FACING ADDICTION WITH HOPE AND UNDERSTANDING

When Hunger Becomes a Haunting: Food Addiction, Comorbidity, and What Families Need to Know About the Hidden Faces of Substance Use Disorder

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There is a particular cruelty in addictions that disguise themselves as ordinary life. A person reaches for food — the most universal of human comforts, the centerpiece of every celebration, every grief, every family gathering — and somewhere in that reaching, something shifts. The behavior that looks like overeating, or poor willpower, or a lack of discipline, begins to follow the same neurological pathways, the same compulsive grooves, as the addiction that tore the family apart in the first place. And no one recognizes it. Not the treatment providers. Not the insurance companies. And often, not the family.

A 2026 study published in *Substance Use & Addiction Journal* by Li and colleagues is asking a question that the addiction treatment world has largely avoided: How is food addiction being addressed at U.S. substance use disorder treatment facilities? The answer, it turns out, is: barely, inconsistently, and without any standardized framework to guide providers who recognize the problem but lack the tools to treat it.

This matters enormously — not just clinically, but for the families sitting in waiting rooms, counting down the days of their loved one's residential treatment, hoping that this time will be different.

THE HIDDEN COMORBIDITY NO ONE WARNED YOU ABOUT

The primary study makes a point that deserves to land with full weight: food addiction is not currently recognized as a diagnosable condition in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth

Edition* (DSM-5). This means that even when treatment providers see it — and according to the research, many do — they have no formal diagnostic category to place it in, no billing code to attach to it, and no evidence-based protocol to follow (Li 2026).

Yet food addiction is understood in the research literature as both a common comorbidity of substance use disorders and a potential *substitute addiction* — meaning that when a person stops using drugs or alcohol, the same neurobiological hunger that drove the substance use can migrate, attach itself to highly palatable foods, and begin the cycle anew. The dopaminergic reward pathways that make opioids or alcohol so difficult to resist are the same pathways activated by sugar, fat, and salt in combination. The brain does not much care what feeds it. It cares about the reward.

For families, this creates an invisible threat in recovery. A parent watches their child come home from a ninety-day treatment program, sober and seemingly well, and notices that something still seems off — that the obsessive quality, the loss of control, the secrecy around eating, has something familiar about it. They may be right. And they deserve research and clinical systems that take that observation seriously.

THE PROBLEM WITH "NOT IN THE DSM"

When food addiction lacks diagnostic status, it doesn't simply disappear from the treatment setting — it goes underground. The Li study surveyed service providers at U.S. substance use disorder facilities specifically to understand the gap between clinical reality and formal recognition. What emerges from this research is a picture of providers who are aware of the phenomenon, who encounter it in their patients, but who operate without guidance, without training, and without institutional support for addressing it (Li 2026).

This is a structural failure, but it is also a human one. It means that a person in SUD recovery who develops or reveals a food addiction is

essentially on their own — or, more accurately, dependent on whether they happen to encounter a provider perceptive and informed enough to recognize the pattern and creative enough to address it outside any formal framework.

The implications for family recovery are significant. Families are often the first and most consistent observers of a loved one's behavior across time. They see the patterns before treatment providers do. They notice the substitutions. And when they bring these observations to clinical teams, they deserve a field that has the language, the tools, and the institutional frameworks to respond.

COMORBIDITY AS A FAMILY EXPERIENCE

One of the most important things families can understand about addiction — and about food addiction as a comorbidity — is that comorbidity is not the exception. It is the rule. Substance use disorders rarely travel alone. They arrive with depression, with anxiety, with trauma, with ADHD, and, as the current research suggests, with disordered relationships to food.

The emerging research on smartphone addiction in Chinese adolescents, published in 2026, offers a useful parallel framework for understanding how behavioral addictions operate alongside and in interaction with psychological vulnerability. That study found that smartphone addiction creates and amplifies loneliness, anxiety, and depression in adolescents through interconnected mechanisms — with each condition feeding and reinforcing the others in what researchers describe as a cascade of compounding harm ("The Impact of Smartphone Addiction" 2026). The specific neurological mechanisms differ across addiction types, but the pattern of comorbidity — one struggle inviting others through shared pathways of distress — is consistent across the literature.

For families, what this means practically is that recovery from one addiction does not automatically confer protection against others. The

underlying vulnerabilities — neurological, psychological, social, environmental — remain present. Recovery is not a destination that, once reached, requires no further tending. It is a landscape that continues to shift.

WHAT TREATMENT FACILITIES ARE AND ARE NOT DOING

The Li study's most significant contribution may be its honest accounting of the gap between the scope of the problem and the sophistication of the response. Service providers at SUD treatment facilities, according to the research, recognize food addiction as a real and relevant clinical concern, but the facility-level response remains fragmented (Li 2026). Without a DSM diagnosis, without standardized screening tools, without treatment protocols specific to food addiction in the SUD population, providers are improvising — relying on individual clinical judgment in the absence of systemic support.

This is not a criticism of individual providers, many of whom are clearly trying to serve their patients as completely as possible. It is a criticism of a system that has not kept pace with the science. The neuroscience of behavioral addiction, of dopaminergic reward pathways, of substitute addiction, has advanced considerably. The diagnostic and treatment infrastructure has not.

For families, this knowledge is power. It means asking questions. It means, when a loved one is in treatment, asking the clinical team: *How do you screen for food addiction? What do you do if you identify it? What happens to this concern after discharge?* These are not hostile questions. They are the questions of people who understand that recovery is multidimensional and who want their loved one to receive care that matches the full complexity of their situation.

HOPE IS NOT NAÏVETÉ — IT IS PRECISION

There is sometimes a temptation, in the face of a clinical landscape this incomplete, to feel despair. The DSM hasn't caught up. The treatment facilities are improvising. The families are watching.

But the Li study itself is an act of hope — methodologically rigorous, compassionately motivated, designed specifically to identify the gap so that the gap can be closed. Research of this kind is how systems change. Providers who participate in studies like this one are saying, collectively: *we see this problem, we want to address it, and we need the field to support us in doing so* (Li 2026).

What families can hold onto is this: the fact that a problem is under-recognized does not mean it is untreatable. It means that treatment requires more intentionality, more self-advocacy, more informed observation from the people closest to the person in recovery. Families who understand the concept of substitute addiction — who know that the brain's hunger for reward does not simply end when the substance is removed — are families who can recognize warning signs earlier, ask better questions, and seek out providers who are themselves staying current with the research.

The approach that FAHU has always advocated — facing addiction with hope and understanding rather than judgment or shame — is not merely a philosophical stance. It is a clinical imperative. Shame does not interrupt substitute addiction. Judgment does not screen for food addiction comorbidity. What works, what the research consistently returns to, is attentive, informed, compassionate engagement — from providers, yes, but also from families who refuse to look away from complexity, who are willing to learn what their loved one's brain is actually doing, and who bring that knowledge into every clinical conversation.

TOWARD A MORE COMPLETE RECOVERY

The field is moving, even if slowly. The Li study, by documenting the gap between clinical reality and formal recognition, lays groundwork for future advocacy, future research, and eventually, future changes to diagnostic frameworks and treatment standards (Li 2026). Families who are engaged with this research, who speak its language, who bring its findings into support groups and treatment consultations, accelerate that movement.

Food addiction as a comorbidity of SUD is not a minor clinical footnote. It is a daily reality for many people in recovery and for the families who love them. It deserves to be named, studied, screened for, and treated — not improvised around.

Until the system catches up, the most powerful thing a family can do is what families have always done in the face of incomplete systems: pay attention, stay informed, ask hard questions with soft hearts, and refuse to let any dimension of a loved one's struggle go unwitnessed.

That is, precisely, what it means to face addiction with hope and understanding.

Works Cited

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