto fare un assessment precoce per mettere in evidenza i DAO sottosoglia che sono destinati ad aggravarsi nel tempo.
5. Le **Opzioni Terapeutiche** per Disturbi Alimentari (DAO) e per le Dipendenze (USP) hanno incominciato a tenere in considerazione queste informazioni per formulare Interventi Terapeutici associati, Farmacologici (Antidepressivi, Topiramato, Antiserotoninergici, ecc) e Psicoterapie (CTB, IPT, DBT, BWL, Self-Help) che possono dare migliori risultati.

Programma

10.00-10.30	Accoglienza
	1° Parte: La Clinica. Melchionda N: Moderazione
10.30-11.00	Melchionda N: Introduzione e Punti chiave: il Vaso di Pandora
11.00-11.30	Degli Esposti L, Tarrini G, Zanetti C: Analisi clinico-diagnostica ed Epicrisi del decorso di un caso clinico 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
	2° Parte: La Terapia. Nizzoli U: Moderazione
13.30-14.00	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	Manzato E: Implicazioni Farmacologiche delle Comorbilità Psichiatriche
15.00-15.30	Interventi Preordinati
15.30-16.30	Franco A, Schumann R : La Multi-Impulsività nei Disturbi del Comportamento Alimentare
15.30-16.30	Dibattito Finale
16.30-17.00	Conclusione: Dopo l'analisi dei "mali del mondo esiste una Speranza?"

NB.1. A coloro che si iscrivono e che parteciperanno al Seminario sarà inviato, come file in pdf, il Volume del 6° Congresso Nazionale della SISDCA - DIABO.2011.BO.SISDCA: Sviluppo di Abilità Motivazionali e Progettualità di Melchionda N e Nizzoli U, edito da Mucchi Editore. Dopo lo svolgimento del Seminario sarà necessario farne richiesta per ricevere il file pdf a melchiondauno@gmail.com e/o zanetti.chiara@gmail.com

NB.2. E' possibile inviare Intervento Preordinato sul tema DAO-USP di 10 righe equivalente a 5' con 5 slide max da inserire nel programma finale dalle 15.00 alle 15.30

NB.3. Comunicare l'eventuale intenzione di partecipare attivamente a Chiara Zanetti: zanetti.chiara@gmail.com e comunque compilare la scheda di iscrizione allegata. Sarà data conferma di accettazione entro il 12 Ott. Considerando il privilegio di accettazione per i Soci Ordinari SISDCA in regola 2012.

NB.4. Le nuove iscrizioni per la SISDCA e il rinnovo per il 2012 possono essere fatte in loco.

Possibili spunti dalla bibliografia per i Relatori e per il Dibattito dei Partecipanti invitati

10-30-11.00: Melchionda: Introduzione.

Il Vaso di Pandora: Scoperchiare una pentola a pressione per verificare se nel fondo esiste una Speranza.

I punti chiave della sistematicità clinico-terapeutica

1. Le cause dei Disturbi Alimentari (Binge Eating, Binge Drinking, Restrizione), dell'Obesità, dell'Anoressia-Bulimia e dell'Uso di Sostanze Psico-attive lecite e illecite sono spesso associate, complesse e specifiche per ciascun individuo: dal 20 al 40% dei soggetti con presentano contemporaneamente abuso di sostanze e/o di alcol. La presenza di Binge Eating è predittore dell'uso di sostanze.
2. Si apre la discussione se l'Obesità possa essere considerata un Disordine Mentale che induce ad utilizzare criteri diagnostici simili a quelli impiegati per le Dipendenze perché la causa dominante è la perdita di controllo, il "Binge Eating" e il "Binge Drinking".
3. Il nucleo focale del costrutto diagnostico fa capo a ricerche neuro-biologiche e psicologico-psichiatriche si interfacciano con le Dipendenze da Sostanze lecite e illecite che caratterizzano molti soggetti obesi e con Disturbi Alimentari dove il Binge Eating e il Binge Drinking sono dominanti.
4. L'associazione del Disturbo Alimentare, della Dipendenza dal sostanze e della Psico-patologia psichiatrica non spiega bene l'iter temporale della storia clinica per cui è necessario fare un assessment precoce per mettere in evidenza i DAO sottosoglia che sono destinati ad aggravarsi nel tempo.
5. Le più recenti ricerche suggeriscono che esistono comunaltà neuro-biologiche tra Obesità, Binge Eating e Dipendenze. Esistono comunaltà comportamentali tra le due condizioni, Obesità e Dipendenze. Sono infatti presenti perdita di controllo o craving per il cibo e/o per sostanze psico-attive lecite (glucosio e trigliceridi) e illecite.
6. Sli studi neuro-biologici, neuro-psicologici, fenomenologici devono essere strettamente considerati nel valutare il comportamento alimentare del soggetto obeso che si identifica alla stregua di una vera e propria dipendenza: la "Food Addiction".
7. Le Opzioni terapeutiche per l'Obesità hanno incominciato a tenere in considerazione queste informazioni per formulare Interventi Terapeutici Farmacologici e Psicoterapie Cognitivo-Comportamentali associati che possono dare migliori risultati.
8. Il trattamento efficace del DA, che si può ottenere, migliora anche il Disturbo di Personalità preesistente.
9. Le Terapie Farmacologiche nel campo delle Dipendenze possono dare informazioni per il trattamento dell'Obesità e viceversa? Possono essere utili o dannose per il controllo del peso?
10. Il management tradizionale del peso può interferire negativamente con il Disturbo Alimentare e con la Dipendenza da sostanze. La restrizione del cibo induce quella innocente perdita di controllo che non permette di rispettare il bilancio calorico fino a determinare il Binge Eating Disorder codificato come Disturbo alimentare nel DSM-IV: la presenza del "Dieting" è positivamente associata con l'uso di sostanze e di alcol e con la perdita di controllo (Binge Eating).
11. Mentre l'Obesità e i DA devono essere considerati come entità nosografiche indipendenti, la sovrapposizione della vulnerabilità genetico-familiare, dei meccanismi basali neuro-biologici e della efficacia dei trattamenti psicofarmacologici e psicoterapeutici, tale sovrapposizione fa ritenere che l'Obesità debba essere considerata come un disordine mentale da includere nel DSM-V.
12. Il oprappeso e l'Obesità possono servire come fattori di protezione contro lo sviluppo dell'uso di sostanze considerando le comuni vie neurobiologiche operative.
13. La Yale Food Addiction Scale (YFAS) può essere uno strumento diagnostico utile nella pratica perché rappresenta un valido predittore del Binge Eating, in particolare con la BES di Gormally.

Sitografia Bibliografica e richieste di pdf

Barry D et al: Obesity and Its Relationship to Addictions: Is Overeating a Form of Addictive Behavior? Am J Addict. 2009 Nov-Dec; 18(6): 439-451.

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

Carr K et al: Reinforcement Pathology and Obesity Curr Drug Abuse Rev. 2011 September; 4(3): 190-196.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405539/>

Davis C et al: Evidence that 'food addiction' is a valid phenotype of obesity Appetite. 2011 Dec;57(3):711-7.

<http://www.ncbi.nlm.nih.gov/pubmed/21907742>

Gearhardt AN et al Preliminary validation of the Yale Food Addiction Scale Appetite 52 (2009) 430-436

<http://www.yaleruddcenter.org/resources/upload/docs/what/addiction/FoodAddictionScaleArticle09.pdf>

Grilo CM et al: Eating disorders with and without substance use disorders: a comparative study of inpatients

Compr Psychiatry. 1995 Jul-Aug;36(4):312-7

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Grosshans M et al: Implications from addiction research towards the understanding and treatment of obesity. Addict Biol. 2011 Apr;16(2):189-98.

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

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

Front Psychiatry. 2012; 3: 64.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3382827/>

Meule A: The translation of substance dependence criteria to food-related behaviors: different views and interpretations.

Frontiers in Psychiatry

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3207274/pdf/fpsvt-02-00061.pdf>

Pickering RP et al: 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.
 J Clin Psychiatry. 2011 72:1494-502
<http://www.ncbi.nlm.nih.gov/pubmed/21457678>

Taylor VH et al: The obesity epidemic: the role of addiction.
 CMAJ, 2010, 182: 327-328
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2831667/?tool=pubmed>

VanBuskirk KA et al: The Treatment of Obesity and Its Co-occurrence with Substance Use Disorders
 J Addict Med. 2010 March 1; 4(1): 1-10.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835148/>

Wilson GT: Eating Disorders Obesity and Addiction
 Eat. Disorders Rev. 18 (2010) 341-351)
 Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

**11.00-11.30: Degli Esposti L, Tarrini G, Zanetti C, Melchionda N:
 Analisi clinico-diagnostica ed Epicrisi del decorso terapeutico di un caso clinico paradigmatico**

1. Componente patologica somatica: Sindrome Metabolica-Obesità (da BMI 39 a 27 con BWL per un anno), Epatite C (esito positivo dopo terapia con interferone), Steato-Epatite Alcolica (diagnosi clinica in assenza di dati morfologici)
2. Componente patologica comportamentale: Binge Eating (BES=33 con riduzione significativa della frequenza degli episodi e BES=12), Binge Drinking settimanale programmato ineludibile con elevatissima "soglia di tolleranza", Pregresso Poli-Abuso di sostanze (cocaina, ectasi, eroina, anfetamine, allucinogeni, ketamina, cannabis) trattato con dosi massicce di benzodiazepine e paroxetina, Abuso sessuale sfrenato e promiscuo seguito da totale astinenza dopo la perdita del compagno a cui era legata da profondo affetto.
3. Componente patologica Ambientale: Abbandono Paterno Adolescenziale, Perdita per overdose del compagno tossico-dipendente, Resilienza familiare inesistente fino a 20 anni e figure di attaccamento buone.
4. Componente patologica Psichiatrica: Disturbo di Personalità borderline in asse II, Attacchi di panico, Disturbo da stress post-traumatico, Ansia generalizzata, Disturbo dell'umore grave (BDI=25)
5. Componente terapeutica: Il Setting in rete e il Setting come Team-Approach multi-disciplinare, multi-professionale integrato sistematico. Verrà discussa la terapia farmacologica, l'intervento nutrizionale e l'appropriatezza delle Psicoterapie Cognitivo-Comportamentali (CBT, IPT, DBT) e Sistemiche associate.

Cohen LR et al: Survey of Eating Disorder Symptoms among Women in Treatment for Substance Abuse
 Am J Addict. 2010 May-Jun; 19(3): 245-251.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2882625/?tool=pubmed>

Courbasson C, Brunshaw JM.: The relationship between concurrent substance use disorders and eating disorders with personality disorders.
 J Environ Res Public Health. 2009 Jul;6(7):2076-89.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2738899/pdf/ijerph-06-02076.pdf?tool=pmcentrez>

Dunn Erin C. et al: A Cross-Lagged Evaluation of Eating Disorder Symptomatology and Substance-Use Problems
 J Stud Alcohol Drugs. 2009 70(1): 106-116
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2629626/?tool=pubmed>
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2629626/?tool=pubmed>

Eichen DM et al: Weight perception, substance use, and disordered eating behaviors: comparing normal weight and overweight high-school students.
 J Youth Adolesc. 2012 41(1):1-13. doi: 10.1007/s10964-010-9612-8. Epub 2010 Nov 27.
 Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Gruzca RA et al: The emerging link between alcoholism risk and obesity in the United States.
 Arch Gen Psychiatry. 2010 Dec;67(12):1301-8.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110764/?tool=pubmed>

Kelly-Weeder S: Binge drinking and disordered eating in college students.
 J Am Acad Nurse Pract. 2011 23(1):33-41.
 Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Liu Y et al: Food addiction and obesity: evidence from bench to bedside.
 J Psychoactive Drugs. 2010 42(2):133-45.
 Link solo per abstract
<http://www.ncbi.nlm.nih.gov/pubmed?term=Liu%20Y%2C%20von%20Deneen%20KM%2C%20Kobeissy%20FH%2C%20Gold%20MS.>

McIntyre RS et al: Substance use disorders and overweight/obesity in bipolar I disorder: preliminary evidence for competing addictions.
 J Clin Psychiatry. 2007 68(9):1352-7.
 Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Moreno C, Tandon R: Should overeating and obesity be classified as an addictive disorder in DSM-5?
 Curr Pharm Des. 2011;17(12):1128-31.

Pelchat ML.: Food addiction in humans.
 J Nutr. 2009 Mar;139(3):620-2
<http://jn.nutrition.org/content/139/3/620.full.pdf+html?sid=55ef1edd-7c3c-4c42-95e2-9b3b6461b51f>

Petry N et al: Overweight and Obesity Are Associated With Psychiatric Disorders: Results From the National Epidemiologic Survey on Alcohol and Related Conditions
 Psychosomatic Medicine 70:288-297 (2008)
 Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

11.30-12.00: Pasquali R: Il Reward Neuroendocrino

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. Liking (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.

Berridge KC: 'Liking' and 'wanting' food rewards: brain substrates and roles in eating disorders. *Physiol Behav.* 2009 14; 97(5):537-50.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2717031/?tool=pubmed>

Berridge K et al: The tempted brain eats: Pleasure and desire circuits in obesity and eating disorders. *Brain Res.* 2010 2; 1350: 43-64.
full text 35 dollari

<http://www.sciencedirect.com/science/article/pii/S0006899310008115>

o Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

12.00-12.30: Cuzzolaro M: Implicazioni psichiatriche: Differenziale tra Binge Eating seguito o non da "purging"

1. Binge eating: sintomo trasversale, suoi legami con il disagio del corpo e le dipendenze patologiche.
2. L'intervento si soffermerà sull'importanza semeiologica del fenomeno binge eating e, insieme, sulla ancora scarsa attendibilità della diagnosi di Binge Eating Disorder.
3. Saranno discussi, in particolare, quattro temi, alla luce della letteratura più recente: rapporti fra BED e obesità, BED e immagine del corpo, BED e food addiction, BED e chirurgia bariatrica.
4. Riferimenti bibliografici: Cuzzolaro M, Vetrone G. Overview of evidence on the underpinnings of binge eating disorder and obesity. In: Dancyger I, Fornari V, editors. Evidence based treatments for eating disorders: children, adolescents and adults. New York: Nova Science Publishers; 2009, pp. 53-70.

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

J Clin Psychopharmacol. 2012 Jun 32(3):376-89

<http://www.ncbi.nlm.nih.gov/pubmed/22544008>

12.30-13.00: Bonfà F: Il dropout: Esiste una relazione con i Disturbi Alimentari?

1. La prevalenza dei Disturbi Alimentari in un gruppo di donne che accedono al trattamento residenziale per l'abuso di sostanze supera il 15%.
2. La presenza del DA condiziona negativamente il dropout e il relapse.
3. La comorbidità psicopatologica associata deve essere considerata per il buon esito del trattamento-

Bonfà F et al:

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

Eat Weight Disord. 2008 13(2):81-6.

<http://www.ncbi.nlm.nih.gov/pubmed/18612256>

Baker JH et al: Eating disorder symptomatology and substance use disorders: prevalence and shared risk in a population based twin sample.

Int J Eat Disord. 2010 Nov 1;43(7):648-58.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2972646/pdf/eat0043-0648.pdf>

Cohen LR et al: Survey of Eating Disorder Symptoms among Women in Treatment for Substance Abuse

Am J Addict. 2010 May-Jun; 19(3): 245-251.

13.30-14.00: Nizzoli U: Implicazioni della rete clinica integrata:

Nizzoli U, Melchionda N, Tarrini G: La Cura dei Disturbi Alimentari: Il Lavoro di Equipe Multidisciplinare, I Quaderni di Personalità/Dipendenze, Mucchi Editore
Inter-disciplinarietà e Multi-professionalità Integrata.

1. L'integrazione delle professionalità va vista non come sovrapposizione di ambiti professionali o affiancamento di discipline diverse, non come somma di competenze, ma come esplicitazione di un ben più impegnativo e serio tentativo di impostare l'intero iter clinico. Non: "Di che ti mando io" ma: "Parliamone insieme".
2. Il primo caso si riferisce al Professionista che invia il Paziente ad un altro Professionista. Nel secondo caso i due (o più) Professionisti si attivano insieme, con un comune linguaggio, per la soluzione di problemi che riguardano l'iter diagnostico-terapeutico. Quindi è possibile ritenere che un Team Multi-disciplinare di Professionisti, integrato all'insegna della Inter-disciplinarietà, possa operare molto meglio di Professionisti isolati, anche se molto preparati ma che non comunicano all'unisono.
3.

Su richiesta è possibile ricevere il volume

melchiondauno@gmail.com e/o zanetti.chiara@gmail.com

14.00-14.30: Giuntoli G: Implicazioni Psicologiche e psicoterapeutiche

1. Il tema ha uno sviluppo a due livelli:
2. L'analisi e l'Epicrisi degli elementi psicologici che definiscono la storia di vita del soggetto e che permettono una specifica Psicodiagnosi
3. Le diverse Psicoterapie che si basano su diversi orientamenti pertinenti a teorie della mente e modelli d'intervento che fanno riferimento ad un impianto epistemologico specifico: psicoterapia cognitivo-comportamentale, psicoterapia psicoanalitica, psicoterapia umanistica, psicoterapia sistemica, psicoterapia psicocorporea e psicoterapia integrativa.

Iacovino JM et al: Psychological Treatments for Binge Eating Disorder

Curr Psychiatry Rep. 2012 14(4): 432-446. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433807/>

Wilson GT.: Treatment of binge eating disorder.

Psychiatr Clin North Am. 2011 34(4):773-83.

<http://www.ncbi.nlm.nih.gov/pubmed/22098803>

[http://www.psych.theclinics.com/article/S0193-953X\(11\)00088-8/fulltext](http://www.psych.theclinics.com/article/S0193-953X(11)00088-8/fulltext)

14.30-15.00: Manzato E: Implicazioni Farmacologiche delle Comorbidità

Psichiatriche

1. Impostare una terapia farmacologica in un percorso multidisciplinare costituisce una decisione delicata e impegnativa sotto molti aspetti:
2. la scelta del timing nel percorso terapeutico,
3. la scelta del farmaco nel quadro diagnostico e le eventuali interazioni del farmaco in presenza di altre terapie farmacologiche,
4. la sicurezza nella compliance del paziente e, non da ultimo,
5. la condivisione della scelta farmacologica con tutti i terapeuti che hanno in carico il paziente.
6. La terapia farmacologica può costituire una tappa del percorso, ma anche può essere un obiettivo non facilmente raggiungibile in un paziente complesso come nel caso dei DAO con abuso di sostanze.
Analizzeremo tutti questi aspetti prendendo in considerazione le principali classi di psicofarmaci.

McElroy SL et al: Pharmacological management of binge eating disorder: current and emerging treatment options.

Therapeutics and Clinical Risk Management 2012;8 219-24

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Reas DL, Grilo CM: Review and meta-analysis of pharmacotherapy for binge-eating disorder. Obesity (Silver Spring). 2008 Sep;16(9):2024-38.

<http://www.nature.com/oby/journal/v16/n9/pdf/oby2008333a.pdf>

15.00-15.30: Interventi Preordinati

Franco A, Schumann R: La multi-impulsività nei Disturbi del Comportamento Alimentare

1. Nella realtà clinica di un gruppo di 93 pazienti con DCA (BN) è stato trovato la presenza di un 47% di comportamenti impulsivi da gestire terapeuticamente.
2. Come comportamenti impulsivi (DSM IV) sono stati considerati l'abuso di sostanze, abuso di droghe, cleptomania, promiscuità e autolesionismo.
3. La diagnosi differenziale dei DCA indaga la presenza di comorbilità con: Disturbo da Uso di Sostanze Psicoattive, Disturbi di Personalità, Disturbi dell'Umore e Disturbi d'Ansia (nel campione il 27% dei casi presenta un PTSD antecedente il DCA).
4. Un adeguato progetto terapeutico interdisciplinare necessita di stabilire la sequenza dello sviluppo dei vari disturbi, come si sono susseguiti ed intrecciati nello scorrere nel tempo attraverso un'indagine parallela sia in campo psicologico che in quello fisico.

Conason AH et al:

Commentare. Recognizing alcohol and drug abuse in patients with eating disorders

QJMed 2006; 99:335-339

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

15.30-16.30: Dibattito finale

16.30-16.35: Melchionda N: Conclusioni e chiusura

Per i Partecipanti che vogliono approfondire con gli abstracts, con i link della sitografia bibliografica per i full texts e richiesta dei pdf: in ordine alfabetico del 1° Autore

Baker JH et al: Eating disorder symptomatology and substance use disorders: prevalence and shared risk in a population based twin sample.

Int J Eat Disord. 2010 43(7):648-58.

1. The objective of this study is to examine the prevalence, chronology, and possibility of shared familial risk between SUD and ED symptomatology.
2. Subjects included 1,206 monozygotic and 877 dizygotic adult female twins. ED symptomatology included anorexia (AN) and bulimia nervosa (BN) diagnosis, symptoms associated with diagnostic criteria, and BN symptom count. SUD included alcohol, illicit drug, and caffeine abuse/dependence. Generalized estimated equation modeling was used to examine phenotypic associations, and Cholesky decompositions were used to delineate the contribution of genes and environment to comorbidity.
3. There were no significant differences between SUD prevalence in women with AN and BN. Women with BN reported BN preceded SUD development while the reverse was true for AN. Twin analyses showed possible familial overlap between BN symptomatology and all SUD examined.
4. Results suggest an important difference in the chronology of EDs and SUDs. Women with BN may be turning to substances to dampen bulimic urges. Women with AN may be engaging in substance use initially in an effort to lose weight. Results also suggest familial factors contribute to the comorbidity between BN and SUD.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2972646/pdf/eat0043-0648.pdf>

Barry D et al: Obesity and Its Relationship to Addictions: Is Overeating a Form of Addictive Behavior?

Am J Addict. 2009 18(6): 439-451.

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 individuals.
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>

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

Physiol Behav. 2009 97(5):537-50.

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

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2717031/?tool=pubmed>

Berridge K et al: The tempted brain eats: Pleasure and desire circuits in obesity and eating disorders

Brain Res. 2010 2; 1350: 43-64.

1. What we eat, when and how much, all are influenced by brain reward mechanisms that generate 'liking' and 'wanting' for foods.
2. As a corollary, dysfunction in reward circuits might contribute to the recent rise of obesity and eating disorders.
3. Here we assess brain mechanisms known to generate 'liking' and 'wanting' for foods, and evaluate their interaction with regulatory mechanisms of hunger and satiety, relevant to clinical issues.
4. 'Liking' mechanisms include hedonic circuits that connect together cubic-millimeter hotspots in forebrain limbic structures such as nucleus accumbens and ventral pallidum (where opioid/endocannabinoid/orexin signals can amplify sensory pleasure).
5. 'Wanting' mechanisms include larger opioid networks in nucleus accumbens, striatum, and amygdala that extend beyond the hedonic hotspots, as well as mesolimbic dopamine systems, and corticolimbic glutamate signals that interact with those systems.
6. We focus on ways in which these brain reward circuits might participate in obesity or in eating disorders.

Full text 35 dollari

<http://www.sciencedirect.com/science/article/pii/S0006899310008115>

o Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Bonfà F et al: Treatment dropout in drug-addicted women: are eating disorders implicated?

Eat Weight Disord. 2008 13(2):81-6.

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 covariable in determining treatment relapse or success.
8. Clinicians should be aware of this potential co-morbidity, and concurrent treatments should be attempted, in order to prevent symptomatic shifting.

<http://www.ncbi.nlm.nih.gov/pubmed/18612256>

Carr K et al: Reinforcement Pathology and Obesity

Curr Drug Abuse Rev. 2011 4(3): 190-196.

1. Obesity is, in part, a result of positive energy balance or energy intake exceeding physiological needs. Excess energy intake is determined by a series of food choices over time. These choices involve both motivational and executive function processes. Problems arise when there is excessive motivation to eat and low impulse control, a situation we have termed reinforcement pathology.
2. Research suggests that the toxic combination of low inhibitory control and high food reinforcement predicts greater energy intake and weight gain. Both the motivational and executive systems are driven through dopamine pathways and common brain centers, including the prefrontal cortex and amygdala. Shared brain structures suggest that imbalances in dopamine may influence both systems.
3. Individual differences in dopaminergic activity could be influenced by genetic predisposition, feedback mechanisms that regulate dopamine and receptor availability, and learning or experience.
4. Reinforcement pathology provides a new theoretical approach to obesity that may lead to new approaches to treatment. In the current obesigenic environment access to unhealthy food is prevalent and effortless.
5. The ease of food access and ready-to-eat food items may exaggerate the impact of impulsivity on eating. Meal decisions are frequently between palatable, easily-prepared food now and a healthy meal that will be available at a delay after it is prepared.
6. Both food reinforcement and impulsivity would predict the choice of immediately available energy dense foods over healthy options, amplifying effects of reinforcement pathology. This leads to the idea that targeting impulsivity and food reinforcement should be an important aspect of a behavioral treatment for obesity to avoid binges or relapses to unhealthy behaviors.
7. The idea of reinforcement pathology suggests that targeting both reinforcing value of food and impulsivity in an obese population should lead to greater weight loss and weight maintenance.
8. Food reinforcement is a significant predictor of energy intake, body mass index (BMI) and weight change over time and impulsivity moderates these relationships. Individuals with high reinforcing value and high impulsivity consume the most energy and have the highest BMI, a condition we have termed reinforcement pathology.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3405539/>

Cohen LR. et al: Survey of Eating Disorder Symptoms among Women in Treatment for Substance Abuse

Am J Addict. 2010 19(3): 245-251.

1. A strong association between substance use disorders (SUD) and eating disorders (ED) in women has been established. Yet, little is known about the rates and impact of ED symptoms in women presenting to addiction treatment.
2. The current investigation assessed the prevalence of ED symptoms and their effect on treatment outcomes in a sample of substance abusing women with co-occurring posttraumatic stress disorder (PTSD) enrolled in outpatient substance use programs. Participants were 122 women who participated in a multi-site clinical trial comparing two behavioral treatments for co-occurring SUD and PTSD.
3. The Eating Disorder Examination-self report (EDE-Q), and measures of PTSD and SUD symptoms were administered at baseline, during treatment and at four follow-up points.
4. Two subgroups emerged; 1. those reporting binge eating in the 28 days prior to baseline, 2. those who reported no binge eating episodes.
5. Women in the Binge group endorsed significantly higher ED, PTSD and depression symptoms at baseline than those in the No Binge group.
6. Though all participants showed significant reductions in PTSD symptoms and improvements in abstinence rates during the study period, the improvements for the Binge group were significantly lower.
7. These findings suggest that a sub-group of women with co-occurring PTSD and SUDs who endorsed binge ED symptoms responded differently to SUD/PTSD group treatment.
8. Identification of eating disorder symptoms among treatment-seeking women with SUDs may be an important element in tailoring interventions and enhancing treatment outcomes.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2882625/?tool=pubmed>

Conason AH et al: Recognizing alcohol and drug abuse in patients with eating disorders

QJM. 2006 May;99(5):335-9.

1. Eating disorders and alcohol/drug abuse are frequently comorbid. Eating-disordered patients are already at an increased risk for morbidity and mortality, so alcohol and drug use pose additional dangers for these patients.
2. Restricting anorexics, binge eaters, and bulimics appear to be distinct subgroups within the eating-disordered population, with binge eaters and bulimics more prone to alcohol and drug use.
3. Personality traits such as impulsivity have been linked to both bulimia nervosa and substance abuse. Many researchers have proposed that an addictive personality is an underlying trait that predisposes individuals to both eating disorders and alcohol abuse.
4. Interviewing is generally the most useful tool in diagnosing alcohol and substance abuse disorders in individuals with eating disorders.

5. It is essential for the physician to be non-judgmental when assessing for substance abuse disorders in this population.
6. We discuss interviewing techniques, screening instruments, physical examination, and biological tests that can be used in evaluating patients with comorbid eating disorders and substance abuse.
7. More studies are needed to understand psychobiological mechanisms of this comorbidity, and to develop treatments for individuals with comorbid eating disorders and substance misuse.

<http://qjmed.oxfordjournals.org/content/99/5/335.full.pdf+html?sid=dca7d165-e225-450a-ac76-a8cb464dae4b>

Courbasson C, Brunshaw JM.: The relationship between concurrent substance use disorders and eating disorders with personality disorders.

J Environ Res Public Health. 2009 Jul;6(7):2076-89.

1. The current pilot study investigated whether patients with concurrent substance use disorders and eating disorders (SUD and ED) who experienced a reduction in SUD and ED symptoms following treatment for SUD and ED also experienced a reduction in personality disorder (PD) symptoms.
2. Twenty patients with SUD and ED and PD were assessed pre and post treatment using clinical interviews, self-report questionnaires, and a therapist questionnaire on DSM-IV-TR symptoms for PD.
3. Symptoms for the personality disorders were reduced following treatment. This reduction was correlated with a decrease in the number of symptoms of ED at post treatment
4. Chronic concurrent SUD and ED may make it difficult to separate PD symptoms from co-occurring disorders. Many features attributed to PDs may be reduced when problematic substance

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2738899/pdf/ijerph-06-02076.pdf?tool=pmcentrez>

Davis C et al: Evidence that 'food addiction' is a valid phenotype of obesity Appetite. 2011 57(3):711-7.

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. 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 co-morbidities, psychological risk factors, abnormal motivation for the addictive substance.
3. 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.
4. They also displayed greater food cravings and the tendency to 'self-soothe' with food.
5. 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

<http://www.ncbi.nlm.nih.gov/pubmed/21907742>

Degli Esposti L, Tarrini G, Zanetti C, Melchionda N: Analisi clinico-diagnostica ed Epicrisi del decorso terapeutico di un caso paradigmatico:

1. Componente patologica somatica
2. Componente patologica comportamentale
3. Componente patologica Ambientale
4. Componente patologica Psichiatrica
5. Componente Terapeutica Farmacologia, Nutrizionale, Psicologica, Setting in Rete e Setting in rete e/o come Team-Approach multi-disciplinare, multi-professionale integrato

Denoth F et al: The association between overweight and illegal drug consumption in adolescents: is there an underlying influence of the sociocultural environment?

PLoS One. 2011;6(11):e27358.

1. Examine the distribution of gender-stratified body mass index, eating attitudes and use of addictive substances, under the hypothesis of a confluent prevalence of weight abnormalities, eating disorders and substance abuse. Demonstrate the extent to which family, peer-related and psychosocial factors are common elements in categories of compulsive behaviour.
2. In the present cross-sectional study, data were collected through self reported questionnaires administered to a large sample of 33 years old adolescents, divided into weight categories based on the BMI percentile distribution.
3. Multinomial analyses were adopted to address the influence of social, family, leisure time factors, Eating Attitude Test on the association between weight categories and drug use.
4. Within the overweight category, adolescents reporting recent drug use, showed greater frequency of having drug-abusing friends, and severe problems with parents and school compared to overweight adolescents without recent drug use.
5. The frequent association of overweight and substance use and the presence of common underlying social factors, highlights the need for an interdisciplinary approach involving individual-focused treatment models as well as public health, social and environmental changes to reduce food- and substances-related problems.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3217959/?tool=pubmed>

Dunn EC et al: A Cross-Lagged Evaluation of Eating Disorder Symptomatology and Substance-Use Problems

J Stud Alcohol Drugs. 2009 70(1): 106–116

1. The purpose of this study was to conduct a temporal examination of the associations among disordered eating behaviors, substance use, and use-related negative consequences in female college students—a population at high risk for developing eating and substance-use disorders.
2. Results support previous research suggesting that disordered eating behaviors are more strongly associated with alcohol- and substance-related problems rather than use per se.
3. With respect to temporal precedence, results indicated that binge eating preceded alcohol-use problems, but a bidirectional relationship was found for vomiting.
4. With regard to drug problems, laxatives use preceded drug problems, whereas drug problems preceded fasting.

5. These associations were not better accounted for by pre-existing eating or substance-use problems or psychiatric distress (e.g., depression, anxiety).
6. This study further supports the importance of assessing consequences, in addition to use patterns, when examining substance use in individuals demonstrating threshold and subthreshold eating-disordered behaviors.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2629626/?tool=pubmed>
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2629626/?tool=pubmed>

Eichen DM et al: Weight perception, substance use, and disordered eating behaviors: comparing normal weight and overweight high-school students.

J Youth Adolesc. 2012 41(1):1-13

1. Disordered eating behaviors and substance use are two risk factors for the development of serious psychopathology and health concerns in adulthood. Despite the negative outcomes associated with these risky behaviors, few studies have examined potential associations between these risk factors as they occur during adolescence.
2. The importance of accurate or inaccurate weight perception among adolescents has received increased interest given documented associations with nutritional beliefs and weight management strategies.
3. The sample consisted of 11,103 adolescents.
4. Overestimation of weight among normal weight adolescents and accurate perceptions of weight among overweight adolescents were associated with higher rates of disordered eating behaviors.
5. In normal weight adolescents, use of all three substances (tobacco, binge drinking, and cocaine) was associated with each disordered eating behavior.
6. In contrast, findings revealed differences for overweight adolescents between the type of substance use and disordered eating behavior
7. Post hoc analyses revealed that gender moderated some of these relationships among overweight individuals. Implications for the development and implementation of secondary prevention programs aimed at reducing disordered eating behaviors, substance use, and obesity risk among normal and overweight adolescents are considered.

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Gearhardt AN et al: Preliminary validation of the Yale Food Addiction Scale

Appetite 52 (2009) 430-436

1. Previous research has found similarities between addiction to psychoactive substances and excessive food consumption. Further exploration is needed to evaluate the concept of "food addiction," as there is currently a lack of psychometrically validated measurement tools in this area.
2. The current study represents a preliminary exploration of the Yale Food Addiction Scale (YFAS), designed to identify those exhibiting signs of addiction towards certain types of foods (e.g., high fat and high sugar).
3. Survey data were collected from 353 respondents from a stratified random sample of young adults. In addition to the YFAS, the survey assessed eating pathology, alcohol consumption and other health behaviors.
4. The YFAS exhibited adequate internal reliability, and showed good convergent validity with measures of similar constructs and good discriminant validity relative to related but dissimilar constructs.
5. Additionally, the YFAS predicted binge-eating behavior above and beyond existing measures of eating pathology, demonstrating incremental validity.
6. The YFAS is a sound tool for identifying eating patterns that are similar to behaviors seen in classic areas of addiction. Further evaluation of the scale is needed, especially due to a low response rate of 24.5% and a non-clinical sample, but confirmation of the reliability and validity of the scale has the potential to facilitate empirical research on the concept of "food addiction".

<http://www.yaleruddcenter.org/resources/upload/docs/what/addiction/FoodAddictionScaleArticle09.pdf>

Grilo CM et al: Eating disorders with and without substance use disorders: a comparative study of inpatients

Compr Psychiatry. 1995 36(4):312-7

1. We assessed the co-occurrence of DSM-III-R axis I and II disorders and self-reported psychologic distress in inpatients with eating disorders with and without substance use disorders (ED-SUD and ED groups, respectively) and in a matched comparison sample with substance use disorders but no eating disorder (SUD group).
2. The three groups showed similar distributions of axis I disorders but differed in the distribution of axis II disorders.
3. Cluster B personality disorders were diagnosed more frequently in SUD and ED-SUD groups than in the ED group.
4. In contrast, cluster C personality disorders were diagnosed more frequently in the ED group than in SUD and ED-SUD groups.
5. The SUD group reported greater psychologic distress than ED and ED-SUD groups.
6. Possible implications of the observed group differences for psychologic models of why these disorders may be associated are considered.

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Grosshans M et al: Implications from addiction research towards the understanding and treatment of obesity.

Addict Biol. 2011 16(2):189-98.

1. Recent research indicates similarities between obesity and addictive disorders on both the phenomenological and neurobiological level.
2. In particular, neuroendocrine and imaging studies suggest a close link between the homeostatic regulation of appetite on the one hand, and motivation and reward expectancy on the other.
3. In addition, findings from neuropsychological studies additionally demonstrate alterations of cognitive function in both obesity and addictive disorders that possibly contribute to a lack of control in resisting consumption.
4. In this review, recent findings on overlapping neurobiological and phenomenological pathways are summarized and the impact with regard to new treatment approaches for obesity is discussed.
5. Studies on phenomenological, neurobiological and neuropsychological similarities of obesity and addictive disorders underline the importance of a closer consideration of eating behaviour of obese individuals with regard to addictive mechanisms.
6. Taking into account the increased incidence of obesity and adjunct concomitant disorders as well as a multiplication of the associated treatment costs, findings with regard to basic mechanisms of addictive behaviour and evidence-based treatment interventions should be applied, at least hypothetically, to this disorder, formerly mainly considered and treated by specialists for internal medicine.
7. The examination of psychotherapeutic interventions primarily influencing motivational processes can be

a first step in this direction.

8. While both addiction and obesity have been considered as independent entities, the relevance of overlapping findings with regard to genetic vulnerability, neurobiological feedback mechanisms and effectiveness of psychopharmacological treatment approaches for the field of psychiatry is reflected at present in the discussion to include obesity as a disorder in the psychiatric chapter of the 5th revision of the Diagnostic and Statistical Manual of Mental Disorders.

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Gruza RA et al: The emerging link between alcoholism risk and obesity in the United States. Arch Gen Psychiatry. 2010 67(12):1301-8.

1. The prevalence of obesity has risen sharply in the United States in the past few decades. Etiologic links between obesity and substance use disorders have been hypothesized.
2. To determine whether familial risk of alcohol dependence predicts obesity and whether any such association became stronger between the early 1990s and early 2000s.
3. We conducted analyses of the repeated cross-sectional National Longitudinal Alcohol Epidemiologic Survey (1991-1992) and National Epidemiologic Survey on Alcohol and Related Conditions (2001-2002). The noninstitutionalized US adult population in 1991-1992 and 2001-2002. Individuals drawn from population-based, multistage, random samples.
4. Obesity, defined as a body mass index of 30 or higher and predicted from family history of alcoholism and/or problem drinking.
5. Women with a family history of alcoholism had 49% higher odds of obesity than those without a family history, a highly significant increase.
6. For men the association was significant but not as strong as for women.
7. These results provide epidemiologic support for a link between familial alcoholism risk and obesity in women and possibly in men. This link has emerged in recent years and may result from an interaction between a changing food environment and predisposition to alcoholism and related disorders.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110764/?tool=pubmed>

Iacovino JM et al.: Psychological Treatments for Binge Eating Disorder Curr Psychiatry Rep. 2012 14(4): 432-446.

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.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433807/>

Kelly-Weeder S: Binge drinking and disordered eating in college students. J Am Acad Nurse Pract. 2011 23(1):33-41.

1. To explore the co-occurrence of binge drinking and disordered eating behaviors in college-aged students.
2. Data were collected from 211 college-aged students at a private university using a web-based survey. Gender-specific binge drinking rates.
3. Disordered eating behaviors included measures of binge eating as well as unhealthy weight loss behaviors (skipping meals, fasting, diet pills, laxatives, and self-induced vomiting).
4. Binge drinking rates were high (63% of female, 83% of male students). Binge eating was reported by 48% of students and was correlated with healthy and unhealthy weight loss behaviors. Female students were more likely to endorse the use of skipping meals, fasting, use of diet pills, laxatives, and self-induced vomiting.
5. Binge drinking and disordered eating behaviors are practiced by both male and female students and are common occurrences on college campuses.
6. Nurse practitioners need to be aware of these behaviors, their co-occurrence, and the need to assess and intervene with students who are at risk for the negative health outcomes associated with the use of these behaviors.

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Liu Y et al: Food addiction and obesity: evidence from bench to bedside. J Psychoactive Drugs. 2010 42(2):133-45.

1. Obesity has become a major health problem and epidemic. However, much of the current debate has been fractious and etiologies of obesity have been attributed to eating behavior or fast food, personality issues, depression, addiction, or genetics.
2. One of the interesting new hypotheses for epidemic obesity is food addiction, which is associated with both substance-related disorder and eating disorder. Accumulating evidences have shown that there are many shared neural and hormonal pathways as well as distinct differences that may help researchers find why certain individuals overeat and become obese.
3. Functional neuroimaging studies have further revealed that good or great smelling, looking, tasting, and reinforcing food has characteristics similar to that of drugs of abuse.
4. Many of the brain changes reported for hedonic eating and obesity are also seen in various forms of addictions.
5. Most importantly, overeating and obesity may have an acquired drive like drug addiction with respect to motivation and incentive; craving, wanting, and liking occur after early and repeated exposures to stimuli.
6. The acquired drive for great food and relative weakness of the satiety signal would cause an imbalance between the drive and hunger/reward centers in the brain and their regulation.

McElroy SL et al: Pharmacological management of binge eating disorder: current and emerging treatment options. Therapeutics and Clinical Risk Management 2012;8 219-24

1. Growing evidence suggests that pharmacotherapy may be beneficial for some patients with binge eating disorder (BED), an eating disorder characterized by repetitive episodes of uncontrollable consumption of abnormally large amounts of food without inappropriate weight loss behaviors.
2. In this paper, we provide a brief overview of BED and review the rationales and data supporting the effectiveness of specific medications or medication classes in treating patients with BED.
3. We conclude by summarizing these data, discussing the role of pharmacotherapy in the BED treatment armamentarium, and suggesting future areas for research.

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

McIntyre RS et al: Substance use disorders and overweight/obesity in bipolar I disorder: preliminary evidence for competing addictions.

J Clin Psychiatry. 2007 68(9):1352-7.

1. This investigation was undertaken to explore the relationship between alcohol/illicit drug dependence and overweight/obesity in individuals with bipolar I disorder.
2. The data for this analysis were procured from the Canadian Community. Bipolar I disorder was defined as persons screening positive for a lifetime manic episode.
3. Substance abuse and illicit drug dependence were determined using criteria commensurate with the DSM-IV-TR.
4. The total sample comprised 36,984 individuals screening positive for a lifetime manic episode. Subgroup analysis indicated that overweight/obese bipolar individuals had a significantly lower rate of substance dependence than the normal weight sample.
5. Conversely, bipolar individuals who screened positive for substance dependence had a lower rate of overweight/obesity when compared with non-substance-dependent bipolar respondents.
6. The inverse association between the presence of these 2 co-morbid conditions in bipolar I disorder continued to be statistically significant in multivariate analysis.
7. An inverse relationship between the presence of comorbid overweight/obesity and substance use disorders was observed in bipolar I disorder.
8. These results suggest that comorbid addictive disorders (i.e., substance use and compulsive overeating) may compete for the same brain reward systems.

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Meule A, Kübler A: 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. 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).
5. 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.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3382827/>

Moreno C, Tandon R.: Should overeating and obesity be classified as an addictive disorder in DSM-5?

Curr Pharm Des. 2011;17(12):1128-31.

1. Overeating and associated obesity are major public health problems. In addition to its notable adverse health consequences, the behavior of overeating has significant neurobiological and psychological underpinnings.
2. Current classification systems of mental disorders address this increasingly prevalent "disorder" in a limited and inconsistent manner.
3. Several similarities between overeating and substance dependence have been documented with regards to phenomenology, shared neurobiology, and treatment.
4. This has led to suggestions that a new category of "food addiction" be added to our psychiatric nosology and that this category be included with substance use disorders under a broad rubric of "addiction disorders".
5. In this article, we consider the rationale for this recommendation and evaluate its pros and cons. We summarize how the problem of overeating is addressed in our current classification systems and discuss DSM-5 approaches to the issue

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Nizzoli U: Implicazioni della rete clinica integrata: Inter-disciplinarietà e Multi-professionalità Integrata.

Nizzoli U, Melchionda N, Tarrini G: La Cura dei Disturbi Alimentari. Il Lavoro di Equipe Multidisciplinare I Quaderni di Personalità/Dipendenze, Mucchi Editore

1. L'integrazione delle professionalità va vista non come sovrapposizione di ambiti professionali o affiancamento di discipline diverse, non come somma di competenze, ma come esplicitazione di un ben più impegnativo e serio tentativo di impostare l'intero iter clinico. Non: "Di che ti mando io" ma: "Parliamone insieme".
2. Il primo caso si riferisce al Professionista che invia il Paziente ad un altro Professionista. Nel secondo caso i due (o più) Professionisti si attivano insieme, con un comune linguaggio, per la soluzione di problemi che riguardano l'iter diagnostico-terapeutico. Quindi è possibile ritenere che un Team Multi-disciplinare di Professionisti, integrato all'insegna della Inter-disciplinarietà, possa operare molto meglio di Professionisti isolati, anche se molto preparati ma che non comunicano all'unisono.
3. Il termine Interdisciplinarietà non va confuso con multi-disciplinarietà che ha un significato differente, cioè quello della semplice giustapposizione di discipline diverse, senza rapporto apparente tra loro. Prima di dare una definizione occorre premettere che un approccio inter-disciplinare non può attuarsi senza aver chiari i nuclei fondanti delle singole discipline.
4. L'inter-disciplinarietà presuppone la ineludibile integrazione dei saperi, delle procedure e dell'elaborazione con un linguaggio comune, che permette scambi concettuali e metodologici. In altri termini l'inter-disciplinarietà può essere definita come l'unitarietà del sapere attraverso la

trasversalità delle competenze.

5. La specificità di un sapere disciplinare deriva dal modo particolare in cui esso declina competenze che sono trasversali a tutti gli ambiti disciplinari. Quindi l'Integrazione delle Professionalità esprime la traduzione operativa dell'Inter-disciplinarietà che significa "toccare nei suoi aspetti principali il modo complessivo di "fare professione". Significa saper partire dalla pratica reale e non dalle sue interpretazioni teoriche. Esse sono già sistematizzate in un ben definito settore conoscitivo, le Discipline e le Specialità professionali.
6. L'Inter-disciplinarietà permette pertanto di saper partire dalle situazioni problematiche della pratica, da fenomeni e realtà globali sempre complessi e mai riconducibili ad un confinato ambito settoriale specifico. Certamente, le discipline o le specialità sono sistemi necessari per la comprensione della realtà, ma devono essere considerati solo "impianti metodologico-conoscitivi di valore sempre relativo e di portata parziale".
7. Questi sono bisognosi di continue e reciproche interazioni tra le dimensioni scientifiche già note e quelle non ancora messe a punto dalla cultura ufficiale per la comprensione della realtà. Quindi nulla è scritto, vale a dire come si deve fare, ma la creatività, l'invenzione e l'uniformità a bisogni emergenti costituiscono un campo affascinante di lavoro eclettico e innovativo. Ovviamente le soluzioni non sono "sul tavolo" ma bisogna inventarle e renderle operative soprattutto quando sono attinenti a interessi professionali.

Su richiesta è possibile ricevere in pdf il volume: melchiondauno@gmail.com e/o zanetti.chiara@gmail.com

Pelchat ML: Food addiction in humans.

J Nutr. 2009 139(3):620-2

1. Most of the evidence for or against food addiction in humans focuses on similarities between food craving and drug craving. There are numerous parallels in neuroanatomy, neurochemistry, and learning.
2. Indeed, brain mechanisms for craving probably evolved to promote seeking of natural rewards and are taken over by drugs of abuse.
3. Healthy, normal weight individuals, by definition, do not suffer from food addiction; however, overweight and obese individuals could meet clinical criteria.
4. Palatable foods are not responsible for the obesity problem, because even nonpalatable foods can come to be desired and potentially overconsumed.
5. It may be the way in which foods are consumed (e.g. alternating access and restriction) rather than their sensory properties that leads to an addictive eating pattern.

<http://jn.nutrition.org/content/139/3/620.full.pdf+html?sid=55ef1edd-7c3c-4c42-95e2-9b3b6461b51f>

Petry N et al: Overweight and Obesity Are Associated With Psychiatric Disorders: Results From the National Epidemiologic Survey on Alcohol and Related Conditions Psychosomatic Medicine 70:288-297 (2008)

1. This study evaluated associations between BMI and psychiatric disorders.
2. Data from respondents in the National Epidemiologic Survey on Alcohol and Related Conditions..
3. The continuous variable of BMI was significantly associated with most mood, anxiety, and personality disorders.
4. Mood and personality disorders associated with obesity included major depression, dysthymia, and manic episode and antisocial, avoidant, schizoid, paranoid, and obsessive-compulsive personality disorders.
5. Compared with normal weight individuals, being moderately overweight was significantly associated with anxiety and some substance use disorders, but not mood or personality disorders.
6. Specific anxiety disorders that occurred at significantly higher rates among all categories of persons exceeding normal weight were generalized anxiety, panic without agoraphobia, and specific phobia.
7. Being underweight was significantly related to only a few disorders; it was positively related to specific phobia and manic episode, and negatively associated with social phobia, panic disorder with agoraphobia, and avoidant personality disorder.
8. Conclusion: These data provide a systematic and comprehensive assessment of the association between body weight and psychiatric conditions. Interventions addressing weight loss may benefit from integrating treatment for psychiatric disorders.

Pdf su richiesta a gtarrini@gmail.com e dca@aosp.bo.it

Pickering RP et al: 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.

J Clin Psychiatry. 2011 72:1494-502

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.

<http://www.ncbi.nlm.nih.gov/pubmed/21457678>

Reas DL, Grilo CM: Review and meta-analysis of pharmacotherapy for binge-eating disorder. Obesity (Silver Spring). 2008 16(9):2024-38.

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/pdf/oby2008333a.pdf>

Taylor VH 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.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2831667/?tool=pubmed>

Umberg EN et al: From disordered eating to addiction: the "food drug" in bulimia nervosa.
J Clin Psychopharmacol. 2012 32(3):376-89

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. 3, This review explores how the specific eating patterns seen in BN (binge eating and 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.

<http://www.ncbi.nlm.nih.gov/pubmed/22544008>

VanBuskirk KA et al: The Treatment of Obesity and Its Co-occurrence with Substance Use Disorders
J Addict Med. 2010 (1): 1-10.

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/>

Wilson GT: Eating Disorders Obesity and Addiction
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. The addiction is viewed as a brain disease that must be directly targeted if treatment is to succeed.
2. Evidence 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.
3. Neurobiological research has shown commonalities in brain reward processes between obesity and substance abuse disorders.
4. Yet emphasis on apparent similarities overlooks important differences between obesity and drug addiction.
5. Interest in obesity as a brain disease should not detract from a public health focus on the 'toxic food environment' that is arguably responsible for the obesity epidemic and related nutrition-based chronic disease.

Pdf su richiesta a qtarrini@gmail.com e dca@aosp.bo.it

Wilson GT: Treatment of binge eating disorder.
Psychiatr Clin North Am. 2011 34(4):773-83.

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

.....

<http://www.ncbi.nlm.nih.gov/pubmed/22098803>

[http://www.psych.theclinics.com/article/S0193-953X\(11\)00088-8/fulltext](http://www.psych.theclinics.com/article/S0193-953X(11)00088-8/fulltext)