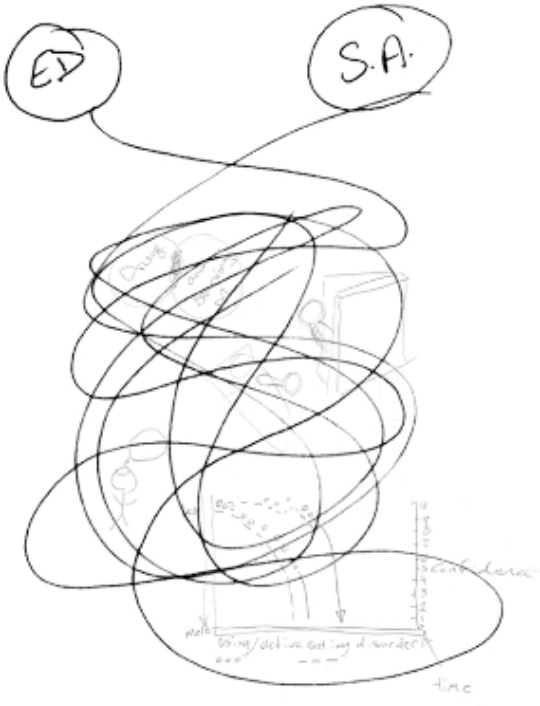
The Interplay of Substance Misuse and Disordered Eating Practices in the Lives of Young Women: Implications for Narrative Therapeutic Practice



By Christine Lee Dennstedt

THE INTERPLAY OF SUBSTANCE MISUSE AND DISORDERED EATING PRACTICES IN THE LIVES OF YOUNG WOMEN: IMPLICATIONS FOR NARRATIVE THERAPEUTIC PRACTICE

PROEFSCHRIFT

ter verkrijging van de graad van doctor aan de Universiteit van Tilburg, op gezag van de rector magnificus, prof. dr. Ph. Eijlander, in het open-baar te verdedigen ten overstaan van een door het college voor promoties aan-gewezen commissie in de Ruth First zaal van de Universiteit op dinsdag 09 februari 2010 om 16.15 uur

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Promotores: Prof. Dr. S. McNamee and Prof. Dr. J.B. Rijsman

ABSTRACT

The majority of studies pertaining to substance misuse and eating disorders are dominated by concurrent disorders research. Within that framework, traditional medical, psychological, biochemical models, and the disease model of addiction prevail. Studies that consult young women about their ideas and knowledge for how to best address these problems in therapy are relatively rare within these fields. Using a narrative approach to therapy, I explore the interplay between these problems, and the ways in which disordered eating practices and substance misuse problems can "feed off of each other," thereby keeping young women ensnared in their grips. Twelve young women (insiders) who attended a residential substance misuse program were interviewed about their personal experience with substance misuse and disordered eating practices in an attempt to explore and identify ways in which helpers and young women can use these similarities to their advantage. Using case examples from 12 semi-structured interview conversations, I demonstrate the merits of co-research practices, and detail the practical and therapeutic applications of a narrative therapeutic approach when working with young women struggling with these problems. Interviews were audio-taped, transcribed, sorted and assigned to thematic categories. The results suggest the importance of highlighting the interplay between these problems and illuminate the young women's insider knowledge regarding these problems. Based on these results, suggestions for ways to best address these problems are offered. In order to contextualize the problems and locate them

within their political and social cultural context, the above ideas are framed within historical accounts of alcohol and drugs, disordered eating, mental illness, social construction, and narrative therapy ideas. This study may benefit counsellors, health-care professionals, parents, and teachers who know or are working with young women who struggle with substance misuse and disordered eating practices in that the study offers practical ways to assist persons in reclaiming their lives from these problems.

DEDICATION

This is dedicated to all the young women whose voices are included in this dissertation. Without your words this writing would not have been possible. I hope that your voices are well represented in this manuscript. I thank you for your courage to speak with me, and I hope your words inspire and assist other young women who are struggling to free themselves from substance misuse and disordered eating to find freedom from these problems.

ACKNOWLEDGEMENTS

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unwavering support of my partner Clark Lewis. I am now ready to join you on our next adventure.

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CHAPTER 1 INTRODUCTION

It is common knowledge within the field of psychotherapy that many young women struggle with the problems of substance misuse and disordered eating practices (Brady, Back & Greenfield, 2009). However, it is less commonly known how to work with these problems as a therapist when they occur simultaneously in a young woman's life. So grew my interest in developing ways to work with young women who struggle with problems that threaten both themselves and challenge their helpers due to their complexity. My purpose in this dissertation is to explore and illuminate the interplay and relational features of disordered eating practices and substance misuse. I will explore what I have learned as a therapist to develop an approach to working with the complex relationship between these two problems. Using case examples from 12 semi-structured interview conversations I conducted with young women who have personal experience with substance misuse and disordered eating practices, I will illustrate the practical and therapeutic applications of this approach for therapeutic work with young women struggling with these problems[1].

There is a wide breadth of understanding in regards to the paradigms used to describe substance misuse and disordered eating practices. Before I move on it is important to clarify the paradigms that my understandings of these two problems are

[1] I am aware that young men also experience a form of body policing and also struggle with disordered eating practices. Yet I chose to only include young women's experience with both problems for a variety of reasons; 1) Rates for disordered eating practices are consistently higher for women than men (Hudson, Hiripi, Pope & Kessler 2007), 2) In my work as a therapist more young women tend to be reporting the struggle with substance misuse and disordered eating practices more than young men and 3) Discussing both young men and women's experience with these problems is beyond the scope of this writing.

located in. When using the term substance misuse I use it to discern from the more commonly used terms substance abuse/dependence. Abuse/dependence are rooted in the dominant addiction terminology, and the disease model of addiction. Rather than use the term eating disorders, which I find conjures up and limits us to traditional and individualistic understandings of anorexia, bulimia, and compulsive eating I chose the term disordered eating practices. I use the term disordered eating practices to encompass "anorexia, bulimia and weight preoccupation" (Brown, 1993, p. 53). As Brown describes "the weight preoccupation continuum often includes fear of fatness, denial of appetite, exaggeration of body size, depression, emotional eating and rigid dieting" (p. 53-54). Brown acknowledges, "only a matter of degree separates those women who diet, work out, and obsess about their body shape and calorie intake from the more extreme behaviours of anorexia and bulimia" (p. 54). My use of the term disordered eating practices is an attempt to conceptualize the societal drive for thinness not as individual pathology, but as problems that are very much connected to their larger social contexts (Brown).

Traditional discourses of eating disorders and addiction can also result in the totalizing labels of 'anorexic/bulimic/alcoholic/addict' being placed on or taken up by persons (Sanders, 2007; Madigan, 1999). While some people describe finding these 'labels' helpful as they give them a way to understand their experience and place to stand, others find that these labels soon begin to define and explain their understanding of who they are and how others know and relate to them (Tomm, 1990)

This dissertation is divided into seven chapters. Chapter one introduces the reader to my own initial interests in this work and the practice, based on theoretical

assumptions that inform my work. Additionally, I briefly introduce the reader to the traditional ways of understanding substance misuse and disordered eating. These traditional treatment models are problematized and an alternative way of addressing them is proposed. The voices that inform my research will also be discussed. Chapter two describes the relational features that disordered eating practices and substance misuse have in common, and ways in which helpers can use these features to their advantage when working with clients. I give an overview of the narrative re-authoring perspective, and present a hypothetical conversation between disordered eating and substance misuse. Chapter three contextualizes disordered eating practices and substance misuse in history and explores the ensuing ways of understanding and treating these problems. I also explore some of the similarities and differences in the ways these problems have been constructed and the ways that this has impacted our current understandings and treatment practices. The second half of chapter three gives the history of the Diagnostic and Statistical Manual (DSM)(APA, 2000) and speaks to the impact this perspective has on persons seeking therapy for substance misuse and disordered eating practices. In chapter four, I explore and give an overview of social construction, which is the orienting discourse of this dissertation. Chapter five explains my research methodology, and chapter six presents the results of my interviews with the young women. Throughout chapter six, therapeutic questions are included in order to give the reader a sense of how these ideas work in praxis. Finally, in chapter seven, I discuss the implications of my research and suggestions for incorporating these practices into the work that we do as counsellors when working with young women struggling with what can be life-threatening problems. This final chapter also describes the

limitations of my dissertation while suggesting possible directions that this work can take in the future.

How I Came to this Work

A significant portion of my therapy career has been spent working alongside young men and women trying to reclaim their lives from drugs and alcohol. For the past eight years I practiced first as a youth counsellor and later as a family therapist at Peak House, a co-ed residential substance misuse program located in Vancouver, British Columbia, where young people live for a period of 10 weeks, participating in individual, group, and family therapy. I was first introduced to Peak House in 2000, while taking a course in Substance Abuse Counselling, a required course for my Master's degree. The course was taught by Colin Sanders, who at that time was the clinical director of the Peak House program. In my Master's program and this course in particular, I studied postmodern and collaborative therapies (Andersen, 1987; Anderson & Goolishian, 1988; Gergen, 1991; White, 1989; White & Epston, 1990; de Shazer, 1985). When I began my practicum at Peak House[2], I witnessed postmodern, narrative and collaborative approaches to therapy come to life (Reynolds, 2002; Radke, Kitchen & Reynolds, 2000; Madigan, 1992; Sanders, 1998, 2007; Bird, 2000, 2004). These practices expanded my previously held notions of what was possible when working from a collaborative approach with people seeking relief from problems.

[2] I would like to acknowledge the therapists, young persons, program directors and youth counsellors whom I worked with at Peak House in helping me to develop the ideas written about in this dissertation.

The theoretical framework of this dissertation is postmodern[3] and social constructionist thought (Burr, 2003; Foucault, 1980; Sarup, 1993; McNamee & Gergen, 1992). Social construction is interested in the "relational and generative nature of knowledge and language" (Anderson, 2003, p. 126). In this approach our understandings of the world are seen as emerging through our relationships with others. They are constructed communally. These paradigms question the commonly accepted modernist notion that there are 'Truths' to be known, which are located within individual minds. Rather than viewing language as an expression of the mind, social constructionists propose that it is in our interactions and performances with others (in language) that we create, understand, and interpret our experiences.

The narrative metaphor has been extremely influential in my work as a therapist. From this perspective, our lives are understood as being storied (Bruner, 1986; White, 2007), and it is through the telling of stories that we come to know and understand ourselves and the world around us. In the narrative approach, the therapist views the client as being in relationship to the problem, which creates linguistic space between person and problem, as the problem is not understood as located within the psyche or biochemistry of the individual. Labelling, deficit based understandings, and pathologizing discourses are resisted and explored in therapeutic conversations. Rather than leaving social, political, cultural, and gendered discourses outside of the therapy room, therapists have a responsibility to address these discourses and the effects that they have on peoples' lives (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003; Hare-Mustin, 1994). Clients' strengths, courage, and understandings of their experiences are

[3] Used here to refer to "a family of concepts that critically challenge the certainty of objective truths, the relevance of universal or meta-narratives, and language as representative of the truth" (Anderson, 2003, p.126).

privileged, and taken for granted assumptions are deconstructed. This stance creates room for people's preferred stories to come to the forefront, and for previously unimagined possibilities to emerge. In writing this dissertation and interviewing the young women, this stance came to life.

The narrative metaphor is complementary to and located in social constructionist ideas, as the telling of stories always occurs in relationships (White & Epston, 1990; White, 1995; Gergen, 1991; McNamee, 2004c). Stories themselves are social constructions, as opposed to truth or fact, one possible story out of a myriad of others that may be told. Both narrative therapy and social construction approaches focus their attention on the relational aspects of human interchange, what people are doing together (McNamee, 2006). This differs from modernist approaches to therapy that concern themselves with the individual, focusing their attention on what occurs inside peoples' minds.

The Problems Overlap

Some of the young people who walked through the Peak House doors not only struggled with the harrowing problem of substance misuse, but they also struggled with weight preoccupation, body image concerns, restricted food intake, binge eating, throwing up after meals, or over-exercising. Some of these youth had previously attended eating disorder programs or treatment centres, while other youth had kept these concerns hidden. The other therapists and youth counsellors working at Peak House worked hard to figure out a way to allow those young women who we knew were struggling with purging, over-exercising, or food restriction to remain in our program. It seemed unjust to prohibit someone from participating in a substance misuse treatment

program simply because she was also struggling with disordered eating practices.[4] To deny treatment in this way would, we worried, only throw these young women back into the arms of drugs or alcohol, and drug dealers (and sending them back into isolation with disordered eating practices). Our continual question was, "Aren't they better off with us?"

Isolating Two Problems

Our program had the same policy as many other substance misuse programs: If you are self-harming or engaging in practices of disordered eating, you need to leave and come back when you can focus on the problem of substance misuse. I can see the good intentions behind this policy, as it can be useful for some youth as it takes a solid position against disordered eating practices, sending the message that it is not welcome here.[5] For them, the fear of having to leave the program should they be caught purging, serves as a motivator for seeking assistance with disordered eating practices. For others, this stance may push disordered eating practices even further underground, hidden from the therapists and youth counsellors' views. For example, youth might comply with the program's eating requirements, but may purge their meal or over-exercise in their rooms afterwards. Alternatively, they may find ways to skip meals by claiming that 'they are still full from lunch,' or 'they feel sick if they eat breakfast.' Instead of asking us for support, they may keep their struggle with food a secret, and in the silence disordered

[4] All prospective youth were required to have a medical evaluation done prior to entering the program and if a person was deemed too unwell and required more intensive medical care than we could offer to them, they were referred to the appropriate organization at that time.

[5] This process of externalizing was developed by Michael White and David Epston (1990) of Dulwich Centre. It is a way of working whereby problems are externalized. "The problem is the problem, the person is not the problem" is a catch phrase used to describe this way of working. Externalizing and Narrative Therapy will be described in greater detail in Chapter 2.

eating practices grows.

In response to this issue, our team of youth counsellors and therapists began to construct ways to make it possible for young women to be "eating-enough," trying to cut down on "purging-enough," and engaging in "healthy-enough" exercise so they could stay in the program (Bird, 2000). I remember many shifts where young women would let us know that they were struggling with their body shape/size after gaining some weight since entering the program. I also remember watching tears pour down a young woman's cheeks as she chewed a piece of lettuce from her salad. She had just been told, on her first day of the program, that eating three meals a day was a requirement to stay in the program.

We saw the shame the young women experienced when their 'secret' was discovered. They begged us not to kick them out or tell their families or their alcohol and drug counsellors. Many of them said that they were trying to cut down on purging, as they binged on plates overflowing with syrup-drenched French toast. We watched as they drank glass after glass of water and then disappeared into the washroom, turning on the faucet to tune out the sound of their heaves. We watched as they walked out of the washroom, face red, eyes glistening and darting anxiously around the room to see whether they had been noticed.

We recognized the need for young women struggling with both substance misuse and disordered eating practices to have a space to address these concerns. They were entitled to have capable, respectful, ethical and well-informed counsellors to assist them in their quest to find freedom from these problems, yet the structures that we had in place then were restricting and limiting. We realized that we needed to work with both

problems if we wished to better serve the clients and their families[6] who approached us for our help. So grew my interest in developing ways to work with people who struggle with problems that threaten both themselves and challenge their helpers due to their complexity.

Disrupting the Isolation

When a young woman struggles with substance misuse and disordered eating practices, it can be daunting to navigate a path to freedom. If you are continually struggling with one problem or the other, you can never really focus on your self, since one of the two is lurking in the background influencing your thinking. Even more difficult is when young women struggling with both problems describe *both problems operating at once* in their lives, especially when they seek professional help or when they are trying to step away from one problem or the other. Addressing the two problems simultaneously disrupts the traditional approach in which each problem is isolated and dealt with individually, the idea being that only one problem—eating disorders *or* substance abuse—can be treated at a time. Traditionally these problems have been seen as separate from each other, and counsellors often specialize in one problem or the other. What does this mean for our youth?

Typically, someone struggling with substance misuse and disordered eating practices would have to address these issues separately, as "historically, those who suffered concurrently with disordered eating and substance misuse found the doors of either type of helping facility shut until they could manage one or the other problem"

[6] When I use the word 'families' I am using it in the broadest possible way. Family includes whomever it is who loves and cares for the young woman and is supporting her in this work, be it moms and dads, two moms, two dads, adopted parents, legal guardians, grandparents, friends, or partners.

(Dennstedt & Grieves, 2004, p. 64). In most eating disorder treatment programs, a person who has had a (self-admitted) history of substance misuse must be abstinent from all substances for three months prior to entering the program. The same is true in most substance misuse programs; people are required to eat three meals a day and expected to abstain from purging, binging, restricting, over exercising, and other disordered eating practices. This means that people often face multiple barriers to treatment access such as treatment refusal, lack of resources/treatment that addresses both disorders, and long wait lists (Dunn, Geller, & Brown, 2008). People seeking support for both problems are often straddling two very different treatment philosophies. In the field of addictions, the disease metaphor underlies most treatment approaches. Treatment is often de-medicalized and governed by 12-Step programs (Alcoholics Anonymous /Narcotics Anonymous), addiction counsellors, detoxification centres, recovery homes, and abstinence based treatment programs. Eating disorders treatments are mainly overseen by hospitals, psychiatrists, psychologists, and inpatient and outpatient programs that are also run within these frameworks. Therapies tend to be cognitive behavioural and interpersonal in nature with psychopharmacological medication prescribed more often than not (Brady, Back & Greenfeld, 2009). Unfortunately this compartmentalization is incongruous with the ways in which people live their lives, and can lead one problem or the other to go underground, defying detection.

Traditional Ways of Understanding Disordered Eating Practices and Substance Misuse

In the mental health field, when eating disorders and substance abuse occur at the same time, they are commonly referred to as a dual diagnosis, co-occurring disorders or

problems of co-morbidity. The term concurrent disorders[7] is defined by Health Canada (2002) as:

> The concurrent disorders population refers to those people who are experiencing a combination of mental/emotional/psychiatric problems with the abuse of alcohol and/or another psychoactive drug. Technically, it refers to any combination of mental health and substance use disorders, as defined for example, with the classification scheme of Diagnostic and Statistical Manual of Mental Disorders [DSM-IV-R] (p. 7).

In the last ten to 20 years there has been an increased focus on concurrent disorders in the mental health field (Cooper & Calderwood, 2004). Many studies have documented the associations between substance misuse and disordered eating (Dunn, Neighbors, Fossos, & Larimer, 2009; Franko, D., Dorer, J., Keel, P., Jackson, S., Manzo, M., Herzog, D., 2008; Piran & Gadalla, 2007; Herzog, Franko, Dorer, Keel, Jackson, Manzo, 2006; O'Brien & Vincent, 2003). These studies have suggested the need to assess patients with eating disorders for drug and alcohol use, and patients with substance misuse problems for eating disorders (Dunn, Et. Al, 2009; Gorden, Johnson, Greenfield, Cohen, Killeen & Roman, 2000; Piran & Gadalla; Courbasson, Smith & Boland, 2004). They also suggest a need for conducting research into effective prevention programs, and integrated treatment programs for patients with co-occurring eating and drug and alcohol disorders (Dunn, et al., 2009; Piran & Gadalla). In these paradigms (12 step approaches (AA/NA), psychiatry, psychology, and the evolving

[7] The words co-morbidity, dual diagnosis and concurrent disorders are often used interchangeably. In Canada the term concurrent disorders is most often used, whereas in the US the term dual diagnosis is used. In Canada dual diagnosis refers to an individual that has a physical disability as well as a mental health disorder (Cooper & Calderwood, 2004).

concurrent disorders field), eating disorders and substance abuse are most often viewed as individualized and static problems. Furthermore, the cause of these disorders is often seen as residing *inside* people inviting us to look inwards for the cause of the problem, for example, at an individual's biochemistry, genes, or personality traits.

A quick search on the PsycInfo computer database (from 1983 to 2009) using the key words "eating disorders" and "substance use" finds 305 results, which illustrates the current interest in this subject matter as an area of research (Retrieved, August 28, 2009). A common thread between the studies is that they try to determine co-morbidity rates for eating disorders and substance use and substance use and eating disorders. For example, studies have examined the co-morbidity rates of disordered eating behaviour in women who seek treatment for substance use/abuse/dependence (Herzog et al., 2006). More commonly, the association between eating disorders and substance consumption is studied in a person's seeking treatment for eating disorders, by exploring his or her past and present patterns of psychoactive consumption (Weiderman & Pryor, 1996; Corcos et al., 2001). These studies often explore the association between the two problems in question. For example, regarding the prevalence of eating disorders among men and women who were hospitalized for substance abuse, it was surmised that the increased stimulant use was because stimulant drugs suppress the appetite thereby increasing weight loss (Hudson et al. 1992).

Other studies attempt to locate common underlying psychopathological factors. For example, Baker, Mazzeo, and Kendler (2007) conducted a study in which they explored the associations between bulimia nervosa and drug use disorders focusing on the common genetic and environmental influences between the two. Many studies focus

their inquiry on the links and common factors between specific substance use and specific eating disorder diagnoses, for example, anorexia nervosa and its associated sub-types, restricting type, binge-eating/purging type and bulimia nervosa and their associated sub-types, and purging or non purging type (Dunn et al., 2009; Dunn, Geller, & Brown, 2008; Herzog et al., 2006; APA, 2000).

Concurrent disorders are studied in various ways with clinically based or community based populations typically examined separately. In some cases, the lifetime prevalence rates of eating disorders and substance abuse are studied and then the likelihood that an individual with an eating disorder would also have a substance use disorder or eating disorder is determined (Piran & Gadalla, 2007). In other cases, information is gathered from individuals who are currently in treatment programs (often referred to as clinical samples) for eating disorders or substance use, having them complete questionnaires regarding their past and present substance use or disordered eating behaviours (Krug et al., 2008; Hudson et al., 1992).

While the studies described above are of interest and show a need for increased research regarding the co-occurrence of these problems (and most certainly generate funding for continued research in this area), most do not lead us in the direction of therapeutic treatment approaches for persons struggling with the problem of substance misuse and disordered eating. When treatment approaches are suggested, they are typically cognitive behavioural therapies[8], interpersonal therapies, or psychopharmacological treatments (for example, antidepressant therapies) (Sysko & Hildebrant, 2009; Brady, Back, & Greenfield, 2009). Brady et al. point out that there is

[8] Cognitive behavioral therapy has been chosen as the treatment of choice for eating disorders by the American Psychiatric Association (Brady, Back & Greenfield, 2009)

currently "no evidence-based treatment that integrates SUD [substance use disorder] and ED [eating disorder] treatment" (p. 235). This demonstrates the need for further investigations into and the development of therapeutic approaches when working with person's struggling with disordered eating and substance misuse.

This dissertation does not focus on the reasons why a young woman may develop a problem with substance misuse and disordered eating. Nor am I interested in what came first, the chicken or the egg. Rather, I am interested in exploring the interplay between these problems, and the ways in which disordered eating practices and substance misuse problems can 'feed off of each other' thereby keeping young women ensnared in their grips. I explore the relational features that these problems share, and ways in which helpers can use these features to their advantage when working with clients. My purpose in this dissertation is to explore the interplay of disordered eating practices and substance misuse in the lives of young women and the implications of this interplay for therapeutic practice. This research involves formally asking youth the kind of questions that have emerged in my therapy sessions with young women at Peak House.

In my therapeutic conversations with young women, I have found that addressing the problem simultaneously creates a common space where the problems come alive in an entirely new way, thereby interrupting the tendency to dichotomize these issues, creating new possibilities for change. Addressing substance misuse and disordered eating problems collectively is important, otherwise these problems remain compartmentalized and separate: defined as this (i.e. disordered eating practices) and that problem (i.e. substance misuse). The problems' interplay between them remains

outside of any categorizations, its location hidden and silenced.

To my knowledge, this is the first qualitative study documenting young women's personal experiences regarding the interplay between substance misuse and disordered eating practices. This is also the first study to detail a therapeutic approach and provide treatment ideas and therapeutic questions for practitioner's working simultaneously with the problems of disordered eating practices and substance misuse.

Youth's Voices

In closing this chapter, I wish to describe the voices that inform this writing, as without them this dissertation would not have been possible. This dissertation is the result of 12 semi-structured interview conversations with young women who have personal experience with substance misuse and disordered eating practices. Of course, all identifying information and names have been changed in order to protect their anonymity. I have paid specific attention to ensure that their voices are highlighted by including quotes and snippets of our conversations throughout the dissertation. Chapter 6, the results sections, is comprised mainly of the young women's voices. Their voices influenced the creation of the chapters and held me accountable to highlighting their local knowledge (Geertz, 1983) and wisdom throughout the chapters. This is important to me as so often youth's voices are not included in professional literature. Instead, the voices of professionals are allowed to 'speak for' the people who are under 'investigation.' This is especially the case where the 'subjects' being studied have diagnoses that pathologize them and separate them from so-called 'normal,' or 'healthy' individuals. Foucault refers to these as "dividing practices" (Rabinow, 1984, p. 8). Often the focus of traditional psychological research is to understand what causes the

deviation from normal behaviour. In these instances, it is assumed that there is an essence to be known and that this essence unlocks the key to understanding the individual's behaviours, actions, and thoughts. When people are categorized as 'well/unwell,' 'normal/abnormal,' health-care professionals are positioned as experts who treat or heal those who require help in specific, culturally agreed upon ways. This stance disqualifies the expertise and knowledge of the person consulting with the health care professional, and places the professional in a position of power over the individual (Foucault, 1980).

I often co-present with youth[9] from Peak House at workshops and at the local college where I teach. In these contexts, the comments of workshop attendees/students are strikingly similar, "Did you pay them to say that?" "They were so articulate!" "I've never heard young people speak so well." What do these comments reflect about the ways in which we view these young people? What does it say about those voices to whom we give credence? How is it that so often professionals are surprised that the individuals who receive 'professional' help/therapy/counselling/treatment, have ideas about what will work best for them at this time in their lives?

North American society lends little credence to the voice of young people. Often their voices are marginalized and not given much room to speak, or if they do have the chance to speak, they may not always be heard. Instead youth are positioned as people who need to be taught, shaped, and moulded. These ideas can contribute to us talking down to youth, or stereotyping them into categories of violent, aggressive, naive, and

[9] This practice was passed down by Colin Sanders (2007) as a way to not speak for those that can speak for themselves, as young persons are so often under represented at therapy conferences, and teaching institutions.

self-centred, rather than positioning youth as having something meaningful to say, and as teachers.

This dissertation is an attempt to privilege youth's voices in a way that will invite them to let us—the professionals—know how we can be more of use to them. Their ideas for future therapeutic conversations with other youth who are also struggling to navigate this rugged and confusing territory are highlighted. I was interested in hearing about the young women's lived experiences with both substance misuse and eating disorders. I was curious about how these problems gained a hold on them, how they made sense of them, and how they have begun to find freedom from these problems. I strongly believe that young persons are intelligent and have much insight into their own lives. They have hopes and preferences about the direction in which they want their lives to go. I also believe that the problems of substance misuse and disordered eating are often initially attempts to cope, after which they take on a life of their own, and that no one imagines or wants their life to be engulfed by these problems.

I believe if you position yourself as curious and interested in what someone has to say, and if you really listen to the other as she is speaking, that you will hear that she has her own ideas and solutions for her problems. I also believe that by positioning yourself as a listener you will be amazed at what it is that you will hear and it is my hope that you, my reader, will be amazed by the many voices of the youth that inform and speak through this dissertation.

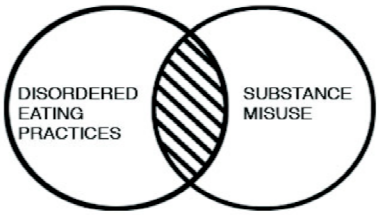
CHAPTER 2 THE INTERPLAY BETWEEN DISORDERED EATING PRACTICES AND SUBSTANCE MISUSE

In order to demonstrate the interplay between substance misuse and disordered eating practices, it will first be useful to look at the many relational features that they share. The relational features are the similarities between the problems and the ways in which these similarities interact to create a new problem. Highlighting these features will illuminate the ways in which the problems may appear together, how they can be a means to a similar end, and how difficult it can be to break free from them. It will also illuminate how these problems, in relationship with each other, can be unrelenting in a young woman's life. Knowing these relationships, and the ways that they work together in a young woman's life, may help us assist young women in finding freedom from the problem.

I do not intend to write an exhaustive list of all the relational features that the problems share. Rather, I wish to describe some of the main ones that I have noticed in my work with young women struggling with disordered eating practices and substance misuse. I will examine the relational context between the two problems and how they can—at times—collude to become a means to the same end, such as to lose weight, deal with emotions, to feel normal, to look/act/be viewed by others in a certain light, or to fit in/belong.

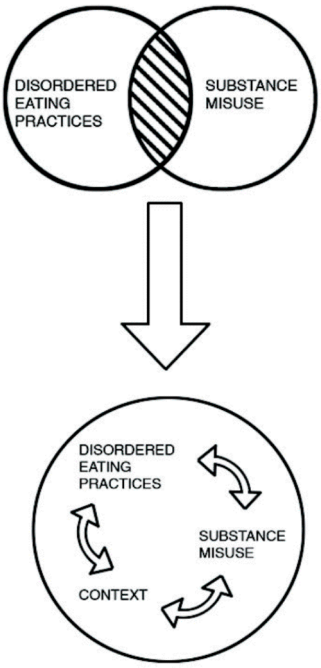
The diagram below illustrates the traditional modernist way of understanding the similarities between disordered eating practices and substance misuse. The problems simply overlap.

Figure 1 Traditional modernist way of understanding the similarities between disordered eating practices and substance misuse



The diagram below illustrates the interplay between the two problems. I will describe the lower circle that represents the relational context that the two problems share. The social context of the young women's lives is always present when discussing the relational context.

Figure 2 The interplay between disordered eating practices and substance misuse



Both problems are skilled at offering empty promises as a way to recruit young women. I describe their promises as empty, as the costs of the promises in the lives of the young women are much greater than they let on. Both substance misuse and disordered eating practices can work as an 'analgesic,' a way to cope with problems or to 'self-medicate.' Both problems can make empty-promises of increased belonging and connection with people. For example, drugs and alcohol might convince people that they are more social, more outgoing, and less boring when they are under the influence. Disordered eating exploits people by leading them to believe that if they are thin that they will be more likely to be socially accepted by others and have more friends. Yet eventually, both problems can lead to isolation and disconnection from family and friends in a way that allows the problems to gain increasing control over the young women's lives.

Another commonality is that, with time, substance misuse or disordered eating practices become the most easily accessible 'solution' in a person's life. If someone is going through a difficult a break-up, it might seem easier to go out and use, or to binge and purge as a way to cope with the barrage of emotions that one would experience when a relationship ends. The other viable solutions—calling a friend to talk, crying, or mourning the loss of the relationship—might not be as available to a person as the above practices and/or the results might lack the immediacy for which the person is looking. This is not to say that people intentionally select problematic ways to deal with difficulties in their lives, but that alcohol and drugs or disordered eating practices may disguise themselves as non-problematic solutions or ways to cope. It is often only with

time, when problems have taken on a life of their own, that the devastating effects of what first might have seemed like a benign act (smoking a joint after a hard day at school or cutting out desserts) becomes apparent.

In our consumer-driven culture both problems receive cultural support; alcohol use and some drug use are socially approved and accepted. Social gatherings, celebrations, and birthdays, often revolve around the consumption of alcohol. Drinking alcohol is often considered a right of passage for teenagers on their way into adulthood, young men's drinking often being strongly tied to discourses of masculinity (Smith & Winslade, 1997; Nylund, 2007). In western countries, drinking among young women is on the rise, mirroring that of young men. In addition, young women are increasingly targeted by alcohol companies in advertisements (Lyons & Willott, 2008). Problems are also supported by ideas or promises of increased belonging and a sense of community. For example, people may begin to drink socially or attempt to lose weight as a way to fit in.

The "relentless pursuit of thinness" (Bruch, 1973, p. 555) and the generalized fear of (being) fat that exists in society, encourages and supports women (and men) to alter their bodies by exercise, limiting their food intake, and dieting. In addition, advances in cosmetic surgery and declining costs in procedures have considerably increased the availability of surgical alteration of the body. For example, liposuction and breast augmentation have become common ways to meet societal body standards (Blum, 2003). The patriarchal male gaze and normative discourses that come through the male gaze, with its emphasis on thinness, fat phobia, and heterosexism, support this (Orbach, 1978). Berger (1972), writes, "Men look at women. Women watch themselves

being looked at. This determines not only most relations between men and women, but also the relation of women to themselves" (p. 47). This can translate into the practices of self-surveillance, perfectionism, self-sacrifice, comparison with other women, and a critical policing of their own bodies (Foucault, 1979).

Disordered eating and substance misuse also support the notion of 'special-ness' amongst its recruits. Young women often describe feeling like they were part of a secret club, or that other people were jealous of them. For example, young women might claim that if they did not have drugs, they would be 'nothing.' In reviewing conversations and transcripts from interviews of young women, disordered eating practices and substance misuse have been frequently personified and described as a 'friend,' (Maisel, Epston & Borden, 2004) just as dealers and pimps are often called lovers and boyfriends. Substance misuse or disordered eating is described as 'having helped' the individual to get through certain periods in her life, 'stood by' her in times when others might not have. Both problems have a way of convincing people that they (substances and disordered eating) can truly be counted on. Once people are free from the problems, they are able to see that the problems are anything but friends and how this façade isolated them from people who cared about them.

At times substance misuse and disordered eating is minimized as a problem. Young women often describe how they could 'stop using at anytime,' or 'its not really a problem.' For example, 'When I loose X[10] pounds then I'll be satisfied' or 'Just one last time, then I'll quit,' 'I'll just have one drink,' 'It is the other people in my life that have the problem, not me, if people would just get off of my back then I would be fine.' In

[10] As an anti-anorexic practice I am putting an X rather than a number as a way to not inadvertently feed anorexia or potentially invite ideas of comparison.

some circles this minimizing would be referred to as denial (Marlatt, 2002).

The term denial has been critiqued in many disciplines, especially the substance misuse field, as it negates peoples' abilities to know themselves and the problems with which they are struggling. It also casts the therapist/helper in an expert role, suggesting that the person is unable to see that she has a problem. Solution focused therapists Berg and Miller (1992) write, "In traditional [treatment] models clients are expected to learn and adapt to the frame of reference of the treatment model or be considered difficult, resistant, or 'in denial'"(p. 7). By asserting that a client is in denial, the therapist is positioned as the expert and is therefore absconded of any professional accountability or responsibility to determine if the help that they are providing 'fits' with the needs of the client (Berg & Miller). The client is simply in denial if they are not responding to the help offered or making the changes deemed necessary by the therapist. Yet resistance can very well be a sign that the therapist is trying to encourage the client to make changes that this client is not yet prepared to make (Miller & Rollnick, 1991; Berg & Miller).

Both problems are associated with increased health risks and mortality rates. Mortality rates for persons with anorexia are higher than any other mental and psychiatric disorder (Keel, Dorer, Eddy, Kamryn, Charatan, Herzog, Franko, 2003; Herpertz-Dahlmann, 2009). Young women aged 15–24 with anorexia have annual death rates that are 12 times higher than other young women of similar age (Sullivan, 1995). Overdose associated with illicit drug injection is one of the leading causes of death for injection drug users (Kerr, Tyndall, Lai, Montaner & Wood, 2006). Hser, Hoffman, Grella, and Anglin (2001) followed persons dependent on heroin for 33 years and found

that 284 of the 581 participants had died with the majority of deaths being caused by overdose.

Some fields of study consider anorexia/bulimia to be an addiction, and 12-step groups such as *Anorexics and Bulimics Anonymous: The Fellowship Details Its Program of Recovery For Anorexia and Bulimia* (Farthing, 2002) have been created. These groups are based on concepts that are the foundation of traditional 12-step programs for Alcoholics Anonymous; for example, ideas of hitting bottom and admitting that you are powerless (Bill, 1955). David Krueger (1982) points out that,

> Perhaps the most common theme of all the eating disorders is that they are addictions: anorexia nervosa is an addiction to food avoidance, to the pursuit of thinness, and to feeling a sense of control and of mastery over one's body; bulimia, an addiction to food binges and perhaps purging or laxative use, often due to the intense affect of depression, emptiness, or isolation and the attempt at affect regulation; and compulsive, addictive overeating, a relentless pursuit of and obsession about food, with the person often automatically turning to food for various types of tension reduction (p. 371).

There are of course important differences between the two problems. One is that it is possible to abstain permanently from drugs and alcohol, whereas we cannot abstain from eating, which has implications for therapy. Thereby a different type of relationship needs to be negotiated with people's relationship to food, and people need to develop healthy-enough eating practices to ensure that they maintain their physical health. Another important issue is that prior to attending a residential therapy program, people need to be medically well enough to participate in therapy. This would mean

detoxification in some cases for those under the influence of drugs and alcohol, and weight gain (which can take the form of re-feeding on hospital wards in extreme cases of malnourishment) for those who are malnourished from lack of eating. Another difference is that people usually start using substances due to curiosity, seeking pleasure and or transcendental and or mood altering experience, whereas people often begin 'dieting' as a way to lose weight.

Below is a chart that highlights the relational features that exist between the two problems, and to also show by way of illustration the times when someone is vulnerable to one of the problems can make it very difficult for a person to break free from the other, as both problems can serve very similar purposes. In this way, the problem keeps the person trapped in a web of difficulty. I have decided to break this chart into two. One chart describes overall relational features between the problems, and the other chart describes the promises that the problems offer to the young women. The categories and charts that I have created are not mutually exclusive. Rather, there is an ebb and flow to them. You may notice some overlap between the two.

Table 1 Relational features between the two problems[11]

Relational Features	Substance Misuse	Disordered Eating
Substance Misuse	Problematic relationship with substances (alcohol & drugs)	Problematic Relationship with substances (food)
Culturally Supported	Social celebrations centre	Normative expectations of

[11] I would like to thank Ali Borden for helping me come up with the idea to create this chart. This chart is an adaptation from a group exercise she facilitates at her place of work.

	around alcohol Glorification of alcohol and drugs in the popular media	thinness for women and a generalized fear of fat that exists in society Glorification of thinness and beauty in the popular media
Creates Isolation	Removes people from their supportive/healthy connections People become preoccupied with using	People are isolated as a result of disordered eating
Patriarchy	Response to abuses of patriarchy Drug use as a challenge of traditional females roles, a way to rebel	Response to objectification, self-surveillance, abuse

Table 2 Promises of the problem

Promises	Substance Misuse	Disordered Eating
Lose weight	A young woman may use substances to help lose weight, or may lose her	A young woman may purge, restrict their food intake, over-exercise in

	appetite because of substance use	order to meet the requirements of anorexia/bulimia
Help deal with memories /trauma/oppression/violence	Feelings numbed by substance misuse Euphoric sensations that substance use creates	Feelings numbed by bingeing/purging/not eating Focus and distract self by thinking about or avoiding the above
Be social/belong	Feel more outgoing when under the influence, fit in, sense of community	As a way to meet social expectations of thinness
Have more energy	Get much more done; stay awake for longer periods of time (with stimulant use)[12]	Feeling high as a result of not eating, more time in day if not eating to do other things
Perfectionism	Use substances in an attempt to be the perfect daughter/young women, have more energy to get all demands of day done,	Be thin /perfect girl/ perfect daughter. Meet parental, societal expectations regarding weight and appearance

[12] There is a specific connection of stimulant use to disordered eating practice. For example, people do not tend to use alcohol as a way to control weight. Cocaine, crystal meth, ecstasy, speed, dexedrine, are the riskier drugs in this regard. And of course there is heroin.

	schoolwork, sports	
Distraction from feelings; a way to self soothe	Get intoxicated, forget for a while/numb out	Purge/ restrict eating keeps focus on food/body and away from feelings
Immediacy	Use and problems are momentarily gone Escape	Purge and problems are momentarily gone, focus on food/body no time to focus on other things
Sense of control	Able to control feelings, memories	Control food intake, body weight
Alleviates Guilt	Make you feel better Temporary distraction	Make you feel better Temporary distraction
Rituals	Getting, buying, using, e.g. setting up to use heroin	Ritualized eating patterns, e.g. purchasing food for a binge
Intense Focus	Preoccupation with getting drugs and alcohol, and using	Focus on avoiding food, or purchasing food/bingeing, getting rid of calories

The above chart depicts the relational features the problems share demonstrating the potential interplay that exists between the two. These features can make someone susceptible to the other problem as both can act as a similar means to the same end. As

further demonstrated in the results section of this dissertation, both problems are clever at morphing their tactics to serve their own survival. The relationship between the two is never static; it is ever changing and as such, our questions and conversations need to reflect the movement between the problems in accordance with how an individual's relationship to the problem may also be changing. The stories behind the problems also need to be heard in order to unpack each young woman's understanding of the problems, the connections between the two, along with their similarities and differences. In doing so, young women might start to get a clearer glimpse of what they need to do in order to separate themselves from the problems.

Some examples of the problems' interplay are as follows:

A woman who defines her main problem as alcohol and drug use might notice that when she is attempting to quit or enters treatment to address her substance misuse problem, she begins to gain weight. Disordered eating thoughts or practices may also show up as a way to lose the weight she is gaining in treatment. Or she might begin to imagine using substances for a week after she leaves the program in order to lose the weight she gained.

As a young woman tries to stop purging, she notices that her substance use begins to increase as a way to deal with uncomfortable feelings that are showing up as a result of no longer purging. Not having access to other easily accessible means to cope with these feelings, substance misuse becomes a way of coping with uncomfortable feelings. The opposite may also be true; another young woman might be in a substance misuse program and is no longer using substances. For that young woman, disordered eating practices, such as restricting or purging, might show up as a way to deal with

uncomfortable feelings that were previously numbed by substance misuse.

A young woman uses amphetamines as it increases her short-term immediate productivity and consequently begins to notice a loss of significant weight. When the amphetamine use begins to cause problems in her life and she stops using, she might notice weight gain, which might be upsetting, in which case she might resort to amphetamine use as a way to try to lose the weight.

In conversations with young women, I have noticed that the ways the two problems might show up in a person's life can vary from person to person, and one problem might be described as being more problematic or more manageable than the other. Where this interplay begins and ends for each person is quite complex and this highlights the importance of looking at the meaning of the problematic behaviour for the person, its purpose, her understanding of it, and what she needs to do for the defined problem to leave her life. In order to understand the interplay, we need to hear people's stories—unpack their understanding of the problem, their connections, similarities, and differences. In doing so we go beyond the behaviour and into the meaning or purpose of these problems in young women's lives. We are also taking into consideration the social and cultural contexts of people's lives and how different situations can make space for certain problems' appearances. As we pay attention to the relationship between the two, we create a linguistic space for something else to be seen, created, and known.

The above discussion illustrates the need to create space to inquire about the two problems. Without such inquiry, one problem may remain underground, silently feeding the other. Within traditional therapeutic frameworks, therapists are trained to address one problem at a time, and therapists often specialize in one field, for example as

substance misuse counsellors, or as eating disorder counsellors. Yet traditional assumptions about how to work with individuals struggling with both problems do not always reflect the ways in which they live their lives, and the way that the problem works in their lives. Accordingly, practitioners need to develop ways that reflect and respect the complexities of their lives. In the following section, I will describe a narrative relational approach to working with disordered eating practices and substance misuse that I have found to be helpful.

The Narrative Re-authoring Perspective

This section describes the therapeutic approach I have used for the past ten years in my work as a therapist. I will describe the narrative approach, discuss externalizing practices, and provide examples of externalizing conversations and questions. I will discuss the benefits as well as common critiques of the narrative approach.

Narrative therapy originated through the work and ideas of David Epston and Michael White (White, 1989, 2007; White & Epston, 1990; Epston, 1988). The narrative approach is probably best known for the practice of externalizing internalized and oppressive problem discourses, a practice which is summarized as 'the person is not the problem, the problem is the problem' (White & Epston, 1990). The narrative approach is also called a re-authoring approach (Myerhoff, 1986) to therapy (White & Epston, 1990). Narrative ideas have a rich history and are rooted in "feminist ideas; the ideas of the philosophers, and cultural historians, such as Foucault, Derrida, Nietzsche, Heidegger, Gadamer, Wittgenstein, Bakhtin, and Rorty; anthropological and sociological sources; literary criticism; personal construct theory; and humanistic and client centered influences" (Smith, 1997, p. 1).

Storying our world

As the word narrative implies, a central tenant of the narrative approach is that we come to know ourselves and the surrounding world through the co-construction of stories. This occurs through the stories we tell about ourselves and through the stories others tell about us. White and Epston (1990) have found the use of the text analogy helpful to describe their approach. The text analogy (also referred to as the interpretive method) explores how people interpret events that have occurred in time and later go on to construe and ascribe meaning to these events (White & Epston, 1990; Bruner, 1996). It is through our "lived experience" (White & Epston, 1990, p. 9) that we come to understand and story our lives. Jerome Bruner (1996), who heavily influenced White and Epston, writes "human beings make sense of the world by telling stories about it —by using the narrative mode for constructing reality" (p. 130). The storying of our lived experience is constructed across time in such as way that a reliable story line begins to emerge allowing persons to have a sense of what might occur next in their lives—this soon becomes the dominant story of a person's life. Events that fit within our dominant way of understanding ourselves are noticed, and events that fall outside of our understanding, are often missed or ignored, as we may have no way to make sense of those events (Bruner, 1996).

At times, these stories or dominant discourses can be problematic and oppressive and constrain people from living their lives in preferred ways. Dominant problem discourses can be very restrictive in people's lives and can become totalizing and constitutive of a person's identity, affecting the way that they see themselves. People begin to internalize stories that others tell about them and the stories that they, as a

result, begin to tell about themselves. When people internalize the problems that plague them they can begin to see themselves as the problem. Within the text analogy, problems are constructed as the "performance of oppressive, dominant story [ies] or knowledge" (White & Epston, 1990, p.6) and these problem stories become constitutive of people's lives. Problems are discussed in such a way that a diagnosis of anorexia or substance abuse does not become superimposed on their identities. For example, 'she is struggling with the problem of anorexia,' rather than 'she is anorexic' disrupts potentially totalizing language practices.

The interpretive method described above differs from the more commonly accepted modernist way of viewing persons. Gremillion (2003) writes, "narrative therapy is centered on the premise that persons' identities are always 'in the making'" (p. 195) which differs greatly from the idea that we have static personalities which remain consistent through time (Gergen, 1991). Cushman (1995) describes the "current configuration of the self [as] the masterful, bounded self of the twentieth century" (p. 28). People are viewed as self-contained individuals (Cushman) with their individual thoughts presumed to reside within their individual minds. From a modernist perspective, it is considered possible to have objective knowledge of others and ourselves and possess "essentialist knowledge of the world" (Madigan & Goldner, 1998, p. 296). From this objective and essentialist space, therapists and professionals are believed to possess expert knowledge about the lives of their patients. This results in people being objectified and described as things (White, 1989). White writes:

> Within the context of these practices, persons are constructed as objects and encouraged to relate to themselves, to their bodies, and to other persons, as

objects. This is fixing and forming of persons. In Western societies, these practices of objectification are very pervasive (p. 22).

These practices are so prevalent and far reaching that they are no longer questioned by many—they have acquired a truth status, (Foucault, 1989) privileged and elevated over other possible ways of knowing.

Externalizing practices

One way to counter these objectifying practices is through the use of externalization practices. Externalizing allows people to consider the impact that the problem(s) has been having on their lives and relationships in a way that does not view the person as the problem. Externalizing practices are particularly useful when it appears that the person's identity has been defined by or co-opted by the problem (White, 2007). It is important to note that not all cases call for externalizing practices as there are times when a person's sense of self has not been totalized by the problem. White maintains that "externalizing conversations have opened many possibilities for people to redefine their identities, to experience their lives anew, and to pursue what is precious to them" (p. 59). By locating the problem outside of persons' bodies through externalizing practices we position people as being in relationship to these problems, rather than the problems being located internally (White & Epston, 1990). Externalizing practices can be liberating for the clients we work with, as they enable clients to hold onto the knowing that they are more than a 'sick' person. Clients are viewed as being in relationship with the problem, rather than totalized or labelled as the problem (Bird, 2000, 2004).

Externalizing conversations create linguistic space (Bird, 2000) between person

and problem, allowing us "to objectify and at times personify the problems that they experience as oppressive" (White & Epston, 1990, p. 38). This shift is as Tom Andersen (1991) proposes, *just different enough* to do something different in the conversation. One of the first steps in externalizing is turning the problem into a noun, which locates the problem outside of the individual thereby externalizing previously internalized problem discourses. Once the problem has been 'named' and 'externalized,' it is possible to become curious about the person's relationship with the problem, the history of the relationship with the problem, and the effects that the problem has had on an individual's life. Through the personification and externalization of problems, therapists can explore the tactics, strategies, and promises the problem uses in an attempt to take over and devastate a person's life.

The following is an excerpt from a conversation in the book *Biting the hand that starves you: inspiring resistance to anorexia/bulimia* (Maisel, Epston, & Borden, 2004) in which David Epston externalizes anorexia with 15-year-old young woman named Riannon. Epson demonstrates how through the personification and externalizing of anorexia, he learns how anorexia operates in Riannon's life.

> David: Can I just ask you why you think it is that anorexia tricks people into going to their death thinking they're feeling fine? Why do you think that is? What purpose would it have in getting you to go to your death smiling? Most people go to their death upset or opposing it, especially when they are being murdered, don't they?
>
> Riannon: Yeah...
>
> David: I've wondered about this…, and you're probably wondering about it too.

Probably it is confusing all of us right now. How can anyone be on death row and not know it? How is anorexia telling you that you're feeling fine when, in fact, it could kill you at any moment?

Riannon: Well, I've got energy.

David: How is anorexia fooling you into that? You're on death row and everyone knows that except you, although you know it sometimes when you take our word for it (p. 102).

Maisel, Epston and Borden (2004) describe this way of talking as anti-anorexic talk as it takes a firm position against anorexia and for the life of the person. Through externalizing conversations we are able to get to know the intentions that problems have for people's lives, and the lived effects that these problems have in their lives.

Colin Sanders (1998) provides a series of questions that therapists can use to explore the influences and effects of substances on a person's life. I am including these questions to further demonstrate the types of questions that can be used to externalize problems in therapeutic conversations. Sander's writes:

Does it sometimes appear to you that drugs are ripping you off?

Could you describe some of the ways in which drugs are doing this too you?

Are there specific situations or contexts in your life that drugs are more likely to take advantage of?

Would you agree that valuable time has been stolen from you by cocaine/pot/heroin, etc? (p. 157).

In externalizing anorexia and substance misuse, both Epston (as cited in *Biting the Hand that Starves You: Inspiring Resistance to Anorexia/Bulimia* by Maisel, Epston &

Borden, 2004) and Sanders (1998) create space for the effects that these problems have been causing in people's lives to become visible. When the real effects of these problems are visible, people can form an opinion about the impact that these problems have been having on their lives. Through this process people often notice that they are no longer living in line with their values and preferences of how they wish to be in the world.

It is important to note that just because people recognize that they are not living in line with their preferences for how they wish to be acting or living, this does not imply that change will occur immediately. This process takes time. Often people understand exactly where the problems are leading them, yet they 'don't care' or they have lost hope that change is possible. It can sometimes take a long time for the problem to get out of the way long enough for care to show up. We may need to stay here for a while (maybe a long while), really mapping out and getting to know the ways in which problems work in a person's lives, all the while listening for exceptions to the problem story (White & Epston, 1990). It is my experience that if we skip ahead too fast, perhaps trying to move the client to a place they are not yet able to get to, that the contradictions in the problem's story that are always present will be written off as flukes or one-offs, rather than reflecting alternative possibilities.

Alternate Stories

When the problem's effects on the life and relationship of the person have been fully mapped out, space is opened for the "authoring of alternate stories" (White & Epston, 1990, p. 6). It now becomes possible to talk about the person's influence on the life of the problem. An alternate or preferred story can be co-created by the therapist

and the person; a story in which the person's strengths are remembered, as well as the way in which the person would prefer to act in the world. The story tells about times when the person acted against the problem, the times when the problem may not be around, and about the person's hopes and dreams for their future. White and Epston, borrowing from Goffman (1961) refer to these developments as unique outcomes, which begins to create an alternate story. Questions that trace the history of these unique outcomes can be explored, further enriching this story, and prompting new developments in the person's life. In this way, people's lives are re-authored.

Narrative therapy has developed creative ways to thicken (Geertz, 1973) unique outcomes which strengthens the meaning persons attach to these unique outcomes and facilitates the re-storying of people's lives by such practices as: letter writing campaigns (Madigan, 1999; Madigan & Epston, 1995; White & Epston, 1990); leagues, such as the Vancouver Anti-Anorexia/Anti-bulimia League (Grieves, 1997); and counter documents and certificates (White & Epston).

A Socio-Political Approach

Narrative therapy is a socio-political approach that is concerned with ideas of social justice and injustice. It does not assume a neutral position. It is political in that the narrative approach brings to light the power practices that create and sustain people's problems and subsequent oppression. The Just Therapy Team (Waldegrave, Tamasese, Tuhaka & Campbell, 2003) stress that therapists have a responsibility to address issues such as poverty, racism, homophobia, and the contributions they make to the problems clients face. When these issues are overlooked, therapists are positioned to inadvertently help their clients be happy or content to live in unjust conditions (Waldegrave,

Tamasese, Tuhaka & Campbell).

In my experience, it is helpful to view disordered eating practices and substance misuse within their larger dominant socio-political and cultural contexts and discourses, rather than as fixed entities that reside within a person. As Bruner (1990), quoting Geertz, writes, "there is no such thing as human nature independent from culture" (p.12). Traditional therapy practices individualize and locate the problem within persons, which serves to decontextualize both the person and problem (Madigan & Goldner, 1998). For example, locating anorexia inside of a young woman suggests that there is something defective within her or her personality that requires fixing.

The narrative approach is quick to point out that people do not create the ideas that are oppressing them, and works to locate 'problems' in institutions of power rather than as pathology located within people. This approach takes into account that people's stories are affected and influenced by their larger social context and "politics of local relationship, as well as the larger social politics of gender, class, professional and institutional dominance" (Wylie, 1994, p. 44). For example, when considering the problem of anorexia, the narrative approach allows us to consider the powerful cultural training and pressures young women receive regarding ideas of thinness, beauty, perfection, gender, and being a person for others, in a cultural context where thinness is revered. To overlook the effects of gender, culture, sexuality, class, and racism is seen as being an injustice to the work and to people's lives. In becoming curious about the contribution that the larger dominant cultural discourse has on anorexia, a therapist may, for example, ask their client, "Why do you think it is that more young women struggle with anorexia than young men?"

Narrative therapy and power

The narrative approach pays careful attention to the power relationship in therapeutic relationships. In traditional approaches, the therapist is positioned as an expert on the client's life. However, in the narrative and collaborative approaches, the therapist is viewed as an expert in facilitating therapeutic conversations (White & Epston, 1990; Anderson & Goolishian, 1992). Rather then working to erase power, power is rendered visible by asking permission to ask certain questions, letting clients know they can choose not to answer questions, asking clients permission to take notes, and letting clients read these notes and the notes contained in the clients' files, letting clients know they can choose to end therapy at anytime, letting the clients decide the direction of therapy, and respecting that the client knows what is best for his or her life (Madsen, 1999).

In terms of specific treatment practices, Gremillion (2003), has written extensively about the need for therapists to pay careful attention to the possibility of replicating power and gender practices within disordered eating treatment services. She argues that, "mainstream therapies participate unwittingly in historically specific, dominant cultural discourses of gender, individualism, physical fitness and family life that help constitute anorexia's conditions of possibility" (p. xv). She maintains that traditional therapies for eating disorders, with their focus on body weight, surveillance practices of weighing and measuring (food portions and young women's bodies) and the replication of traditional gender practices between doctors, nurses, psychiatrists and therapists, inadvertently reproduce and replicate some of the very practices that anorexia uses in the lives of young women. For example, anorexia thrives on body surveillance,

control, and a preoccupation with food/exercise, measuring/weighing practices, and comparison with others. Treatment programs often reproduce these elements in the name of helping clients get better, thus reinforcing anorexic practices (Maisel, Epston, & Borden, 2004). Comparison and competition can also be inadvertently encouraged simply by the diagnosis that young women receive. The diagnosis of anorexia is often given a higher status than bulimia by disordered eating sufferers (Grieves, 1997)

Michael White (1986) has discussed how young women with anorexia inadvertently surrender "the responsibility for the supervision of their lives to others" (p.72). He continues, "If freedom has to do with choice, these women experience increasing oppression as they become more 'taken over' by those around them and by the symptoms of anorexia nervosa" (p. 72). While White is referring to the increased responsibility that families begin to assume in the lives of a young woman when anorexia is refusing to let their daughter eat, the same oppression occurs when therapists and treatment centres act as if they know best for the young woman's life. Ali Borden (2007), building on White's work, writes:

> …treatment programs specifically can be critiqued as constituting another call to perpetual effort of self improvement and named as another powerful opportunity for clients to scrutinize themselves for inadequacies and deficiencies and engage in the consistent and 'necessary' work to improve one's body, mind and self along these pre-determined lines of health (p. 39).

I suggest that the same argument can be made for persons entering substance misuse treatment centres to learn how to properly engage in life, that is, without the use of substances. In most substance misuse programs it is assumed that one must abstain

from substances entirely in order to improve. Abstinence is promoted and encouraged over practices of drinking in moderation or harm reduction (Peele, 1995).

Responses to Common Critiques of the Narrative Approach

There have been some critiques of the narrative approach which I feel should be addressed as they help alleviate the same criticism of my work. One common critique is that the externalization of problems places people in passive positions where they have little or no control over their own actions. It is also suggested that, through the externalization process, therapists overlook the fact that people are often resisting something through their use of the problem. It is overlooked that through the problem, young women are gaining a sense of control over themselves and their lives. This critique is especially common where narrative practices of externalization have been used when working with persons experiencing the problem of eating disorders (Vitousek, 2005; Brown, 2007). As Brown says:

> What is so evidently missed here is that anorexia is protest: It is not just compliance. So committed is this approach [narrative therapy] to rescuing women from their compliance, their victimhood, it negates the complex, multiple, and contradictory stories of anorexic body talk (p. 285).

These writers suggest that people are placed in dichotomous positions of good and bad, people good and the problems bad.

It is my understanding that externalization practices can and do co-exist with agency. By engaging in externalizing practices I am not suggesting that people have no control or are victims in their lives. I recognize that people choose to engage in disordered eating and substance misuse practices. These are choices that people make,

often to feel better, or to cope, and they may offer them something that they cannot otherwise find. I believe that we can externalize problems while at same time enquiring about the ways that these problems did or continue to 'help them out.'

Yet people are in different positions in regards to choice (Elliott, 1998). For example, when a young woman begins to experiment with alcohol she may do that out of curiosity, for fun, or because this is what her friends are doing. Should that same young woman continue to choose to drink on a regular basis, she may, in the long term, develop a problem with alcohol. The longer she chooses to drink, the more problems this may begin to cause in her life. For example, the drinking that once occurred only on weekend nights, may begin to spill over into weeknights, which begins to affect her ability to go to school and her grades may drop. The drinking may begin to get her into trouble with her parents, and teachers, and as a result, she may have more 'reasons' to drink. Drinking may no longer be a way to connect with friends and to have fun, it might begin to serve the purpose of making her feel better. The methods she previously used to cope with difficulties may no longer seem available to her. For example, if she used to confide in her mother as a way to work through problems, this may no longer seem like an option if her mom is 'mad at her' because of her drinking, skipping school, and lying. Drinking may become a way to 'forget' about her problems, yet paradoxically the more she drinks, the more problems are created. She may begin to crave alcohol, and she may begin to feel better if she has a drink. Thus the choice to choose to not drink is no longer as easy as it once was when she first began to experiment with alcohol.

I believe that it is in this way that people's choices to engage with 'the problem' becomes limiting. The problem of alcohol, in this example, begins to exert its own control over the young women and begins to control and limit the choices that are available. Quitting drinking is no longer as easy when you are kicked out of school, do not have a routine, all your friends drink, and your body has developed a tolerance to alcohol. Therapists can enquire about how drinking makes sense for these young women and 'helps them out' while also enquiring about how it begins to play such a large role in their lives. Externalizing problems while at same time enquiring about the ways that these problems did or continue to help them out will give us better insight in the issues at hand and will enable us to honour the complexity of the problems and of the young women's lives.

Michael White (2007) addresses these critiques and writes:

> It has at times been assumed that externalizing conversations are complicit with a trend toward constructing people as autonomous units of thought and action. It is my hope that I have given sufficient illustration of the practices of externalizing conversations to dispel this assumption. These practices make it possible for people not only to redefine their relationship with the problems of their lives, but also to redefine their relationships with each other in ways that acknowledge each other's voices in the development of their sense of identity. (p. 59).

White (1989) describes how people are able to take more responsibility for their lives through the externalizing process. Through externalizing practices, the effects that the problem has been having on a person's life becomes clearer, and people are able to

counteract these practices in a way that they were unable to before the problems tactics and effects were unveiled (White). In this way, the young woman's responsibility for her actions is increased rather than decreased.

Another critique is the idea that metaphors of warring or fighting are commonly used to describe the process needed for young women to achieve some space from the problems (Brown, 2007). Brown states that, within the narrative approach, therapists "are determined to situate women's struggles with anorexia and bulimia within a gendered social context. All wish to encourage women to claim power back over their lives by fighting back against or resisting the power of anorexia or bulimia" (p. 283). In some cases a strong position against these problems is warranted, as there are times when people describe, *fighting for their lives* in regards to substance misuse and disordered eating (White, 2007).

Maisel, Epston and Borden (2004), clarify their position:

> …when we talk about 'fighting' a/b, we do not mean fighting in the sense of defeating or conquering. A/b cannot be conquered, but it can be foiled. When we speak of fighting a/b, we mean resisting it and eventually finding ways of escaping or disengaging from it (p. 144).

Given the power that anorexia has over and in young women's lives, externalizing practice help counter the powerful pathologizing impact of internalized problem discourses (Gremillion, 2003). White has also spoken to this concern that warring or fighting metaphors are commonly used in his work, for example encouraging people to 'stand up to problems.' White reviewed his work and found that in only a few

case examples has he used these metaphors, and that in most cases the client had introduced the metaphor themselves (2007).

In Closing

In closing this chapter I discussed the relational features of disordered eating practices and substance misuse, as well as the narrative approach and the concept of externalizing. Narrative therapy has been referred to as an alternative to the mainstream approaches of therapy, aligning itself with postmodern and social construction understandings of the world rather then modernist or scientific paradigms. Given that the narrative practices of personification and externalization are found throughout the dissertation it was important to discuss these concepts. Without this background the reader may have found the dissertation difficult to read, as for those unfamiliar with the narrative approach, people often describe finding it an odd way of talking about people and problems. This speaks to the insidiousness of the modernist way of thinking—how locating problems as inside of individuals and as pathology has become second nature. As a way to bring to life the complexity of the interplay between substance misuse and disordered eating practices, I thought that it would be helpful to illustrate this by way of eavesdropping on an imaginary conversation between substance misuse and disordered eating. In this conversation you will hear how the problems of substance misuse and disordered eating befriend each other and begin to be in cohoots with one another. Scheming together they try to drive a young woman into the ground. In hearing the inner workings of the problems and the ways that they can converse with each other you will have a richer understanding of the relational features the problems share, which will add depth to your reading of this dissertation. This fictional

conversation is a compilation of young women's experiences with both problems that I have been told over the years as a therapist. If it bears resemblance to your own experience or that of someone you know it is purely coincidental while also speaking to the similarities in the ways the problems operate in people's lives.

Substance misuse: Well I'm sure you've heard, Georgia's parents are forcing her to go to a treatment program to deal with what everyone is calling her drug problem. But she doesn't even have a problem. She knows it and I know it.

Disordered eating: Of course I've heard. I know everything that's going on in her life.

Substance misuse: I'm trying to talk her out of it of course. I've told her that I'm the only one that really cares for her, and the proof is that her parents are planning to ship her off to treatment. I think they just want to get rid of her. I've been telling her to look around at the friends she hangs out with, some of those people are way worse off than she is. She's only having fun! Apparently the school is saying that if she is caught one more time being high at school she'll be kicked out. Her parents are livid, and they are threatening her that she'll have to move out if she doesn't stop using me and go to treatment. Can you believe it? Luckily her parent's actions are working in my favour. I keep telling her "See no body understands you like I do," "even your parents are trying to get rid of you." But she's been talking back to me lately, telling me she hates me, that I ruined her life. I just keep telling her about all the good times we've had, the fun, the parties, the friends, the highs….

Disordered eating: I don't know what's gotten into her either. Lately she has been eating like a pig. I think its since she's been trying to cut back on the drugs. Whatever it is she is looking fat these days. I keep telling her that she is not gonna have any friends if she keeps gaining weight. She is gonna look disgusting.

Substance misuse: There is no way that she will be able to quit me. She is not strong enough to do that. But I feel like I am starting to loose my grip on her. We can't let her go to the treatment program. The bunch of losers there will want her to kick us both out of her life.

Disordered eating: Well I don't have to worry about myself. She never tells anyone about me, I'm like her dirty little secret. She'd be too ashamed for people to know that the only reason she can fit into her jeans is because of me. If it wasn't for me she'd have been laughed out of school for being the fat kid. I'm the only reason she has any friends. She won't say anything about me.

Substance misuse: What? You're trying to take the credit for her weight? That's me, that's all me. I work way better at keeping weight off than you, everyone knows that. People forget about food when I'm around, it makes them sick. You are too much work, people think about eating all the time, planning what they would eat if you'd let them, planning how to avoid eating. In fact you should thank me. Some people who might never have thought about you start to when they see what I can do for them.

Disordered eating: No. You have it all wrong. You should thank me. Young women start out losing weight because of me, and then they find out about you

and I'll admit it you can make the weight come off pretty quick. But anyways after they are done with drugs they tend to stick with me. Most women in the world are on a diet.

Substance misuse: This could go on forever and we don't have that kinda time. Right now we might have to work together to ensure that we don't loose her.

Disordered eating: What? Now you wanna be friends with me? I'll remember this when you are trying to take the credit for killing her.

Substance misuse: Here's the plan, when she goes into treatment I'll try to convince her to sneak some drugs in with her- just in case she decides she can't handle it without me. Plus maybe they'll catch her with them and she'll be thrown out. Wouldn't that be the best? Getting kicked out of treatment! She'd need to use a ton of me then to ease that shame. Once she is in there we'll just do like we've always done. The counsellors at the treatment program are going to force her to eat three meals a day there, and she is obviously going to be hungry given that she has been consuming more drugs than food lately. She'll start gaining weight pretty soon into the program.

Disordered eating: And that's where I come in. Soon she will notice that her clothes are not fitting like they used to. Then she won't be able to fit into her pants. I can have her agonizing over her body in the mirror, staring at the rolls of fat pouring over the tops of her jeans. But luckily I can solve all that. She'll just have to gain some control over her huge appetite and begin to restrict her meals. Or she could always start purging- no one there would catch on to that.

Substance misuse: And if her weight doesn't get her back to you, my guess is that she'll need some way to deal with all the memories of all the shit she has done over the past couple years.

Disordered eating: Yeah I've got many ways to help her out with that, purging being one of them. I can keep her so focused on her unhappiness with her body that she won't have any time to think of any thing else but me.

Substance misuse: Perfect! If she is preoccupied thinking about her weight or trying to not eat, she'll miss most of what they are trying to teach her in treatment. She'll be way too distracted to get anything out of it, which will make it much easier for me to sneak back into her life once she's done treatment (that's if she can even finish the program). That's where we can really start working together. I'll start telling her that all she has to do when she leaves treatment is to use me for like a week and then she'll be happy with her body.

Disordered eating: Perfect, then I'll tell her that once all that weight's off she can just start going to the gym, and be healthy. They always fall for that.

Disordered eating and substance misuse: Excellent! She won't have seen this coming and she won't even know what hit her!

CHAPTER 3 THE HISTORICAL CONTEXT

This chapter traces the history of substance misuse and disordered eating practices. In tracing their rich and varied histories we begin to see the many transformations that our understanding of these problems have gone through. It becomes clear that our present day concepts of anorexia/bulimia and substance abuse bear little resemblance to that of our ancestors' experience of the same phenomena. This chapter demonstrates the changes in our understanding of concepts of self, illness, and socially acceptable behaviours over time. This chapter is broken into three sections. In the first section, I trace the history and emergence of the phenomena we now know as eating disorders. In the second sections I sketch the history of substance misuse. The third and final section examines these problems together looking at the historical similarities and differences that exist between the two.

Eating Disorders

Brumberg (2000) writes, "The story of anorexia nervosa lays bare the extent to which disease is a cultural artifact, defined and refined over time, and therefore illustrative of fundamental historical transformations" (p. 6). This section will describe some of these historical and cultural shifts in an attempt to demonstrate the extent to which anorexia is, in fact, a cultural artifact, and also to illustrate how our response to it or treatment of it varies depending on the way in which it is constructed.

Medieval Europe

Although anorexia nervosa attracted medical attention and was formally named in the 1870s, women's food refusal can be traced back to Medieval European times (Brumberg, 2000; Bell, 1985; Bynum, 1987). As early as 1200 AD, women's food refusal and fasting is documented. For example, Catherine of Siena (1347-1380) was said to eat "only a few handfuls of herbs each day," (Brumberg, p. 43) and she would often eat twigs to make herself throw up if she was forced to eat. In the Roman Catholic Church, fasting was a practice women used as an expression of their piety. "The medieval women's capacity for survival without eating meant that she found other forms of food: prayer provided sustenance, as did the Christian Eucharist—the body and blood of Christ—ingested as wafer and wine" (Brumberg, p. 44). Fasting was commonly understood as a devotional practice and was as such supported in the Medieval Era (Brumberg). During fasts, Medieval women often experienced visions, and during these visions women frequently reported being fed by "eucharistic food" (Bynum, p. 131). The intent of this self induced starvation was not to become thin, in fact a plump body was considered the ideal as it showed one's elevated social standing. Instead this self-induced starvation signified one's dedication to God, and demonstrated the importance of the spirit of the body, and over the flesh.

The Protestant Reformation and 17th and 18th Centuries

In the 16th Century, during the Protestant Reformation, some of the practices central to the Roman Catholic religion were called into question, such as praying to Saints and fasting. These were considered practices of the devil. Yet cases of female self-starvation continued, as can be seen in the story of Saint Veronica in the 17th

century. She was said to fast for three days at a time, and then "on Fridays permitted herself to chew on five orange seeds, in memory of the five wounds of Jesus" (Brumberg, 2000, p. 43). During the 17th and 18th centuries, physicians began to refer "to periods of prolonged fasting or 'self starvation' as, anorexia mirabilis (miraculously inspired loss of appetite)" (Brumberg, p. 44). As stories of women surviving on little to no food persisted, there was an increased need from the medical profession to authenticate these cases.

Questions were being raised as to how these women were able to survive without eating for prolonged periods of time, or by abstaining from eating altogether (Brumberg, 2000). Entrusting the how to faith or miracles no longer satisfied the newly emerging medical professions. Physicians and the clergy were deemed the appropriate agents to determine the authenticity of a person's fast. Typically these authentications consisted of watching the fasting patient 24 hours a day for weeks on end to determine if they were indeed surviving without food. These authentications often ended with the discovery that the patient was being kept alive by consuming very small amounts of food or drinks brought to them by their family members (Brumberg). In some cases young women died of starvation during these watches, and a number of fraudulent cases resulted in the young women being condemned to die (Brumberg).

The 19th Century: Anorexia is named

The late 19th century was a time of medical discovery. Diseases were beginning to be named and classified and it was during this time that anorexia nervosa was itself named as a new disease. As a way to increase understanding amongst physicians, anorexia nervosa was distinguished from other diseases that also had lack or loss of

appetite as a symptom. Anorexia was seen as separate from 'lunacy' and physicians' treatments tended to occur at the young women's homes or private hospitals, as opposed to asylums where the poor tended to be housed and treated. Private physicians enjoyed special status treating young women from middle to upper classes, where cases of anorexia were most common.

In the late 19th century, cases of fasting girls continued, and improvements in the printing press made it possible for cases to be widely and rapidly published for both physicians and the general public. Cases such as Sarah Jacob and Mollie Fancher were well known and attracted much attention, often in the form of pilgrimages to the young women's houses (Brumberg, 2000). These fasting girls continued to generate a conflict between science and religion, as their ability to sustain life without food seemed to defy logic.

In 19th century Victorian England, anorexia was typically seen as a form of hysteria, a nervous disorder[13]. The etiology of the word hysteria is derived from the Greek word, 'hustera' which means womb (Soanes, 2001, p. 445-6). According to Greek physicians hysteria was thought to be "a rising of the womb" (Burstow, 1992, p. 26). One of the believed causes of hysteria was a lack of sex, which resulted in the uterus drying up and then floating upwards, which caused fits, convulsions, weakness, muteness, and melancholy. Puberty was thought to be an especially risky period for the development of hysteria, as was any demanding intellectual pursuit, since women presenting with hysterias were regularly noted to be of strong intellect (Bordo, 2003). The treatment for hysteria

[13] "Hysteria…, neurasthenia, and anorexia…were three recognized Victorian ills of the middle and upper classes" (Cushman, 1995, p. 103).

was often what caused it in the first place: isolation, rest, and a limit on mental stimulation, work, or study. Hysteria was a gendered and class based phenomenon; it was not seen among the poor, males, or working class females. Femininity became linked with hysteria, illustrating patriarchy's power to define women by their biology (Mitchell, 1974; Foucault, 1978). This illustrates how our understanding of problems such as anorexia and hysteria are shaped and constructed by historical and cultural contexts, and the extent to which these disorders are mere cultural constructions (Malson, 1998; Bordo).

In the nineteenth century, women's dress in high Victorian society was as restrictive as the rules surrounding women's behaviour. Waists were tightly corseted severely limiting movement. Occupational choices for upper and middle class women were very restricted, making them economically dependent on men (Cushman, 1995). For the most part, women were considered possessions and their value was increasingly intertwined with their appearance and home making skills (Hesse-Biber, 2007). In accordance with what was considered desirable at the time, a frail, subservient, and attractive woman stood a good chance of finding a husband. Hesse-Biber, citing historian Helen E. Roberts, writes, "In an age when alternatives to marriage for women were grim and good husbands scarce, the pressures to conform to the submissive ideal that men demanded were enormous" (p. 39). As men and women's lives divided into breadwinner and homemaker, and women were forced into the domestic sphere, advertisers began directing their ads towards women who were quickly becoming the "primary consumers" (Hesse-Biber, p. 40). Women could purchase items for their home and the latest beauty products, promising self-improvement and increased femininity

(Hesse-Biber; Cushman). Consumption soon became linked with salvation (Cushman), and manufacturing businesses quickly recognized that "as long as a woman viewed her body as an object, she was controllable and profitable" (Hesse-Biber, p. 40).

In 1873 the French physician Lasegue (1873) used the term hysterical anorexia to describe anorexia is his paper, "Del'anorexie hysterique." He details the pressures that upper and middle class girls faced and the way in which these pressures may contribute to the development of hysterical anorexia. He illustrated the power that food refusal had within the context of Victorian England homes, where family life often centred on meal times. A young girl who refused to eat would have caused major distress at meals. In Victorian England, young women of the upper and middles classes were discouraged from eating large amounts, and a delicate appetite was encouraged, as a women's appetite, thinness, and frailty was equated with her class standing, morals, and ability to marry into a respectable family of high standing (Brumberg, 2000). Appetite was also tied to sexuality, eating meat was discouraged among females as it was thought to generate heat within the body, and a voracious appetite was reflective of one's sexual attitude. With this understanding of food in Victorian society, as well as the lack of possible outlets for women's distress and unhappiness, food refusal became an especially powerful form of protest[14] during this time period (Bynum, 1987). Cushman (1995) writes:

> Physical symptoms were one of the few avenues of expression available to women within the Victorian terrain: where else could women express the restrictions and frustrations of their roles but in the body, that realm

[14] The idea of food refusal as protest will be expanded upon later in this chapter.

wholly identified with, and expressive of, their "untamed" nature? (p. 104).

Malson (1998) describes how "'the hysterical woman' or 'the anorexic woman' *parodies* the deeply embedded gender ideologies that devalue women, insisting that we inhabit a dependent and restricted social role" (p. 21).

In 1873, shortly after the publication of Lasegue's paper, anorexia nervosa was classified as a diagnosis by British physician, Sir William Withey Gull (Brumberg, 2000).[15] The classification was based on Gull's work with upper and middle class young women. According to Brumberg, Gull

> conceived of anorexia nervosa as a coherent disease entity distinct from starvation among the insane, and unrelated to organic diseases such as tuberculosis, diabetes, or cancer…this disease had a specific clientele: young women between the ages of sixteen and twenty-three (p. 110).

Both Lasegue's and Gull's descriptions of anorexia had at the centre a young women who would not eat and who exhibited "low body temperature, amenorrhea and hyperactivity" (Brumberg, 2000, p. 160).

Treatment for anorexia consisted of bed rest and feeding at regular intervals. It was preferred that the girl's family not be responsible for the feeding, and, if possible, it was considered best for the youth to be separated from her family, her care entrusted to a nurse until her health was regained. Young women were considered cured when they had regained weight. Young women were often fed by force with a stomach pump if they refused to eat. Being force-fed is an inherently violating act. In the case of using a

[15] Even though anorexia was named in the 1870s, "until the 1920s and 1930s …American doctors used the two terms almost interchangeably: 'hysterical anorexia' (a reference to a neurological conception) and anorexia nervosa" (Brumberg, 2000, p. 109).

stomach pump, the use of the benign word feeding minimizes the force involved in the act of being fed in this manner[16] (Coates & Wade, 2007). These methods show how young women were not seen as autonomous individuals, instead decisions for their care and treatment were left up to others. Underlying the anorexia nervosa (as with hysteria) was believed to be an irrational longing for attention and sympathy. This interpretation basically negates all potential claims at distress that a young woman was making, and located the distress as originating within the women themselves.

The 20th Century

Physicians continued to search for possible biological explanations for women's food refusal and in 1914, the discovery of Simmond's disease was used to explain a woman's lack of appetite (Brumberg, 2000). A deterioration of the anterior lobe of the pituitary gland was thought to be the cause of Simmond's disease (Brumberg). Treatments consisted of giving patients hormones with the hope of stimulating their appetites. Though this was later disproved and Simmond's disease was found to be relatively rare, the search for biological causes and hormonal treatments for anorexia nervosa continued into the 1920s and 1930s.

The Flapper Era

In the Flapper Era of the 1920s there was a societal emphasis on thinness as the boyish look of the flapper took center stage. Transgressing traditional gender roles,

[16] Today woman are force-fed using nasal gastric tubes. This is a procedure that can be live saving, and in extreme cases of malnourishment necessary to keep someone alive. Maisel, Epston & Borden (2004) describe how "when the will of the treatment team is imposed upon the person, violations of spirit are bound to occur. At times these impositions may be necessary to save a life (p.279). In their book "Biting the Hand that Starves You" they offer suggestions for how to proceed in the most respectful way possible should it be deemed necessary that a person be hospitalized or tube-fed (Maisel, et. al.).

women's breasts were bound, hemlines raised and hairstyles became shorter and freer. These acts of resistance were part of women's on-going attempts to challenge the long lists of behaviors that were deemed unacceptable for women such as drinking and casual sex. They were also a response to the hegemonic policing of women's bodies and desires (Gramsci, 1971). Standardized ready-to-wear clothing was also introduced during this period, which meant that women's bodies were now required to fit the clothing, compared to having clothing tailor-made to fit an individual woman's body. Women with larger bodies were at a disadvantage and often unable to fit into the newly arriving collections of fashionable clothes (Brumberg, 2000).

Though psychoanalysis was developed in the late 1800s it did not actually take hold until the 1930s when the medical field's interest in exploring endocrinologically and biologically based reasons for anorexia waned (Brumberg, 2000). In the late 1800s, Sigmund Freud and Pierre Janet began talking to their patients in hope of uncovering the emotional reasons for the development of anorexia. "Freud posed the important conceptual question that had not been asked before: What does the anorectic's lack of appetite *mean?*" (Brumberg, p. 212). Of course, given the time period and social context in which they lived, Janet and Freud based their theories of anorexia in ideas of sexuality. It is important to note that Freud is one of the first theorists to consider the importance of the symbolism involved in food refusal and thinness. He discussed how many of his patients described being fearful of the fat that accumulated on their stomach, hips, and breasts—areas that are typically seen as defining characteristics of a woman's body (Bordo, 2003). In this way, women were resisting their own bodies by dieting and food refusal (Bordo).

In the 1930s and 1940s, Freud's theories of anorexia as a psychosexual dysfunction were brought to the forefront. Psychiatrists linked anorexia to the unconscious and sexuality, claiming among other things, that anorexia was an attempt to hold onto a small, childlike body, and a fear of oral impregnation (Brumberg, 2000; Gremillion, 2003). Psychiatrists agreed that, for a patient to recover, she needed to gain weight as well as undergo psychotherapy to discover the reasons behind her refusal to eat (Brumberg). During this period, psychiatrists began to talk about an 'anorexic personality,'—women who had anorexia were found to be intelligent, willful, driven, introspective (Brumberg). Here we see the beginning of the diagnosis of anorexia becoming fixed to the young woman's identities. Freud's theories continued to be influential up until the 1950s when people began to move away from the heavy focus on psychosexual stages and instinctual drives, and toward the behavioral approaches that became popular are still in use today (Gremillion, 2003).

The Sixties

In the 1960s, anorexia was characterized by an intense focus on thinness, and an aversion or fear of becoming fat (Malson, 1998). Twiggy, a 97-pound British fashion model, emulated the fashion style of the sixties, and became a fashion icon to many of her generation (Hesse-Biber, 2007). Interestingly the pressure to conform to a slender body occurred as women were beginning to take up more space in the public sphere, attending university and working out of the home (Hesse-Biber). Anorexia was still not well known by the general population, yet around this time there began to be an increase in the number of patients diagnosed with anorexia. Hilde Bruch (1973) revolutionized the ways in which eating disorders were treated when she detailed the meaning behind

food behavior and its relationship to the development of women diagnosed with anorexia. As a result of her conversations with hundreds of women and professionals, she described anorexia as a longing to be thin coupled with the feeling of being fat.

Psychiatry began to recognize that anorexic patients were not suffering from a lack of appetite; in fact they were denying their appetite in spite of their hunger. By talking with their patients, they realized the extent that patients were going to in order not to eat and avoid food. Bruch also linked under-consumption and excessive food consumption together, describing them both as diseases in need of treatment (Brumberg, 2000). The increased number of patients diagnosed with anorexia during this time has been linked with the abundance of food and food choices, coupled with 'norms' for how the female body should look. In the 1970s, in addition to body size standards for woman, there was also an emphasis on health and fitness. Women were not only to be thin but also fit and toned, which placed more pressure and responsibility for the shaping of their bodies. Women's bodies began to become sites of prescription where hegemony was scripted onto the bodies of women (Foucault, 1979; Diamond & Quimby, 1988). Treatment during this time centered on weight gain, and was based in behaviorist approaches using both positive and negative behavioral reinforcements to attain the desired treatment outcome (Gremillion, 2003). Once an individual's weight was stabilized, cognitive/behavioral, family therapy or psychotherapy could commence.

Capitalism and patriarchy joined forces further commodifying women's bodies as a product and, by the 1980s, dieting had become a common practice to the extent that over five billion dollars was spent on dieting, exercise, and weight loss regimes (Brumberg, 2000). Cushman (1995), citing Lears, writes how "the influence of

advertising… has had a negative effect on the feminist movement, preoccupying women with the perfectionist pursuit of cleanliness in the middle class home and the ambitious pursuit of a life a glamour in the celebrity spotlight" (p. 69). Singer Karen Carpenter's death in 1983 from anorexia spurred a new awareness of the disease and for the first time, anorexia became known outside the medical profession.

Present day understandings

Current "lifetime prevalence estimates of DSM-IVR anorexia nervosa, bulimia nervosa, and binge eating disorder are .9%, 1.5%, and 3.5% among women, and .3% .5%, and 2.0% among men" (Hudson, et. al., 2007). The main criteria for eating disorders, specified by the Diagnostic and Statistical Manual–IVR (APA, 2000), defines different features for anorexia nervosa, bulimia, and eating disorders not otherwise specified.

The following features define Anorexia Nervosa:

Table 3 Features of Anorexia Nervosa

A. Refusal to maintain body weight at or above 85% of normal weight for age and height.
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight, shape or size is experienced.
D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles (p. 263)

Bulimia Nervosa is defined as:

Table 4 Features of Bulimia

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both the following:

1) Eating, in a discrete period of time (e.g.. within any 2-hour period), and amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

2) A sense of lack of control over eating during the episode (e.g., a feeling that one can not stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influence by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa. (p. 264-5).

Eating Disorder Not Other Wise Specified:

Table 5 Features of eating disorders not otherwise specified

The Eating Disorder Not Otherwise Specified category is for disorders of eating that do not meet the criteria for any specific Eating Disorder (p. 265).

Treatment for anorexia and bulimia tends to be based on inpatient or outpatient programs, which are often located in hospitals or specialized treatment centres.

Treatment, while still focusing on weight gain, is often in the form of behaviour modification therapies, and includes individual, family, group and psycho-educational therapies (Gremillion, 2003). But, as Gremillion explains,

> …even with this multipronged treatment approach, anorexia—widely understood since the 1960s to be a syndrome of complex ('multifactorial') or unknown etiology—remains extremely difficult to treat. It has the highest mortality rate of any psychiatric illness (approximately 10%), and according to a number of studies, most patients continue to struggle with significant anorexic symptoms many years after treatment (p. 3).

I will now trace the historical perspectives of drugs and alcohol, and our present day understandings of substance abuse and dependence.

Historical Perspectives on Drugs and Alcohol

Alcohol

In order to conceptualize how our current understandings of substance misuse have developed, it is helpful to have an historical understanding of the context out of which the treatments and attitudes towards drugs and alcohol have grown. This means tracing the etiology of alcohol and drugs as well as contextualizing their use and the social meaning of their use at that time.

As I live in Canada, it is particularly relevant that I include a discussion about the impact that alcohol use has had on the First Nation People in Canada. First Nations people were the original settlers of Canada, with prolonged European contact not occurring until the 17th and 18th centuries (Brody, 1988). As the European settlers encroached upon First Nations' land the First Nations people began to experience a

cultural dislocation. The Hudson Bay Company began to trade alcohol for furs, which led to the breakdown of communal, kinship-based, cultures (Ray, 1998). Prior to contact with Europeans, alcohol was not a part of First Nations people's diet. Brody writes:

> Traders soon recognized that they had an almost ideal trade commodity in alcohol: it is soon consumed and tends to be addictive. They exchanged drink—traditionally rum—for furs, or sold it for the money they had paid for furs, or simply gave it away. The Indians promptly drank it all. The traders were left with the furs and the Indians were left with as great a need as ever—if not an increasing need—for trade goods. Trading, thus helped by alcohol, led to more trading (p. 251).

The devastating and destructive effects of alcohol and colonization continue today in Canada in the lives of First Nations people.

People have been trying to alter their states of consciousness for most of our documented history. Beer jugs have been found dating back as early as 3700 BC, and wine is believed to have been around since 1700 BC (Levinthal, 2005). Prior to the 18th century, alcohol was one of the few beverages able to be consumed since water was not always safe to drink. Fermented alcohol served an important dietary role; it was a staple of early diets and provided important nutrients (Levine, 1978). Alcohol was also used as a medicinal substance, prescribed by physicians to relieve aches/pains, soothe indigestion, and to fight fatigue. Levine states, "liquor was food, medicine and social lubricant, and even such a Puritan divine as Cotton Mather called it the 'good creature of God'" (p. 494).

In the 17th and 18th centuries, drinking was part of daily life. Levine (1978) writes, "Americans drank wine, beer, cider, and distilled spirits, especially rum. They drank at home, at work and while travelling, noon and night. And they got drunk" (p. 495). Heavy drinking was built into the culture of social celebrations, and the tavern keeper was an esteemed member of town (Heron, 2003). The tavern acted as a community centre for gatherings and get-togethers (Heron). People who chose to drink to excess did so for their love of the drink, they were not judged to be doing so because of the addictive power of alcohol, or from a lack of will power or a need to drink. They got drunk because they enjoyed it and because they wanted to (Levine).

Dating back to at least the 17th century, the occasional complaints about the amount of drinking in the colonies came, more often than not, from wealthy colonials or preachers (Roth, 2004; Levine, 1978). Habitual drunkenness did not go unnoticed. Towns often had lists of 'drunkards' as they were referred to during that time and tavern keepers could be fined or shut down if they provided them with alcohol. But for the most part, drunkenness was an accepted part of life in colonial America. It is important to note that most histories of drinking are specific to males; taverns were for the most part dominated by males, and most stories of 'drunkenness' (especially in public spaces) pertain to males. The existing stories of public displays of female drunkenness are typically about prostitutes. Women who drank to excess most likely did so within the confines of their homes due to the harsh judgment of female behaviour and the very different standards as to what was acceptable for men and women (Heron, 2003).

With the change from an agrarian society to an industrialized one in the 18th and 19th centuries, attitudes towards alcohol hardened, and concern regarding "habitual

drunkenness" (Levine, 1978, p. 496) increased. Industrialization meant the break up of small and connected communities as individuals moved to larger cities looking for work, and immigrated to Canada and the US. In agrarian communities, employers provided alcohol and employees drank on their breaks at work as a way to ease the hard work's toil on the body (Heron, 2003). The use of heavy machinery meant that it was no longer safe for workers to drink on the job and more important, productivity and financial gains could be threatened. As industrialization progressed and capitalism strengthened, stronger divides emerged between the upper and lower class. Capitalism was beginning to play a central role in defining a person's position and worth in new post-colonial America (Severns, 2004), and increasingly the values of the upper class and the emerging middle classes were forced upon those below. Industrialization also marked the end of family and community regulation of alcohol consumption. The poorhouses, prisons, asylums, and sanitaria increasingly handled these problems.

In the mid 18th century we begin to see concerns arising regarding the amount of alcohol that people were consuming, the number of taverns that existed, and the amount of time people were spending in them (Levine, 1978). Temperance groups that promoted moderate drinking emerged and their reasons for encouraging drinking in moderation were tied to religious discourses of good and evil, which were increasingly moralistic and pejorative. Interestingly, the amount of alcohol that was being consumed did not change between the 16th and 19th century. What did change, however, were the attitudes that people held towards alcohol (Roth, 2004). In Canada and the US in the 1820s and 1830s, temperance movements emerged from the previously formed temperance groups, and we increasingly see drunkenness portrayed as if it were a disease (Heron, 2003;

Levine). This movement emphasized morality, self-control, moderation, and the avoidance of spirits (Heron; Roth). Advocates of the movement believed that if spirits were avoided, then most of the social problems faced by colonial America would disappear (Levine). Members of the temperance movement rallied to encourage people to stop drinking alcohol as a beverage and to pledge that they would abstain from drinking entirely (Heron).

Benjamin Rush, a physician and a signatory on the Declaration of Independence,[17] was adopted as a 'spokesperson' for the temperance movement after writing a pamphlet in 1785 that detailed the impact that alcohol had on both the mind and body (Levinthal, 2005). Citing Sander's (1994) description of Benjamin Rush's ideas on the effects of alcohol, "alcohol, in the lives of some persons, was a misused substance that eroded 'willpower' and led to a troubled existence and impoverished life" (p. 26). Levine describes how:

> Rush's contribution to a new model of habitual drunkenness was fourfold: First, he identified the causal agent-spirituous liquors; second, he clearly described the drunkard's condition as a loss of control over drinking behavior- as compulsive activity; third, he declared the condition to be a disease; and forth, he prescribed total abstinence as the only way to cure the drunkard (p. 500).

Women became more involved in the prohibition movement, and according to Heron (2003), "by mid-century women had a prominent role in many temperance organizations, even as speakers and organizers, and sometimes had their own branches such as the Daughters of Temperance" (p. 56). Women were included in many of the

[17] Rush is also considered the Father of American Psychiatry (Brodsky, 2004).

temperance activities "to set a higher moral tone and to keep male excesses under control" (Heron, p. 56). Within this context, people who fell prey to 'drunkenness' were viewed with compassion, and sober houses were set up where people could stay until they lost their desire for the drunkenness—women often providing assistance to families whose member had fallen prey to the drink (Heron; Levine, 1978).

Nearing the end of the 19th century and entering into the 20th century, temperance was fuelled by the middle classes who insisted that those who drank were weak willed and of lower moral standing than those who refrained or drank in moderation. Roth (2004) describes how, "the now more aware middle class cast the proletariat-as-drunk as its Other" (p. 23). For example, the Irish working class were generally Catholic, while the middle class were mostly Protestant. The derogatory slang phrase, 'paddy wagon' is thought to be derived from inebriated 'Patty's,' referring to Irish persons (C.J. Sanders, personal communication, March 1, 2009).

The middle and upper classes began to avoid the taverns and saloons that they had previously frequented, choosing instead, if they did drink, to drink in the privacy of their own home with friends of the same class standing (Roth, 2004). Saloons began to be demonized as breeding grounds for corruption, and sites for immoral behaviour. Public drinking among the working class became more visible and apt to be judged as the divide between those who could choose to drink and remain unseen behind closed doors widened.

As the temperance movement gained momentum, alcohol was portrayed as a dangerous drug that no one could use safely or in moderation; therefore no one should have access to it. "Demon Rum" (Levinthal, 2005, p. 235) was viewed as an entity that

could destroy the lives of even the most well to do, and much concern existed for members of their own classes; anyone could become alcohol's victim (Levine). Clearly, the language used to describe alcohol and its effects was not neutral. Terms such as 'demon rum' imply that alcohol was evil and consumption of it would result in possession by the devil.

Prohibition parties began pressuring the government to ban the manufacture, sale, transportation, and importation of alcohol, and on January 29, 1920, the Eighteenth Amendment of the Constitution in the United Stated implemented prohibition (Hartmann & Millea, 1996). In Canada, retail outlets closed and shipments of alcohol were restricted but brewers, distillers, and wine-makers were allowed to continue making and selling their products for export which set the stage for bootlegging alcohol to the US[18] (Heron, 2003). Legally, alcohol could still be purchased, but only from "properly licensed wholesalers or… official government-run dispensaries and only for 'medicinal, mechanical, scientific, and sacramental purposes'"(Heron, p. 181).

[Distilled] Hard alcohol replaced beer or wine because it could be transported more easily and illegal clubs—'speakeasies'—appeared in cities all over the US. In these 'speakeasies' only spirits were served and intoxication was the norm. It quickly became apparent that prohibition was not working—organized crime surrounding alcohol consumption increased, the government lost out on revenue from the taxation of alcohol. It is estimated that "by 1927 well over 50, 000 people had died from drinking poorly made alcohol" (Severns, 2004, p. 159; Hartmann & Millea, 1996). For the aforementioned reasons as well as the financial devastation that the economy was in due

[18] And the ascendancy of the Bronfman "Seagram" dynasty. (Heron, 2003)

to the depression, in 1933, the Volstead Act, which had made prohibition possible beginning in 1919, was repealed by the 21st Amendment, and alcohol was again legalized (Levinthal, 2005; Hartmann & Millea).

Only two years after Prohibition was repealed, Alcoholics Anonymous (AA) came into being as a way to support individuals who wanted to stop drinking. AA was started by Bill Wilson (often simply referred to as Bill W.), with ideas based in the traditions of the Oxford Group, a religious group that centred on "performing self inventory, admitting wrongs, making amends, using prayer, and meditation and carrying the message to others" (Alcohol Anonymous Worldwide Services Ltd., 2008, ¶1). AA is a fellowship-based group with a spiritual component that relies on sober AA members to support and sponsor other alcoholics who want to quit drinking. Thus began a real self-help model regarding the treatment of addiction.

Within the AA framework, the word "'illness,' 'allergy,' 'sickness,' and 'malady'" were used (Severns, 2004, p. 161) to help explain the problem of addiction. The word disease was intentionally not used so as to not offend the medical profession, as they were generally not in favour of treating alcoholics and they wished to "re-involve the medical profession in treatment" (Severns, p. 161). Another reason the word allergy was chosen was:

> AA members were anxious not to give the impression of genetic anomaly because, until the rise of Nazi Germany, the United States led the world in eugenics. AA members did not wish to be the target of forced sterilization or more noxious strategies by which they would be denied the possibility of procreation (Severns, p. 161).

The dominant view of alcohol at this time was that problems were caused by the nature of alcohol itself, as opposed to the problem residing with the person drinking alcohol. In 1940, AA members formed The Committee for Education on Alcoholism, which later became the National Counsel on Alcoholism (NCA) (Hatmann & Millea, 1996). These groups arose partially in response to the type of inhumane treatments that were available to alcoholics and addicts—institutionalization, criminalization, and experimental surgeries such as frontal lobotomies—and also due to a lack of funding and research initiatives directed towards alcoholism and addiction (Severn, 2004). Severns writes, "isolated and without help, alcoholics were viewed as hopeless, their treatment reduced to sterilization and end-stage warehousing, with frontal lobotomies becoming a popular option in the 1940s" (p. 158).

Now that alcohol was again legal, the liquor industry needed to find ways to undo the fear towards alcohol that over 100 years of temperance had created. One way was to build on the 'allergy' idea being promoted by AA, which meant that alcohol was only addicting to a small group of people and that others were safe to drink it. Jellineck began researching the disease idea in the 1940s, and throughout his career he was a lifelong advocate for the medical treatment of alcoholism (Severns, 2004). It is of interest to note that Jellineck's research studies were "financed by the liquor industry, which reported that about 10% of U.S. citizens were predisposed to alcohol addiction" (Severns, p. 159).[19]

[19] This sort of association continues today with the medical profession being courted and recruited by pharmaceutical companies to distribute new drugs. For more information regarding this phenomena see David Healy (2002) The Creation of Psychopharmacology. Harvard University Press: USA; Robert Whitaker, (2001) Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill. Basic Books: USA.

In 1960, Jellineck expanded on the allergy idea and wrote a book categorizing alcoholism into five distinct types, titled, *The Disease Concept of Alcoholism* (Hartman & Millea, 1996, p. 40). With this, the 'disease' concept of addiction blossomed (Severns, 2004). The American Medical Association affirmed the disease concept of alcoholism in 1968, but it was still considered "an indicator of 'mental illness'" (Hartmann & Millea, p. 41). In 1970, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was formed and the disease concept of alcoholism was advanced. The NIAAA expanded treatment programs and research funding for alcoholism, and also ensured that most addiction treatment programs were based in AA philosophy and the disease model of alcoholism (Hartmann & Millea; Peele, 1999).

The ascendance of drug use

Drug use can be seen as entering the western scene during a time when alcohol use was being scrutinized and intolerance towards alcohol was growing. Up until the 1800s, drugs were used in their natural, unaltered form, and when used in this manner there was less likelihood of addiction occurring (Musto, 1991). In South America, the use of the coca leaf can be traced back to Inca civilizations in the 13th century. Coca leaves (from which cocaine is derived) were known to have stimulant properties and were used for years by locals, in the way of chewing coca leaves, which contain about 2% cocaine.

Opium, which comes from the head of the Opium Poppy, was used for centuries almost exclusively on a medicinal basis without addiction; in China, it was used as early as 973 AD by Chinese herbalists, and by the indigenous populations of South America,

particularly, in Peru. The active agent, morphine, is diluted when opium is taken orally. It wasn't until people began smoking opium in the 18th century, that problems with opium addiction began (Levinthal, 2005). In terms of the effects of colonization, it is important to note that it was Britain that fuelled the demand for opium among the Chinese, by demanding that China trade Chinese silk and teas for opium, effectively forcing the Chinese people into addiction. This culminated in the Opium Wars of 1839-1842 and 1856–1860 between China and Britain, which China lost (Chang, 1970).

When Chinese labourers were brought to North America to build the Western Railroads, they brought with them the tradition of smoking opium (Willutzki & Wiesner, 1996). The Chinese received harsh treatment for their opium smoking practices, which was fuelled by fear and racism. Opium used in this form was seen as a vice and associated with the lowest class of people, whereas opium taken in the form of a drink called Laudanum was both acceptable and common practice by both English and Americans. 'Mrs. Winslow' Soothing Syrup is one such mixture of Laudanum, and was used for pain relief, sleep, and for common coughs or colds. Western practices of consuming narcotics were considered legitimate and licit, yet the Chinese immigrants' practice of consuming the same narcotic substance by smoking it was viewed as dirty and illicit (Musto, 1991).

With advances in science in the 1800s, drugs were chemically isolated from their raw state and became available in purer form (cocaine, morphine, codeine, and later heroin in 1898). Physicians and lay people, not knowing the addictive potential of these substances, used them unabashedly for their medicinal, euphoric and, relaxation inducing properties—they were widely available and their advertising was unrestrained.

In 1812, many Civil War soldiers became addicted to opium after being given opium preparations when they were wounded, ill, or 'shell shocked' (the origins of what became post-traumatic stress disorder) (Kutchins & Kirk, 1997). With the discovery of morphine, it was assumed that this would be a cure for opium addiction due to less of it being needed. In 1870, the hypodermic syringe was perfected and had become a familiar instrument to both doctors and patients. Doctors falsely assumed that because a person was injecting less morphine they were less likely to become addicted to it. As doctors continued to isolate new chemical forms of drugs they would unwillingly replace one drug addiction for another. For example, when in 1884 Sigmund Freud promoted cocaine to mainstream medicine, he described it as a 'magical drug' and a safe, non-habit forming, treatment for morphine addiction (Levinthal, 2005). By 1885 the Parke Davis Company had made cocaine available in 15 different forms, cocaine cigarettes, cocaine for injection, and cocaine for sniffing. In 1863, cocaine was also used in a beverage mixed with wine called Vin Mariani (Musto, 1991). Later the alcohol was removed and Coca Cola was born, advertising the benefits of cocaine without the 'harmful' effects of alcohol (Musto).

After about 100 years of unrestrained use and unrestrained advertising of drugs, public fear of opiates and their addictive properties increased. The increase in fears was a response to capitalism, increased criminalization of drugs (Severns, 2004), and the marginalization of the Chinese people who had been brought to America to build the railways (who had brought with them the practice of opium smoking), (Willutzki & Wiesner, 1996). Due to these fears, we begin to see a decline in the general public's consumption of drugs. Some states responded to these fears by allowing morphine to be

available only by prescription. With fears increasing about morphine addiction, physicians were looking for other substances to replace morphine, and in 1898 the Bayer Aspirin Company believed they had found the answer through heroin (Willutzki & Wiesner, 1996. p. 52). Heroin was believed to be less addictive than morphine, with fewer side effects. It was even included as an ingredient in cough syrup as it was useful in suppressing the cough reflex (Musto, 1991). The addictive potential of heroin was soon discovered and quickly associated with criminal use, as it was not a drug regularly used by the medical profession (Willutzki & Wiesner).

As a result of the growing temperance movement in the 1800s and increasing unease towards alcohol, a burgeoning patent medicine mail order trade had developed, of which doctors were trying to gain control, mainly because of the profits to be made (Severns, 2004). In part, the use of mail order patent medications was one way to avoid the shaming that was occurring when people consumed alcohol (Severns, 2004). In 1847 the American Medical Association (AMA) was formed, which allowed them, in 1914, to gain control of patent medications and drugs (except nicotine and alcohol) under the Harrison Act (Severns, 2004). In 1914, the Harrison Drug Act was enacted which gave the American Medical Association (AMA) control of patent medications and drugs (nicotine and alcohol were excluded) and categorized all substances as narcotics (Severns, 2004). The Harrison Act oversaw any opium coming into the United Sates as well as the dispensing of it. The sale and production of opiates were now prohibited except through prescription, which made it possible for physicians to maintain a patient's addiction. No longer could any patent remedies contain any trace of narcotics. The Harrison Act was also an attempt to stop illicit drug use and the importation of

narcotics by immigrants into the United States. This act drew a clear line between white American's licit drug use (laudanum) and illicit drug use by the Chinese (opium smoking).

In 1919 the Supreme Court ruled that "indefinite maintenance for 'mere addiction' was outside of legitimate medical practice hence, physicians were no longer able to maintain a patient's 'addiction'"(Musto, 1991, p. 44). Now patients who were dependent on narcotics had to obtain them by other means, which created a large black market for drugs and increased crime rates. Similarly, prohibition put alcohol's control in the hands of organized crime and created an illegal market for alcohol. Increasingly individuals who used drugs and alcohol were criminalized, leaving 'addiction' treatment in the hands of law enforcement (Severns, 2004). As described by Willutzki and Weisner (1996):

> In the next decades early attempts by the medical profession to work in the area of drug use were very much restricted by the Federal Bureau of Narcotics….thousands of physicians and drug users were criminalized and put in jail; eventually the medical profession mostly dropped out of the field (p. 52).

So disappeared years of treatment practices, addiction knowledge, and medical remedies treating addiction (Levine, 1978; Severns, 2004).

In the 1950s, doctors again began treating 'addiction' (Willutzki & Wiesner, 1996) based mainly in AA ideas, and in the disease model of addiction. Addiction was seen as a progressive disease that would end in death if drinking or substance use was not stopped, therefore abstinence was always prescribed. Even today, the judgment towards individuals misusing alcohol and drugs tends to be quite strong and paternalistic. The

general belief is that people not willing to seek help are in denial, that they choose addiction, and that they can stop if they so desired.

Present day understandings

As insurance companies are increasingly outcome orientated and institutions compete with academia and research for funding, there has been an increasing demand for the treatment providers to have an education that extends beyond personal experience in the field (Hartmann and Millea, 1996). As more money goes into research, the disease concept of addiction is increasingly called into question although the search continues for the ever-elusive human gene responsible for causing addiction. Colin Sanders (2007) writes, "The tendency to locate the etiology of the addiction experience within a person's biochemistry is the latest, albeit most sophisticated, variant of the history of the disease metaphor" (p. 60).

The American Psychiatric Association (APA) DSM-IVR (2000) outlines the criteria for substance dependence and substance abuse as follows:

Table 6 Criteria for substance dependence:

A maladaptive pattern of substance, use, leading to a clinically significant impairment or distress, as manifested by three or more of the following, occurring at any time in the same 12-month period:[20]

[20] The APA has been criticized for the use of the word dependence, claiming that it is too general of a term (Peele, 2009). As Peele (2009) writes, "people can become dependent on medications for good medical reasons, but that this doesn't comprise a disorder…. Why is there no addiction in the DSM-IV? Addiction experts used to consider narcotic withdrawal the penultimate characteristic of addiction. That was called "physical" dependence. But that left out cocaine (and nicotine)…. So physical dependence and what used to be called "physic" dependence were folded into one big dependence ball of wax" www.peel.net/blog/090425.html

1) Tolerance, as defined by either of the following:

a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect

b) Markedly diminished effect with continued use of the same amount of the substance

2) Withdrawal, as manifested by either of the following:

a) The characteristic withdrawal syndrome for the substance

b) The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

3) The substance is often taken in larger amounts or over a longer period than was intended

4) There is a persistent desire or unsuccessful efforts to cut down or control substance use

5) A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

6) Important social, occupational, or recreational activities are given up or reduced because of substance use.

7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (p. 110-111).

Table 7 The criteria for substance abuse as defined by the DSM-IV-TR (APA, 2000)

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1) Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
2) Recurrent substance use in situations in which it is physically hazardous (e.g., Driving an automobile or operating a machine when impaired by substance use)
3) Recurrent substance-related legal problems (e.g. arrests for substance- related disorderly conduct)
4) Continued substance use despite having persistent or recurrent social or interpersonal problems cause or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance (p. 114-115).

Harm Reduction

In Europe, Australia and Canada since the 1980s, there has been a growing harm reduction movement, which has begun to shift the focus away from the hegemony of the

disease model of addiction that continues to prevail in the United States (Marlatt, 2002). It is important to note as Marlatt points out that, "the origins of this approach to drug problems can be traced back to the 19th century" (Marlatt, p. 30) Harm reduction practices meet the individual where they are at, with services geared towards reducing harm at the individual and societal level. Harm reduction practices do not expect the individual to just say 'No' to drugs and alcohol, and instead provide services for individuals who do not wish to stop using. Examples of harm reduction practices are; needle exchange programs, methadone maintenance programs, and supervised injection sites, among others. These practices focus on the health and dignity of the person using substances, and on creating safer options and alternatives for persons who wish to continue using drugs and alcohol.

Crafting Alternative Understandings of Eating Disorders and Substance Misuse

It is important to consider the historical context from which both alcohol/drugs and eating disorders came for a few reasons. First, it allows us to see how the concepts of substance misuse and disordered eating have evolved through time—they are clearly not static categories. Instead they have subtly transformed into new categories that are quite different from their original understandings. In each different historical context, substance misuse and food refusal have been given new meanings based on the beliefs and values that existed at that given time. Looking back, we are able to see how people coordinated their actions based on their beliefs, values, and expectations (McNamee, 1992) regarding drugs, alcohol, and food. These beliefs, values, and expectations emerged within communities as generalized notions of the correct or appropriate way to behave during given time periods (McNamee). Knowing that the theories we use to

make sense of ourselves and of our surroundings are not universal truths better positions us to deconstruct our current understandings of substance misuse and disordered eating.

Second, a historical looking back sheds light on how people who drink, use drugs, or refuse food are viewed in the context of particular time frames. For example, according to Willutzki and Weisner (1996), "The historical perspective of drug use in the U.S. during the last 200 years seems particularly instructive because it covers the full range from autonomy to disease to criminality concepts and back" (p. 53). The discourse surrounding drug use and misuse, particularly marijuana, cocaine and heroin, has been influenced by race and racism, not just class. The Chinese were feared for smoking opium, Mexicans for marijuana use, and African Americans for cocaine and heroin use. The 'other' is usually constructed regarding a race, class, and ethnicity by privileged whites (C. J. Sanders, personal communication, March 1, 2009), and, as has been demonstrated, this 'othering' has strong implications for an individual's social and medical treatment (Sampson, 1993).

Third, the historical context demonstrates how meaning and subsequent language practices influence our understandings of phenomena. This understanding is very much tied to a society's specific cultural values, ethnicities, and moralities (Epstein, 1996). In my opinion, nothing illustrates the importance of this better than the concept of gluttony. Gluttony was originally tied to excessive food consumption, and a refined appetite that showed restraint was highly regarded. As Roth (2004), explains, "The most obvious early taxonomy for bad behaviour was the Seven Deadly Sins, in which gluttony marked the place of sins of consumption, but it was uniformly associated with food, not drink" (p. 20). As has been demonstrated, excessive drinking soon surpassed excessive food

consumption as a sinful and immoral behaviour. The cultural meaning given to the behaviour of gluttony changed, and people adapted their beliefs accordingly. The behaviour remained the same yet the values attached to it had changed. This illustrates the power a discourse has in disseminating what is acceptable or not at a given period in history.

Changes in the Way the Problem is Understood

When tracing the history of substance misuse and food refusal, what becomes apparent is the change that occurred in the ways that they were understood. Initially not much thought was given to 'why' people drank or drank in excess. It was just not seen as a problem. With time, this changed and people began looking for explanations as to why people drank. What they found was that people drank simply because they loved to drink, and they loved liquor itself. The same can be said of food refusal. Originally it was understood within the context of religion. Religious women, whose faith was strong, were believed to be able to survive on the Eucharist alone due to the strength of their faith (Bell, 1985).

However, within a few hundred years, food refusal and drinking or drugging to excess was understood in very different ways. Drinking to excess was now the result of 'an allergy' and eventually was believed to be 'a disease' that some people had and some people did not have (Severns, 2004). It was even given a name, alcoholism. Bateson writes (1972) "They [AA (alcoholics anonymous)] try to have the alcoholic place alcoholism within the self" (p. 322), for example, 'I am an alcoholic.' A similar phenomenon happened with food refusal. In the later part of the 1800s, physicians began searching for the biological location of the problem, and offered treatments such

as bed rest, stimulation of internal organs, and re-feeding. When no plausible biological explanations could be found, the search moved from the body to the psyche, and psychotherapists began to 'talk' to their patients, who could now be diagnosed with anorexia nervosa, which would eventually lead to them being described as 'anorexic' (Brumberg, 2000).

Before problems could be attached to a person's identity or personality, people first needed to be conceptualized as individuals. But what changes had to occur in society to allow for such a huge shift in perspective? Phillip Cushman (1995) writes,

> We can see the beginnings of individualism in a myriad of small changes, such as portraits that began to reflect personal idiosyncrasies as well as one's place in the social hierarchy; the concept of personal friendship rather than corporate feudal bonds; the philosophical growth of mysticism that emphasized personal communion, rather than a solely institutional, mediated relationship with God; the shift in art from a fixed to a moveable perspective; and literary forms such as the biography and autobiography. (p. 364)

As Cushman (1995) clearly illustrates, it was not just one change that occurred; instead many small shifts in perspective needed to occur in order for people to *become individuals*. Industrialization and capitalism were two very influential factors in the demise of communal identity and communal ties by which people had previously defined themselves (Sampson, 1989). As people moved to larger cities looking for work, small and tightly knit communities dissolved. Individuals became more autonomous and there was less family and community regulation of social disruptions,

crime, and physical ailments. As others have suggested, and I concur, the social dislocation (Engels, 1987; Alexander, 2008) caused by industrialization set the stage for the development of social problems like drinking to excess and food refusal in the forms that we begin to see in the nineteenth century. Severns (2004) describes how:

> Jellinek's belief was that communal systems had previously provided context and ritual whereby life was given meaning and reason, which safeguarded members for the personal disintegration that Jellinek saw to be prevalent in his day. He saw the value of alcohol as having shifted from symbolic to ritualistic use, to the level of folk custom, as a cultural attempt to reduce the tension produced by individualism (p. 162).

Additionally, people began to be conceptualized as possessing stable 'personalities' that were assumed to reside inside a person's mind (Geertz, 1973). When the words we speak are seen as the portal to the mind, words become constitutive of individuals. Gergen (1991) writes, "the idea of single minds behind words is a cornerstone of Western individualism" (p. 106). Disciplinary power further positions people as subjects or things to be acted upon—"docile bodies" becoming a thing to discipline and control (Foucault, 1979, p. 135).

As societies became increasingly saturated with work and responsibilities, and increasingly disconnected from their communal bonds, the way was paved for professionals, doctors, and—eventually in the twentieth and twenty-first centuries—therapists, and counsellors, to step into our lives to perform roles that had previously been assigned to our families, friends, and loved ones (Gergen, 1991). The

medicalization of illness slowly replaced the religious views that had been dominant up until the 1600s.

Medicine has played an increasingly important role in the current understandings of disordered eating practices and substance misuse. We see a reliance on the diagnoses of professionals to explain what was going on inside of people's bodies/minds and a stepping away from more traditional ways of knowing and healing practices. This gave increasing authority to the medical professions to create new and more elaborate categories of deficit by which to define people (Peele, 1989). Phillip Cushman (1995) describes how keeping individuals focused on their personal deficit qualities and failures ensured that they would not look outwards to their surrounding community for the source of their unhappiness. To Cushman, if deficit or personal failure

> …is thought to be caused by the biochemical structure of our genes—our human nature—not the particular political arrangements of twentieth century capitalism Thus it is foolish and ultimately ineffective to blame, and then advocate resisting, current social structures (p. 342).

For the above to take place, mechanisms of surveillance by an unjust society needed to be put into place as methods of individual social control (Foucault, 1979). Initially these mechanisms of control were externally located. The genealogy of eating problems best illustrates these mechanisms. It shows a history of women being watched over by patriarchy and being prescribed certain appropriate avenues in which to demonstrate that they were women. In Victorian England, corsets and full skirts limiting a woman's mobility were considered fashionable and a thin waist was the ultimate in femininity. In the 20th century, the appropriate size of women's bodies

began to be dictated by standardized clothing sizes, insurance companies, and the diet industry. By the 1960s, medicine and a burgeoning diet and beauty industry had developed and women had internalized what a women's body ought to look like. When individuals began to watch over their own body, the mechanisms of control unknowingly became internally located. For example, 'the gaze' as described by Foucault, has us acting and controlling our actions as if there is always someone watching. Foucault (1979) states:

> The efficiency of power, its constraining force has, in a sense, passed over to the other side- to the side of its surface of application. He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection (p. 202-203).

This is not to say that women are personally responsible for their subjugations. Instead, they are responding to power structures and hegemonic processes that direct and coerce their choices. Our bodies become docile bodies (Foucault, 1979) objects upon which things can be done, and we as individuals are then solely responsible for their form and their shape. Women are indirectly and directly socially encouraged to try to reach the ever-unattainable goals of thinness, which ensures an ever-present awareness of the ways that their body is not meeting society's norms for beauty. This often occurs at the expense of educational pursuits and other life enriching options. In this way, our bodies

also become commodities from which others may profit in terms of clothing, diet and beauty industries.

Substance Misuse and Eating Disorders as a Form of Protest[21]/Resistance

To some extent both substance misuse and food refusal can be viewed as a form of protest of the conditions within which individuals are living. According to Bynum, (1987) food refusal in the medieval ages even though a spiritual meaning was attached to it, was very significant beyond the meaning of food itself. Bynum writes:

> Far from substituting control of self for control of circumstance or destroying ego and body while attempting to direct the attention of others towards them, women's food practices frequently enabled them to determine the shape of their lives—to reject unwanted marriages, to substitute religious activities for more menial duties within the family, to redirect the use of fathers' or husbands' resources, to change or convert family members, to criticize powerful secular or religious authorities, and to claim for themselves teaching, counseling, and reforming roles for which the religious tradition provided, at best, ambivalent support (p. 220).

Entering into the doctrine of religion allowed women access to other roles that were not possible if one were married, raising children and responsible for the care of others. Something similar can be seen amongst the middle and upper class young women in Victorian England, as they too were very much confined to a life of

[21] For more information on resistance or protest to oppression please see Allan Wade's article, *Small Acts of Living* (1997), which is based on the premise that where there is oppression there is resistance.

domesticity. Young women's lives were highly controlled by their parents, who wished to raise daughters suitable to be married into even higher social standings. Education and work was believed to be detrimental to a woman's reproductive organs and too stressful for her overall constitution (Hesse-Biber, 2007).

In these conditions, food refusal served as a statement of protest to the stiflingly and potentially un-stimulating activities to which young women were allowed access, as well perhaps to the conforming standards of beauty exemplified by thinness and paleness common at the time. Brumberg (2000) describes how the frailness and food refusal associated with middle and upper class women was not seen in lower or working class women, as it was not an influential form of protest. Many writers have noted that women's control of the body as a form of protest or resistance to the prescribed gender roles and patriarchy actually restricts and limits women's possibilities (Bordo, 2003; Gremillion, 2003; Malson, 1998; Orbach, 1978). To quote Bordo:

> The anorexic's experience of power is, of course, deeply and dangerously illusory. To reshape one's body into a male body is not to put on male power and privilege. To feel autonomous and free while harnessing body and soul to an obsessive body-practice is to serve, and not transform, a social order that limits female possibilities (p. 179).

Substance misuse can also be viewed as a form of protest and in some cases a form of resistance. When the Chinese immigrated to North America to build the Western Railroads, they brought with them the tradition of smoking opium. As mentioned earlier, Chinese labourers used opium while doing extremely dangerous work that was seen as unfit for their North American counterparts. Chinese immigrants were

surrounded by racial violence, attempts to destroy their dignity, and attempts to stop their immigration into America. Holding onto their familiar practices may have been a refusal to assimilate in a country that was treating them with hate and disdain as well as an escape from the stress of their circumstances. During the civil war, fighters were some of the first casualties of morphine addiction, morphine perhaps dulling the pain of the memories of the atrocities that they both participated in and witnessed while in the battlefield. Similarly, the housewife at the turn of the 20th century, addicted to Laudanum, which was widely prescribed for minor problems such as sleep disturbances, developed an addiction problem as well. Later, in a similar vein, Valium was lovingly referred to as "mother's little helper" (The Rolling Stones, 1967), indicating its use as a way to survive the monotony of a housewife's days [this role, too, being a capitalist construct that would later evolve, post-feminism, post-60's, into the heterosexual 'family' where both mother and father required being in the work force] (C. J., Sanders, personal communication, March 1, 2009).

As a gendered response, substance misuse can be seen as women's refusal to conform to the 'acceptable' standards of drinking and drug use by which she is surrounded. Drinking and drug use in this way can be a form of rebellion, as it is not considered typical of a 'proper' woman's behaviour. Women have been responsible for child rearing, managing the household, keeping the family intact, and if a woman is using illicit drugs or drinking to excess, the chances of this occurring can be lessened. Women's drug using behaviour can then be seen as a threat to traditional gender roles and 'life' as it has always been. In the book *Using Women*, Campbell (2000) traces "how women's drug use has been constructed as a gendered, racialized, and sexualized

threat to modernity, capitalist production, social reproduction and democratic citizenship" (p. 14). This is illustrative of how women's substance taking behaviour has far reaching implications on so many levels other then the substance use itself.

How People Were Seen and Subsequently Treated

Initially, excessive drinking was not seen as a problem, but with time people who were considered habitual 'drunkards' were looked down upon, condemned, and judged. Habitual drunkenness became associated with the lowest form of citizen, and was an attack on their morality (Sanders, 1994). In the mid to late 20th century, both substance misuse problems and food refusal came to be defined by the American Psychiatric Association (APA) as problems that resided inside an individual and were considered a deviation from what was considered 'normal' (Kutchins & Kirk, 1997). Now, someone who drank to excess was viewed as doing so because *s/he was an alcoholic*. Someone who refused to eat did so because *s/he was an anorexic*. The reason for the existence of the problem was assumed to be a deficit or pathology that resided *within the individual*. This explanation made it possible for a problem to define a person's identity, without the person's consent.

A certain "meaning and value" (McNamee & Gergen, 1999, p. 4) is attributed to people's actions, and the actions of consuming too much of a particular substance, or eating to excess or too little, are likely to have a typical response of distain, pity, or judgment passed for their actions. Persons struggling with substance misuse are commonly faced with a contradictory judgement. It is assumed they have no control over themselves, yet it is expected that they could choose to stop using at anytime they want. People with anorexia are often called spoiled, selfish, and narcissistic. When

people are constructed as individuals, divorced from their context, they become solely responsible for their actions and pathologized accordingly (Bruner, 1990).

Cultural influence

"In Maurice Merleau-Ponty's famous phrase, culture, through everyday social practices, is "sedimented" in the body. This is what is meant by the social "construction" of the individual" (Cushman, 1995, p. 18).

In the social world, our actions are co-ordinated (McNamee & Gergen, 1999) with those around us, as are the resulting ways we come to understand and give meaning to people's actions. This includes people's decisions (and our understandings of people's decisions) to use or abstain from alcohol and drugs, and/or restrict/purge/over-consume food. Yet the cultural influence is often overlooked resulting in anorexia, bulimia and substance misuse being pathologized. For example, the 2000 edition of the DSM-IV included culture bound syndromes in its Appendix I, acknowledging the importance of cultural difference in the understandings of disorders. Yet anorexia nervosa, bulimia, eating disorders not otherwise specified, substance abuse and substance dependence were not included as culture bound syndromes (APA, 2000). The description reads:

> The term culture-bound syndrome denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be 'illnesses,' or at least afflictions, and most have local names . . . culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings

> for certain repetitive, patterned, and troubling sets of experiences and observations (p. 844).

Some writers have made strong cases for disordered eating and substance misuse to be considered as culture bound phenomena (Malson, 1998; Peele, 1995; Cushman, 1995). For example Helen Malson describes how:

> Anorexia nervosa, like some other illnesses can be viewed as a metaphor for, and a manifestation of, a *multiplicity* of socio-cultural concerns of the late twentieth century; concerns about femininity and feminism, about the body, and about individual control and consumption within consumer society (p. 5-6).

Stanton Peele (1995) has written extensively of the differences in the historical treatment and understanding of drinking compared with our current understandings of the same behaviour. The behaviour has not changed yet our understandings of the behaviour have. He states:

> What people believe about their drinking *actually affects how they react to alcohol*… In other words, the readier people are to decide that their behavior is a symptom of an irreversible addictive disease, the more readily they fall into a disease state. For example, we *will* have more bulimia now that bulimia has been discovered, labelled, and promulgated as a disease (p. 170).

Culture is powerfully generative of our identities, communities, and our beliefs. Our identities are communally constructed within the cultural frame we are surrounded by, with popular culture playing an important role in this. For example, when television

arrived in Fiji in 1995, anorexia was relatively unknown and young Fijian women reported feeling good about the size and shape of their bodies (Becker, Burwell, Gilman, Herzog & Hamburg, 2002). Only three years later there was a statistically significant increase in the numbers of young women no longer content with their bodies and/or dieting as a way to alter the shape of their bodies (Becker et. al.). In North America some people will go to any means necessary to attain beauty—invasive plastic surgery, liposuction and gastroplasty (stapling of the stomach) being fairly common procedures. The reality television show *Nip Tuck* demonstrates just how far men and women will go to surgically alter their bodies—all in the name of beauty.

Alcohol use is also built into western cultural social celebrations and heterosexual male identities are strongly associated with drinking. David Nylund (2007) in his book *Beer, balls, and babes: masculinity and sports talk radio*, describes how drinking culture has become an integral part of our understanding of what it means to be a heterosexual male in the 21st century. When we consider the context of people's lives a different understanding of their lives is possible. Today the general consensus amongst mainstream professionals is that both problems are individually and medically based, which excludes any cultural, historical and social based reasons for the development and progression of these problems. Yet when people's actions are seen solely within the confines of biological causes this leaves little room for the impact of trauma, poverty, racism, homophobia, and gender training on a person's behaviour.

In the following section I briefly describe the history of the Diagnostic and Statisticians Manual (DSM) and the impact that the DSM has had on our societal understandings of mental illness and treatment practices.

A brief history of the DSM

There are many perspectives from which to view eating disorders and substance misuse. The stance that we adopt impacts our interaction with the persons consulting us for therapy, as well as the solutions that are possible within the chosen approach. In this section, I will briefly trace the history of the Diagnostic Statisticians Manual (DSM) and then discuss the implications that the DSM can have on the clients who consult us for therapy. Of particular concern to this writing is the pathologizing discourse that stems from the DSM. Especially as the classifications that define 'normal' grow smaller and the possibilities to be diagnosed as having a DSM diagnosis grows larger given the ever-growing list of disorders housed within the text. This is very relevant to this dissertation as young women seeking treatment for anorexia and bulimia are often required to meet the 'criteria' listed in the DSM-IV in order to access treatment for disordered eating. I will argue that the criteria that have been created to support young women can inadvertently strengthen disordered eating practices (Gremillion, 2003).[22]

Madness as a concept has existed long before the profession of psychology or psychiatry emerged (psychiatry as a profession did not exist before the end of the 18th century (Shorter, 1997). Individuals considered 'mad,' or 'insane,' were commonly seen as a threat to society in Roman and Greek societies, who preferred to remove this element from society. The Spartans routinely tossed defective offspring of the cliffs, while Plato suggested to take the 'offspring of the inferior' to an unknown place (as cited in Blatt, 1966). During the middle ages, the initial spread of Christianity fostered a more charitable view of the insane: as in need of help and protection from the devil. The

[22] In British Columbia, Canada most youth treatment programs for alcohol and drug misuse are not hospital based therefore young persons are not required to have a DSM diagnosis of substance abuse or dependence in order to be admitted.

bishop of Myra for example (also know as Saint Nicholas) offered shelter for the mentally ill in the fourth century (Wever-Rabehl, 2001). Treatment or education was not a consideration however (Wever-Rabehl). Mental illness and developmental delays were seen as incurable and hopeless. This did not change until the late 1700s, with work of Jean-Marc Gaspard Itard and his 'wild boy of Aveyron' (Wever-Rabehl).

Throughout the 18th and early 19th centuries, the medical profession searched for the cause of madness, which was believed to be located inside the body (Cushman, 1995). By the latter half of the 19th century North America had gone through massive social change and disruption as the result industrialization, which lead to social problems such as unemployment, homelessness, slums, and crime. 'Defective genes' were identified as the cause of these problems (Wever-Rabehl, 2001). Much research took place, in the US as well as in Europe, on the interplay between mental status and crime. The eugenics movement provided an answer in that they offered a scientific method for the improvement of the human race through selective breeding and sterilization (Wever-Rabehl). Till well into the 1900s, federal and state governments issued various social control measures directed against the 'mentally retarded' and the 'insane:' sterilization, restriction on marriage and sexual relationships, and even euthanasia (Wever-Rabehl). Sterilization continued on a broad scale until the 1960s, and eventuated in the forced sterilization of 31,038 Americans (Knoblock, 1987, as cited in Wever-Rabehl). In Germany, eugenics was taken to an extreme. Some 275,000 mentally retarded and mentally ill were killed in 'mercy deaths' (Werthman, 1978, as cited in Wever-Rabehl).

Science and medicine became more and more influential in the care of people's physical and mental health in the early twentieth century (Cushman, 1995), and insanity was increasingly associated with the pathological (Wever-Rabehl, 2001). In order to standardize and humanize treatment for the mentally ill within asylums, the American-Medico Psychological Association was founded in 1892 by G. Stanley Hall (Reisman, 1991). In 1921 it was changed to its current name, the American Psychiatric Association (APA). In 1952 the APA published the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* or DSM-I (American Psychiatric Association, 1952). Karl Tomm (1990) describes how the DSM was "originally intended to stabilize psychiatric nomenclature in American Psychiatry and to clarify the description of diagnostic terms" (p. 1). It also offered a common language for psychiatrists to use when consulting with one another about their patients. Tomm (1990) describes how when the second edition of the DSM (DSM-II) was released in 1968, the name referring to the mental 'disorders' had been changed. For example, what had previously been called mental 'reactions' in the first edition, were now called mental 'illnesses' (Tomm, 1990). As a result the field of psychiatry was now closer aligned the field of medicine (Tomm, 1990).

To get a sense of the changing nature of the contents of the DSM, DSM-III was released in 1980, and DSM-III-R was released just seven years later (Kutchins & Kirk, 1997). DSM-IV was released in 1997 and DSM-IV-TR was release in 2000. With each revision, categories have been deleted or added, and terminology changed, all in the name of 'diagnostic reliability' (Kutchins & Kirk, 1997, p. 27). Regarding the DSM-IV the APA itself claims: "one of the most important features of the DSM-IV is its

provision of diagnostic criteria to improve the reliability of diagnostic judgments " (APA, 2000, p. ix). The next version DSM-V is expected to be released in 2012 (APA, 2009, ¶ 9).

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders is commonly referred to within mental health fields as 'the bible,' as it defines and outlines the current diagnostic criteria for the mental disorders contained within it (Tomm, 1990). The DSM-IV-TR (2000) includes the criteria for Anorexia Nervosa (307.1), Bulimia Nervosa (307.51), and Eating Disorders Not Otherwise Specified (307.50). Also included are the criteria for Substance Abuse or Substance Dependence Disorder. (Please refer back in this chapter for the full diagnostic criteria of the aforementioned disorders). As our society changes, what is collectively deemed acceptable waxes or wanes, and so do the criteria in the DSM. This helps explain why what started out as a book of 66 disorders now includes almost 400 (Kutchins & Kirk, 1997).

The DSM has been critiqued for its "pathologizing of everyday behaviour" (Kutchins & Kirk, 1997) as it identifies what could be seen as normal healthy responses to problems or ways of living as forms of mental illness. For example, homosexuality was included in the second edition of the DSM under the category of sexual deviations (Kutchins & Kirk). Implicit in the initial creation of homosexuality as a disorder is a value judgment of 'normal' being assigned to heterosexual behaviour and deviant or 'abnormal' being attached to homosexual behaviour. Homosexuality was subsequently eliminated from the third edition. Kutchins and Kirk link the removal of the diagnosis to a combination of four factors, one of which was the "historical changes in the category

of homosexuality" (p. 58). Because of societal changes, increasing acceptance of homosexuality, and a developing gay liberation movement, homosexuality could no longer be classified as a mental illness. This underscores that categories of mental illness are invented constructions, created by individuals with the power to label others (Kutchins & Kirk; Foucault, 1982).

Anti-psychiatrist, Szasz (1972) describes mental illness as a myth. The mental illnesses contained within the DSM are social constructions, yet nowhere does the DSM mention that mental illness is, in itself, a construct. Nor is there mention of how the various categories of disorder listed in the DSM are by-products of socially negotiated practices. The problem with the diagnoses listed within the DSM as Caplan (1996) describes is how "these subjective determinants of diagnoses masquerade as solid science and truth" (Caplan, 1996. p. xvi). These truths can have serious consequences on people's lives. For example there is a common belief that alcohol abuse 'runs in families,' and if you come from an 'alcoholic home' you will either become an 'alcoholic,' or become 'co-dependent.' While there likely is a genetic predisposition, this remains to be proven as no gene has yet been found. Meanwhile, some people live their lives as if genetics were fully to blame, which runs the risk of becoming a self-fulfilling prophecy (Peele, 1995).

In a similar vein, Kutchins and Kirk (1997) note that:

> The DSM can be an instrument that pathologizes those in our society who are undesirable and powerless; this occurs not because of any malicious intent but because of unspoken cultural biases about what should be considered normal and what should be considered disease (p. 19).

Foucault has argued along similar lines that the institution of psychiatry has the power to shape the lives of individuals based on the norms of acceptable behavior, and truth claims of certain discourses (Rabinow, 1984). In this way psychiatry becomes a "dividing practice," separating the normal from the deviants, the sane from the insane (Foucault, 1986, p. 208).

The impact of this perspective

The DSM locates mental illness 'in an individual.' This suggests that there is something wrong with that individual's makeup. Tomm (1990) writes:

> The authors seemed oblivious to the theoretical significance of their individualistic presuppositions. There was no mention of the possibility of another point of view. They simply ignored the body of knowledge based on an alternative assumption, namely that the human behavior, the mind, and its disorders, may be more fundamentally grounded in social phenomena than individual phenomena (p. 2).

The diagnosis of mental illness has far-reaching consequences on a person's sense of self and identity. The language of the DSM has the power to both construct and colonizes a person's identity (Kutchins & Kirk, 1997). Coates and Wade (2007) invite us to consider the inherent violations that occur in this 'benign languaging' of identity that have serious implications for how people see themselves and the way that others relate to them. Sanders (1994), citing Karl Tomm writes:

> The diagnostic label imparts a defective personal identity to the patient, it will henceforth identify him to others and will govern their conduct towards him, and his towards them. The psychiatric nosologist, thus, not only describes his

> patient's so called illness, but the ramifications of this description have been horrifying for many persons, who have experienced the debilitating and totalizing effects of diagnostic labels in terms of self-blame, self loathing, and intense self monitoring (Sanders, 1994, p. 27).

If the language we use constructs the reality we live in, then it is possible that the terminology of pathology trickles into the culture at large. Today it is commonplace for people to describe themselves and others by these DSM-IV based terms. For example, 'I'm so depressed,' 'he's a sociopath,' 'I am bulimic' (Gergen, 1991). This way of describing each other and ourselves has become so common that even children can not escape this rampant labelling. For example, the diagnosis of children with Attention Deficit Hyperactivity Disorder (ADHD) reached epidemic proportions during the 1990s (Nylund, 2000). Gergen (1991) refers to the labels that are housed within the DSM as "terms of mental deficit. They discredit the individual, drawing attention to problems, shortcomings, or incapacities" (Gergen, 1991, p.13). As this occurs and the language of the medical profession becomes the language of the everyday—even more specialized discourse needs to be created, and the public ever more relies on the medical profession in order to be 'cured' from their ailments (Gergen, 1991; McNamee, 2002).

The use of the DSM in North America has become so commonplace that more often than not medical insurance companies often require individuals to have a DSM diagnosis in order for them to receive help, and for practitioners to be compensated for their work (Cushman, 1995). The problem then expands; in order for people to receive help, they need to be 'diagnosed' which results in their being pathologized. On one hand they benefit from getting help, yet on the other they receive a label and its associated

stigma. As a notable conflict of interest, the APA is closely linked to the pharmaceutical industry, which contributes massive funding and monies to research and hospitals (Healy, 2004).

What this means for this dissertation

Of importance to this writing is how social construction and the narrative approach to therapy positions us to question the truth status that has been assigned to the diagnostic labels listed in the Diagnostic and Statistical Manual (APA, 2000) by much of the larger health-care profession and society at large. When positioned as one possible idea among many, we can question the impact that labels have on the clients who consult us, as well as how it impacts our interactions and relationships with those clients. The writing of this dissertation has allowed me to question the utility of those ideas and to privilege the young women's ideas about how to find freedom from the problems with which they struggle.

The intent of the DSM is not to locate problems in their socio-political context. Yet it is easy to see the relevancy of the socio-political context. The diagnosis of an eating disorder exists mainly in industrialized societies, and upwards of 90% of diagnoses pertains to young women. Many have experienced sexualized violence and/or abuse (Bordo, 2003). As well, activities that are focused on body size, appearance and display women's bodies such as modelling, gymnastics, and ballet are often associated with increased rates of disordered eating (Maisel & Epston, 2004). Correspondingly, rates of substance misuse are found to be higher for people who live in poverty, have a mental health diagnosis, are impacted by racism, homophobia, or disabilities, and have experienced sexualized violence or physical or emotional violence/abuse (Gitberg &

Van Wyk, 2004). To overlook the contributions of the socio-political context of diagnosis is a grave error, as we then pathologize individuals for their actions rather than placing them back in the socio-political context in which they belong (Waldegrave, Tamasese, Tuhaka, & Campbell, 2003). If we continue to look at problems as individually based problems of 'the self' there is little space to include culture and the importance of human relationships and connection on individuals actions. The diagnostic criteria of the DSM leaves out the richness of human experience, and the context behind people's use, and the 'technical descriptions' of the diagnoses often look very different than peoples lived experiences with these diagnoses (Madsen, 1999).

The Gergen's (1996) write: "constructionism supports systemic views in providing a rationale for therapists to step back from the typical 'rage to classify' clients into diagnostic categories and to canonize or universalize any particular mode of treatment" (Gergen & Gergen, p. 77). The social constructionist and postmodern framework in which this writing is located allows for the privileging of young women's experiences of substance misuse and disordered eating practices, rather than trying to fit their experiences within the classifications of the DSM. Young women's experiences of distress can be dismissed when expert categories of health and illness are privileged. The DSM focuses on behaviour, while overlooking the personal experience and meanings that these problems have in someone's life. The level of distress that a person feels does not necessarily translate into meeting the DSM criteria for eating disorders or substance misuse.

This dissertation describes an approach to working with the problems of substance misuse and disordered eating practices that honours the young women's

knowledge of, and personal experience with, the problem. Stepping out of the "rage to classify" (Gergen & Gergen, 1996, p. 77) allows us to step into relationships with our clients, and co-construct preferred stories for their lives. Our questions become inquiries into trying to get a better sense of their experience, as opposed to asking questions to determine if the client fits better in category A or B. My therapeutic approach fits with what Michael White (1997), borrowing from what Geertz (1973), describes as contributing to thick or rich descriptions of persons lives, rather than the thin descriptions that are afforded by those based in the DSM (i.e. 'all people who have these problems are like this').

In Closing

In summary, substance misuse and disordered eating have undergone many transformations since their initial inception. I traced the history of substance use from their natural forms, to the resulting chemical isolation of their psychoactive properties, their increased use by the medical community, and the criminalization of some narcotics, which has created a large black market for these substances (Musto, 1992). The resulting effect of criminalization of drugs has negatively impacted the view of and treatment of persons who use illicit substances (for example, illegal street drugs like heroin, and cocaine), and misuse licit ones (for example, legal substances like alcohol and prescription medications). I also looked at the changes in our cultural understanding of substance use itself. I traced the history of food refusal, it first being a practice associated with female saints, its understanding based in religion. Later when food refusal could not be reduced to a definite biological cause it was understood as a problem in the young women or in their relationships with others (especially their

mothers) (Gremillion, 2003). It wasn't until the 1960s that it was understood that those struggling with anorexia or bulimia had not lost their appetites, but rather they were denying their appetites.

Lastly, I discussed some of the historical and linguistic shifts that occurred making it possible for persons to be viewed as individuals. This dramatically changed the way we began to view persons affected by the problems of substance misuse and disordered eating. With this shift, both anorexia/bulimia and substance misuse began to be viewed as biological problems in need of medicalized treatments. Seeing persons as individuals paved the way for the dominant approach to mental illness as described by the DSM (APA, 2000). The underlying 'biological' cause for both problems has yet to be found, yet the search continues. In the next chapter, I offer an alternative perspective from which to understand ourselves, the world around us, and the problems of substance misuse and disordered eating practices.

CHAPTER 4 SOCIAL CONSTRUCTION

This dissertation is located in the larger frame of postmodern and social constructionist thought (Gergen, 1991; Burr, 2003; Foucault, 1989). Social constructionism is a orientation that was developed by Berger and Luckmann (1966), Gergen, (1985, 1994, 1999), McNamee & Gergen, (2000), Anderson & Goolishian (1988) and John Shotter (1989) to name a few. This philosophical movement has emerged over the last 30 years and is a radical departure from the ways in which we traditionally understood reality (Gergen, 1985). As such, social constructionism has had far-reaching implications on how we understand self, identity, meaning and truth, dialogue, and the significance of relationships (McNamee, 2004a; Gergen, 2005). As described by Ken Gergen (1985) "social constructionist inquiry is principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live" (p. 266).

Social constructionism is a philosophical response to individualism, the enlightenment, and modernist ideas that have profoundly influenced how we understand the individual and the world around us. To gain a sense of the significance of social construction it is helpful to trace the history of the modernist and positivist ideas from which social construction emerged. Prior to the 17th century, the Church and nobility governed society in a manner that emphasized an unquestioned faith in God and religion. People had little freedom of choice, and were expected to live life by the doctrines of the church and as they were instructed. The Enlightenment era

philosophers Locke, Hume, Descartes, and other empiricists of the 17th century began to publicly question the taken for granted ideas of religion, the church and the power that these institutions held (Cushman, 1995; Gergen, 1985). The Enlightenment sought to grant power to each individual choice over their actions, and emphasized each individual's ability to think, to reason, and to observe, which threatened the sovereign rule of the church.[23] Until this time, the church had ruled with unquestioned authority.

Philosophers imagined a self that was separate from the dogma of the church, and a self that could reason independently from the will of God (Cushman, 1995). Reason and observation became one way that individuals could challenge the power of the Church. If through reason and observation individuals could choose courses of action that were appropriate for themselves they no longer had to rely on God's doctrine for moral order and direction (Gergen, 1991).

Rene Descartes (1596-1650) is described as being the father of modern philosophy (Robinson & Groves, 2004) with the term Cartesian being coined from his name (Burr, 2003). Rene Descartes' well-known quotation, "I think, therefore I am," or *Cogito Ergo Sum* (Robinson & Groves, p. 56) epitomizes the importance placed on each individual's ability to reason. Descartes prioritized the act of thinking (which he believed occurred in the mind) above all other forms of knowing. This revelation, referred to as the Enlightenment transformed the way in which self and activity were conceptualized as we see the re-emergence of a dichotomy between the mind and body (Gergen, 2005). Geertz (1973) describes how the focus of the Enlightenment was to find the essence or core of "actual men" (p. 51) and this was believed to be possible

[23] I am referring solely to men as during this time period women were not believed to be capable of rational thought.

once man was stripped down to the core. In order to truly know the individual, the culture surrounding the individual needed to be removed, and then the essence or "natural man" (Geertz, p. 51) was left to be seen and known.

The Enlightenment prioritized knowledge that was based on fact, reason, and observation. Descarte's 'Discourse on Method' (1637) introduced the idea of doubt, and prioritized objective certainty above all forms of knowing (Robinson & Groves, 2004). He began questioning all that he had previously known and taken for granted, believing that our senses lie to us. Therefore he believed that we can only be certain of what we know through reason derived from mathematics. The general consensus being that if individual's possessed enough knowledge then they could predict and control the behaviours of others, the environment and, in theory, the world (Gergen, 2005). Society began to be conceptualized as composed of individual thinkers, and activities were focused on the acquisition of knowledge (Gergen, 1985). During this time people began to advocate for their own rights, and important advances in law, democratic thought, and institutions appeared (Gergen, 2005). Cushman (1995) writes, "the self became constituted by rationality and the scientific empirical process, the material word became the realm properly controlled and dominated by humankind, and the new empirical science became the vehicle of domination and the measure of all things" (p. 31).

The Romantic period that followed the Enlightenment, with its emphasis on love, powerful emotions, the soul, and "the deep interior" (Gergen, 1991, p. 20). This contrasted the emphasis on reason alone that the Enlightenment proposed. During the Romantic period, art, poetry, and literature were celebrated, as were romantic notions of love that are still prominent today.

Dating from the late 19th century, modernism brought with it a revitalization of the ideas of the enlightenment. Modernism emphasized individualism and privileged 'a self-contained' individual (Sampson, 1993). Individuals began to be conceptualized as independent from the world around them, separate from their social context. Sampson describes the conditions that needed to occur in order for this to occur as:

> We first need to think of the self as a kind of bounded container, separate from other similarly bounded containers and in possession or ownership of its own capacities and abilities. In order to ensure this container's integrity we need to think of whatever lies outside its boundaries as potentially threatening and dangerous, and whatever lies inside as sufficiently worthy to protect. These beliefs establish a possessively individualistic view of the person and the assumption of a negative relation between the self and other, both of which understandings permeate much of western civilization (p. 31).

With these ideas firmly in place our modern day notion of the individual self was born (Gergen, 1989; Geertz, 1973; Sampson, 1993).

Modernism is based in the philosophical approach known as positivism. Positivism describes knowledge as existing within the confines of observation, rationale thought and science. Armed with these tools, the researcher is positioned to discover new knowledge. Gergen (2004) describes how these ideas are lodged in a "metaphysical dualism" (p. 46). He writes, "here one presumes a real world (objective, material) somewhere 'out there' and a psychological world of the experiencing agent 'in here'" (Gergen, 2004, p. 46). He goes on to say, "Knowledge is essentially achieved when the mind of the individual agent has mastered the complexities of the material

world. And this knowledge is ideally reduced to propositional networks (theories and descriptions) for purposes of communication" (p. 46).

With people considered to be separate from their surroundings and others, people were thought capable of observing the world in a non-biased way. Gergen (1991) writes that "reason and observation" began to be seen 'as the central ingredients of human functioning'" (p. 19). Describing the traditional "positivist-empiricist conception of knowledge" (Gergen, 1985, p. 266), Gergen writes how it is assumed that "scientific theory serves to reflect or map reality" (p. 266). There are two popular understandings of the way that information is garnered and transmitted. One view is that if we observe things correctly, then we can map and transmit our understanding of the world to others. In this approach, our knowledge is believed to mirror the way things actually are— out there in the world—"knowledge copies (or should ideally copy) the contours of the world" (Gergen, p. 269). This is what Gergen refers to as the "exogenic perspective" (p. 269). Gergen describes a second popular way of understanding knowledge as the "endogenic perspective" (p. 269). In this view, the drive to think is internal and inherent to humans. This view of human nature is the foundation for the popular cognitive behavioural approach to therapy (Gergen). Traditional approaches view thinking/knowledge as an internal individual mental process that can be measured (Gergen, 1994), for example through intelligence tests.

Within this paradigm, language becomes an expression of the mind (Gergen, 1985). Indeed, in a modernist perspective, language is representative of reality; when a person speaks, s/he is expressing what is in his/her mind, and the knowledge that s/he possesses. Now people can describe their private world of mental events, what they

think, what they see, what they feel, and what they know (Gergen). The above concepts underscore our current notions of scientific progress and universal knowledge, which pervades universities, positivism, scientific classifications and individualism.

Relationships, Language, and Reality

Social constructionism offers another perspective illuminating how we come to know what we know, a perspective that privileges language and relationships as central to our understanding and the co-creation of our world. In this way, language is a way to share and build information and knowledge, a conduit of knowledge. From a social constructionist perspective, our words do more than transmit information: they construct and constitute our understanding of our world (McNamee, 2004b). This section will describe some of the central assumptions behind social constructionism, specifically the centrality of language, meaning making, relationships, and reality.

The power of language in the construction of reality

While the modernist view of language contends that language represents reality, social constructionism proposes that our language use constructs reality (Gergen, 1989). This means that through our language use, we actively construct the world around us in relationship with others. Language plays a central role in how we make and share meaning (Gergen & Gergen, 2003). Through language we communicate, describe, explain, organize and make sense of each other and our surroundings. Language does not simply refer to the words we use, but also encompasses our body movements, our tone of voice, and the subtleties of how we use words (Andersen, 1992, 1998).

The philosopher Ludwig Wittgenstein's ideas regarding language have strongly influenced social constructionist thought. Wittgenstein proposed that we "look at the way we *use* the word to find out what it means" (de Shazer, 1985, p. 89). Words in themselves do not mean anything, or hold any particular essence or meaning; it is through the use of words that they gain their meaning (Wittgenstein, 1953). As Sampson (1993) writes "our task is to examine how language used in the public, social world of communication between people holds the key to our understanding" (p. 98). The words we use constitute the reality in which we are surrounded. While I can say that I feel sad, or disappointed, Wittgenstein proposes that the words we use, for example sad or disappointed, do not in themselves reflect actual inner mental representations (Gergen, 1989). Rather, our words are brought to life through social interactions. Through language we create and bring things, ideas, and objects to life.

One can only participate in language once we know the rules of language and these rules determine how we use language. Social constructionism emphasizes how "words gain their meaning through their use in social interchange, within the 'language games' of the culture" (Gergen, 1991, p. 102). Wittgenstein's (1953) concept of language games describes how the use of language is an activity and there are social rules governing the ways in which we use words. For example, in order for us to have conversations with one another there needs to be some shared understanding of what words means, in order for us to understand and converse with one other. Social constructionism proposes we have arrived at this shared consensus in relationships with one another. As McNamee has described, we co-ordinate our actions with others, and rituals and patterns emerge, as do, rules, expectations and standards of behaviour, and

corresponding beliefs and values (McNamee, 1992; McNamee & Gergen, 1999). The focus then becomes on what we are creating together, in a performance with the other through dialogue.

In order to have conversations with others there needs to be agreed upon social conventions as to how we will use language such as greeting a person with the words 'hello' and departing with the word 'goodbye.' If we greeted a stranger by saying 'goodbye' at the outset of the conversation, we would be breaking the conventional agreed upon rules of language use. These rules emerge out of daily use, as do the meanings of the words we use and they are affected by their historical and contextual surroundings. We socially agree on what words 'mean' and in doing so language is not neutral. We can accomplish things with language for example, someone can be 'sentenced to death' or someone can be given a new identity, 'she is an alcoholic.'

In addition, the idea that "the meanings carried by language are never fixed, always open to question, always contestable, always temporary—is fundamental to post structuralism and has major implications for our understanding of the person, their identity and the possibilities for personal and social change" (Burr, 2003, p. 53). There are many examples of the wide changes that have occurred in our word usage and some words are virtually obsolete after many years of non-use. These changes support social constructionists claim towards anti-essentialism. If words described the 'real' truth, or essence of something, then with the exception of the object disappearing there should be no way to explain a word falling out of usage, especially if what it describes is 'the truth.' This supports social constructionists practice of not defining people in

essentialist terms. People are not thought to have an essence or true self; instead people are always changing and renegotiating themselves depending on their surroundings.

Relational Beings

Meaning making is not something that happens in isolation, it is co-constructed. As McNamee (2004b) writes, "to the constructionist, meaning making is a relational activity" (p. 39). Relationships play a crucial role in how we come to know ourselves, the world around us, and in the creation of knowledge. Within a social constructionist approach, people are seen as socially co-creating and co-constructing the world in language through interactions with each other. Social construction takes a profound shift from modernist ways of knowing and proposes that it is through our relationships that things come into being. Relationships create knowledge, language, and our sense of sense. What we do with each other takes precedence, over what we independently think or observe.

From a social constructionist perspective, there can be no knowledge without relationships, as knowledge is created in our relationships with others. John Shotter (1999) writes "all our meaningful social practices originate in and develop as refinements of the spontaneous, responsive reactions occurring between us, out in the world. Meaning originates between us not from within us" (p. 129). Relationships are the starting place for understanding the world and through relationships we negotiate agreed upon meanings and use for language, and that together creates knowledge. Knowledge has its roots in shared interactions with others and is gained through social exchanges, relationships, and dialogue (Gergen & Gergen, 1996). As Vivian Burr

(2003) writes, "Knowledge is therefore seen not as something that a person has or doesn't have, but as something that people do together" (p. 9).

Power and Social Constructionism

Social constructionism proposes that what we see and believe to be true has its roots in communal exchanges with others and these exchanges are agreed upon by groups of people as being the right or correct way of doing or thinking about things (Gergen, 1989). These collectively agreed upon ideas are integrated into the everyday fabric our lives (in a way that we can no longer see where they began) and granted the status of truth (McNamee, 2006). In these social exchanges, certain things are overlooked while other things are granted a superior status. Social constructionism encourages us to look at how we come to know what we know and how taken for granted ideas become such. In doing so social construction takes a hard look at—and questions—our taken for granted ideas of truth. Why is this truth greater than that one, who benefits from one truth prevailing over another, and how did this occur (McNamee & Gergen, 1999)? This is especially relevant to consider when discourses become factified, for example the discourses of psychiatry, psychology and science.

> Ken Gergen (1991) writes: "If our discourses are not derived from the facts, but once embraced they create what we take to be the factual world, then a more critical look at these discourses is in order" (p. 96).

To expand on social constructionist concepts of truth, I will discuss Foucault's concept of power/knowledge, which he describes as being inexplicably linked. Foucault's idea of power/knowledge differs from traditional ideas of power. Traditionally, moments or processes where an individual is seen as gaining power are

linked to the possession of knowledge. Instead, Foucault as quoted by Sarup (1993) argues, "knowledge is a power over others, the power to define others" (p. 67).

Foucault, a French historian and philosopher, describes individuals as being constituted or made up by power relations. He addresses the ways in which disciplinary power positions people as subjects or things to be acted upon (Foucault, 1980). Foucault describes power not as a 'thing' to be had or owned, as it is not a commodity, but as being constructed with others in relationship.

Foucault uses Jeremy Bentham's Pancopticon, a model for a prison, to illustrate how a discourse of social control is created (Foucault, 1979). The Pancopticon was constructed in such a way that the guard's tower was positioned in the centre of circular prison cells, which allowed the guards a constant watch over the prisoners. Because of the way the prison was constructed, the prisoners never knew when they were being watched and so they began to monitor their own actions and watch themselves (Foucault, 1979). Similar to Bentham's prisoners, people become subjects of power as they begin to conform to the norms set out for them in society. Foucault makes reference to how power is tolerable only on the condition that it masks a substantial part of itself. He writes, "its success is proportional to its ability to hide its own mechanisms" (Foucault, 1978, p. 86).

The idea that people are under constant surveillance also offers insight into the mechanics of problems such as body policing. The prevalence of the dominant discourses and pressures surrounding thinness and beauty in western society assures that persons are never free of the 'body police.' People watch their bodies (while also assuming that others are watching their bodies) in ways that may lead to their trying to

have their bodies conform to the standards of how they should look. Persons internalize and monitor themselves to fit in to the standardized notions of what has been deemed attractive. The internalization of thinness as the correct way to be results in the subjectification of persons and can help explain the collective dieting epidemic occurring in most westernized cultures.

In North America, the discourses that have traditionally influenced us and that are often automatically granted a 'truth status' include economics, science, education, and medicine, to name a few. For example, a medical doctor could diagnose a patient as having bulimia, and because of the power relations involved in a doctor/patient relationship, the patient may not question or challenge the diagnosis, and they will accept that they 'have bulimia.' In fact, they might even start to refer to themselves as 'a bulimic' or 'I am bulimic,' and, in time, this diagnosis might become part of, or all of, how they define themselves. According to Stephen Madigan (1998) the dominant discourse refers to—what can be said, who can say it, and with what authority. If a medical doctor says you are bulimic and writes it in your chart, then you are. Our words are not neutral and they have serious consequences on the lives of others. Being able to define someone's identity in ways that benefit you provides you with certain advantages over other people (Burr, 2003; Foucault, 1982). For example, depending on your location in western categories of wellness and mental illness, you may experience certain advantages or disadvantages based on how you are situated. If someone is labelled as mentally ill s/he might not enjoy such freedoms or rights as someone who has not been defined as such.

Cushman (1995) makes reference to how the helping professions inadvertently benefit from having both a steady supply of mental illnesses and patients. He writes:

> Without psychotherapists realizing it, our theories have reflected the post-World War II consumer landscape, normalized it necessary ingredients such as the empty self, and explained away its unavoidable consequences, such as emotional isolation, selfishness, drug addiction, and the nihilistic use of others. Psychotherapy theories consider these consequences to be anomalies, deviations from the healthy norm and therefore we set out to heal them (p. 277-278).

He goes on to say that unwittingly our willingness to pathogolize those things that could in fact be considered normal, creates the very 'patients' that we then treat (Cushman, 1995).

Subjugated Knowledge

As shown above, language has the power to define others, and thereby positions us in specific ways in society. This positioning may be to our advantage ('I am a successful lawyer'), or to our detriment ('I am mentally ill') (Harre, 1990). In time, we begin to experience ourselves through the stories that we and others use to describe ourselves. These stories can define what is possible for us, as our identities are created in and through discourse. To quote Burr (2003) "once we take up a subject position in discourse, we have available to us a particular, limited set of concepts, images, metaphors, ways of speaking, self-narratives, and so on that we take on as our own" (p. 119). This is how power is constitutive in shaping our identities, and how the words we use influence how we describe and experience the world and the people in it.

Foucault invites us to take a critical look at the process by which ideas and concepts become normalized and taken for granted while other possibilities fall to the wayside. This intentional re-storying of history constitutes the 'knowledge' that we hold and 'truth claims' we make about the way things are (Foucault, 1980). On the other hand, "subjugated knowledge" (Foucault, 1980, p. 81) refers to the historical ideas, theories, knowledge and events that are written out of history, as others are privileged, elevated to a truth status, and become unquestioned, the real chain of events. One could describe subjugated knowledge as traditional or alternative health practices that do not fall within standardized western medical practices. Western medicine has been centralized and granted hegemony to diagnose, treat, and cure people who are ill, thereby locating other healing practices (homeopathy or traditional Chinese medicine, for example) as 'alternative' (Madigan, 1992). Narrative therapist Michael White (1989) introduced the concept of subjugated knowledge into the field of therapy and he illustrates how therapists can work in ways that privilege their clients' subjugated knowledge to re-author their lives in ways that they prefer. Foucault's (1980) ideas of "subjugated knowledge" (p. 81) remind us of the many truths and various ways of seeing the world. When Foucault's ideas collide with therapeutic ideas the results can be libratory (Martín-Baró, 1994).

Foucault's later writing focuses on the usefulness of power. He writes:

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals.' In fact, power produces; it produces reality, it produces domains of

objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production (Foucault, 1979, p. 194).

Within this frame, power is seen as producing reality; it "produces domains of objects and rituals of truth" (Sarup, 1993. p. 74). This view of power positions people as active agents in their lives and creates space for people to resist power that is oppressive. Utilizing subjugated knowledge and stepping 'out of the box' of traditional therapies can be an act of resisting power, and opening up new possibilities for people in their lives.

Social Constructionism, This Writing, and Therapy

Gergen and Gergen (1996) borrowing from the ideas of Wittgenstein, write, "if our language forms the limits of our relationship, than expanding the languages of the therapeutic relationship may offer the greatest liberatory potential for participation in cultural life" (p.80). Social constructionism allows us to step outside of the totalizing and essentialist language of traditional psychology (Burr, 2003), and to question the truth claims of psychiatric diagnosis, labels, and the idea of static personalities. In other words, it enables us to co-create new possibilities with our clients.

Within this dissertation, social construction as an approach allows for new and generative ways of engaging with the young women struggling with disordered eating practices and substance misuse. Steve de Shazer (1993) quoting Wittgenstein writes, "All of the facts belong only to the problem, not to its solutions" (p. 85). And if we take the facts to be constructions then we can question them looking at the real effects the facts have on clients lives. Now we are positioned to talk to the solutions, to the young woman's hopes and preferences for her life.

In a social constructionist stance, therapists are not positioned as all knowing experts set to tell their clients what is wrong with them. Instead we are positioned as listeners (Andersen, 1992a), and conversational partners (Anderson & Goolishian, 1992) positioned to help keep the conversation going. In order to do this, we need to coordinate our meaning with the other as opposed to putting our meaning on the other (McNamee & Gergen, 1999). Instead of listening to figure out what is occurring within their mind or listening with the intent to label or diagnose, we listen with the intent of entering into a dialogue that is transformative. The focus is to open up conversational space rather than shutting it down. For example, if my identity is totalized and rendered to a label of an alcoholic, where do I go from there? What possibility does this mean for my life? It shuts down possibilities rather than opening new ones. Tom Andersen writes (1998), "the listener is not only a receiver of a story, but also by being present, an encouragement to the act of making the story. And that act is the act of constituting one's self" (p. 66).

As previously mentioned in chapter 1, social construction has influenced narrative therapies and creates new possibilities for therapists working with young women whose identities have been constituted by problems new places to stand which may allow them to say "Now I know how to go on!" (Andersen, 1998, p. 79).

The following chapter details the narrative methodological approach to co-research used in this study.

CHAPTER 5 A NARRATIVE CO-RESEARCH METHODOLOGICAL APPROACH

In this chapter, I detail a methodology that prioritizes the usefulness of the research to the participants involved. Rather than participating in an inquiry process where research is *done to* participants—I propose a research style that is more of a *doing with*. I will outline the ideas informing a qualitative narrative methodological approach to co-research, and describe the steps I took while conducting the research.

The term co-research, as I am using it, stems from the ideas described by New Zealand narrative therapist David Epston (1999). He describes a process whereby the person being consulted is believed to have knowledge about his or her own personal experience that others, including professionals, cannot know or possess. This position makes possible "the co-production of knowledge by sufferers and therapist" (Epston, p. 142). There are many ways to describe the process by which the researcher consults with his or her clients (Katz & Shotter, 1996; Shotter & Katz, 1999; Andersen, 1987, 1991,1992a; Anderson & Goolishian, 1992; Shotter, 1989; White & Epston, 1990; McNamee, 1989; Freire, 1989; Bruner, 1986). Before elaborating on the contributions of the above writers, I wish to describe a brief history of the ideas that have contributed to the evolution of the research practices I describe.

My research approach can be contrasted to the modernist understandings of science described in the previous chapter. There I noted the traditions that began to appear in the sixteenth century (Cushman, 1995), that were strongly grounded in ideas of science and empirical knowing.

The ideas of the enlightenment, and modernism—with their focus on essences, progress, observation, science, truth and knowledge—contributed to the ideas of empirical research. Social constructionist Ken Gergen (2005) describes five guiding principles of empirical research: "remain dispassionate…control the conditions…convert observation to numerals… search for *the* answer… and …separate truth from practice" (p. 91-93). At the centre of empirical research is the search for *the truth,* for the *one single truth*.

In order to find the truth, empirical researchers position the research participants as objects where they are done to and acted upon. The researcher is positioned as the subject, separate from, yet looking in on those being studied (Parker, 2005). From this perspective the researcher is located as outside of the research and positioned as an objective observer, disconnected from, and not influenced by or influencing the research participants. Empirical research assumes that researchers can yield a precise and unbiased understanding of the research participants' experiences and tends to be quantitative in nature. Scientific knowledge is exalted and granted a privileged status over other ways of knowing—the emphasis being on rational thought and on "absolute forms of knowledge" (Crotty, 1998, p. 185).

Philosophical Hermeneutics

Martin Heidegger and Hans-Georg Gadamer are two 20th century philosophers who influenced social science research by their views regarding the interaction that occurs between text and reader and ideas of the centrality of language (Eagleton, 1983). Heidegger felt that language breathed life into our existence, and is what creates the

world (Eagleton). Central to their work is the notion that in order to understand and interpret literary texts, the texts needs to be considered in the historical and cultural context in which they are embedded. Heidegger proposed that the researcher's pre-understandings shape, influence, and inform the researcher's understandings of what it is that s/he is studying (Eagleton). Building on this notion, Gadamer proposed that the person reading the text brings his or her presupposed knowings that influences his or her interpretation and understanding of the texts (Eagleton). This understanding is not fixed in time; rather it changes with time—this he referred to as our '*horizon of understanding'* (Gergen, 1991, p. 104). Both Heidegger and Gadamer "argued that it is not possible to exist as a human outside of a cultural context" (Cushman, 1995, p. 20). Gadamer also proposed that language and understanding is a shared or "social matter" (Eagleton, p. 71). As a result, understanding is produced in dialogue (Gehart, Tarragona, & Bava, 2007). Given that understanding occurs with others and is influenced by our pre-understandings or biases, we can never be sure that we know the truth of a matter. Gadamer questioned whether it is possible for a researcher to be detached from the research that s/he studies (Gehart, Tarragona, & Bava). His ideas are important in regards to this dissertation as he proposes that all knowing needs to be placed within its cultural context.

Research and Social Construction

Some of the new developments in research methodology were a response to the research practices of the sixties where research participants were treated as subjects and at times perhaps unethically done to or acted upon (Parker, 2005). Using a

constructionist stance positions the researcher to embrace the diversity that exists in the world, privileges relationships, views language as generative, and aims to have multiple truths and perspectives co-exist. Constructionist research allows for the researcher to bring his or her biases and knowledge of what is being studied to the work. The researcher's knowledge is not seen as something that hinders the research. Rather it is seen to enhance it.

Sheila McNamee (1989) advocates for "blurring the distinction" between therapy and research (p. 96). "Blurring the distinction" (McNamee, p. 96) embraces the similarities between research and therapy. Research becomes therapeutic and therapy a form of research. For example, in therapy, a therapist investigates the life of the problem and the ways that it impacts the person s/he is speaking with, and an interview for research can be experienced as therapeutic. By stepping out of the traditional confines of researcher and therapist, I believe that the manner in which I conducted the interviews with the young women, allowed for this blurring to occur.

The History of Co-research/Collaborative Research/Narrative Inquiry

The ideas of co-research have a rich tradition. Edward Bruner (1986) described how there is no clear distinction between researcher and researched yet how we have a false sense of separation. Coming from this perspective, the researcher is no longer positioned to discover (Bruner) new universal knowledge. Rather, the researcher is positioned to resurrect subjugated or local knowledges (Geertz, 1983; Foucault, 1980) with those being researched, and this resurrection occurs in dialogue. Borrowing from Epston (1999; Maisel, Epston & Borden, 2004) I use the term 'insiders' to refer to the

young women as it is a term that honours and elevates the young women's local knowledge as a result of their personal experience with substance misuse and disordered eating practices. Insiders, is a term that refers to 'subjugated knowledges' which Foucault (1980) defines as "knowledges that survive only at the margins of society and are lowly ranked" (p. 81) compared to so-called expert or professional knowledge.

Collaborative research, as described by Andersen (1997), re-positions the therapist (researcher) and client (researched) as exerting influence on each other. From this perspective, knowledge and ideas are not contained in people. Rather, these are processes that occur between people (McNamee & Gergen, 1999). As Edward Bruner (1986) writes, "Our ethnographies are coauthored, not simply because informants contribute data to the text, but because . . . ethnographer and informant come to share the same narratives" (p. 148).

It is through collaboration, dialogue, conversation and our relationships with others that the generation of new knowledge and meaning is co-constructed. There is no presumption that the therapist does not influence the client, nor is it possible for the client to not influence the therapist. The implications of this premise change the nature of our research. The focus changes from *a doing to* to *a doing with*. No longer can the researcher remain a separate and unbiased observer regarding the entity s/he studies (McNamee, 1988). We cannot remove observer bias as it is embedded in the language that we use (Gehert, Tarragona, & Bava, 2007).

Co-research Within the Field of Therapy

Collaboration in the field between therapists and clients can be traced to the work of Tom Andersen (1987, 1991, 1992a, 1992b). Andersen derived a method in which he broke some of the 'rules' of therapy and brought into the open the private conversations that therapists and consultants were having *about* their clients. He came to call this work reflecting teams (Andersen, 1991). I will briefly describe this process. The therapist has a conversation with the family while team members watch. At an appropriate time in the course of this conversation, and with the permission of the family the therapist asks questions of the reflecting team members, inviting their ideas/thoughts/opinions about what the family and therapist have just discussed. Once the therapist and team members have had a conversation with each other, the family and therapist converse about what they have heard.

It is my understanding that these conversations generate new knowledge as conversations are built upon and added to. The families can correct or highlight what they are most interested in and what resonated for them. This process also forces therapists to be more respectful of the words/descriptions they use to describe families. In Andersen's words, "nasty" (1991, p. 58) reflections were avoided. Andersen's work can be seen as revolutionary as it challenged the idea that professionals know more about their clients' lives than the clients do. Reflecting teams positioned families and clients as having insight, awareness, and hopes about and for their own lives. Andersen described this work as creating more "egalitarian relationships" (p. 66) between clients and therapists.

When describing his therapeutic approach Tom Andersen (1992b) writes, "I can say that theories and methods have been relegated to the backseat whereas relationships, language and prior assumptions have been given more attention" (p. 87). In a similar vein, rather then prioritizing the research that I was conducting, I prioritized the relationship and the conversation that was unfolding between myself and the young women that I was interviewing at the time.

Harlene Anderson and Harry Goolishian introduced the idea "the language that we use makes us who we are in the moment we use it" into therapeutic practice (as cited in Andersen, 1992a, p. 64). In therapy and in co-research we are co-creating with clients their knowing of themselves, and our knowings of them, at that moment. Together at the Galveston Institute Anderson and Goolishian (1992) developed a therapy process where they positioned themselves as learners and the client as the expert. Rather than make hypotheses about clients, they consulted with them, they took a 'not knowing stance' and let the client lead the conversation. The therapist is simply an expert in creating conversational space (Anderson & Goolishian), follows the clients story and the therapist's questions are informed by their curiosities rather than assumptions or beliefs about what the client means or what the solution to their problem is. Their approach to therapeutic conversations placed therapeutic questions as tools to open up space in a conversation in order to loosen the grip that the problems had over people, rather than as interventions, or to affirm assumptions the therapist had made about the client (Anderson & Goolishian).

As mentioned in chapters one and two, narrative therapists White and Epston (1990) catapulted the idea of narrative and collaboration into therapy. They positioned

themselves as experts in the therapeutic process but not on the lives of the clients who sought consultation They made transparent their position that the client is the expert on his or her own life. David Epston (1999) connects co-research to the work of philosopher Michel Foucault. Epston writes, "The philosopher Michel Foucault advised the documentation, authentication and circulation of 'alternative knowledges' if they were to do what he proposed was their work—that of critique" (Epston, p. 6). Co-research generates 'alternate knowledge' as it makes space for the knowledge of the young women to be brought forward. This knowledge is often in stark contrast to the knowledge generated by psychiatrists, physicians, psychologists and other professionals who have been granted the power to label and diagnose others. Alternative knowledge also refrains from positioning the young women as objects to be studied, which Foucault has written extensively about (1980).

Positioning oneself as a co-researcher makes space for the generation of "insider knowledge" (Epston, 1999, p. 3). Insider knowledge is distinct from ideas of professional knowledge. These knowledges are often overlooked, and called local or "subjucated knowledges" (Foucault, 1980, p. 81). Epston's approach brings the voices and wisdom of the young women to the foreground. Describing co-research he writes, "co-research implies, firstly, that the answer is unknown but, secondly, that it can be discovered by an experimental attitude on a day-to-day basis" (p. 4). David Epson has used co-research with a wide range of people and problems. For example he has consulted with young children suffering with medical problems, young women struggling with anorexia and bulimia, and men under the influence of depression (1989, 1993, 1999).

Arlene Katz and John Shotter (Katz & Mishler, 2003; Shotter, 1983, 1993, 1995; Shotter & Katz, 1996, 1999, 2004) have written extensively about the ways that clients and therapist lean into one another and become mutually responsive to the other. They describe a synchronizing that occurs in the presence of another in actions, words, movement and body (2004). They introduce yet another way of conceptualizing the therapeutic process, one where therapist and client inform what occurs between them. In this process there is an intentional 'dwelling' in words that resonate deeply with therapist and client, and from this place, new possibilities for hearing, speaking, and ways to go forward arise. Katz and her colleagues (Katz & Shotter, 1996; Katz, Conant, Inui, Baron, Bor, 2000; Katz & Mishler) have conceptualized a style of co-research that brings in the voice of the client to inform the creation of new knowledge. What is exciting about their collaborative research practices is how it has been conducted within health care settings and the field of medicine, which traditionally have been dominated by quantitative research methodology and practices.

Co-research has also been used in the field of education. Paulo Freire (1989) a Brazilian educator, was responsible for teaching poor and illiterate adults in Latin America. Freire believed that through pedagogy, individuals and communities could find liberation. He describes liberatory education as a form of education where the teachers allow themselves to be taught and educated by their 'students.' Freire writes,

> Through dialogue the teacher-of-the students and the students-of-the-teacher cease to exist and a new term emerges: teacher-student with student-teachers. The teacher is no longer merely the one-who-teaches, but one who is himself taught in dialogue with the students, who in turn while being taught also teach. *They*

become jointly responsible for a process in which all grow [italics added for emphasis] (1989, p. 67).

Narrative Analysis

"Narrative analysis—and there is no one method here—has to do with how protagonists interpret things, and how we can go about interpreting their interpretations" (Bruner, 1990, p. 51).

One could say that it has always been through narrative and telling stories that people have made sense of events (Bruner, 1990). But what does the word narrative mean? Riessman (2002) points out that there are many definitions but not much consensus. I found the description given by White and Epston (1990) satisfying. They write:

> In striving to make sense of life, persons face the task of arranging their experiences of events in sequences across time in such a way to arrive at a coherent account of themselves and the world around them. Specific experiences of events of past and present, and those that are predicted to occur in the future, must be connected in a lineal sequence to develop this account (p. 10).

The interest in narrative as a qualitative research approach has been described as the "narrative turn" (Riessman, 2005, p. 1) in social sciences. In France, developments in structuralism in the late 1960s contributed to theories of narrative (Barthes, in Thody & Course, 1997; de Saussure, 1983; Lacan, 1977; Levi Strauss, 1976; Herman, Jahn & Ryan, 2005) and narrative research has been described as an approach that cuts across disciplines (Riessman, 2002; Herman et al.). It has been used in social work,

anthropology, psychology, and medicine (Riessman, 2005). I used a narrative qualitative inquiry in this dissertation, as it was the method that resonated the most for me and one that I felt was the most respectful with the young women's words. It allowed their experiences and their stories to be told in a way that honoured what it was that they shared with me. It also allowed me to create a theory out of the resulting data, rather than create a theory and then find data that support it.

It is my understanding that co-research and narrative analysis are complementary, as within this process both researcher and researched are seen as active participants, contributing to the "construction of the text" (Riessman, 2005, p. 5). The young women and I both participated in the conversation, co-constructing and generating ideas as we talked. I have not just included the young women's words or responses to my questions. Rather both our contributions are included in the writing. Throughout the research process, during the creation of the interview questions, the field notes I wrote, selecting sections of the transcripts, all these acts positioned myself as an active participant in the research process and as interpreter of the text. "Just as interview participants tell stories, investigators construct stories from their data" (Riessman, 2008, p. 4).

Similar to grounded theory based on the work of Glaser and Strauss (1967) groupings or categories were generated from the interviews with the young women. From these grouping I organized the young women's narratives into themes that had emerged (or that I interpreted) from the data (Riesmann, 2005). In both narrative analysis and grounded theory it is the data that generate the theory, rather than the theory generating the data.

Why this Approach Fits

The research that I conducted occurred while interviewing the young women (Andersen, 1997). In this process both myself and the young women were pivotal—together we generated new paradigms from which to move forward. The questions that I posed brought forward their tellings and experiences of substance misuse and disordered eating practices. Their answers then informed the questions that I asked them and the other young women I had yet to interview. I am not an objective researcher and I must acknowledge that I bring with me to all the conversations that I have had, all of my years of schooling, years of doing therapy with people struggling with disordered eating practices and substance misuse, and my personal experience of living as a woman in a culture where thinness and body image issues regularly confront me. I cannot leave these things at the door. Instead they came into the room with me when I met with the young women that I interviewed. The young women brought with them their struggles with disordered eating practices and substance misuse and all of who they are to the interview. In this sense, I could not walk away from the research process with a clear sense of this is the sole truth of these problems, because each young women's experience is different and each conversation generated something new.

I used a narrative co-research analysis to:

1) Explore the young women's account of the problems of disordered eating practices and substance misuse, and how these problems contributed to their sense of self

2) Locate these problems in their social context and discuss the young women's experience of how society may contribute to these discourses and the problem's development
3) Illuminate their voices and wisdom regarding how these problems work together and ways that therapists, family members and their own insider knowledge may help other young women and themselves in finding freedom from these problems

The Research Process

I decided at the outset of my research that there were certain research practices that I did not want to replicate. I once worked in a youth secure custody centre, and University students would come in and interview the youth with questionnaires about whatever it was that they were studying and then the researchers would leave. I would watch the youth be called from their cells and enter the room with the researchers. From an outsider perspective, the youth appeared to be 'studied and watched,' as if they were inside of a fishbowl—the researchers looking in, trying to make sense of the youths' behaviour. Later, some of the youth described the interviews as being hard, having been asked about personal and difficult details of their lives. Something unsettled me about watching and hearing this. It didn't seem right; the youth seemed too vulnerable. I wondered who benefited from this experience—the researchers or the researched? The researchers had gathered their data and were presumably content once the interviews ended. But what about the youth? What about the conversations or memories that had

been re-membered or touched upon? How was this of use to them? What did they gain from having their lives and experiences studied and 'dissected' in this way?

With this in mind, I began imagining this dissertation and how it might unfold. I knew the type of research in which I did not want to participate. I knew that I wanted to co-create something with the young women who I planned to interview. I also knew that in dialogue something new would be created. I wanted the youth to get as much out of this as I thought that I and the other therapists, parents, teachers, and other health care providers, who would subsequently be reading it, would be getting out of it. I did not want them to tell me personal details about their lives just for the sake of the telling or because they had been asked. The questions needed to have a sense of purpose and be very intentional. I wanted the youth to experience a sense of connection and engagement with the ideas that we were exploring. I wanted them to have a sense of having connected more with what they knew about the inner-workings of substance misuse and disordered eating while also having more ideas about what they needed to do to stay free from them. I did not want the youth walking away or waking up the next morning regretting what they had said, thinking that they had said too much or feeling as if they had been talked over or down to as if their ideas were second to mine.

I did my best to ensure that this interview would be therapeutic, borrowing from Karl Tomm's adaptation of Humberto Maturana's and Francisco Varela's ideas regarding love and its needed presence in the field of therapy (Maturana & Varela, 1987). Karl Tomm (Tomm, Hoyt & Madigan, 2001) describes how we can choose to participate in practices of therapeutic love or therapeutic violence. In a conversation with Stephen Madigan (Tomm, Hoyt & Madigan), Tomm states "I use the word *love* in

the way that Maturana [Maturana & Varela] does, to talk about opening space for the existence of the other" (p. 256). Therapeutic violence, Tomm describes, shuts down possibilities and can include knowledge that is possessed by a certain group of professionals and is often used at the expense of others, to label them or to pathologize them. For example, as Tomm (1990) describes the information contained within the DSM could be called therapeutic violence, as:

> The labelling process initiates permanent stigmatizing patterns of social interaction in the human network of relationships in which a person so embedded is embedded. A person, once authoritatively labelled a schizophrenic is never treated the same again in his or her social network (p. 3).

In order to avoid practices of therapeutic violence and to open up space for new and unimagined possibilities, I positioned the young people as the experts on their own lives (White & Epston, 1990), prioritizing their lived experiences rather than the ideas of other professionals or information contained within the DSM.

The questions that I asked during our interviews were very intentional. I asked questions about their ideas, about how these problems worked, and positioned the young women as insiders and co-researchers (Epston, 1999), rather than as people who are being studied and in need of help. From this place, therapist and client can explore the ways in which the problems under consideration work in their lives and the minute details and implications that it can have in people's lives. In order to position the young women as co-researchers rather than 'subjects,' the young women needed to be positioned and I needed to really believe and see the young women as the expert of their own lives (White & Epston 1990; Anderson & Goolishan, 2000) with knowledges and

preferences for the direction of their lives. I asked questions that I was genuinely curious about and to which I really didn't know the answers. With this framework as my foundation, together we were both ready to go forward in conversation to discover the ways that substance misuse and disordered eating practices worked in their lives. And in this way, 'we' both gained a clearer understanding of these problems.

I sought to know more about the ways that the problems worked in their lives and with each other, rather than trying to discern 'what was wrong with them' or 'why they had these problems.' This position distinguishes postmodern social construction practices apart from more modernist ways of knowing and working. I consider the aforementioned practices having contributed to a foundation from which to move forward, and this foundation contributed to the richness of our interviews, and what was possible for the young women to speak with me about. And importantly, it made space for the young women to reflect on and consider the aspects of disordered eating practices and substance misuse that were relevant and important to them at this time in their lives. I credit these practices to the young women's descriptions of our interviews as being useful to them.

Participant Selection Criteria

The research described in this dissertation is based on semi-structured interviews with 12 young women. All the young women interviewed were either attending or had attended Peak House, a residential substance misuse program for youth. Thus, they had all self-identified as having a substance misuse problem. There was, therefore, no need to meet DSM-IV-TR criteria for Substance Dependence and Substance Abuse, although some of the women most certainly would. When deciding the selection criteria based on

their experience of 'disordered eating practices,' I was presented with a couple of options. One option was to include youth who had attended or were attending Peak House who had been diagnosed with having or having had an eating disorder as defined by the Diagnostic Statistical Manual of Mental Disorders (DSM-IV-TR). Within the DSM-IV-TR, an individual can be diagnosed as either having or not having met the criteria for a substance use disorder or an eating disorder, based on specific behavioural and emotional criteria, and these criteria can then determine the types of support, therapy, or treatment that they can access. Choosing to only include young women who met the DSM-IV-TR criteria for eating disorders option would have limited the amount of participants in the study, privileged the voices of the medical profession and more importantly have left out many young women who fall outside the traditional diagnosis of anorexia and bulimia, yet still struggle with disordered eating practices, for example, body image, dieting, food restriction, purging and over-exercise to name a few. As well, the DSM -IV-TR does not take into consideration the social context of peoples' lives nor the cultural support that both thinness and alcohol and, to some extent, drugs receive in western culture.

The second option was to include youth who had attended or were attending Peak House and self-defined as either having or having had struggles with disordered eating practices. This then included anorexia, bulimia and all spectrums of concerns as described by Brown's (1993) "weight preoccupation continuum" (p. 53), which I discussed in chapter 1. This selection criteria privileged the young women's experiences of disordered eating and weight preoccupation practices and allowed those who might not meet the DSM-IV-TR criteria for an eating disorder a place to voice the distress

and/or impact that an experience of eating disorders, as well as substance misuse, had had or was having on them.

I chose the second option, which was to have the young woman self-define as having, or having had, struggles with disordered eating practices, which included anorexia, bulimia and weight preoccupation (Brown, 1993). This option privileges the young women's experience as the deciding factor for inclusion in the study and throughout the writing of the dissertation. This option also honours the young women's voices in determining the extent to which substance misuse and disordered eating/food/weight preoccupation have been problems in their lives.

Creation of the Interview Questions

Central to social constructionism is the idea that it is impossible for a researcher to be a neutral observer in the research process (Burr, 2003). By locating myself as a co-researcher, I am a central player in it. My theoretical orientation, values, and personal experience inform the questions that I chose to include in the interview with both therapists and youth. This includes questions that I could not ask as they were not yet in my social lexicon/awareness. As part of this process, I had conversations with other therapists about what would be of most interest to them when reading my dissertation, and I incorporated some of their ideas into the questions that I formulated for both the youth and therapist interviews.

I wanted the young women to benefit from their participation in the interviews, and made every attempt to ask questions of them that were thoughtful and intentful. The questions posed brought forward their strengths and resourcefulness as well as their

ideas about how therapists could be most helpful to their clients with both substance misuse and disordered eating problems. In no way did I want to replicate practices of what Karl Tomm, borrowing from the ideas of Maturana, refers to as 'therapeutic violence' (Tomm, 2001; Maturana & Varela, 1987). Instead, I wanted the youth to walk away from the interviews having a richer understanding about the ways that substance misuse and disordered eating practices work or have worked in their own lives and the skills and resources that can support them in staying free from these problems, all of which is more in line with the practices Karl Tomm refers to as 'therapeutic love' (Tomm; Maturana & Varela).

Questions for Therapists

I began my interviews with therapists hoping that our conversations would illuminate gaps in the current research regarding the convergence of disordered eating practices and substance misuse. The questions were based in my curiosities about how other professionals in the field of eating disorders and substance misuse were working with these problems and to determine if this was a relevant area of study. (See Appendix A for the list of the Therapist Interview Questions).

Questions for Insiders

While creating the initial list of questions for the insiders, I paid close attention to the language used, its accessibility, wording of the questions, and tried to ask questions that were generative in nature and that brought forward the young women's

personal knowledge, expertise and insight into the inner workings of disordered eating practices and substance misuse.

An important part in the design of the interview questions was having the questions reviewed by the young women at Peak House. As my questions will show my own biases and interests, I tried to interrupt this by having other youth play a role in the construction of the questions, as well as including other therapists' voices and curiosities in the questions. Kenneth Gergen (2005) refers to this process as "collaborative inquiry," (p. 98) whereby the interests of the research participants help shape the direction of the research. When I had created my initial list of candidate questions, there were five young women in the program and I let them know about the research that I was doing concerning the interplay between disordered eating practices and substance misuse. I asked if they would be interested in looking over a list of 20 questions that would be used to interview young women about their understanding of the connections between substance misuse and disordered eating practices. All five young women expressed an interest in reviewing the questions. When reviewing the questions, they were asked to comment and give feedback in order to help determine the utility of each question. They were instructed to pay specific attention to the language used, the ease of understanding the questions, the relevance of questions, and whether there were any questions that needed to be asked that were not currently being asked. In addition, they were encouraged to ask for clarification if the wording of the questions did not make sense.

The young women were informed that if they changed their minds and chose not to edit/look over the questions, that they did not need to give a reason or to explain why.

Given my positioning as an adult and therapist at the program, I was very aware of the imbalance of power that existed between the young women and myself. I wanted to ensure that I did not replicate practices of power where the client's voice is not given the same respect or weight as the therapist's. These practices of accountability were extremely important in positioning the young women as consultants (Madsen, 1999) to the work.

The idea to have youth review the questions was inspired by Arlene Katz's creation of *The Council of Elders* (Katz, Conant, Inui, Baron, & Bor, 2000). In her work, Katz invites a group of elderly patients to consult with medical students about some of the cases with which they are having difficulty. The elders are consulted regarding best practices and advice for the medical students' work with elderly patients (Katz, et. al.). Over lunch, Katz suggested that, similar to her work with the Council of Elders, I could let other youth look over the interview questions that I planned to use as a way to make visible the questions that are most important (A. Katz, personal communication, August, 17, 2007).

The young women who reviewed the interview questions were also told that if they wanted, they could be interviewed by the questions that they were helping to create. Of the five sets of questions that I handed out, one was returned with comments for editing and all five youth expressed an interest in being interviewed. Each was informed that if she wanted to be interviewed, she—along with her legal guardians—would need to sign a consent form. Additionally, each young woman was informed that she could decide to change her mind at any time and withdraw from the research project. (See

Appendix B for the list of the Questions for Insiders).

The Research Process

Recruitment of participants

In this study, 12 young women who were interested in sharing their experiences with substance misuse and disordered eating practices were interviewed. The youth had all attended Peak House a residential substance misuse program that was two and a half months in duration. For a period of six months, all current female residents of the Peak House program were asked if they would be interested in participating in an interview about substance misuse and disordered eating practices as a way to investigate the inner workings of both problems.

Potential participants were required to meet the following criteria:

- They had all attended the Peak House program, which is a residential substance misuse program
- They described having personal experience with substance misuse and disordered eating practices
- They were willing to have a detailed conversation regarding their experience with substance misuse and disordered eating practices
- They understood the premise of the research project
- They understood that there are always certain risks associated with revealing personal information about their experiences

- They were willing to provide signed consent and have our conversation audio-taped
- Their guardian was also willing to provide signed consent to allow them to participate in the study

There was also a period of time between the signing of the consent form and the interview in order to let the young women fully reflect on their decision to participate in the interviews. In order to keep the young women's identities' confidential, pseudonyms were used throughout the written dissertation. I have not included the dates or time frame that the actual interviews were conducted in order to help keep the young woman's identities anonymous.

Two youth who had previously completed the Peak House program were asked to participate in the interviews based on their experience of having been in both our program and a hospital based residential program for disordered eating. Prior to entering our program, they had been hospitalized for anorexia and were both hospitalized again after completing our program. Given their experience with both problems, I thought that their personal experiences would add a layer of personal insight regarding the potential interplay between both disordered eating practices and substance misuse.

All youth were young women between 15 and 21 years of age and lived in different areas of British Columbia. Regarding substance use, Peak House requires all residents to have a minimum of seven days free from alcohol and drugs prior to entering the program. And all the young women that were currently attending the program had been in the program for a minimum of two weeks. I do not know as I did not ask how

much time free from substances the two young women who were not in the program had. The young women's self-described substance of choice ranged from alcohol, marijuana, cocaine, ecstasy, heroin, crystal meth, and crack cocaine. They all described having struggled with disordered eating practices to some extent either currently or in the past.

Therapists were chosen because of the therapeutic work that they have been involved in with substance misuse and/or disordered eating. Many of these therapists are considered 'experts' in their field and have been published widely. I was curious about their ideas about the interplay between substance misuse and disordered eating practices and the decisions they make regarding the treatment of these problems. One other therapist was asked to participate, but declined due to the length of time he felt it would take him to adequately and thoughtfully answer the questions.

Data collection

I conducted private, semi-structured interviews with five therapists. Four therapists were interviewed at their place of employment and one therapist was interviewed at Peak House, as it was a location that was convenient for her. In the consent form, therapists were informed that their identities would not be kept confidential in order to fully credit and reference their ideas directly to them. The therapists all consented that they understood the nature of the research project, were willing to provide signed consent and have the interview be audio-taped. (See Appendix D Consent Form for Therapists/Researchers).

I also conducted private semi-structured interviews with 12 young women, all of whom were or had been residents in the Peak House program. All current female

residents at Peak House expressed an interest in participating in the interviews. Because Peak House is a voluntary program, some of the young women who had expressed an interest in participating in the interviews made a decision to leave the program or were asked to leave the program prior to being interviewed. I choose not to track down these youth once the decision that they would be leaving the program had been made. This was partly because many of the youth live outside of the Lower Mainland, making it difficult to connect in person due to distance.

Eleven of the interviews took place at Peak House, and one was held at a young woman's home. The participants and their legal guardians signed a letter of consent that was drafted in accordance with Human Research Ethics Committees. (See Appendix C Consent Form for Insiders).

The interviews

The interviews were conducted privately, and were semi-structured. I asked the young women approximately 20 questions, and the therapists/researchers were asked approximately 10 questions. Depending on the answer to the questions, I might have asked for them to elaborate further on their answers, or have asked a question in response to what they had just said. The interviews took approximately and hour to an hour and a half to complete.

The interview process

Participants were told that they could stop the interview, the audio-taping, or their involvement in the study at any time. The youth were informed that they did not have to answer any questions they did not want to answer, and that they did not need to give an explanation for their decision. This is based on the idea that therapists need to

be able to hear 'No' when working with clients. Additionally, clients have the right to decide what conversations they wish to have and what conversations are best left unspoken. This means being able to hear 'no' in a myriad of ways, for example hearing 'no' in actions (e.g., having a youth not return the consent form) or hearing 'no' by the feeling in the room or noticing changes in posture after the asking of certain questions (Reynolds, 2002). These practices position the client as having some important knowledge regarding what is best for his or her own life and the conversations that will best assist them in getting there.

At the start of the interview, youth were asked to think of a word that would best describe their relationship with disordered eating practices. That word would be used throughout the interview. Youth were given a list of candidate language (Epston, 2004) if no words came to mind and the candidate word selected could then be played with and altered to best fit their experience of the problem. This was an attempt to minimize the specificity of language that might obscure a youth's experience, as well as an attempt to interrupt the possibility of anorexia or bulimia or alcohol and drugs influencing people's thoughts or causing them to doubt if their problem was significant enough to warrant the interview. Once the young women had defined the problem in their own terms, their words could be brought into the interview, and hopefully something meaningful and relevant to their own lives could occur. In addition, we could begin to bring to life the ways in which the two problems work together. In this way, the interview became a process of discovery for both the participants and myself. With each interview, a different level of depth and richness was added. During the interviews I asked the young women for permission to take notes, which all the young women gave. I let the young

women know that at any time during the course of the interview or afterwards they could look at what I was writing and ask me questions about it if they wanted.

Reflexivity

When the youth were signing the consent forms, I asked them for their email addresses in order to send them a copy of their interview transcript. Of the 12 young women only three said they would be interested in having a copy of their transcript and gave me their email addresses. As another level of accountability, I let them know that while reviewing their interview transcript should they decide that they would like certain parts of the interview excluded from the dissertation, they could let me know and I would remove those parts. If interested they were also invited to give feedback and comment on any part of the interview process—perhaps thoughts they have had about the interview, or if our conversation has showed up in their life in any way since the time of the interview. This was an attempt to give more weight to the voices of the participants, and to interrupt my own 'interpretation' of the interview results. I did not want to make my own meaning about the impact that these conversations had on the lives of the young women, and wanted their description of the usefulness or not of our conversation.

Compiling the interview results

The results of the interviews were very rich. After the interviews were recorded I found myself listening to them almost immediately, writing down words and phrases that stood out, or surprised me. Once the interviews were transcribed, I found myself pouring over the transcripts. The young women's accounts of how the problems of

substance misuse and disordered eating worked together and their ideas regarding the ways these problems received support in their lives was fascinating. In order to make sense of the information from the interviews, I printed out a hard copy of all 12 transcripts. At first I gave all the transcripts a quick read. Ideas, words, and phrases that struck me and that I was moved by (Shotter & Katz, 1999) were highlighted and a word that might encapsulate the phrase was written next to it. Then I re-read all 12 transcripts looking for themes, similarities and differences in the young women's accounts. Reading the transcripts together was like watching invisible ink come to life, and themes and connections began emerging between the young woman's accounts.

While I was looking through transcripts, I kept the context surrounding the young women's responses intact. I did not want quotes to be taken out of context and my meaning to be superimposed on the young women's words. As a result I had a very hard time cutting down the transcripts, not wanting to erase the young women's words. I became very attached to what they had said and wanted meaning to come from their interpretation of events. During the process of data reduction, I did not want to replicate the following qualitative research practice as described by Riessman and Quinney (2005), "many investigators adopted reductionist techniques, similar in effect to what quantitative researchers do with numbers: lengthy accounts of lives were abstracted from their contexts of production, stripped of language, and transformed into brief summaries" (p. 398).

After compiling the young woman's quotes into 12 different themes, I got together a group of three therapists (Allison Rice, Dennis Dion, and Lorraine Grieves) whom I had worked with at Peak House to participate in a 'forced sort' (Stainton

Rogers, 1995). I wanted to ensure that, within a community of narrative informed therapists, these categories made sense and did something meaningful with the data. For the forced sort I printed out three to five quotes from each of the 12 thematic categories I had created. These were; 1) requirements of the problem; 2) effects of the problem; 3) culturally sanctioned practices; 4) ways the young women were recruited by the problems; 5) ways the young women described the problems being different; 6) the ways the problems acted as tools of the other; 7) movement away from the problems; 8) folk psychology/modernist ideas; 9) communal solutions; 10) insider knowledge; 11) recursiveness, the ways research can be of use to both researcher and insider, and lastly 12) the ways the problems defined peoples identities.

I then pasted each quote on its own cue card. When we met to do the forced sort each therapist was handed an identical package of 60 cue cards and a list of the 12 themes. We had a discussion regarding the names of the themes and what I meant by them and I answered any questions that they had. Then individually, each therapist went through their pile of cue cards and assigned a number from 1-12 on each of the cue cards that corresponded with the theme that they felt that quote was best represented by.

During the forced sort an interesting conversation arose. The therapists began to comment on the questions that I had asked the young women. For example, "Good question," "Nice question." They were very interested in the questions that I asked that brought forward the young women's responses. I then recognized the utility of the work I had co-created with the young women. After they had completed the task we had conversations about the themes and questions I had asked and the young women's responses that they found interesting.

After I went home I complied the results of the forced sort. I analyzed this in three different ways. I first looked to see if they had assigned the same themes to the quotes as I had. Then I looked at the quotes that they had assigned a different theme then I had. And finally I compared the three therapists results against each other to see if any new categories had been created. As a result of the forced sort I combined the themes 1) requirements of the problem with theme 2) effects of the problem, which I call *conditions and requirements* in the next chapter. Themes 5, 7, 9, and 10 were combined to create the theme *movement away and communal solutions*. Themes 3) *culturally sanctioned practices*, 4) *ways the young women were recruited by the problems*, theme 11) *recursiveness, the ways research can be of use to both researcher and consultant*, and theme 6) *the ways the substance misuse and disordered eating practices can act as tools of the other* were left unchanged. Theme 8) folk psychology/modernist ideas and theme 12) the ways the problems defined peoples' identities were combined and called *folk psychology*.

When compiling the results into thematic sections I also wanted the reader to gain a sense of the time line of events that resulted in the young women's struggles with substance misuse and disordered eating practices. And I wanted the reader to have an understanding of the ways that the problems began to work together, the way they developed into their own problem. This would not have been possible had the reader been dropped into the story, they needed to watch the story unfold. Riessman and Quinney (2005) refer to this as "sequence and consequence" (p. 397). When relevant, I also brought in theory in order to further locate their words in context and/or further support them. Both co-research and narrative analysis makes space for me to take into

account the wider societal discourses and contexts of production (Riesmann & Quinney) that support substance misuse and disordered eating practices. For example, equating thinness with beauty and substance use as a form of socializing, as well as their glorification in the media.

The following chapter describes the results of the interviews with the young women.

CHAPTER 6 RESULTS

In this chapter, segments from the interviews that I conducted with the young women will be used to illuminate the interplay and relational features that substance misuse and disordered eating practices have in common. The chapter will be divided up into seven separate sections. These are:

1) Culturally Sanctioned Practices
2) Folk Psychology
3) Conditions and Requirements of the Problems for their Survival
4) Ways People are Recruited/Ensnared by the Problems
5) Tools of the Other
6) Movement Away/Communal Solutions, and
7) Recursiveness

I will draw from semi-structured interviews with 12 young women, ten of which were attending a live-in substance misuse program. The other two young women had previously attended the program and all 12 young women self-reported to struggle to some extent with disordered eating practices. In this section my questions and responses are denoted with the letter 'C' for Christine and the young women's responses are indicted by the letter 'A' for Answer.

I will examine the cultural discourses that the young women described being influenced by and which led them to believe that there are specific ways for them to be, act, and look. I will also explore their ideas about the ways in which disordered eating

practices and substance misuse interact together and the types of tactics these problems use and share in order to become influential. This will lead into a discussion about what has helped them find some space from the problems as well as their ideas about what therapists can do to help support young women who may be struggling with these problems. At the end of each section the questions that illuminated and brought forth these responses will be highlighted.

The data were put into specific themes as they emerged across the interviews and by the patterns that emerged. I am aware that any classification is necessarily limiting (Bateson, 1972), yet in order to make sense of the data from the interviews I needed to categorize and classify the data in a way that highlights patterns or a lack thereof. All categories were influenced by my ideas and experiences as well as by my position as a white middle class, well-educated woman who is informed by feminist, post-modernist ideas and lives within a culture where I too am surrounded by ideals of thinness and beauty. The trouble with committing words to paper is that they can imply a certainty that may not be intended by the writer. In no way do I want these sections to be assigned a 'truth status.' Rather, there is fluidity to all of the sections, themes and categories in this chapter—they are not distinct and isolated. Some themes appear to flow from one section to the next and others appear to belong in several different sections, and many of the youths' responses could have easily appeared in a few or all of the sections.

This chapter is intended to provide another lens from which to see the problems and as a way to bring the readers into a different way of thinking. It asks what we see differently when viewing the problems in this way. I believe that in stepping outside of

the confines of dual diagnosis, 12-step, and traditional psychotherapy practices many new and exciting possibilities arise.

Section 1. Culturally Sanctioned Practices

Given that I began the interviews with the young women by asking them to describe how disordered eating practices and substance misuse may receive support (inadvertently or otherwise) in their lives, I felt it fitting to begin the results chapter in the same fashion, as it is important to me to highlight the many ways in which disordered eating practices and substance misuse find support in western societal practices (Orbach, 1978) and to locate eating disorders and substance misuse problems within the contexts that support their development and existence. Any discussion on eating disorders and substance misuse that omits this 'context' lacks substance, and risks pathologizing the young women. According to Brown and Jasper (1993), "Women who develop anorexia or bulimia should not be singled out as pathological. Their behaviour and thinking needs to be understood within the context of a culture which produces weight preoccupation" (p. 13). Widening the lens to include the context of young women's lives de-centers the young women as problems and invites us to look at the cultural discourses and circumstances that can support substance misuse and disordered eating practices to flourish in a young women's life.[24] Bordo (2003) describes the body "as a medium of culture" (p. 165) and "a text of culture" (p. 165). In other words, culture imprints itself on our skin and shows up in the words we use to describe ourselves, and others. Other writers have described anorexia as a culture bound

[24] David Epston and Rick Maisel have written a wonderful article detailing the circumstances that can support disordered eating practices in young people's lives entitled *Beyond Coercion & Surveillance in the Treatment of A/B: Building Anti-Anorexic Alliances* (2004).

phenomena (Malson, 1998; Peele, 1995; Cushman, 1995), and Bruce Alexander (2001) describes the globalization of addiction that has resulted from mass social dislocation that we as a culture have experienced since the industrial revolution. These writers highlight the importance of viewing the problems within the local discourses and contexts that we live in. The Just Therapy Team (2003) stresses the importance of "social, gender, cultural and political data" (p. 8) whenever it is relevant to the problems that bring people to therapy. As I have previously shown (see chapter 3), these problems are very much informed by larger cultural discourses and practices and as such, socio-political and cultural influences are very relevant to therapy.

The questions that I asked the young women at the beginning of the interview invited them to consider some of the pressures that they experienced in regard to how they should be, act, and look. These questions positioned the young women to consider the impact of these pressures and the impact they have had on their ideas about how they should be, potentially exposing the limiting avenues with which these pressures have left them. These questions also illuminated some of the ways in which substance misuse and disordered eating practices use these pressures to their advantage. This practice of taking apart and breaking down taken for granted ideas, realities, and assumptions is referred to as deconstruction (Derrida & Caputo, 1997). When considering the meaning of the word 'deconstruction' I am drawing from Michael White's (1993) use of the term:

> …deconstruction has to do with procedures that subvert taken-for-granted realities and practices: these so-called 'truths' that are split off from the conditions and the context of their production; those disembodied ways of speaking that hide their biases and prejudices; and those familiar practices of self

> and relationship that are subjugating of persons' lives. Many of the methods of deconstruction render strange these familiar and everyday taken-for-granted realities and practices by objectifying them (p. 34-35).

White (1993), drawing from the work of Bourdieu refers to this practice as "exoticizing the domestic" (p. 34-35). Deconstructing "everyday taken-for granted realities and practices" (White, p. 34) allows young women to consider the structures that are in place in society that support a certain way of looking or being and the resulting impact on their lives. Therapeutic questions that highlight the gendered training that young women received can invite young women to consider the impact that this has had on their experience of their body and their relationship to it.

- What were they taught about how a young woman should look or act?
- How did substance use or their appearance/weight begin take up as much space in their lives to the extent that it did?
- Were these practices in any way supported by others? If so, how?
- Why do they think so many young women struggle with the problems of substance misuse and disordered eating practices?

These questions can help peel back the many societal layers that support substance misuse, privileged forms of beauty, dieting, and related ways of being. Therapist Lorraine Grieves (as cited in Madigan & Epston, 1998) writes,

> …the element of the sociocultural manufacturing and perpetuation of anorexia/bulimia is a piece that is often ignored in therapy and research on anorexia/bulimia. Taking the focus off the person/self as the problem and returning the gaze back to the place where the problem originates has been

> incredibly empowering and relieving for me. Once blame is relieved, there is so much energy available to use in the construction of a new storyline for one's life (p. 270).

After mapping out the ideas women hold, we are in a better position to ask about where they think these ideas have come from, and we can ask questions regarding who benefits from these ideas and what the costs of subscribing to them may be.

Below the young women describe their ideas and the unspoken rules regarding the ways that the media, relationships with families, friends and other young women served as important (and often inadvertent) 'training grounds' for disordered eating practices and substance misuse.

Media

One of the first things that the young women mentioned when I asked the question "What are some of the pressures that young women face today about how they should be and how they should look?" was the media. Young women described being bombarded by pictures of thin, beautiful, perfect women. They described the lack of diversity in these images, the push towards sameness, and how the pictures do not accurately reflect women's bodies. Women's bodies and their body parts have been commodified to sell goods and services (Jhally, 1990; Hesse-Bibber, 2007). This has led to a 'standardized' look for women, in which thinness is revered (Wolf, 1997). I am not suggesting a causal effect between media and disordered eating practices and substance misuse. Instead I am suggesting that the media, combined with gender training that values female beauty over their skills/competencies, passivity, and

selflessness, can set the stage for body dissatisfaction, disordered eating practices, and substance misuse (Wolf; Bordo, 2003).

Jill:

C: What are some of the pressures that young women face about how they should be? And how they should look?

A: Well the media is really bad for training women and how they think they should be. Blond, skinny, you know, big boobs, tight ass, a small waist. They should be Barbie-ish. And like, they don't have very important roles.

Jill later adds,

A: Well, for drinking, you look at all the beer ads and everything, there are these girls being hammered, like drunk and it's like they're really pretty and they seem very happy like and all the guys are around them. Like in advertisements, girls are drinking Captain Morgan and guys are surrounding her and she gives this image that if you drink this you will be wanted. You know. You'll have a sort of coolness that you don't have without it.

Jill clearly articulates the power of the media. Orbach (1978) writes:

… she attempts to make herself in the image of womanhood presented by billboards, newspapers, magazines and television. The media present woman in either a sexual context or within family, reflecting a woman's two prescribed roles, first as a sex object and then as a mother (p. 7).

Michelle:

C: Can you think of some ways that young women are trained into thinking that they need to look or act or be a certain way?

A: Well a lot by the media. When you look at girls on TV and you don't see anything wrong with them, their makeup is done perfectly, their clothes are nice. They're the perfect size. They have nice boobs, nice butt, it's like what all girls are made to believe they should have.

Jessica expresses similar perceptions.

A: I don't know. Probably just like the media, obviously. Like, if you flip through a magazine and you see like ads, you see like there are no overweight girls in ads, like none are like normal size girls. They all have like perfect stomachs and like perfect legs and they're basically all perfect, you know.

C: Okay. Were there other forms of training that you can think of having gotten when you were younger?

A: It's really funny because YM magazine. You've heard of it, right? They used to have things on like exercises and like I remember this one that said your thighs shouldn't touch. I remember there was this one article saying your thighs shouldn't touch when you put your ankles together. And if you order like fries at a restaurant, if you have a guy with you, you should like let him eat half of it. Instead of buying a whole bunch of candy if you feel like buying candy you should get a tootsie pop and chew the gum after.

Studies have shown that women who read fashion magazines and appearance focused media tend to be less satisfied with their bodies than women who do not read fashion magazines (Morry & Staska, 2001; Anschutz, Van Strien & Engels, 2008; Dunkley, Wertheim, & Paxton, 2001). Michelle's comments below clearly illustrate the power of this notion.

C: Did you ever experience pressure to look a certain way or fit in?

A: Yeah.

C: Was that like an external pressure? Like a pressure that people were talking about or was it a pressure that you just felt like it was there?

A: It was both. Like I was always watching TV, like always at a young age and I was always watching like MTV and Much Music and I was watching like watching reality shows where girls always wanted to be skinnier and all that so I always thought that I had to be skinnier. So it was like coming from outside of myself and then on the inside of me I was terrified. Like I had this fear of weighing over a hundred pounds and like I still have that fear to a point. So it's just like you get it inside your head. Once you hear it on the outside you get it on the inside of your head.

C: So it's a bit of an outside inside transfer?

A: Yeah.

These questions invited the young women to consider the type of support that the problems of disordered eating practices and substance use receive in the larger society. My questions invited the young women to look at the ways that they were and are 'recruited' into particular ways of being and the forces that dictate how they should be. Knowing these forces better enables therapists to help young women deconstruct the ways that they are 'trained' and encouraged to be young women. We can also explore the impact the media may have had on their ideas about how they should look, be, or act. I am not drawing the simple conclusion that the media causes disordered eating practices (or substance misuse for that mater). If this were true, then all women exposed

to the media would have an eating disorder. I am suggesting however, that the media, along with societal pressures toward thinness as ideal for women, views 'fatness' as being equated with poor health and laziness (Wolf, 1997 p. 187), and where women are raised to be more passive and men are encouraged to be powerful (Jhully, 2007; Gilligan, 1982), and women are more likely to be victims of sexualized and physical violence than men (Statistics Canada, 2008) that these factors contributes to a culture where disordered eating practices among women are perpetuated and encouraged.

To further illustrate the magnitude of the influence that the media has in regards to gender training, Susan Bordo (2003) writes:

> … now in 2003, virtually every celebrity image you see—in the magazines, in the videos, and sometimes even in the movies—has been digitally modified. Virtually every image. Let that sink in. Don't just let your mind passively receive it. Confront its implications. This is not just a mater of deception-boring old stuff, which ads have traded in from their beginnings. This is perceptual pedagogy, How to Interpret Your Body 101. These images are teaching us how to see. Filtered, smoothed, polished, softened sharpened, re-arranged…Training our perception in what's a defect and what is normal (p. xviii).

This quote illustrates the power of the media, and how there are many ways that we are taught (pedagogy) how we should look and trained into what is the right way to be. In therapeutic conversations we can take apart the aforementioned cultural trainings in the hopes of supporting young women in finding some freedom from these ideas.

Family pressures

Many of the young women described the subtle and not so subtle pressures that

they received from their families, regarding how they 'should' look, even at very early ages. Girls as young as five report dissatisfaction with their bodies (Dohnt & Tiggemann, 2006). This section is not meant to contribute to ideas of mother blame, whereby parents especially mothers are held responsible for their children's actions. Family therapist Lynn Hoffman (2002) describes how within the field of family therapy mothers have been described as "… 'overinvolved' if they were seen to be too concerned about their children, 'disengaged' if they left them too much alone" (p. 119).

Parents, guardians, mothers, and fathers are part of and therefore influenced by western ideals of beauty. In the interviews some young women spoke about how they struggled with weight in part because they witnessed their mother's struggles with weight and of wanting to be the same size or smaller as their moms. They also described the impact that their father's comments and actions have had on their relationship with their body. These comments may not have been intended as malicious, but may have been made to help young girls to fit in, knowing that being a woman of size will be painful and hard. This can be viewed as a response to oppression in a fat-phobic society.

Savannah:

C: Can you think of some of the ways that young women are trained into thinking that they need to look or act or be a certain way?

A: Well my dad was always very image-focused, and focused on calories and his body image. He always wanted me to jog with him. And I remember him making comments about only liking thin women.

Later in the interview Savannah described how she used to take ballet lessons, and

later began to model. When she was 13, she started using cocaine as a way to lose weight, which she 'learned' from other people at the modelling agency.

Megan:

C: So I am wondering, is there a way that people in our lives might support the problem of drugs or alcohol or disordered eating practices showing up in our lives?

A: Like support using?

C: Yeah and thinness.

A: Yeah, I found there was lots of pressure from my dad and stuff when I was younger, and also from my parents. Like when I was in figure skating and dance, to not looking totally different from all the other people in your class, and in competitions. There was a pressure to look, well, really skinny in your outfit.

C: So that pressure came from dance and skating, as well as from your parents to sort of look a certain way?

A: Yeah, like without them knowing it, like from them pointing out little things.

C: And was there a different kind of pressure from your dad and your mom?

A: Well my mom was more like healthy, like let's go exercise together and my dad was more like, "don't eat all the cookies" kinda thing. So it got me thinking like if I want to have good relationship with my dad I can't be overweight. I can't have the chubby thing going on.

Michelle describes a similar perspective.

C: Were there things going on in your life that made the problems look like a good option?

A: Yeah. Like, when me and my mom or my step-dad would fight, or like when my step-dad and my mom would fight or when I would hear my mom talking about my dad, I thought drugs would make it better.

C: And how about disordered eating practices, did they ever get you thinking that they could make things better?

A: Well I thought that if I was skinnier it would make my parents happier.

C: Really?

A: Yeah. I don't know why. And I know I was a really small kid but I always thought the skinnier I was the happier other people were.

C: The happier other people around you would be?

A: Yeah. So I tried to be as skinny as I could but I didn't realize that they were getting more worried about me.

Some of the young women spoke about the impact that their mother's struggles with weight and body size had on them growing up, which normalized disordered eating practices and showed the lengths that it is worth going to in order to be thin. Beth and Amanda described the impact of watching their mother's struggles with eating.

Beth:

A: Honestly a big thing had to do with the way I felt and how tiny my mom is. Because I want to be able to fit into like little tiny clothes like her and stuff, right?

Savannah:

A: Well, my mom struggled with disordered eating, and we would try to lose weight together.

Some young women describe their sense of worth becoming tied up in their appearance or body size, rather than what they can offer to people or the skills and strengths that they possess. Brown and Jasper (1993), describe how, in a culture:

> …where body size and shape are crucial to their social value, women learn to focus on appearance. As a result, policing and controlling appearance becomes an imperative for achieving both inner satisfaction and social success. Women internalize the fashionable body image, recognizing that how they appear affects how they are valued and treated. How women feel when they compare themselves with other women, including women depicted in the media, in advertising, and in the fashion industry, shapes their experience of their own bodies and selves (p. 19).

Rachel:

C: Do you think that our family and friends can impact our ideas about how our bodies should look?

A: Yeah. Family and people that joke around, like don't have seconds or you'll get fat, ha-ha. But it's not funny because like it sticks with you. Like being a girl those kinds of things automatically stick because there is such a pressure to look a certain way that the little things that seem harmless aren't.

Jessica:

C: Can you think of some ways that young women are trained into thinking that they need to look, act or be a certain way?

A: Well my grandmother always said that I shouldn't eat dessert and that I should cut my food up into little small pieces and eat it really slowly and take lots of sips of water between it so I get full faster, because women aren't supposed to eat a lot.

Friends and school

The young women I interviewed also described how ideas of thinness were perpetuated and encouraged by friends and other youth.

Megan:

C: So I'm wondering if there are some pressures that you think that young women face about how they should be or how they should look?

A: Yes definitely.

C: What would those pressures be or how would you describe them?

A: Like the misconception that really skinny, really pretty perfect girls are fun and that they are good friends, and you know people who are social, and that to be in that centre social scene that you have to fit somewhat of that mold.

Beth:

C: So you said that you think that the media affects our experience of how we should be. Do you think that the magazines, our families and our schools affect our sense of how we should be?

A: I think so. I think school is a huge one because everybody is like—they're combing their hair, they're going to get their nails done. They're wearing certain brands of clothing. It's not just the weight, but it's everything. Like everybody is categorized by how you look, how you act, what you eat, what you don't eat.

Below Jessica, Michelle and Alexa describe the power of 'the male gaze' (Berger, 1972; Mulvey, 1975). The 'male gaze' refers to the idea that females are typically the objects or receivers of the male gaze and that males do the gazing. Mulvey writes:

> In a world ordered by sexual imbalance, pleasure in looking has been split between active/male and passive/female. The determining male gaze projects its phantasy on to the female figure, which is styled accordingly. In their traditional exhibitionist role women are simultaneously looked at and displayed, with their appearance coded for strong visual and erotic impact so that they can be said to connote to-be-looked-at-ness (p. 10).

This contributes to a sense of women being objects for male attention in art and the media, and is later acted out with men and women feeling free to comment on other women's bodies.

Jessica describes:

> C: Did you ever experience pressure to look a certain way to fit in?
>
> A: When I was in elementary school, yeah. Like in grade six or seven I noticed a lot of the guys started making fun of me. I remember this one trip we went on, it was—this cruise thing you do on a sailboat, like an overnight thing and I remember I bought a bikini and I wore it and I guess I got into a little bit trouble. I'm in grade 7 right, obviously, like people still haven't really lost their baby fat by then sometimes and I remember like most of the bigger girls in my class didn't wear bikinis or bathing suits because they don't look good in them at all, so they avoided it. And the other girls who, like, had more toned stomachs they

did more sports, like there was this girl, Robin, she like went to the gym like three times a week with her dad. Well the guys made fun of me because I was the biggest girl there and had like a bit of a tummy and one of them said I had cellulite on my tummy, which I don't think I had.

Michelle:

A: Another thing is like when you're walking in the mall, you know a group of guys and they are like, "Oh, look at that fat chick," and right away you're like okay I don't want to be the girl who he is talking about like that.

Alexa:

A: For myself, my self-esteem went down. I started hanging out with the wrong people and I started hanging out with guys that any time any slightly overweight girl would walk by, they'd be like what a fat bitch, you know like look at her. Those thunder thighs. I'm already in a bad place because my brain is all fucked up from all the drugs so it's like oh, maybe they're right. So like then disordered eating practices comes in and you're like oh well maybe they would like it if I was skinny. I was just trying to please other people.

The above quotes illustrate the ways that young women are indoctrinated into policing their bodies and how this is supported by the 'male gaze' (Mulvey 1975; Berger, 1972). These insidious comments contribute to people's understandings of how they should be and their sense of what qualities are valued in young women. When surrounded by these discourses, young women learn that gaining weight is not desirable, and fat begins to be feared, while thinness is revered. The above discourses all suggest that the correct way to be female is to be thin, not to have a healthy appetite, and

conform to the beauty standards portrayed in the media.

Unspoken rules

The young women I interviewed also spoke about the 'unspoken rules' that they see as existing for young women.

Rachel:

C: What are some of the pressures that young women face in today's society about how they should be?

A: How they should be? Personality or look-wise?

C: Both, looks and personality if those are the areas you think women face pressures to be a certain way.

A: Okay. Looks wise, nice hair, nice nails, nice clothes, like good teeth, good breasts, you gotta like, you know, do your makeup perfectly, you know, you can't walk funny. You have to have like the ideal body and like personality, you have to be funny. You have to be nice and you have to be confident somehow and all these other things at the same time. And like, yeah, I think it's really, like, unreal. I don't think I've ever met a person that perfect. And is that even perfect to me? No. That's society's view of being perfect.

Rachel's comment about you have to be confident 'somehow' and 'all these other things at the same time' suggests that it is a staggering feat or perhaps even impossible for someone to 'be' all these things. Her last statement positions her as questioning the notion of perfection, indicating that her own views on perfection and society's views differ. Brown and Jasper (1993) make a similar observation when describing the many qualities that are required of women today; "this perfect all-round

woman is expected to perform the contradictory roles of the nurturing and caring mother; the soft, sexy and giving wife; the sexually independent, competitive, and ambitious, career woman" (p. 28).

Drugs as a right of passage

Some young women described alcohol and drugs as a rite of passage; a way of showing that you are an adult. Teenagers often binge drink, which is problematic and a health risk. Drinking and drugging often places people in situations where they are unsupervised, for example a friend's home when the parents are out, or school fields at night. In these places young women may be encouraged to try other substances, and they might not have the full information that is needed to make an informed decision. Being intoxicated creates space for things such as coercive sex to occur which can then be a reason to use more drugs or alcohol (or make space for disordered eating practices to appear) as a way to get rid of the memories and/or feelings.

Emma:

C: Do you think that drugs, alcohol, or disordered eating practices ever tried to convince you that they could help you become the sort of young women that society thinks you should be?

A: Definitely.

C: How did they do that?

A: The more cocaine that I did, the wealthier I appeared. It also suppressed my appetite, and basically, I grew up in a part of town where you can never be too rich or too thin.

Emma astutely observes how her economic privileges in fact oppressed her (V. Reynolds, personal communication, May 19, 2009). Hannah describes having known since she was little that she would try drugs. She says,

A: I don't know. My mom used to always drive me down to the area of town where the homeless people lived and say if you ever do drugs that's what you'll turn into, and she like wanted me to be afraid of them but I wasn't. I wanted to be like them.

C: What was it about them that you wanted to be like?

A: I don't know. They just looked so happy and like free and could do whatever they wanted and ever since I was little I said, "I'm going to do drugs." I didn't think it would turn bad and I just met the wrong people and it kind of happened before I even knew it.

Ava:

C: Did drugs and alcohol or disordered eating practices ever try to convince you that they could help you become the kind of young women that society says you should be?

A: Well, I think with drugs you start so young, you're so naive about it and you don't really know what it does. And so before you know it you're hooked right and no matter what reason you started you're hooked and there is no turning back. And so, when I started it was more of a matter of like thinking that was the cool thing. Drugs are what everybody is doing. That's what's normal. All teenagers do it. You have to do it, too. You know, get the best of your teenage years while you can. And just drinking and smoking or drugs were just like a

part of that. That's what we do, right. I thought everyone else was a homebody, how boring you know.

C: So doing drugs was in a sense "the cool" thing to do?

A: Yeah that's normalized, yeah. And because at parties all the girls look the same and dress the same and that's just the way it is, which I now know isn't. I think it's cooler not to be like that and I realize now all those people that weren't doing that knew the whole time we think we're the cool ones. And the popular crowds in school they kind of claim that, because they go to all the parties and have all the nicer clothes and do drugs and stay skinny. But it's not, it's made up.

In the above example, Ava can clearly identify some of the pressures that led her to drugs and alcohol and while doing so she also takes a position against them. She considers where these ideas come from, and the impact that they have on her and on her life, and she is redefining her own ideas of what is cool. When speaking with clients we need to be 'double listening' (White, 1986). That is, listening to what they are saying while paying close attention to ideas that suggest change and for instances when young women take positions against drugs and alcohol and disordered eating practices. We can take note of and highlight these moments, later inviting clients to speak more about this, and about what supported them in arriving at these new conclusions/ideas. Michael White and David Epston (1990) refer to this as "resurrecting the subjugated knowledges" (p. 31) which then,

> … assists persons in challenging the 'truths' that specify their lives- to protest their subjugation to unitary knowledges. Also, in helping the person separate

from these unitary knowledges, externalization opens space for the identification of and circulation of alternative or subjugated knowledges (p. 32).

Dirty little secret

Interestingly, the idea of eating disorders as a 'dirty little secret' showed up in a few of my conversations. This appeared to be supported by the assumption that everybody diets—people just don't always talk about it, and that disordered eating practices 'seemed' to be the lesser of the two evils.

Beth:

A: People think that if you use substances you can die, but if you get sick [purge] you don't.

C: Hmmm.

A: I think a lot of people think that, like I did as well, that's why I did it so often [purging] because I knew that drugs were gonna kill me faster. That kind of thing.

C: Okay like bulimia was the lesser of the two evils?

A: Yeah.

Megan:

A: I never thought of like an eating disorder as a problem even though we worked on them in school. I never thought of them as problems. I always thought addictions were bad. I never thought of eating disorders as an addiction.

C: Okay. So addiction bad. Eating disorder not so bad?

A: Yeah, that's a little dirty secret. But addictions, oh my gosh.

Therapeutic Questions Regarding Sanctioning and Training

The following therapeutic questions can be asked in order to track the ways media/parents/caregivers/friends/coaches/teachers may have inadvertently and against their best intentions supported substance misuse and disordered eating practices in young women's lives. These questions can shed a new light on the problems, and help young women evaluate these problems in new ways.

- Can you think of some of the ways that young women are trained into thinking that they need to look or act or be a certain way?
- What are the pressures that young women face regarding how they should be and how they should look? How would you describe these pressures?
- Do you think that the media, or our families and friends impacts how we feel we should look as young women?
- Are there ways that substance misuse and disordered eating practices may have been either inadvertently or otherwise supported by people in your life?
- How did they do this?
- Was this support 'invisible'? If it had been easier to see it occurring—might this have made a difference?
- Do you think that drugs, and alcohol, or disordered eating practices ever tried to convince you that they could help you become the sort of young women that society thinks you should be?

Once the young women have identified the pressures and rules that govern 'how they should be,' we can inquire about the ways that disordered eating practices and substance misuse may have taken advantage of or convinced them that they can help them become the sort of young women that society says they should be. For example, if young women 'believe' that they should be fun, outgoing, social, and thin, are there ways in which disordered eating practices and substance use might support them in attaining this way of being?

Section 2. Folk Psychology

Jerome Bruner (1990) describes the way in which folk psychology can influence the ideas we hold about ourselves and others. Bruner writes:

> All cultures have as one of their most powerful constitutive instruments a folk psychology, a set of more or less connected, more or less normative descriptions about how human beings 'tick,' what our own and other minds are like, what one can expect situated action to be like, what are possible modes of life, how one commits oneself to them and so on. We learn our culture's folk psychology early, learn it as we learn to use the very language we acquire and to conduct the interpersonal transactions required in communal life (p. 35).

In this section, I will examine the power of folk psychology (Bruner, 1990) and the ways in which it can influence the young women's meaning making regarding their experiences and their relationship with disordered eating practices and substance misuse. Given that the language of medicine and science has become increasingly common in the ways in which we describe ourselves and the people around us, I was

interested in the way that these ideas, when languaged, can in a sense become predictive and therefore constitutive of peoples' experiences (Andersen, 1998).

The discourses and categories that are used to describe people struggling with alcohol and drugs and disordered eating practices are more often than not pejorative, with labels like 'addict,' 'alcoholic,' 'bulimic,' 'anorexic,' 'bum,' 'self-centered,' and 'junkie,' being the norm. Along with these labels comes a common understanding about what these descriptions mean. If in conversation someone comments, 'look at that junkie,' or 'she looks anorexic,' people often nod their heads, or gesture a look of agreement/understanding. No explanation is needed for what these terms mean. In this section you will see the ease in which the young women whom I interviewed used the above terms or other common deficit based understandings to describe themselves. The language of popular psychological and medical terminology has become increasingly common in the ways that we explain and understand our behaviours. Gergen (1991) describes the process whereby this occurs:

> As psychiatrists and psychologists try to explain undesirable behaviour, they generate a technical vocabulary of deficit. This language is slowly disseminated to the public at large, so that they too can become conscious of mental-health issues. As people acquire the vocabulary, they also come to see self and others in these terms. They judge themselves and others as superior or inferior, as worthy, or not of admirations or commitment (p. 14-15).

In the interviews this language of deficit was often used by the young women as an explanation for their experience of disordered eating practices and substance misuse.

Some commonly accepted ideas regarding substance misuse and disordered eating practices described by the young women:

- Addictions are diseases (Peele, 1995)
- Once you are an addict, you are an addict for life. The same goes for an eating disorder; once you have an eating disorder you will most likely always have an eating disorder. These ideas use the static nature of personality to solidify their claims (Bird, 2000)
- Hitting rock bottom is a pre-requisite for change
- Some people have addictive personalities; you are born with it
- There is an inherited gene for alcoholism (distinct from the idea of a genetic predisposition to alcoholism)
- The only cure for alcoholism and drug addiction is abstinence
- Medical treatment is a requirement to combat substance misuse and eating disorders
- Both substance misuse and eating disorders are progressive diseases that if left untreated can result in death
- Addiction is a choice

The above beliefs are very commonly held by treatment providers (physicians, counsellors, psychologists, correction officers), and constitute the dominant discourses surrounding eating disorders and substance misuse. These ideas have slowly become truths and are now used to explain people with eating disorders and substance misuse as well as treatment options. Stanton Peele (1995) raised questions as to why it is that bad

habits get pathologized, whose interests this serves, and who gets to decide when a bad habit turns into an addiction.

Individualized responsibility

In the following section the young women allude to how it is their fault for having developed these problems. This understanding builds on the commonly accepted idea that if people have lapsed into alcohol and drugs or eating disorders then they have no one else but themselves to blame. The individualistic perspective of the west holds that we are personally responsible for our successes and our failures. These young women put the onus of the development of the problem on themselves.

Beth:

C: So why do you think that some people struggle with both problems and some do not?

A: I think it depends on your personality. Like some people they just think it is absolutely disgusting when they get sick [purge], but they don't think it's bad to take a pill to lose weight. I don't know. I think it's all about who you are. And I think it also has something to do with like your addictive personality and stuff, right?

Beth diagnoses herself and others who also have both problems as having an 'addictive personality.' I am disconcerted by her participation in a language of pathology. Many women like her are well versed in the language of psychologists and psychiatrists and able to diagnosis each other on the basis of stereotypes. These diagnoses and labels do not come without costs. As McNamee (2002) writes:

Most important in terms of the ways diagnosis stigmatizes people is the

> observation that, in so doing, diagnosis is rendered a valuational process. It is not, as scientific discourse would claim, value neutral. Diagnosis does not simply describe what is *there*. Rather, diagnosis functions as a moral judgment. It conveys the deficit of one to others (p. 151).

As McNamee (2002) and others have described, diagnoses and labels are not always disempowering, they give people a sense of understanding about the difficulty they may be struggling with, giving them a name for something they thought was nameless, and can connect them to others experiencing similar problems (O'Hanlon, 1993). Yet diagnoses and labels also wipe out the complexity, diversity, and richness that we are comprised of, reducing people simply to 'a bulimic' or 'an addict.' Self-diagnoses like 'addictive personalities' speak to the insidious nature these ideas can have on us. If substance misuse or disordered eating practices are indeed a result of an addictive personality, then there is not a lot you can do about it, which in turn does not leave much space for exploring the context in which the problem may have developed and potentially supported in a young person's life. Sampson (1993) writes:

> Our view of addiction and co-dependence conveys our cultural folk psychology of human development. An addiction has become any pattern of behavior in which a person might engage that is done beyond a certain level of self-control, including nearly everything that people do: sexual addiction, eating addiction, sleeping addiction, waking addiction, walking addiction, jogging addiction, people addiction, and so on endlessly (p. 39).

This idea while perhaps abolishing people of all responsibility in a moral sense (they can't help it) – can leave people positioned as having no autonomy or say over

their life- things are being done to them.

In the quote below, Emma describes how 'low self esteem' can cause eating disorders and substance misuse. She says that, 'she wants to say the media' but instead, she places more of the responsibility onto herself, however she does include her early childhood. She negates any possibility that the media might have contributed to her ideas about herself, and the ideals of thinness and beauty that it perpetuates. This idea also makes the individual responsible for the problems, as if they are the sole cause of their own mental deficit. The person rather than "patterns of behaviour" or "interactional patterns" become responsible for the development of the problem (Dickerson & Zimmerman, 1995, p. 35; Tomm, 1991). These discourses place the responsibility for the development of the problem on and inside the individual, absolving all other potential contributors.

Emma:

C: So can you think of some of the ways that young women are trained into thinking that they need to look or act or be a certain way?

A: I really want to say the media, but I actually think that it stems from low self-esteem and how your environment affected you in early childhood. And I really want to say the media because it builds people up so much to think they should look like that. But at the end of the day, we're the ones buying the magazines and fuelling it so that's really a big copout.

C: So don't put the blame on,

A: On something that I kind of fuel.

C: What is it about the media that has you thinking that it has been a big influence?

A: I sought it out as an influence myself because I felt so terrible about myself and my body and all of my appearance for so long, and that just gave me something, like photos of models or Vogue magazines, it gave me validation in what I already believed.

Emma's response negates the support that the media contributes towards ideas of thinness and beauty and that while she indeed is responsible for buying magazines and 'seeking them out,' the other contextual layers that contribute to ideas of beauty and thinness are missed in her explanation.

Jill:

C: Are there times when you might be more or less vulnerable to the teaming up?

A: I think you could be more vulnerable to having a slip up, if you are not emotionally or mentally strong enough.

The above comment, 'if you are not emotionally or mentally strong enough,' is interesting. It implies that a person might resort to substance misuse or disordered eating practices because of a lapse in strength, or a mental weakness occurs. This judgment suggests that if a person had strong moral character, willpower, or a strong faith in a higher power, then they would have the strength needed to withstand the temptation of alcohol, drugs, and/or disordered eating practices.

Deficit identities

Somehow, young women begin to define themselves as addicts or anorexics rather than as daughters, best friends, or athletes. These deficit descriptions become totalizing of people's identities. In this way, problems take over people's identities and highjack their sense of who they are and what they can become. Stanton Peele (1995) writes, "this discrepancy between understanding addiction within the larger context of a person's life and regarding it as an *explanation* of that life underlies my opposition to the 'disease theory' of addiction" (p. 3). The prevalence of these deficit identity terms used by the young women to define themselves can be seen in the examples that follow.

Hannah:

C: Were there times when alcohol and drugs or disordered eating practices defined your identity, like they defined who you were?

A: Yeah. Like I was still using or I wouldn't be but I still had the behaviours. Like I'm still a drug addict.

Megan:

A: kept that addict part of me—the lying, the manipulating.

A potential problem with the idea of becoming 'an addict' is the commonly held belief 'that once you are an addict, you are *alway*s an addict.' Hannah says above, "Like I was still using or *I wouldn't be* but I *still had the behaviours*." Even if she wasn't using she still acted "like an addict." It is like the lyrics in an Ani DiFranco (1999) song, "they say that alcoholics are always alcoholics even when they're as dry as my lips for years even when they're stranded on a small desert island with no place in two thousand miles to buy beer." The idea of alcoholism as having staying power can be

traced back to the mid 1900s when alcoholism was first conceptualized as an illness or a disease (as discussed in detail in chapter 3). The idea of addiction as a progressive illness that results in death if left untreated is a central concept of the disease model of addiction (Marlett & Gorden, 1985). For some, it is an idea that saves lives. Yet perhaps for others it sets limits around what they can do, what is possible, and how others see them under this label.

Stanton Peele (1995) states, "What people believe about their drinking *actually affects how they react to alcohol"* (p. 170). So consider then the impact of teaching young people 'that once they are an alcoholic, they are always an alcoholic.' How might this notion influence their sense of self and of what is possible in their lives. How might this impact their relationship with alcohol and drugs? The same can be said of disordered eating practices. If a youth believes that once you have an eating disorder, you will always have an eating disorder, how does this affect her relationship with food and her body? Especially as abstinence from food and eating is impossible.

In the interviews, I explored the impact that these deficit based and totalizing descriptions of self–the impact of seeing yourself as an addict or anorexic—had on the young women's sense of who they are. Below Hannah clearly articulates how this 'thin description' (Geertz, 1973) of her life caused her to be miserable. This is the paradox of substance misuse and disordered eating practices. These problems create and cause misery in peoples lives, yet they also offer promises of escape and freedom from the misery, which they are responsible for in the first place. People are then further ensnared in the web of disordered eating practices and substance misuse by promises of pain relief just beyond their reach.

Hannah:

C: So was that a useful way to think about yourself, as some one who has no care for their family, no self respect, etc… ?

A: No.

C: No. How come?

A: That I was a drug addict?

C: Yeah, why wasn't that how you wanted to see yourself?

A: I shut down and it made me more miserable than ever.

Diagnostic lexicons and treatment practices

Given the above, it is not surprising that the diagnostic lexicon also flows into ideas about treatment for substance misuse and disordered eating practices. Some of the following ideas are common:

- You have to hit rock bottom before you can get better
- You have to want help to get better
- Once you are an alcoholic or anorexic then you will always be an alcoholic or an anorexic
- Abstinence is the only cure for addiction

Below Emma describes her understanding of the idea of hitting rock bottom.

C: For other young people struggling with eating disorders and drugs and alcohol, what would you want them to know? What support, advice or insider knowledge might you offer them?

A: It only gets better from rock bottom, and I would actually encourage people to try to hit rock bottom.

C: Okay, how come?

A: Because that's when you know you're going to die and that's when it becomes real. It's not a game any more.

The idea of hitting rock bottom can work in favour of the problem. The problem can easily find others who are 'worse off' than the person considering stopping and can convince someone that, 'you're not that bad, you have not hit rock bottom yet.' I believe that this idea then could lead someone to die since rock bottom could, in theory, be the grave.

Jessica:

C: Are there times in your life that you might be more vulnerable or less vulnerable to the teaming up between drugs and alcohol and disordered eating practices?

A: Yeah, definitely. Like, I'll have a whole bunch of problems that I don't know how to deal with and there is nobody around to talk about with them. Obviously that's going to be like—going to be something that's gonna go through my head. It's an option that I'm not going to consider but it's always going to be there.

Jessica alludes to the idea that once an alcoholic always an alcoholic, which may inadvertently support disordered eating practices and substance misuse in incising their way deeper into her life. When young women believe that disordered eating practice or substance misuse is a part of them, this can impact how they see and present themselves. As Sampson (1993) has discussed in order to enquire about problems differently we

need to see begin to see people as being more than what exists within the confines of their skin.

Therapeutic Questions to Deconstruct the Power of the Language of Deficit and Folk Psychology

- Why do you think that some people struggle with the problems of disordered eating practices and substance misuse and some do not?
- Where do you think that these ideas [for example, hitting rock bottom, addict, that once you are an alcoholic you are always an alcoholic] come from?
- What impact does seeing yourself as an addict/bulimic have on your sense of self?
- Who might benefit from the holding of these ideas?
- Is this a way that you would prefer to see yourself? Why or why not?
- Does the idea of viewing yourself as an addict, limit or enhance your sense of yourself in anyway?
- How might substance misuse or disordered eating practices benefit from the idea of needing to hit rock bottom in order for change to occur?
- If substance misuse and disordered eating practices are considered 'lifelong problems' what might this mean for your life? Do you think that some people might be able to kick these problems out of their lives for good? How might they do this?

Section 3. Conditions and Requirements of the Problem

Substance misuse and disordered eating practices are very clever entities that will use whatever means and devices they have at their disposal to make themselves a

constant force in someone's life. The word requirement is defined as "1. something needed. 2. Something compulsory" (Soanes, 2001, p. 767). And I wondered could substance misuse and disordered eating practices create the conditions that would allow them to invade someone's life? How might poverty, violence, sexualized violence, abuse, racism, homophobia, pave the way for these practices in a young woman's life? If disordered eating practices and substance misuse are parasitic problems, what feeds them? How can these problems be so alluring that they tear people away from their values and preferences regarding how they wish to be in the world? This section will examine what the young women described as the conditions in which substance misuse and disordered eating practices flourish.

This section is based on my assumption that there are structures that support the construction of problems in people's lives. These structures include our western societal drive towards individualism, which can create isolation and a sense of disconnection from oneself and ones community (Cushman, 1995). This drive towards individualism has increased since the postwar era and is responsible for the creation of the "empty self" (p. 79) which Cushman defines as "…a self that experiences these social absences and their consequences 'interiorly' as a lack of personal conviction and worth; a self that embodies the absences, loneliness, and disappointments of life as a chronic, undifferentiated emotional hunger" (Cushman, p. 79). I believe that eating disordered practices and substance misuse can take advantage of this 'empty self' and promise to fill the void.

This "empty self" (Cushman, 1995, p. 79) thrives under cultural notions of what is an acceptable body size, the demonization of fatness, comparison and competition

with other women, the normalizing gaze, and body surveillance (Orbach, 1978). The human body has become something to be acted upon and altered, like a piece of machinery (Foucault, 1978), in an endless quest for the perfect body. Both problems leverage themselves against the societal discourses of thinness, the idea of women being a person for others, self-sacrifice and substance use being seen as an escape, and a 'right of passage' for young persons.

The search for relief

What becomes quite evident is how disordered eating practices and substance misuse use the young women's experience of pain to their advantage. What gives these problems their strength is the young women's relationship with uncertainty, ideas of comparison/not measuring up, pain, or a sense of a lack of control. The young women clearly are not resigned to a life of feeling badly and go in search of ways to feel better.

Hannah:

C: Were there things that were going on in your life at that time that disordered eating practices took advantage of?

A: Just like fighting with my parents and stuff, like I couldn't control my life but I could control how I felt and how I looked.

Alexa:

C: Did alcohol and drugs or disordered eating practices ever promise that it was going to help you out in any way?

A: Yeah, I would say like it helped me in—like feeling better. It helped me out in the sense that like if I got in a fight with my mom and it's like after dinner or

something like I can just go to the bathroom and stick my finger down my throat. Like ha ha, fuck you. You still can't stop me from doing certain things.

C: Hmmm.

A: It helped me in other ways too, like when my Grandpa died I was free from drugs. How do I cope with it, don't eat. It's like 'don't eat and you'll feel fine.'

C: How does not eating equal coping and feeling fine? How did that become a way to cope?

A: It's showing that you have control over something.

C: And how did that make it better or easier to get through that period of time?

A: You can't control other things like I can't control my Grandpa dying. I can't control my mom yelling at me so it's like here is something I can control.

Alexa goes on to explain that this was not the kind of control over herself and her body that she preferred and that in fact she now believes that disordered eating practices and substance misuse controlled her.

Emma:

A: Like when emotionally I felt like I couldn't control what was going on, when everything seemed to keep building up, and I had the sense of mental loss of control. I would revert to anorexia. And when I was severely depressed, that's when I would go to the drugs. They killed that pain.

Beth:

C: Were there any problems that were going on in your life that alcohol and drugs actually tried to convince you that they could help you with? I don't know

if there were things going on in your life, that drugs showed with promises to help or make you feel better?

A: Oh, yeah. If I was pissed off, or if I wanted to make somebody pissed off. I knew if I did drugs it pissed them off and I would feel better at that moment.

The above excerpts illustrate the young women's agency, their attempts to gain a sense of agency or control through substance misuse or disordered eating practices. 'They hurt me, so I'll hurt them by doing this.' If our options or choices are limited, we use what we have at our disposal, which may not be the choice we prefer to take but it just might be the most easily accessible or most familiar. I would take this a step further and imagine that drugs are instrumental in this argument. Many young women have described having 'picked fights' with people that they love in order to have a reason to use. Drugs are in the background orchestrating things to their advantage, and not caring who they hurt in the process.

One of the first requirements of substance misuse and disordered eating practices is that the young women need to begin to believe 'the lies' that they are being told, or perhaps have a sense that what disordered eating practices and substance misuse is offering might be better than the situation they are currently faced with. Another requirement is not caring, when this occurs, these problems have much more power in a young women's life.

Megan:

C: Did you think about the negative?

A: No. I didn't care.

In a sense alcohol and drugs and disordered eating practices can also serve as a means to rebel and resist conventional norms.

Secrecy

Disordered eating practices and substance misuse flourish in secrecy. The more they can keep people alone and isolated, the more the young woman can be consumed with the thoughts that will benefit substance misuse or disordered eating practices. For example, if disordered eating practices can isolate a young woman in her bedroom in front of a mirror, they can keep her preoccupied with picking apart specific parts of her body convincing her that her face is too round and the skin on the back of her thighs is too dimply. Eating disorders can then offer up a 'solution' to correct this calamity, for example by losing X pounds. By keeping the young woman in isolation and on an endless quest for the 'promises' the problem offers they are able to ensure that they won't have anyone interfering with their plans to take over and destroy the young women's life.

Hannah speaks to the qualities that substance misuse and disordered eating practices tried to have her forget.

Hannah:

C: What qualities did alcohol and drugs and eating disorders try to get you to forget? Like, when you became a drug addict [this is how she described herself earlier in the interview] what might you have had to question—or did you have to push aside?

A: Care for yourself and other people, like love. Love for my family. Anything good.

When the young women are separated from important relationships in their lives, disordered eating practices and substance misuse benefit.

Beth:

A: Bulimia was like ‘keep hiding me, don't tell anybody,’ right.

Michelle:

A: Well disordered eating practices still affects your relationships with people because you have to lie in order to cover it up which is the same with drugs. You have to lie in order to cover it up but there comes a time when you can't cover it up any more because it's right there.

Foucault (1978), writes, “where there is power, there is resistance” (p. 95) and this appears to be true in regards to substance misuse and disordered eating practices. It is as if the problems can anticipate that there will be resistance from the young women if they knew where these problems were leading them (Wade, 1997). Substance misuse and eating disorders thrive in isolation because they have no one to contradict them. In isolation, substance misuse and disordered eating practices can tell her how she is alone because she is bad/worthless (leaving out the fact that the young woman is alone because of what the problems demands of her and the rules she has to follow). The problems can also offer consolation in that if the young woman follows substance misuse and eating disorder rules well enough, then maybe she will be good. Through tactics of isolation, the problems steal her away from the people and things she likes and loves and that sustain her. Soon, substance misuse and eating disorders become the loudest voice in her life.

Secrecy builds distance between the young women and her friends, family members and community and creates wedges between herself and her loved ones. Below Alexa describes how both problems began to talk to her in ways that pitted her against the people that had her best interests at heart. When this occurs, it can cause the young women to become further isolated from their communities of support and care and even more alone with the problems.

Alexa:

C: Were there ever tactics that disordered eating practices and substance misuse used to make you second-guess your decisions?

A: Like you're not strong enough. The real you would be strong enough to be lying to these people. They're taking over you, they're changing you. You're letting these people that think they know it all change you. They are taking away that special power you have over yourself.

Alexa describes how substance misuse and disordered eating provide a 'rationale' for why she should not listen to the people who are offering her support. Interestingly, they try to convince her that the 'real her,' the one that they are working hard to create, would be strong enough to stand up to the people around her. Once the problems have gained some space in a person's life, the problems work like a skilled defense lawyer – refuting any evidence and arguing their position in a definitive and authoritarian manner.

Shame

The problems also use tactics of shame and embarrassment to further entrench and isolate the young women. Beth, Michelle, and Rachel speak about their experience

with shame concerning their involvement with disordered eating practices and substance misuse below.

Beth:

A: You can't talk about it with anybody else because you're so embarrassed and ashamed.

Michelle:

A: A lot of the times we're really ashamed of being addicted to drugs and having an eating disorder.

Rachel:

A: It spawns more and more of those things you want to cover up and you don't want to feel it anymore. Cause it's so shameful and you feel so guilty and then your confidence is like ruined because you're like 'Oh my God.'

Disordered eating practices and alcohol and drugs can cause shame, which serves to keep them silent about disordered eating practices and substance misuse 's presence. The presence of shame speaks to what Michael White calls the absent but implicit (White, 2000). Meaning that this sense of shame may speak to what they hold dear or cherish in their life (White). This shame and embarrassment is a double-edged sword as disordered eating practices and substance misuse can use this experience to their advantage, promising to take away the discomforting feelings. Disordered eating practices and substance misuse act as 'saviours' while trying to keep obscure how they have contributed to the development of these feeling of shame. Young women become trapped in a cycle of substance misuse and disordered eating practices and feeling shameful.

Defining identities

Disordered eating practices and substance misuse can lead people to feel disconnected from their sense of who they are and how they know themselves. When the problems take over, people can begin to see themselves as single or mono-storied (White & Epston, 1990). Other, non-problematic, storied parts of them may begin to disappear. When this occurs, people's lives lose their sense of richness and meaning, and as Geertz (1973) explains, people's descriptions of themselves become thin. Reconnecting with their preferences of how they wish to act in the world and their actions prior to substance misuse and disordered eating practices appearing in their lives can be potential antidotes to these problems (this concept will be discussed further in section 5. Movement Away and Communal Solutions). Below Alexa, Aimee, and Rachel all describe themselves as defined by the problems of substance misuse and disordered eating practices.

Alexa:

A: You loose who you are. It's like a new you, and not a positive thing.

Substance misuse and disordered eating practices can launch an identity attack on the young women, which leaves them questioning and feeling disconnected from who they know themselves to be and act in the world.

Hannah:

C: Were there certain qualities about yourself that alcohol and drugs did not want you to remember? Like that you were a dancer, or to forget the things that you were good at.

A: Yeah, like it's a little circle and nothing can get in and nothing can get out. But maybe there is a little part of you that stays with you—or else I wouldn't be clean right?

C: Yeah, that's a lovely way of putting it.

A: Yeah there is that little part that stays with you but I don't think that there is anything you used to do, it doesn't seem important. Like all the stuff you wanted to do when you were clean doesn't exist any more.

Hannah described how substance misuse and disordered eating practices came between her and her dancing. Originally, Hannah had been seduced into believing that being thin would make her a better dancer, and her chances at joining a larger dance company would increase. Yet soon the goal of being thin and obtaining drugs and alcohol took over the goal of being a successful dancer.

Hannah:

C: What happened to your dancing the thinner you got?

A: I couldn't do it.

Substance misuse and disordered eating practices made it impossible for her to dance. In this way the problems 'promises' soon prove to be false.

Below Ava describes what the problems needed to do in order to become such a huge influence in her life.

Ava:

C: So what did the problems need to take advantage of in order to become a part of your life in the way that it did?

A: My confidence. My worth.

Rachel:

A: Yeah. It's [the eating disorder] supporting your addiction and you're like altered, like your view of who you should be and stuff. It was like horrible.

Ava describes how it was that disordered eating practices and substance misuse began to define her sense of who she was.

Ava:

C: Were there times when eating disorders and drugs and alcohol defined your identity?

A: Oh yeah. Fuck yeah. Absolutely.

C: Absolutely?

A: Oh God.

C: Did they do this separately or together?

A: Together. Altogether.

C: Okay, how did they do that?

A: I was so angry and like you just want to like fight people and get fucked up and do stupid shit, and have this sort of lifestyle that right now I do not want. You'll see people going from being completely normal to totally different and I could feel when I was smoking something, not cigarettes. I would go from being like kind of normal, I could feel it go, kind of like a blindfold being put over my head and I'm different and it changed the way I looked at people, the way I thought, talked and everything. It totally changes you. That's like a given. Like people, you hear about people who will like drink and kill someone, they would never do that normally, like it totally changes you and brings out the worst in

you. Like totally absolutely. And that's not my preferred self. What I did when I was drinking or when I was under the influence, oh my God. There are so many things that I can think of that I would never do if I was my preferred self.

Disordered eating practices and substance misuse change the young women's relationship with themselves, tearing them away from the ways that they want to be known and act in the world. White & Epston (1990) write,

> And there are persons who are endeavoring to situate their lives in preferred stories and to embrace alternative knowledges, but who are finding it difficult to do so because of the dominant and disqualifying stories or knowledges that others have about them and their relationships (p. 76).

Taking this a step further it is my understanding that the problems also create their own "disqualifying stories," (White & Epston, 1990, p. 76) which are used against the young women in a way that strengthens the problems standing in a young women's life. For example, should a young woman get in an argument with someone in her life, the problem might berate her for her 'inability' to get along with people. This might lead to the young woman doubting herself and feeling bad which then leads to the problems showing up offering ways to take the feelings away, however temporary this may be.

Alexa:

C: Were there times that substance misuse and disordered eating practices defined your identity?

A: Yes.

C: What would it have defined you as at that time do you think?

A: As a party animal, I changed who I was. I've always been a tomboy and I cared about people, my friends, family, and the people that were close to me. And then when eating disorders came in I was lying to everybody about everything and you couldn't tell me what to do. I was right. People would say 'you look too skinny.' No, I look good. 'You are doing too many drugs' No, I'm just having fun; you're jealous that I don't care as much about school so I can skip whenever I want. Your jealous that I have an eating disorder and I can be as skinny as I want. They defined me as that.

Both problems work to turn Alexa against the people who care about her. Substance misuse and disordered eating practices are always ready with a response to anything that may threaten their survival. Often, once the problem begins to take on a life of its own, friends and family in the young women's lives begin to disperse this problem-storied notion of the young women. Friends, family, and teachers get caught up and participate in the construction of a new problem-dominated story of the young women (White & Epston, 1990). Stories about the young women's strengths and accomplishments are in the background, while stories about the young women's failures, wrongdoings, and troubles are increasingly in the foreground. Alexa who was once well known for her abilities in school and at sports, might be relegated as an alcoholic. Hannah was once described as a talented dancer but is now depicted as an anorexic and a drug addict. Below, Beth describes how drugs gave her a reputation that she then began to be known by.

Beth:

C: Were there times that anorexia and bulimia or substance misuse defined your identity? Did they do this separately or together?

A: Separately.

C: Separately, okay how?

A: Drugs, totally defined who I was, because almost everybody knew me a certain way and that's because of the drugs and stuff where a lot of people knew me because of the drugs and the things I was doing. Like everybody knew my name kind of thing. And that's just totally who they think I am now.

In our conversation, Beth also touched upon how she thinks that is going to be difficult for her friends to imagine her as anything other than the ways they have known her as, and that if they knew she was in treatment for substance misuse they would be 'killing themselves laughing.'

Below Emma describes the pain of the realization of how just how far she had been separated from herself.

Emma:

C: Were there certain qualities that alcohol and drugs and disordered eating practices had to get you to forget in order to take over your life the way that they did?

A: Um-hmm.

C: What did you have to forget about you?

A: I had to forget everything about myself at a certain point in my addiction. And I think that's actually, at that point it's a very serious physical addiction. I could not function physically without a substance and that's when it wasn't

Emma anymore, it was addiction. And I couldn't remember who I was because then I would not be physically well. Yeah. Like a lot of this stuff that you do in you're addiction, you look back at now from a healthy perspective and it's completely disassociated from you. That's not you doing those things. It's like an out-of-body experience. But that's just it. You have to forget in order to feed that addiction.

C: What happens if you were to remember?

A: Oh my God. There were times when I did, too. Then you want to kill yourself.

The discussion above has hopefully illustrated that disordered eating practices and substance misuse have a myriad of ways in which they can enter into a young woman's life. The above is only a small sampling of some of the conditions that can set the stage for this to occur. Disordered eating practices and substance misuse harness themselves on lies, secrecy, shame, embarrassment, guilt, fear, and a loss of care for oneself. In this process, the young woman disconnects from the ways she knew herself and away from her family, friends, and activities or hobbies that used to fulfill her. The stage is now set for these problems to really take hold.

Questions to Highlight the Requirements of the Problems

- What did the problems need to take advantage of or convince you of in order to become apart of your life in the way that they did?
- Did the problems sneak into your life or immediately highjack it? Why do you think they operated in this way?

- Did you find that your life began to revolve around the problem? How did this occur? At what point did you notice that this was occurring? What did you make of this development? Were there things that got in the way of you noticing this sooner? What difference might it have made if you had noticed it sooner?
- Were there certain qualities that alcohol and drugs and disordered eating practices had to get you to forget in order to take over your life the way that they did?
- How did they get you to believe those things? What was the impact of this?
- Were there certain things that the problems required of you?
- If you had known what the problems were going to ask of you, would you have been okay with this? Why or why not?

Questions Regarding Identity Construction

- How did disordered eating practices and substance misuse impact the way you saw yourself?
- What was the impact of seeing yourself in this way?
- Where there parts of you that eating disorders or substance misuse tried to get you to forget about yourself? Why would they do this?
- Did eating disorders practices and substance misuse begin to define the kind of person that you were/are?
- Were there times that alcohol and drugs and eating disorders defined your identity? Kind of defined who you were?
- How did substance misuse and eating disorders practices impact your relationship with yourself or your sense of yourself?

- How would you prefer to see yourself?
- Since stepping away from the problem's description of you have you begun to see things or re-remember qualities that you had forgotten or perhaps not seen in quite some time? What has that been like?

Section 4. Ways in Which Young Women are Recruited/Ensnared by the Problems

In this section I will explore how the young women I interviewed describe being recruited and ensnared by substance misuse and disordered eating practices. Substance misuse and disordered eating practices are initially very real attempts at problem solving. This notion is often overlooked. There are many reasons why people become involved with disordered eating practices and substance misuse, the scope of which is beyond the focus of this writing. However, it is important to mention that pain, violence, homophobia, racism, sexism, curiosity, friends, and the empty-promises offered by disordered eating practices and substance misuse often inform people's decisions to enter into this territory. For some young women, these promises and curiosities do not come without a price. And this price is that their life soon begins to centre on attaining alcohol and drugs and/or food/ thinness at all costs. For example, 'dieting' takes on a whole new shape when it becomes the focus of everyday life, when 'what to eat', 'what to not eat', 'calorie counting', and 'how to hide that they are not eating' takes over. I will also take a closer look at some of the empty promises that substance misuse and disordered eating practices make and the ways that it then creates new promises to absolve itself of any responsibility for the pain or discomfort that it is causing in the young woman's life.

In order for disordered eating practices and substance misuse to become such a large part of a young woman's life, they must offer them something invaluable. Young women can become convinced that it is through the use of disordered eating practices or substance misuse that they will achieve what they are searching for. It is the young women's search for this 'something' that the problems use to their advantage. As people get farther down the path with substance misuse and disordered eating practices, these problems have more and more say as the young women begin to live by the rules that the problems stipulate. When this occurs, the young women become increasingly disconnected from how they previously acted. When thinness or substance misuse begins to play a central role in a young woman's life, there are often costs to this. As the young women's lives begin to revolve around the problems they begin to be separated from their values and move away from what gives their life meaning and purpose, be it a job, hobbies, academic or sports pursuits, friends and family. (In some cases the lack of these things may be the driving force behind substance misuse and disordered eating practices). It is my understanding that when this occurs, people are more likely to continue to act in ways that would otherwise not fit for them as the problems can condemn them for the actions that they took while under their influence. Using excerpts from the interviews, I will illustrate the interplay of relational features the problems use to capture and captivate the young woman and how difficult this can be when both problems are 'working' together.

The intent behind this section is to render transparent some of the many ways that substance misuse and disordered eating practices manoeuvre themselves into a person's life. If we as therapists are aware of the ways in which these problems become

entrenched in young women's lives, then we are better equipped to help the young women identify these tactics in their own lives. The descriptions of the problems' tactics and empty-strategies included below may not be identical to other women's struggles but they may be familiar enough to use as a springboard. Ali Borden (2007), a therapist who has worked extensively with women struggling with disordered eating practices writes about her surprise that the voice of anorexia and bulimia is often the same regardless of the country the young women is from. Luckily tactics often repeat themselves, perhaps using different words, but the general way they go about doing things is similar from one person to another. Madigan describes how therapists need to "know where the problem is arguing from" (S. Madigan, personal communication, April 24, 2009). What follows is an attempt to do just that: to give a rich description of where substance misuse and disordered eating practices are arguing from.

While disordered eating practices and substance misuse do kill pain (and often make people feel good) and in a sense 'help people out,' it becomes quite clear, quite quickly, that they also cause much more pain than they purport to relieve. In order for the problems to work effectively in the young women's lives, the problems need to try to keep this hidden. If the young women were told up front by the problems 'I am going to temporarily relieve your pain, but in exchange for this relief I am going to rob you of your hopes and dreams, your family and perhaps your will to live. I will take control of your life and you will have to live by my rules and do as I say' young women may think twice before walking down this road. And this soon becomes one of the ways that it keeps young women close. Disordered eating practices and substance misuse creates

more pain, which then requires more pain killers, and so on, which contributes to the cycle we will look at below.

The empty promises

Alcohol and drugs and disordered eating practices bear promises of what life could be like with their assistance. These may be promises of friends, popularity, self-improvement, thinness, escape, freedom, a way to cope, or happiness. However, the cost of these promises is often much higher than anyone would have imagined or bargained for. Enquiring about the 'promises' of substance misuse and disordered eating practices creates a relational space for young women to understand how these problems gained such a hold on their lives, and what they may need in order to develop other options for coping with the difficulties in their lives. Once the problems gain an edge in someone's life they both work very hard to get people believing that you can never use enough drugs/alcohol or lose enough weight. Both problems are sustained and supported to some extent by the problems promises of 'what will be' if only the young women follow the problem's rules, and the imagined misery they will endure if they fail to follow them.

Rachel explains how the problems became a part of her life.

Rachel:

C: So what did it need to take advantage of to become part of your life in the way it did?

A: You needed to believe those lies.

C: Okay. How did it convince you of those lies? How did it get you to believe them?

A: I don't know. When you're so submerged in that kind of life and all your friends and everyone is like—it didn't really have anything to do with the fact that everyone else is doing it, you are just so submerged in it that you believe it without questioning anymore.

Rachel describes the impact of having been submerged in that kind of life and how she began to believe 'those lies.' Rachel refers to disordered eating practices and substance misuse as lying to her. Rachel is now aware that the promises that disordered eating practices and substance misuse originally offered her, were, in the long run empty. Though substance misuse and eating disorders may have helped her out at the outset, and perhaps continued to be helpful to some degree, disordered eating practices and substance misuse did not come without costs. For example, the problems left out that she might end up in a treatment centre for substance misuse. In this sense she experienced the problems as 'lying' to her as they left out the possible consequences of their use, she was only informed of what she would gain.

Rachel's use of the word 'anymore' suggests that there was a time when she did have some questions about the life she was beginning to lead, perhaps about the impact that it was having on her sense of self, her health, and her family. Yet, once this 'submersion' occurs, disordered eating practices and substance misuse have a strong foothold in the young woman's life and no longer need to work as hard to entice people to follow them. Instead it's like the fable of the Pied Piper where the children followed the Piper willingly. Substance misuse and eating disorders are 'nice' at first, offering the young women some 'help' with their struggles. If they were cruel and caused them much pain at the get-go, young women might be more inclined to ignore them

Hannah describes the promises of disordered eating practices and alcohol and drugs in the following way:

C: What did drugs and alcohol and disordered eating practices need to do or need to convince you of, in order to become part of your life in such a big way.

A: To make it better, it promises you these good things, things that you can't see.

So the promises are often far off, but the promise to 'make it better' is often captivating enough to take a risk and see if substance misuse and disordered eating practices can offer what they say they will. She continues,

C: Were there any other promises that eating disorders made?

A: That I would be pretty.

C: Pretty.

A: Um-hmm. And happy. Happy with myself, like more self-confidence.

C: Were these the same promises that drugs and alcohol offered?

A: No.

C: What promises did drugs and alcohol offer you?

A: Only good ones, like nothing negative. Fun, like anything good. It would make my life so much fun, I can stop when I want to, it will be cool, and I'll look cool in people's eyes.

Beth continues along the same lines:

A: Just like, well, if you do this you'll feel better. It's not how will it make you feel worse. It's how this will make you feel better. You're not thinking about anything else.

C: So if you do this you'll feel better that's one of the promises?

A: Yeah. I'll make you thinner, I'll make you forget, kind of thing, right. You'll feel better about yourself.

Female gender training can encourage young women to prioritize self-sacrifice and selflessness (Gilligan, 1982). This gender training can lead to diminished care for one's self, which and can be taken advantage of by substance misuse and eating disorders. Substance misuse and disordered eating practices can masquerade as care, taking advantage of the fact that for the young women this is a real attempt at trying to feel better or to have a say in their life, regardless of the costs. Young people will argue the merits of drug use as a way to help them concentrate and stay focused at school. This may be true. Amphetamines were used by fighter pilots during WWII as away to stay alert (Rasmussen, 2008). Yet drug use and disordered eating practices do have consequences in people's lives. In the example below, disordered eating practices talks itself into being a health solution and as a way for self-improvement.

> Alexa: I was like when I had disordered eating, like—well last year.... everyone cares about how they look and I'm like oh its not that bad. I'm just doing something about it and I'm happy about it. So like there are fat people out there who aren't happy about it or aren't happy about their self and so I'm just fixing it for myself, I'm doing something good for myself.

I'll help you cope and make it all better

The young women described how drugs and alcohol and disordered eating practices offered them 'solutions' to the difficulties that they were facing. They described being enticed with promises of feeling better about themselves, and

importantly, they are deceived into believing that they would be able to stop whenever they wanted to. The problems position themselves as offering them the solutions to whatever it is that ails them like a magic elixir promising to take it all away.

Emma:

C: Were there things going on in your life that made them [substance misuse and disordered eating practices] seem like a decent option?

A: Yes. I think that everyone has the experience where the coping mechanism does help them in the beginning. It does. It's just that it turns into something really horrible.

Emma acknowledges that while it helps in the beginning it begins to take on a life of its own. (This of course the problem leaves out).

Beth:

C: Are there ways the problems tries to convince you that they can help you out?

A: 'Oh if you just do me for a little bit, and if you just lose a little bit of weight then everything will be fine and dandy'- those types of empty promises. But I know that's not how its gonna be.

C: What is it that you now know that has you saying 'that's not how its gonna be'?

A: Cause I know that was my original plan in the first place, the first time I got clean and then I was like, 'Oh I'll just use and loose a little bit of weight and nobody will know and it will be all fine and dandy.'

C: And did it stop there?

A: No, No. No.

Jessica below speaks to how disordered eating practices and substance misuse served a purpose and how 'she took them for her problems.'

Jessica:

A: Yeah. Yeah. Because I did take them for my problems, right. They masked my problems for a long time. They were a good cover up. When people were like, 'Oh, what the fuck is wrong with you.' It wasn't like, 'well this, this, and this is wrong with me and this is what actually happened to me and this is why I'm feeling sad.' Instead it would be like, 'Oh, I'm a drug addict,' or, 'I have an eating disorder.' It was a good excuse.

Jessica touches on something very important. Disordered eating practices and substance misuse can obscure and divert both helpers and the young women from what actually may be going on in the young women's life that contributes to the problems. For example, all energy may be focused on not eating, leaving none left to invest into looking at the possible solutions to the problem. Or as Jessica said, addressing the reasons behind her sadness. Disordered eating practices and substance misuse get in the way of school, turning them against the people that love them, and thus, the young women get stuck in a vicious cycle in which substance misuse or disordered eating practices works as a smoke screen to distract and deflect all attention that may come its way.

Rachel articulates this idea very clearly. She reflected on how 'she started drinking and doing drugs for fun' but soon found that it began to take on a life of its own, and became a way to ease the pain of the memories that it was causing.

Rachel:

A: Okay, I started drinking and doing drugs for fun or whatever, but I ended up doing so much stupid shit and having to do things I didn't want to do to get more drugs. But like it ended up being a coping mechanism to get rid of those memories and like it's just kind of like a vicious circle because every time you do it, it spawns more and more of those things you want to cover up and you don't want to feel anymore. Cause its so shameful and you feel so guilty and like and then your confidence is like ruined because you're like oh my God, I have to look okay so people don't think there is something wrong with me so then the eating disorder part comes in. And its like the problem just keeps getting worse and worse.

She continues,

A: And then it's like all of a sudden you can remember more things and it's like oh, you tried to forget when that thing happened or this thing and you're like you used again after this to try to forget but then this happened and it's 'Oh my God, there is so much shit.' And somehow, in some crazy way it makes you want to use again. Which is just like 'make some new worries.'

Shape-shifters

Disordered eating practices and substance misuse are shape shifters, they both have the ability to morph into whatever form of 'help' the young women requires at the time. For example, disordered eating practices and substance misuse might describe themselves as experts in weight loss, pain removal, creating a sense of specialness, or a way to cope. They also have the ability to fine-tune their promises in order to meet the

needs of each young woman as closely as possible. Like a well-groomed salesperson, they can sell you anything and make you think that you are getting a fantastic deal.

Emma:

A: A constant. I needed something constant in my life and I didn't care what it was. And so an eating disorder stays with you forever, and I just wanted something that was mine. I wanted something that I could almost like I could steer it, and something that would reassure me that I was actually doing something. With every pound that I've lost, it was weighed on the scale. It's like when you get a report card and it says this is the percent you got. You got an 'A' and you're like sick, I can put this on my fridge for my parents to see and everyone is like 'wow, you did a good job.' But this one is kind of, kind of like your own personal report card where you're doing it just for yourself.

Ava:

A: Drugs and alcohol, you know, it's covering up the emotional pain and it helps you know. Like oh, I'm pissed off at my parents or boyfriend I'll go get drunk and this is a temporary remedy.

Aimee:

A: Yeah, they promised that they could help me get through the tough times and stuff and they could get me through anything. I don't know why I would think that, but drugs are like if you do this everything will go away, but it doesn't. It all comes back harder.

Get male attention, join the popular crowd

Interestingly, many of the young women's responses about the promises that lured them were tied to ideas of thinness that would gain them attention from men, and thinness as a way to hang out with the 'popular' crowd. This highlights the prevalence of idea of thinness being equated with notions of beauty, and the power of the 'gaze' (Foucault, 1981; Berger, 1972) in regulating and controlling woman's actions. This is not a neutral idea and has far reaching consequences, specifically in relation to ideas of worth and what is valued regarding women's bodies and women's appearance. We live in a pro-anorexic culture, which endorses and encourages a thin and fit body for both men and women (Hesse- Biber, 2007; Orbach, 1978). In many cultures, beauty equates thinness and wealth, men have more power than women, sexualized violence towards women is promoted by media, and pornography flourishes (Jhally, 1990). It makes sense that young women begin to internalize and live this very specific gender training at an early age, as this becomes gender normative behaviour. In fact it begs the question of how is it that more women are not taken in by these pro-anorexic notions.

In my conversations with the young women it appears that for heterosexual women, being thin is believed to be a requirement for attracting and capturing attention from the opposite sex (Malson, 1998). The young women described how disordered eating practices and drugs and alcohol teamed up together and worked to support thinness in their lives. In the examples below, young women are comparing themselves based on their body size rather than what they have to offer intellectually, or conversationally. They describe the hoped for result for all their efforts was that they

would attract male attention. Below the young women describe their ideas about the 'benefits' that will occur if they are thin.

Ava:

A: It's a pressure. I think it's a pressure to impress the guys and compete with the girls.

From this perspective, women become the enemy, and women are pitted against other women, rather than as allies supporting each other in challenging traditional ideas of thinness and beauty.

Hannah:

C: In terms of using drugs and alcohol, why would you want to be thinner than someone else?

A: Because I felt I was pretty that way.

C: So if you were smaller than your friends or if your friends pants didn't fit you [In reference to what she had said earlier].

A: I was the one the guys would pick first.

Alexa:

C: Did drugs, alcohol or disordered eating practices offer you any promises?

A: Yeah. For me it was always, I'll be happy if I'm skinny. I'm gonna be happy. I'm going to get attention from guys and I'm going to have more fun.

Aimee:

C: Were there things going on in your life that made the problems seem like a good option?

A: Maybe a little bit. My ex-boy friend and stuff and other girls were skinnier and I didn't think I was skinny enough so I was using a lot more.

C: In order to get thin?

A: To get thin so he would like me. But he always did like me, but I just thought he was looking at all these skinny other girls and I already was skinny but I was starting not to think it, so I started to use a lot more I thought would he liked it so I used more and it got me down to a lower weight.

Thinness, fun, male attention, competition with other women. When this becomes the focus of young women's energies, their appearance can take centre stage over other qualities such as academic achievement, sports, friendships, and work pursuits. Naomi Wolf (1997) writes, "beauty is a currency, like gold" (p. 13) and from the conversations it appears that young women learn the value of this currency quite early.

Aimee:

C: You said that disordered eating practices got you thinking that you would be able to hang out with certain people?

A: Yeah. I used to think that if you're a certain weight you can hang with a certain group. And I figured, I always thought if I'm the skinniest one in the group then everyone will like me. The guys will like me more and I'll have a chance to hook up with them faster before everyone else.

Megan:

C: Do you think that drugs alcohol or disordered eating practices ever tried to convince you that they could help you out to be any of those things?

A: Yes, definitely.

C: How or in what ways did they do that?

A: When I started using and like when I started losing weight I had more confidence and it was easier to fit in with more people and to get that status that I wanted.

C: What kind of status did they promise you?

A: Just popularity and everyone wants to be your friend, and you're always booked for the weekend and every night you have more plans than you can handle.

C: And that was true for both disordered eating practices and drugs and alcohol, they kind of came hand in hand?

A: Definitely.

C: In a way did they convince you that you should be a certain way or that in order to be popular you had to look a certain way?

A: Yeah, you had to fit those smaller sizes and look great in them no matter what you wore, and if you went to a party you'd have to wear the tightest jeans that you owned so that every one would want to talk to you, those kinds of things.

Rachel:

A: And like I think the idea like is that if you're ugly or whatever, nobody can take the time to listen to what you have to say. They're all going to think you're stupid and just you know, you'll die alone and you'll be miserable.

Referring back to section 1, culturally sanctioned practices, in this chapter, many of the young women mentioned being made fun of because of their weight, or wanting

to be thin in order to avoid being picked on. The above comments can then be seen as a way to avoid being punished or disciplined by way of abusive comments about their bodies. As Rachel alludes to 'you are destined to die alone if you are ugly.' Both problems benefit if they can convince young women that if they can succeed in becoming or staying thin, then they can perhaps avoid being ridiculed, or perhaps worse, be alone. Orbach (1978) states:

> This emphasis on presentation as the central aspect of a woman's existence makes her extremely self-conscious. It demands she occupy herself with a self-image that others will find pleasing and attractive—an image that will immediately convey what kind of woman she is. She must observe and evaluate herself, scrutinizing every detail of herself as though she were an outside judge (p. 7).

It is through this very specific type of gender training that young women learn how they should be and act which benefits substance misuse and disordered eating practices.

From friend to captor

Once substance misuse and disordered eating practices have moved themselves into a person's life the young women often begin to describe the voice changing from that of a 'friend' to that of a 'captor' that is relentless with its demands. The voice of substance misuse and disordered eating practices slowly begins to erode and override the young women's voice. Substance misuse and disordered eating practices question their actions and shames them when they don't follow the rules that they have laid out.

These problems have been compared to that of an abusive partner, they start out nice and then they develop into something horrible.

Rachel:

C: So the voice of drugs wasn't always a friendly voice then?

A: No. But it is in the beginning and then eventually it becomes the voice that you listen to because you haven't ever questioned it before. Like until that point usually.

C: In terms of the voices, are the voices of alcohol and drugs and disordered eating similar voices? For example, is one more caring than the other or do they take turns being caring?

A: No. Like at the beginning when you start not eating and you're happy, right, oh yeah, its like 'oh my God you're so fat like just like stop eating already', right. 'Look at you, you're disgusting' and everything like that. So both of them work over time. Like once they've got you, they've really got you and they think you know, 'all right like now we can just lay it out just like it is.'

Megan:

C: Did drugs and alcohol and disordered eating practices, did they talk to you in a voice of a friend? Were they mean friends?

A: Sometimes. Yeah, when you're looking in a mirror it's like 'oh my gosh, what's that, look at those thighs and what are you doing. Like you obviously haven't been exercising, you obviously have been eating way too much.' Friends wouldn't say that but thoughts did. Then like if one day you are happy with what you see its like–it's like the best friend you can imagine, 'Like that's so good!'

C: Yeah.

A: Or like if you were purging and afterwards 'yeah, that looks better or you don't have to worry about that any more. That's gone.'

Hannah in a similar vein describes the degrading voice that the problem began to speak to her in when she began to gain weight once she stopped using alcohol and drugs.

Hannah:

A: That you're fat and ugly and no one will ever like you, and you'll have no friends.

Rachel explains the process by which when she was trying to free herself from these problems they would degrade as a way to keep her close.

Rachel:

A: When you're like trying not to use and if you think to yourself like 'I'm not good enough, like I don't even deserve this anyway, like why do I deserve clean time after all the stupid shit I've done?' You kind of think 'oh well, then I might as well go back and use again because I'm not worth it.' But same with like eating disorders, you're like, 'I'm so ugly,' or 'I'm like not worth like, you know, trying to be healthy' or like 'at least I can be thin' then.

It is important to gain a sense of how these problems gained a strong hold in peoples lives, in order for the young women to gain a sense of the problems tactics. Once these tactics have been uncovered the young women are better able to notice when they begin to appear.

The Lies are Unveiled

Below the young women describe what is left off of the list of empty promises (lies), which is generally that disordered eating practices and substance misuse take control over their lives. It has replaced the control that they imagined to be gaining on their lives.

Ava:

A: They trick you, completely, 'you'll be thin, you'll be beautiful.' It totally tricks you and you think if you just keep using it, everything will be fine. You'll just keep getting skinnier and more beautiful. But really you're not.

Hannah:

C: What kind of things did they promise you that you know now that they don't actually do?

A: That it will be fun. They'll make your life better. That it's just something fun to do. It doesn't show you how much you'll get sucked in and how much it will ruin everything.

You can always do better and the bar always moves

In order to keep its victims ensnared, the bar needs to keep moving. What is 'thin enough' is always changing, and what was once 'enough drugs' will no longer do.

Ava describes this.

A: Because, well for drugs and alcohol it is changing your mood, changing your outlook on things. With the eating disorder, maybe, let's say you don't feel good about the way you look, it changes the way you look but it doesn't change the way you feel about yourself you know what I mean? You're always looking for

something. You're always like, trying, you're always just looking for something but I find that I never found it. I could never ever find it. It was never enough. I had to always lose a little bit more weight.

Ava describes an important tactic that substance misuse and disordered eating practices use. If the bar of what is 'good-enough' is constantly moving, the solution that people are looking for is always just out of reach. The problems try to convince the young women that this is because 'they are not trying hard enough.' If they were trying harder they would achieve the results they are searching for.

Information filter

Disordered eating practices and substance misuse acts as a filter where it morphs information to best serve its own purposes. The following is an excerpt where Beth describes ending up in the hospital.

Beth:

C: Had you seen bulimia as a health issue before?

A: No. I always thought the doctors were trying to scare me.

C: You thought they were making it up?

A: Yeah. I was thinking no, this isn't bad. Its just cause I took one too many pills, it's not that I'm that underweight. It's not because of that. I'm fine; you're just over exaggerating.

C: Was that your voice or was that bulimia speaking for you?

A: I think that was the bulimia speaking for me. Yeah. And not letting me, like, get at the full information or letting me hear it.

Alexa describes how disordered eating practices and substance misuse played off of each other and had her thinking that in order for her to attend a treatment centre for substance misuse that she needed to look like a 'drug addict.'

Alexa:

A: Like—I stopped using drugs. Then the eating disorder came in—and at first when I was trying to stop having an eating disorder before coming here drugs, and the eating disorder got bigger as well. It thought, okay like, it's actually good—well there is a certain drug addicts look – so I should go into that program looking like a drug addict.

Other young women whom I have worked with have described disordered eating practices getting worse prior to attending a program for disordered eating. They have described thinking that they don't look sick enough or thin enough to attend. In substance misuse programs things are always not much better, young people can compare how many drugs other people did, how much they drank, or compare bodies. In this way the problems can be encouraged and sustained by comparison with others. Many young women have talked about how this process contributed to their getting worse, in the extreme leaving treatment to lose more weight or do more drugs.

Questions Regarding Recruitment Tactics and Strategies

In order for young women to consider the impact that disordered eating practices and substance misuse had or is having on them, we can begin to ask questions that highlight and make transparent substance misuse and disordered eating practices' recruitment tactics. Once young women are aware of the ways in which the problems

gained so much authority in their lives, the young women are better positioned to resist them.

- What did drugs and alcohol and disordered eating practices need to do or need to convince you of, in order to become part of your life in such a big way?
- What were the promises that substance misuse and disordered eating practices made to you? Did they offer the same or different promises?
- What kind of things did they promise you that you know now that they don't actually do?
- Were there things that were going on in your life at that time that disordered eating practices or substance misuse used to their advantage, or made them seem like a decent option?
- How is it that substance misuse disordered eating practices began to tear you away from your self, your family and your friends?
- How did substance misuse and disordered eating practices get in between you and the people you love?
- What did substance misuse and disordered eating practices begin to do in order to create a wedge between yourself and the people that love you?
- What do you think of this?
- Are you okay with that? Why or why not?
- Were there things you had to forget about yourself in order for substance misuse and disordered eating practices to become such a large part of your life?
- Are there ways that substance misuse and disordered eating practices might play off of or benefit from western notions of beauty?

- Did substance misuse or disordered eating practices ever speak to you in the voice of a friend? Was there a time when they may have become a mean friend? Why do you think they would do this?

Section 5. How Substance Misuse and Disordered Eating Practices Become Tools of the Other

This section describes how disordered eating practices and substance misuse can work together to keep a person ensnared. I am describing them as 'tools of the other,' as it is my understanding that when the problems of substance misuse and disordered eating practices are both present in someone's life, they begin to work together in order to keep people trapped in problems. As Ali Borden (personal communication, May 14, 2007) described it, if you imagine disordered eating practices loosing its grip on a young woman, disordered eating practices might yell out 'I don't have her!' At that moment, substance misuse, working as an outfielder, might respond, 'It's okay, I'll get her!' (A. Borden). The alliance between disordered eating practices and substance misuse can make it difficult for a person experiencing both to break free from them. When they begin to resist or take some steps away from one problem, the other one begins to tighten its grip. If therapists are aware of the possibility of disordered eating practices or substance misuse lurking in the background, then they may be more likely to enquire about them. Therapists are also in a better position to prepare a young woman to manoeuvre her way through the problems' attempted comeback. The more prepared a young woman is for this possibility, the better she will be able to resist disordered eating practices and substance misuse's tricks and tactics.

How substance misuse and disordered eating practices can work together

I was curious about the ways in which disordered eating practices and substance misuse can serve the same purpose or help people achieve similar goals by working together. Can one stand in for the other if one is not available or convenient in a particular moment? And, if so, how does this occur? I was curious about the young women's experiences with the two and their ideas about how substance misuse and disordered eating practices may have recruited the other problem into their lives. In this section, I will look at the times young women are aware of being vulnerable to the teaming up between both problems, how the problems can start to team up (specifically when they try to step away from one or the other), and then offer descriptions of the ways in which these problems can work together when a young woman enters treatment.

Emma explains the ways that she sees these two problems co-existing in her life.

Emma:

A: It's kinda cool this is how I've always imagined these two in my life though, is like here's a closet door. And here is one of the monsters creeping out like that. Here is me, like, in my bed and I'm safe underneath the covers, you know, and then there is one crawling up and pulling them off of me. It's not about overlapping, it's about this one already got it started and so this one can come in and take advantage of the fact that the ball is already rolling. They're buddies.

Rachel:

C: How do you explain the fact that they shared so many of the same tactics?

A: Well, I think they're both an addiction. They're both like so strong in your mind, like drugs like just push you to use them again and again. Promising

you'll be happier when you use them and like this time it will be different. This time you won't do anything stupid. It will be just like the first time and same with like the eating disorder, I'll make you skinny, and then I'll make you happy. Everyone will love you.

Hannah:

C: Okay. If you were to describe it to or explain to someone the way that they both worked in your life, how would you describe how they kind of showed up together?

A: Like one brought on the other and it feels like they fed off each other.

Below Ava astutely makes connections between the images of what someone is trying to project or achieve through substance misuse or disordered eating practices as being similar. In this way, the problems have a common goal with which to attract people.

Ava:

A: I would say they unconsciously lead you to one another whether you know it or not, its linked because it all has to do with some sort of image. The cigarette in hand. Its because you want to be part of that image. The alcohol, the martini, the joint or the line, its all about image. The eating disorder, the stars do it, the important people do it, you can do it too. It's all about the image.

Ava describes her understanding of their shared tactics as follows.

Ava:

A: They even have the same tactics it's all down to the same thing and comes from the same pain.

C: What are some of the same tactics that they share or the pain they take advantage of?

A: Doubting yourself, people and yourself telling you that you aren't good enough. That feeling of acceptance and acceptance from a community. And like what you're told, is right. It's what you're supposed to do. Instead of what you're really supposed to do, you know what I mean? Does that make sense?

Ava alludes to a sense that there is a certain way that she was being recruited into acting and a way that she knew she was supposed to be acting.

Disordered eating practices recruit substance misuse

Hannah:

C: Do you think disordered eating practices and substance misuse share any of the same promises, like play off of each other in any way?

A: Like how?

C: Like one kind of compliments the other?

A: Well, like being skinny and having an eating disorder and if you do drugs it's a lot less work and better results

C: Okay, so how did you begin to figure that out?

A: I wanted to do it and then I saw what it did and I was like 'Whoa.'

C: When you saw what it did? When you saw what it did on your own body or other people's bodies?

A: On mine, I remember looking in the mirror and I thought, 'Oh my God that's so skinny. That's fantastic.' And seeing other people that I hung around with getting skinner too.

Previously in the interview, Hannah told me that disordered eating practices appeared in her life before misusing substances. She had already become accustomed to ideas and practices of losing weight. Above she describes the thinness attained through drug use as 'fantastic.' Young women quickly learn that drugs can intensify the thinness they may be looking for, and in this way, drug use becomes a tool of disordered eating practices.

Alexa describes how some of the requirements of disordered eating practices (for example purging, over exercising, calorie counting) begin to subside as drugs begin to play a larger role in her life. Alexa soon learns that drugs can be used to quell her appetite, and in this way drug use can begin to increase in young women's lives.

Alexa:

A: But then I just really didn't care because I was like fuck it I'm so skinny I don't need the exercise. So the drugs became part of my eating disorder, too. I was using them more and more to get skinny. Like if I woke up and I was hungry, I'd be 'Oh, I'll just do a rail.'

Beth:

C: Given that bulimia showed up first in your life, how do you think it was that alcohol and drugs then showed up? Do you have any ideas about that?

A: I saw how much weight my girlfriend had lost but I hadn't known how and I was like, oh my God, and that was the first time she gave me a cap of Ecstasy and she said they were weight loss pills. I didn't know they were drugs and I just saw that she had lost so much weight in such a short period of time. Like easy X

pounds, a lot of weight, and I was like holy crap. I didn't care how she was doing it, right.

Beth spells it out quite clearly: thinness at whatever cost. Both Beth above and Jill below speak about learning about thinness as a 'side effect' from drugs from their friends. They saw their friends bodies begin to change in ways that they themselves were after.

Jill:

A: I tried the whole bulimia thing; I tried throwing up after meals and that kind of thing. Like I did it one or two times but like it didn't feel right doing it, you know what I mean? But like when it came to drugs and alcohol, I used to use crystal meth. I wanted to be really skinny, so I would like do that to look good and be skinny.

C: So I can look good if I do this drug, is that right? How did you figure out that you could look this way if you did this drug? How did you come to know that?

A: Well, I have friends that were doing the drugs. They got really skinny.

C: Okay.

A: And I figured, okay, well, they're going to be skinny, why can't I. I want to be skinny too. Because I've always had a weight problem when I was young I was chubbier and everything, like I was always too big. I could never be happy with the way I looked so when I started using drugs and alcohol, I got to wear smaller clothes. I could wear tight T-shirts that showed my belly button, which I never wore before. It was just, it's attractive that whole lifestyle, being really fit.

I was struck by Jill's use of the words 'look good' and 'it's attractive that whole lifestyle being really fit.' I wondered how these words became the words that described her experience of crystal meth use. As I write this I am confronted with images of crystal meth and cocaine users that have been driven to the streets by their habit; left to scour the streets of East Vancouver looking for 'rock' that someone may have dropped. Their faces hollow and scabbed. Their bodies malnourished and dirty. How is it that substance misuse can keep young women from seeing its darker side even when this is where they are being driven? I realize that this is an extreme example, and that not all substance misuse takes people to the places I just described. Yet, I wonder how a drugged image of 'high society' and 'fun' can get in the way of people seeing other real possibilities of where drugs can and do take people. I am especially interested in how drugs keep this hidden from the young women that I interviewed given that they were all (or had been) in a substance misuse program at the time of our interviews.

Substance misuse recruits disordered eating practices

Below Megan describes 'the state of mind' that contributes to thinness becoming a focus in a person's life.

Megan:

C: Some women struggle with both disordered eating practices and substance misuse. Why do you think this is?

A: I think it's because when you start using or drinking you're already kind of in that state of mind where you like to have fun you have to be using and drinking. And then you also start thinking that to have fun you also have to be as small or be smaller than the other girls you're partying with or you have to look just as

good, so you end up using to lose weight or to maintain your weight and as well as resorting to disordered eating practices, if you can't get your hands on drugs or alcohol.

C: How does disordered eating practices fit in? Like if you can't get your hands on drugs or alcohol how might disordered eating practices show up?

A: Just like because using and drinking kind of help you to lose weight and so if you didn't have access to drugs, then you can resort to like portion control, or limiting what you eat or purging, that might come up too.

Megan describes how substance misuse began to co-opt her ideas of 'fun.' In order to have 'fun,' she describes how important drinking or drugging is and eventually, in order to have fun, she 'has to look as good as the other girls.' Slowly alcohol and drugs begin to redefine fun as 'alcohol and drugs' and creates rules and conditions that need to be met in order to have fun. She also describes how drugs can create the conditions for disordered eating practices to appear in someone's life. If you want to 'stay thin' but don't have access to drugs, then disordered eating practices can appear, offering 'solutions' to help you maintain the thinness that you desire. According to Megan, these solutions take the form of 'portion control, limiting what you eat or purging.'

Megan:

C: Did you notice any similarities in the way drugs and alcohol and disordered eating practices worked in your life or did they share any of the same tactics or fulfil the same purposes?

A: When I used to lose weight or used to fit a certain pair of pants kind of thing then yeah they did because it was both to lose weight or to wear a pair of pants or to feel good on the first day of summer, to fit a bikini. For that kind of stuff, yeah.

A: But they also kinda worked together. It wasn't just using and then eating all I wanted. It was using and making sure that I wouldn't eat during the day, but like if you don't eat during the day you'll be dead tired. So I would use and then I had energy and I wouldn't get quite so tired.

C. So that kept you tied to both of them then.

A: Definitely.

Megan explains how at times 'drug use' became a means to attain thinness. She also explains how they began to work together, as drug use gave her energy that she was lacking as a result of not eating.

Ava:

C: At the time when you started to lose weight as a result of doing drugs, what happened with ideas of thinness? Did they become more of a preoccupation for you, like did ideas of losing more weight begin to show up?

A: Yes. I didn't think of it at first—no one said drugs will make you skinny. I learned that on my own. Like the more drugs I did, the more weight I would lose. And I kind of went like oh, okay that's kind of a new realization, how the drug brought that on. But I didn't know that before. But the more drugs I did the more weight I lost. And then the more drugs I would do, cause the more weight I would loose.

There is a moment when Ava slows down in our conversation and appears to make some meaningful connections between the ways that substance misuse and disordered eating practices worked in her life. In fact, she says 'Oh, okay, that's kind of a new realization, how the drug brought that on.' This illustrates how having conversations about the ways that these problems work in people's lives can support young woman in beginning to see the actual 'strategies and tactics' used by the problems. It helps bring the known and familiar into a different light, which may create new, richer learnings to help the young women recognize the inner workings of these problems in their lives.

Below Emma describes the seriousness of where these problems took her—to not knowing if she was going to live or die. Disordered eating practices will use whatever it can to its advantage. In this case, thinness from the drug and alcohol use. Disordered eating practices takes things a step further mandating over-exercise along with not eating and continued substance use.

Emma:

C: Okay. You had said that there was a time that they both overlapped?

A: Yeah.

C: How did that look?[25]

A: It looked terrible, frightening. I had gone from being six feet tall and X pounds, just fresh out of the eating disorder unit, and in two months I had gone down to X pounds and that was with drugs and alcohol and the eating disorder. That was the

[25] Some of these questions and the responses they draw could be referred to as what the Fifth Province Approach (Byrne & McCarthy, 1999) calls "questions on the extremes" (p.97), as they are attentive to how these problems at times can be about life and death for people.

point in my life where it was the crossroads of if I was going to live or if I was going to die.

Times vulnerable to the teaming up

The young women I interviewed were all very clear about the times that substance misuse and disordered eating 'worked together' in their lives. It is my understanding that if the young women are aware of the times that they are more vulnerable to the teaming up of the two problems, then they can begin to avoid falling into the problems traps. During the interviews I asked questions that began to deconstruct the ways that these problems worked together. I wanted find out from their experience the ways that these problems worked together, what fed them, and what might provoke them. It is important to enquire about when they are likely to team up because it helps the young women to begin to recognize, in detail, how it is that these problems work in their lives. It also helps them recognize the times that they are most vulnerable to these problems. As my therapeutic supervisor Heather Elliott describes, if you want to be able to track an animal, you need to know where it eats, where it lives, what times of the day it is active, when it sleeps, what its predators are, and what it looks like (H. Elliott, personal communication, September 13, 2004). It is only when these details are unveiled that we can begin to 'track' the ways that the problems work in people's lives. Then the young women are better equipped to 'catch' it as they know what they are looking for, and what form it can take. Helping them to take small steps or large leaps away from these problems.

Alexa:

A: Like they sneak in when I'm not feeling good you know. Sometimes I look at myself and think, 'you know I used to be so skinny, why can't I be like that any more?' And then that's when the disordered eating practices come in and then the drugs come in. Then I just want to binge on Ecstasy for like for two weeks, you know, like I'd be so skinny, cause I won't be eating for two weeks. But then sometimes it just helps me and I—it's not a positive thought but just to think, even the thought of just saying if I do that the second I start eating again I'll gain it all back.

Disordered eating practices berate Alexa for not being as skinny as she used to be. Drugs piggyback on the idea of Alexa needing to loose weight, and show up as a friend offering a suggestion. Alexa has begun to resist both problems and talks back to the problems. This act of playing the tape through[26] is an important act of resistance against the problems she talks back to and questions the promises that disordered eating practices and substance misuse offer her. Having had some experience with these problems, she knows when they are promising her lies, and can see through them.

Alexa:

C: How do substance misuse and disordered eating play off of each other?

A: They get you when maybe you're not feeling good; you know when you're feeling down, like not self-confident and you give up on some things. Drugs are like, 'we'll make your life fun again,' and disordered eating practices, 'well come to me. I'll make you skinny and beautiful.'

[26] This is a practice often used by Alcoholics Anonymous and Narcotics Anonymous and persons in recovery, as a way to move through drug or alcohol cravings. It involves thinking through what would happen if you were to use again, where it has taken you in the past and where it would most likely take you now. The idea being that in thinking through the consequences of where substance misuse may take them it might interrupt a person's craving to use a substance.

Jessica:

C: Have you found that these problems have a way of kind of teaming up together?

A: Yeah. Well I found for a while when I would get clean off of, like, drugs I would go back to, like, the eating disorder. It was either one or the other happening until, like, a couple of years ago.

C: How did that work? Do you have any ideas as to how come when you tried to quit drugs you went back to the eating disorder?

A: Because I needed, like, something else there. Like, I hadn't dealt with the problems that were actually like the rooted problems of it. I hadn't dealt with the whole mental aspect, so I was just like basically trading one addiction for the other.

C: Okay. So once you stopped using drugs. I'm quitting, I'm done?

A: I'm done, yeah.

C: Did it take a while for disordered eating practices to show up again?

A: Maybe like a week or two.

C: So do you remember …,

A: When I stopped doing drugs, I started gaining weight back, right, so then I went back to an eating disorder because I couldn't go back to drugs. Like then, I would like do my eating disorder shit and then I would relapse, like go get drugs and then the whole eating disorder would be put on hold because I wouldn't have to worry about it because I wasn't eating anyway.

A pattern begins to emerge, when a young woman begins to step away from one problem, say substance misuse as Jessica describes above, then disordered eating practices resurfaced as an attempt to deal with the problems that had not yet been dealt with, and/or to try to lose weight. As Jessica says, 'I needed something else.' When a young woman is making an attempt to stop using, disordered eating practices can show up with promises of taking away the feelings/memories a person may be having, or a way to maintain their weight. In bringing the private conversations that either problem is having with the person into the open, we can examine the promises for what they are, look at what they are trying to convince them of and explore their ideas about this (Andersen, 1998; Madigan, 2007). This highlights the importance of talking about and developing with young woman other ways to deal with, be with and learn that feelings pass. Unless people develop other ways to be with pain other than numbing it out [for example, with drugs, alcohol, over-exercise, purging] the problems can always show up with promises of taking it all away. Below, the young women all describe how drugs showed up with promises that they would be able to lose weight quickly and then they would no longer need to use, and they would be happy with their bodies.

Jessica:

C: What was it promising you?

A: The promise for me was do drugs for about two weeks. About two weeks and that way your stomach would shrink to a certain point and you would feel confident enough not to use the drugs and your stomach would feel small, which is what happens, you know, you won't be hungry anymore.

Megan:

A: When I stepped away from drugs and alcohol I realized that I was dealing with eating disorders and if I wasn't putting substances into my body I still wanted my body to stay the same way. I didn't want to start gaining weight back when I was eating and having an appetite. So without really thinking about it I just carried on with disordered eating practices and then I realized this wasn't normal.

Hannah:

A: Like when I was using there was so much weight loss right, and I thought that was like the total like way to be and then I stopped using and gained weight and I didn't like the way I was looking and that resulted in not eating and then eating so much and then throwing up.

Emma also describes the ways the problems used each other to get back into her life.

Emma:

C: Did one ever use the other to get back into your life?

A: Definitely.

C: How did that happen?

A: When I was doing well in terms of substance abuse, when I would stop using, I would gain weight naturally. Like, when you have bean starving yourself for so long and putting so much substances into your body, when you stop that, your body will change. That's natural. But the eating disorder was still there and still in full motion. And so, I would try to starve myself or diet even, I

still call it dieting. And that little voice would creep up and say 'I know how you can lose the weight faster.'

C: And what was that little voice? What did it say?

A: That and it is true, is put things up your nose and you won't put things in your mouth.

Emma catches herself when she uses the phrase 'starve myself,' and quickly replaces it with the word 'diet.' And comments how she 'still calls it dieting.' It is important to note the difference between the meanings of the words. The words, 'starve myself' calls anorexia for what it is. The word 'dieting' sugar coats anorexia and minimizes the inherent violence of anorexia and disordered eating practices.[27] So when the young women began to take steps away from substance misuse, disordered eating practices is right there waiting on the sidelines ready to pull them back in. The young women describe similar patterns of disordered eating practices re-appearing in their lives when they begin to notice their body gaining some shape. Disordered eating practices can show up promising to take that shape away or help them to deal with the feelings that substances may have been numbing.

Megan talked about the ways that disordered eating practices and substance misuse tried to get themselves back into her life.

Megan:

C: So like what kind of promises did drugs make you in those moments when you started to notice that your clothes weren't fitting?

[27] For more see Coates & Wade (2007) regarding the ways that language can be used to minimize violence and responsibility.

A: Just that drugs can make you go back to how you were before. Make you small again and make you fit all your clothes again. So 'have fun.'

C: So was that drugs voice speaking? I can help you with the weight and then you'll be done after that, like did the idea of just one more time, just lose X pounds and then you'll be done ever show up?

A: All the time, yeah. Just use this week and then you'll be back and then you will go to the gym everyday and you won't need to use drugs or, disordered eating practices because you'll be healthy and exercising and everything else will be fine because your exercising.

C: So then once you quit using drugs did disordered eating practices start to show up and make promises as well?

A: Yeah. If you don't have time to go to the gym today, then you can just purge everything you ate today. Or just don't eat today. You don't need energy cause you are not going to the gym.

C: Wow it sounds like an evil tag team.

A: Oh yeah, it was one or the other. Like if I didn't have enough money for drugs, then I guess I won't eat today.

It is interesting that when disordered eating practices and substance misuse show up, they present themselves as quick solutions to get Megan to where she wants to be. It appears as a way to help her. It is as if both problems know that she does not want them in her life, but they offer her a fast way to achieve thinness, and then in a week she can stop the drugs and the disordered eating practices, and she'll be 'healthy and exercising.'

They work out what ‘she wants’ and knowing that she doesn’t want to use again, offer it as a temporary way to achieve what she does want.

Below Hannah describes how she used eating disorders as a cover up for her drug use, one problem taking the fall for the other. People can then attribute her ‘thinness’ to an eating disorder rather than to drugs and alcohol. We can see how in this example disordered eating practices become an alibi for substance misuse. It takes the blame and diverts the attention from the substance misuse problem. Clever, very clever. It also speaks to her understanding that disordered eating practices may be a more ‘acceptable’ problem for a young woman to have than a drug habit. During the interviews another young woman described how she felt justified in ‘having an eating disorder’ as it was just her ‘dirty little secret’ and thinking ‘everyone does it.’

Hannah:

C: Like, did eating disorders ever try to define your identity? Did you ever refer to yourself as anorexic?

A: If I said I was it was like to hide that I was, like using at first. I told people I had an eating disorder. Don't worry about it.

Any means necessary to lure people back

It is often when people begin to gain some freedom from one problem or the other that the other problem begins to rear its head.

Beth describes how the problems attempt to ‘get her back.’

A: Or it's like you try on an old pair of pants that don't fit any more. I think that's a big one, too.

C: So how would drugs and alcohol team up with a pair of pants not fitting in that moment?

A: Because I'm really skinny when I'm doing drugs. I may not have looked as healthy but I was a lot thinner.

C: And could you go quickly down that path?

A: Oh yeah.

Megan:

C: Did you find that disordered eating practices affected your thoughts or showed up at points when you were at Peak House?

A: At first, yeah, when I started like eating regularly and like regularly eating three meals a day and even though it was healthy, you know I noticed that I was gaining weight because my body is like, 'Oh my God, what's going on?'

Beth:

A: Well with the whole, anorexia that totally made drugs come back into my life.

C: Yeah?

A: Oh, yeah. Like when I quit, I had a year clean, right, and I wasn't purging or anything and then all of a sudden I got back into that [disordered eating practices] and shortly after that, I was back into drugs.

C: Okay, so how do you explain that?

A: I didn't lose enough weight and I was like so focused on weight that I wasn't dealing with anything anymore. I was trying to figure out something else to push it off to again and it was a hell of a lot easier like I said.

C: At the time did you know that's what pulled you back, like, were you aware of it at the time?

A: No.

C: No? What did it have to do to get you to not really notice what was happening? Like, how did it sneak in there without your knowing?

A: Because I wasn't dealing or looking at anything, right?

Beth describes how the problems begin to take up all of a person's time and energy. She became distracted with losing weight and stopped dealing with other things in her life, which then made more space for the problem to show up and become a way to help her cope with whatever she needed help with.

Hannah:

C: Okay. Did one ever use the other to sneak back into your life? Or did you ever try to quit drugs and then maybe gained a little bit of weight and then,

A: Yup.

C: Do you want to say more about that?

A: Like, when I quit drugs I gained the weight back. I would eat so much and then I would be so unhappy with myself that I was actually eating so I would like throw it up. Then I would go days without eating and I became so unhappy with myself that I went back to drugs. And I remembered how fast it worked [losing weight] like the first time.

C: So when you went back to drugs was it like I'll go back and I'll be loaded for a long time or was it like, I'll go back and lose X pounds and then stop using?

A: Yeah. I'll just do it a couple of nights and then I'll be fine.

C: And did that work?

A: No. Not at all

C: So it lied to you in order to get back into your life?

A: Um-hmm. Yeah.

Teaming up in treatment

Interestingly, the places that are designed and set up to help people find freedom from their problems are often the places where people find other problems rearing their ugly heads. The 'other' problem (substance misuse or disordered eating) is most often shrouded in secrecy, which helps the problem flourish. Jessica astutely describes this when she entered treatment for substance misuse. She did not mention struggles with disordered eating practices so it could be her back-up to fall on should she need it. Because of this sort of reasoning, we need to find ways to support young women in coming forward with these problems so that they are not left at the mercy of eating disorder practices or substance misuse.

Jessica:

C: When you were working with therapists or other counsellors did you ever have the experience of having to hide one problem or the other?

A: Yeah. I felt like I did. I wasn't completely honest.

C: And which one ended up getting hidden?

A: I think the eating disorder. I never really told people about that.

C: How come?

A: I don't know. I thought it was embarrassing.

C: Did people ask you questions about it at all?

A: Yeah. They're like have you ever had an eating disorder and I was like 'No, I haven't.'

C: So you kept quiet about it because you thought it was embarrassing. Were there other reasons that you kept quiet about it?

A: Yeah, that I won't be able to go back to it [to the eating disorder]. If I decided I wanted to go back to it, it would be harder for me to go back to it when I was there [in a treatment program]. If I found that I couldn't handle not having drugs, I could go back to the eating disorder without people being suspicious of me because they wouldn't be looking out for it. That was my thinking back then.

C: Do you think the eating disorder was influencing your decision not to tell anyone?

A: Yeah, I had something to fall back on if I couldn't handle not doing drugs.

In this way disordered eating practices shows up as a safety net, promising to help her out should she need it. This begs the question, what 'safety nets' can treatment providers put in place for young women as they are getting free from both problems so that either substance misuse or disordered eating practices do not seem so appealing.

Beth:

C: When you were at Peak House did you think that you were going to have to hide it? Like did you think that you'd get kicked out if you were caught throwing up here?

A: Yeah.

C: So in a way did that put more pressure on you that you couldn't say anything?

A: Yeah.

C: Was that a useful kind of pressure? Or was that a pressure that worked or sided with bulimia?

A: The pressure sided with bulimia, bulimia was like keep hiding me, don't tell anybody right.

Emma:

C: What did like drugs and alcohol and eating disorders need to take advantage of or convince of you in order to become part of your life in the way they did?

A: Yeah. That's a really, really good question.

C: It is? How come?

A: Yeah. That's a really good question. Because I can't honestly say that there has been a time where I have been getting treatment for one thing where the other hasn't been secretly active. Like I felt like I had to hide it.

Beth:

C: You said purging showed up for you here [at Peak House] once you quit using drugs?

A: Yeah.

C: Did it show up in a bigger way than it had been around in your life before, or the same kind of way?

A: I think in a bigger way because I knew that this time I actually wanted to quit using drugs. People kept telling me I was going to gain a lot of weight in treatment and I flipped out because I didn't want to gain weight, so I started purging really bad.

C: So when you were purging was it just about trying to lose weight or did it also serve other purposes?

A: No, it helped me through my feelings of anger and like upsetness. Instead of crying you can just get sick [purge] and get it all out, I guess.

C: When you were here did bulimia offer you different promises about helping you out when drugs were not in your life?

A: Yeah, it substituted something. It replaced the drugs because like I still knew that it was going to make my feelings like not so bad. It was going to make me thinner like you know. All those kind of thoughts. It became just another way of escaping and not dealing with everything, right?

It is interesting how disordered eating shows up as a way to take care of her problems, promising to help her feel better. They promise an escape.

Alexa:

A: Doing drugs like you know, I didn't feel anything for maybe a year—since grade nine, I've been smoking weed or drinking regularly since then. Then when I started using 'blow' it took all my feelings away. Whereas with disordered eating practices, well it was still there, but it snuck in a lot more here. It was like it knew that I was trying to get on with other things.

C: How do you explain that it snuck in a lot more here?

A: Because I was gaining weight back and I didn't want to turn to drugs to lose that weight, you know, but I didn't think it was wrong to have disordered eating practices. But then slowly, you know when I was here I was looking at myself, like I'm such a fuck-up and I'm18 years old, my best friends are going to school,

or working, you know, and I have my little niece coming to rehab to visit her auntie, you know. It's fucked up. Fucked up.

C: Did that thinking ever make more space for disordered eating practices in your life because you were thinking that you're such a fuck up?

A: Yeah. It was like well at least I'm not doing drugs, so it doesn't matter if I have disordered eating practices you know. Its like fuck it. Like I don't care.

The above section has illuminated the ways that the problems of disordered eating practices and substance misuse can work together to stay active in a young woman's life. By unmasking the tactics that the problems use we are better equipped to ask questions about them, and change our practices to better reflect the ways that the problems work in the young women's lives. Below are some questions that can be of use to help unmask the 'relationship' between substance misuse and disordered eating practices.

Questions Regarding the Interplay between Disordered Eating Practices and Substance Misuse

- Did one problem ever try to use the other to sneak back into your life? How did they do that?
- How do substance misuse and disordered eating play off of each other?
- Have you noticed any similarities in the way drugs and alcohol and disordered eating practices worked in your life?
- What do you now know about the ways that the two problems interacted in your life?
- How did you begin to understand this?

- Have you noticed that substance misuse and disordered eating practices share any of the same tactics or fulfil the same purposes?
- Did they offer you different promises? Or were they the same promises
- Are there times when substance misuse and disordered eating practices were more likely to try to use one or the other to sneak back into your life?
- Are there times or places when/where you may be more vulnerable to the problems trying to sneak back into your life?
- Did the problems ever try to get you to stay quiet about them? Why do you think they did this? Did they ever bully you into doing so?
- Do you have any ideas about how one problem or the other might flourish in a treatment centre?

Section 6. Movement Away and Communal Solutions

In section 3 of this chapter I described the requirements of the problems for their survival as secrecy, a changed sense of who you are, diminished care for oneself, and believing the empty-promises that the problems tell. In section 4 I looked at how young women were ensnared, and recruited by the problems of disordered eating practices and substance misuse. This section will focus on ways in which young women begin to move away from these problems and keep some space between themselves and the problems. This section will be sub-divided under four headings: (1) what the young women describe as helping them gain some space from the problems, (2) what family members and supportive people in their lives did, (3) what therapists did or what they would like them to do in order to support them in gaining space from the problems, and (4) the advice that they would give to young women struggling with similar problems.

Throughout the interviews, the young women were invited to reflect on the actions that they had taken to begin to free themselves from disordered eating practices and substance misuse and to reconnect with how they preferred to be acting in their lives. Inviting youth to take a reflective position supported them in accessing the knowledge they had about themselves and the problems interconnections. When people are involved with substance misuse and disordered eating practices, they are ripped away from what Adams-Wescott, Dafforn and Sterne (1993) refer to as self-knowledge. Having therapeutic conversations that highlight this knowing positions the young women as capable of challenging the problem-storied notions that they may believe define them and creates alternate possibilities for these young women's futures. Karl Tomm (1989), describes how "…reflexive questions [that- deleted] enable self-healing…these questions embed the notion that the patient does have choices, and that the patient is an active agent in the course of their own lives" (p. 56). It was my hope that during our conversations the young women experienced a sense of agency in their lives and over the problems (Tomm).

A large part of the therapeutic work with the young women involves unveiling the lies of the problems. Doing so supports them in seeing the *actual effects* that these problems have in their lives. A slow and careful line of questioning about the impact that the interconnections of these problems have on their lives can open the door to noticing or articulating the effects of these problems. This part of the work often involves a detailed exploration of the influence that disordered eating practices and substance misuse has been having on their lives and then asking the young people what

they make of this (White & Epston, 1990). A dialogic space is created where the young women can question the impact that the problem is having on them.

For example

- Are you okay with the impact that disordered eating practices and substance misuse have been having on your life—that they have ripped you away from the people that you love? Why or why not?
- Are there any aspects of the problem that you did not sign on for?
- If you had been given a full disclosure as to where these problems planned to take you would you have signed on for them? Why or why not?
- Are there any aspects of the way that the problems are treating you that you have questions about or are not okay with?

In taking a position against these problems, the young women begin to take a position for themselves and their own lives. Therapists should be aware that while we are having a conversation with the young women, the problems may be countering and interpreting every question that the therapist asks. Given that we are taking a position for the person and against the problem, we are a threat to the problem. In order to counter this, therapists can inquire about what the problems are making of our conversations, and what the problem thinks about the questions that we are asking. For example, we might ask the young women what they think substance misuse or disordered eating practices thinks about our conversation, or if the problems are trying hard to influence the way the questions are being answered. We can also ask about anorexia's and substance misuse's rules that they had to break in order to attend therapy.

One of the things that the young women described as helpful was looking at the actual effects and impact that these problems were having in their lives. Therapists can support young women in breaking the spell of substance misuse and disordered eating practices by asking about the young women's strengths and about the things substance misuse and eating disorders have ripped them away from. We can support them by enquiring about qualities that they might have forgotten because of the focus on disordered eating practices and substance misuse. It may be helpful to speak to their loved one should the young women have a time remembering preferred qualities (Maisel, Epston, & Borden, 2004). In doing the above we are supporting the young women to reconnect with themselves in preferred ways.

What Young People Described as Helpful

No longer believing the promises

The young women described different ways to get some space from the problems, but some of the recurring themes were that they 'got fed up' or 'tired' of the impact these problems were having in and on their lives. They described a sort of space developing between themselves and the problems, which enabled them to see the promises of disordered eating practices and substance misuse for what they are. Some young women described beginning to see that the 'costs' of the promises no longer outweighed the 'benefits' of disordered eating practices or substance misuse. Slowly the young women see through the problems' lies and question the promises that they offered them. In regards to the promises, Savannah says she now knows "that they are a bunch of bullshit, and that they [disordered eating practices and substance misuse] keep you stuck in one place."

Jill describes a similar experience below where the cloak of lies surrounding substance misuse and disordered eating practices appears to have been lifted.

Jill:

C: How did you begin to figure out that there were other ways to feel good about yourself that were not dependent on your appearance?

A: Well first I had to realize that those things didn't help me, they didn't help me! They may have changed the way I looked, but they didn't change the way I felt about myself. They did temporarily, but then I wasn't happy. It didn't change my life, it didn't work for me and it didn't solve anything, it just made things worse.

As previously mentioned all the young women I interviewed (with the exception of two) were attending a residential substance misuse program and were free from drugs and alcohol. For many of the young women this was the first time in a long while that they were free from substances. After being in the program for a couple of weeks, the women described noticing that their thinking cleared once the fog of drugs and alcohol began to lift, better enabling them to see the consequences of substance misuse and disordered eating practices for what they are and just how much of an impact they had on their lives.

Rachel describes how shortly after arriving at Peak House she recognized that change was possible.

Rachel:

A: Like when I first got here, things were a little hard, like you know, not easy or whatever, but after like the first few days, I actually started to notice how

things can be different, and seeing a few changes in myself right at the beginning. It kind of made me feel that things really can be different and it made me, like, not want to go back. Like okay, if just being here has made some changes, what can I do when I'm really trying to change.

When people get some time away from substance misuse and disordered eating practices, their thinking becomes clearer and they begin to see the impact that drugs and alcohol has been having on their lives. In stepping away from the problem even just a little, they have a different perspective from which to view the problems. If the problem is not running their lives and directing their thinking, they are better able to see the devastation the problems have caused in their lives and their relationships. When people gain a sense of agency, they can begin to have some hope that they can gain some freedom from the problems. One of the ways that substance misuse and disordered eating practices keeps people captive is by convincing them that they don't have a problem and that they can stop at anytime. Both problems work very hard to keep people believing that they don't have a problem. For example, 'look at that person, they are way worse off than you' and telling them 'you can stop anytime you want to.' Often the young women only begin to recognize just how much of a problem they have when they attempt to stop. As Rachel said above, she began to notice changes in herself, and these changes had her wondering if she might be able to make more changes in her life. In recognizing these changes she may begin to have some hope that things can be different.

Using the strategies of one to get free from the other

Once young women find some freedom/distance from one problem, they might notice that they are still struggling with another problem. For example, when a young woman enters a substance misuse program and has some time away from drugs and alcohol she might notice that thoughts or practices of weight preoccupation, restricting, bingeing, or purging begin to show up, reappear, or increase. These may be familiar thoughts and practices or they may be new. This is where the knowledge of what it took to get free from one problem can be useful in finding freedom from the other. In other words, the strategies that a young woman uses to get free from alcohol and drugs may also free her from disordered eating practices. Alexa describes how she used what she knew about freeing herself from drugs and alcohol to help her get some space from disordered eating practices by thinking about it as a drug.

Alexa:

C: So what did you have to do to get free from drugs and disordered eating practices in a way that you're no longer vulnerable to them teaming up together?

A: Learning here that all the things that drugs do, and then once I learned all those things that made me strong against drugs. I learned more and more about disordered eating practices by myself. You know we don't have therapy sessions everyday on disordered eating practices, so it's like, I learned by myself, by almost thinking of it as a drug and if I thought of it as a drug – I'm still—I'm being weak like I was to the drugs. I'm just letting it [disordered eating practices] take over me. Like 'You're still depending on me ha-ha ha, sucker.'

That's not me, I didn't – I had disordered eating practices when I was using. It was part of my using habits and I don't want my using habits any more.

C: So you began to think of it almost like a drug. What did you begin to notice about the two that led to that discovery or way of thinking?

A: Just thinking about the fact that it takes over my mind. It's not a question whether or not I was going to use every day. I was going to use every day because you use, you know. I'm a drug addict. I use every day. And I was like I have an eating disorder. I'm going to eat as little as I can each day and throw up whatever I eat, each day. It is not a question it was part of my lifestyle, which took place while I was using, so it was my using lifestyle. Like lying, stealing, and cheating. That was all part of everything.

Alexa describes how both problems made her 'weak' and had her 'depending' on something other than herself. Alexa knew that substance misuse and disordered eating practices were intertwined in her life and that if she wanted to be entirely free from one problem than she also needed address the other. In recognizing this she realized that if she wanted drugs and the lifestyle that went with it out of her life, then all of the practices that went with it; lying, cheating, stealing and disordered eating practices needed to stop as well. Below Megan speaks of a similar experience, and how cutting out drugs and alcohol led her to consider the impact that disordered eating practices were having in her life.

Megan:

A: Yeah. It came hand in hand for me, and now I'm glad that they came together so that when I cut drugs and alcohol out of my life it wasn't as hard for

me to cut disordered eating practices from my life too. It wasn't two totally separate problems for me. Like, I kind of learned to deal with drugs and alcohol, and then thought well why am I still doing this? It doesn't make sense. Just being open to criticizing yourself.

C: What do you mean? Say more.

A: Like, kind of getting mad at myself too. Like why are you doing that? For the first week I was still trying to purge, cause I didn't like what was going on.

C: Like what was going on with your body?

A: Yeah. I didn't know anybody here so I wanted to still be that smaller person, cause people would then want to be my friends. But now I look back and I think that was stupid. Like now if I ever get those thoughts I think why would you do that? That doesn't make sense. It's like calling yourself on what you're doing.

Megan describes how one of the tactics that disordered eating practices used to try to sneak back into her life was that it would be a way to help make her body smaller, and that if she was thin then other people would want to be friends with her. Just recognizing these tactics makes a person less vulnerable to them appearing in their lives, as they can notice when the problems are making a play for them, and interrupt them rather than acting on it.

From the interviews it became apparent that the realization that they go hand in hand is very important. There appears to be a turning point when the young women decided that they no longer wanted any of these problems in their lives, as they were not in line with their hopes for their lives. When people begin to see both problems as 'a problem' rather than separate problems, they begin to realize that in order to break free

from one there can be no room for the other. At this point the recognition that one problem can lead to the other and can feed off of the other can be very helpful. For example, if a young woman is taking a firm position against drugs, and knows that disordered eating thoughts and practices bring her closer to drugs, then this gives her all the more reason to be on the lookout for the ways in which disordered eating practices can sneak back in. When young women become astute at recognizing the 'tactics' of the problems they are less vulnerable to them sneaking back in. This discovery appears to be important in helping people get free from both problems.

Michelle articulates her knowings of the interconnections as follows:

A: If I don't keep up the healthy eating habits then I'm going to fall back to drugs. Because for me, they go hand in hand. Other people, they, other people can just have one, which in a way I kind of, I don't know. Like sometimes I think it would be easier to only have one of the problems. But at the same time, I think it would be a lot harder, because – like being in here, I know once I get out, if I start doing drugs, the eating disorder will come back. But if I start having the eating disorder again, then the drugs are coming to come back. But if I only had one, I don't know what would be – like holding me up – keeping me away from them.

C: Having both keeps you away from both?

A: Yeah. Yeah. And I don't, like, a lot of people don't think like that but that's kind of what keeps me holding on to staying away from both of them.

As people take steps away from problems they also take steps toward acting in ways that are more in line with their values for how they wish to be in the world.

Below, Alexa describes how she wants to be honest with the people in her life, which then leaves no room for substance misuse or disordered eating practices as they both involve lying to people around her.

Alexa:

C: Are there things you tell yourself that help remind you of how when you are happy with yourself you don't need disordered eating practices or drugs?

A: Yeah I remind myself of all the people I have hurt by lying and that I was hurting them by lying all the time.

C: How does that keep you away from disordered eating practices?

A: Cause I don't wanna be lying and I'm not gonna tell my mom 'Okay I'm just gonna go puke now.' Like disordered eating practices can lead me back, and I don't want to go there. And I just remind myself of that on days where I think 'Ahh, I ate a lot, and I don't want to feel this way.' But I just think about the feelings on other days that I felt that I'm too good for it I know I'm better than what I'd be putting myself through. Cause it hurts people and I remind myself of what people said. Like I have friends that tell me Alexa you're beautiful. Or I'll remind myself of the days when I thought that I looked too skinny. And people have told me, 'you were too skinny, like you look so gorgeous now that you're healthy.'

Alexa also gives a detailed list of the ways in which she speaks back to disordered eating practices. This keeps her from acting on the thinking 'Ahhh, I ate a lot, and I don't want to feel this way.'

As Michelle describes,

A: I mean I still have that craving to use drugs but I also have that fear in me that I'm going to turn into one of those girls that weights X pounds and they're like 25 years old, and I don't want that. And I know that if I keep doing drugs the eating disorder will stay with me.

People begin to take positions based on what it is they want for their lives rather than allowing disordered eating practices and substance misuse to run their lives. In doing so they begin to have more agency in their lives. As therapists we can ask questions that highlight these new developments. For example,

- Is there a disconnect between what you want for your life and what the problems want for your life?
- What type of plans do you have for yourself given that substance misuse and disordered eating practices are no longer directing your life?
- How do these plans differ from the types of plans that disordered eating practices and substance misuse may have had for your future?

Asking questions that highlight these new developments can be seen as asking thickening the stories the young women's may prefer to tell about their lives (White & Epston, 1990; Geertz, 1973).

Preferred selves

When the young women get some space from these problems, their actions begin to line up with how they wish to be living in the world. People are then in a better position to imagine different possibilities for their lives. People also begin to contradict the stories that disordered eating practices and substance misuse tell about them. According to White and Epston (1990):

> …when persons seek therapy, an acceptable outcome would be the identification or generation of alternative stories that enable them to perform new meanings, bringing with them desired possibilities-new meanings that persons will experience as more helpful, satisfying, and open-ended (p. 15).

To this effect, therapists can ask clients to distinguish between how they want to be acting versus how they are acting. For example,

> Megan:
>
> C: It sounds like there is a disconnect between what you want for your life and what disordered eating practices and drugs and alcohol want for your life and those things don't fit together.
>
> A: No. Like being skinny doesn't make you successful.
>
> C: So if you don't want to see yourself as a partier and someone who is all about their looks. How would you prefer to see yourself?
>
> A: I'd rather be seen as someone who does what she says she's gonna do—someone who follows through with her word. I see myself as a person who is strong, like a strong person. Like if I say I'm not going to do something, I'm not gonna turn around and do it.

Drugs and alcohol and disordered eating practices disconnect people from themselves, and rob them from knowing who they are. If they had lived differently in the very far off past, the problems try to convince them that is now unreachable and unattainable. 'That's the old you.' When people gain some freedom from these problems, their preferred actions are often radically different than when they are weighed down by these influences. As we can see above, Megan wishes to be known as

'someone who follows through with her word.' By getting some space from the problems she was able to see that the problems were influencing her actions in ways that were not in line with her values.

Navigating a new territory

An important part of the work in getting free from substance misuse and disordered eating practices is finding ways to get some space from the problems, and to find a way to turn down the volume on the voice of substance misuse and disordered eating practices. When the problems have an enormous influence on how people view themselves and over their lives, there is little space left for the young women to assert influence over their own lives. Once people are aware of the ways the problems work in their lives, such as the times that they are most likely to appear, people and places they might show up around, times when they don't appear, people can begin to learn to navigate themselves away from the problem's territory. People also gain a sense of just how it was that these problems gained the upper hand in their lives. When this occurs, young women can question and talk back to the problems; to the promises, and the lies, and remind themselves of where the problem has taken them in the past and where it can take them again in the future. Below the young women describe the actions that they have found helpful in not getting lured back in by substance misuse and disordered eating practices.

Alexa:

C: Are there things that you do to keep some distance from drugs and alcohol and eating disorders? Are there things you do to keep them from showing up in your life?

A: Yeah.

C: What do you do? Are they the same strategies for both or are they different strategies?

A: These days it's getting more control over my thinking. I am writing in my journal positively. It's like me having a choice in that happy self. And when I look at everything in a good way then I constantly keep seeing things in a good way, then I don't need disordered eating practices and when I'm happy with myself I don't need those drugs. You know they are nothing to me. And being truthful and like honest to myself and others.

Beth describes what she needed to learn in order to step away from the problems, Beth:

C: Okay. So, what did you have to learn to be able to break free from alcohol and drugs and eating disorders?

A: What did I have to learn?

C: Yeah.

A: Yeah, I had to learn different techniques of dealing with things. Like instead of throwing up, I'll go journal, that kind of thing or I'll go sit with people and not sit by myself. And then sometimes I just, like, take a hot bath or put on really comfy clothes so I feel better.

C: Were there things you had to learn to move through cravings for alcohol and drugs? Like maybe how to be with the feelings that alcohol and drugs took away?

A: Yeah. I had to learn how to deal with feelings again.

C: Were there specific feelings you had to learn to deal or sit with?

A: Like, I had to learn that it was okay to cry. I had never really done, that's not how my family is and then it's learning that it's all right to cry. Like oh my god if I ever saw someone cry, I started laughing. Like 'what are you doing?' because I was so like nervous 'Oh my God, why is this guy crying?' So I really have to learn, like, to deal with emotions.

Below Jill describes how caring about 'an image' was getting in the way of her stepping into a better life for herself.

Jill:

C: Were there things that you did that helped catch the problem's reappearance?

A: Catch the problems' reappearance? Hmm, umm I just stopped caring. I just stopped caring about that image that I wanted to be. I just stopped trying to achieve the unachievable.

C: Okay. What did that allow you to step into?

A: A better life, happiness, good self-esteem.

In my experience this is one of the most important aspects of therapy—helping people move forwards in ways that they want to be living their lives. Michael White (2007) writes:

> …intentional state categories like purposes, aspirations, quests, hopes, dreams, visions, values, beliefs, and commitments. It is into these filing cabinets of the mind that people file a range of conclusions about their own and each other's identities. … All of these conclusions, including those of the internal state categories, significantly influence people's actions; they are shaping of life. Put

another way, it is not actually "things" like motives and needs that shape life, but socially constructed conclusions about life (p. 107).

It follows that the questions we ask in therapy can be influential in shaping of young women's lives. Our questions are not neutral and they can begin to be constitutive of a young woman (Andersen, 1992a).

Megan:

C: Okay. So in order for you to break free of this view of yourself, that you had to look a certain way, and had to fit a certain size of clothes and had to be the girl everyone wants to spend time with, what did you have to do to break out of that way of thinking?

A: I had to take a serious look at what I was doing and if that's what I wanted to be remembered for. Like I don't want to look back at myself and think I was at every party and don't remember any of them. And like, yeah she was probably a smallish girl in grade 11 but she looked disgusting. I don't want to be remembered as that. I'd rather be remembered as somebody who was super healthy, right. Like she may have been at a few parties right but she was never like the person passed out on the floor and locked in the bathroom all night.

Our conversations can act as resources to further strengthen how the young women want to be in the world.

Becoming comfortable with ones' self

It appears that care for oneself is an anti-dote to the practices and ways of disordered eating and substance misuse. The young women described how when they began to have care for themselves they were no longer willing to act towards themselves

in the ways that disordered eating and substance misuse require. Breaking free from the grasp of substance misuse and disordered eating practices helped people be OK with themselves on their own terms. The young women described starting to speak to themselves with care, and this appeared to be a turning point in their lives.

Ava:

C: What did you have to do or did you have to learn, in order to break free from taking drugs or say the idea that you have to look a certain way in order to fit in?

A: I used to like looking a certain way, and I think when you get enough self-love, self-care and confidence, it doesn't matter, right. I'm totally comfortable with my body and I'm really comfortable with my face now and I can wear less makeup. I don't care.

C: What did you have to do to get there?

A: Go to treatment.

C: Really and how did that make a difference? How did treatment help you find self-love, self-care, and self-confidence?

A: For the first time in five years I'm not using drugs. I'm not being fooled. I'm taken out of society and the brainwashing and the commercials and the people. Away from the people in my community, where I have to be a certain way and it's just, it's real here. And it's just like accepting I look the way I look. I'm always gonna look the way I look so deal with it. And I know that if I am confident then I'm much more beautiful than the way I actually look and when it comes to like my body and stuff, it's the confidence. If you have the confidence

it shines through more than your actual look, you know. And real people see that. And if you want real people in your life then you gotta be real.

C: Is that the same thing then for drugs and alcohol, self-care, self-love and confidence, that those things act as an antidote to the drugs and alcohol in your life as well?

A: Yeah. Because like when you are using you don't have self-care.

Ava describes how she developed a different understanding of what it means to be beautiful. This new understanding led to a different relationship with her body and to self-confidence. She speaks to how getting some distance from 'society and the brainwashing and the commercials and the people' allowed her to question these practices. She now wants to surround herself with the types of people that support this way of being. Interestingly, Ava remarks that she learned this in treatment. What does this say about the way in which we are raising our young women that they need to leave their people and communities and come into treatment to learn about care for themselves?

Megan:

C: With drugs and alcohol and disordered eating practices are there times when you might be more or more or less vulnerable to the teaming up say in the past or even now?

A: Like now is when you find that self-love, and self-worth and you are happy, not a hundred percent happy but happy enough with yourself that one little thing won't affect you as much as it would have before when everything else is crumbling down. Like if I gain an extra X pounds it's not the end of the world.

Cause I still feel comfortable with myself, in other aspects. Like weight is not everything.

Disordered eating practices have lost their grip on Megan; she no longer believes 'that weight is everything.' Disordered eating practices flourish when they can convince young women that weight is everything—then they will be willing to submit themselves to extreme measures and regimes that disordered eating practices requires. But as Megan states, 'like if I gain an extra X pounds it's not the end of the world,' she can see that she is more than what she weighs or what she looks like. And with this mindset, anorexia looses its power. Hannah describes something similar when she starts to re-think ideas of beauty, and in fact she describes the thinness that she once idolized as 'disgusting.'

Hannah:

C: Okay. So at Peak House when you quit using substances were there times that eating disorders tried to sneak in here?

A: At first, yeah. Like I was eating regularly, like I have to eat when I'm here so it's like 'Oh my God, I'm going to gain so much weight.' Especially the first couple of weeks, right.

C: The first couple of weeks, what happened after the first couple of weeks that made it easier?

A: Well then I started to look at myself and become happier like yeah, I look disgusting. I don't have to look like that any more. I can learn to be happy with who I am. I don't need anything to make or that change that.

The young women spoke of no longer being influenced by the problems in the same way. It was almost like a curtain had been lifted, and they could see the impact that these problems had over their lives. When the curtain lifted they could see themselves, and they were no longer seeing themselves and others through the problems' eyes.

Alexa:

C: So what did you have to learn or what did you have to figure out in order to break free from substance misuse and disordered eating practices so that it didn't have the same kind of power over you.

A: What did I have to do?

C: Yeah?

A: Find self-love.

C: For both problems?

A: Yeah. I didn't love myself while I was using and I didn't love myself while I had disordered eating practices. And as soon as I started seeing that it, it was oh I don't need it. Once I started recognizing all the good things about myself, I didn't need either of them.

C: Very cool.

A: And I recognized that I was fun you know and people cared about me so I didn't need to use drugs. I was looking for more in life. Like I was looking for more friends, more fun, but it's just because I took for granted—I took everything I had for granted already like my good friends. I took them for granted while using and I was looking for new friends. Taking for granted like

how I acted, and how good I looked being sporty kinda thing you know. But then the eating disorder came in.

I was surprised by the amount of times that the young people mentioned self-love as an antidote to these problems. The simplicity of it struck me. As did the discourses, media, dialogue, and practices that rip us away from this place. This simple notion is not so simple when we think of the structures that would need to be dismantled in order to do just this.

Beth:

A: I think just getting away and realizing that it's not what's on the outside that matters it's on the inside. Beauty is on the inside it's much more than skin deep. It's totally your inner beauty that counts and it outweighs the outer beauty by far. Like, you can be totally gorgeous but just a nasty person, you know. Like, would you rather be like this nasty person that looks absolutely gorgeous or an average looking person that has a gorgeous personality.

The young women described developing a gentleness with themselves. They recognized that the re-appearance of thoughts of disordered eating practices or substance misuse does not mean they have to act on those thoughts. In this way they began having more of a say in their lives and over their actions.

Jessica says,

A: In my life, I'm always going to have body image issues and I have acceptance over that. But any time where it's been sobriety from both, the eating disorder is still there, it's just about managing the thought. It's keeping it as a thought and not practices.

Rachel:

C: And how about eating disorders? How long has it been since you've been free from those ideas, and practices?

A: I don't know. Like the ideas reappear all the time and it's just knowing when to be reasonable with yourself.

This suggests that when the young women reconnect with the care they have for themselves that it works as an anti-dote to these problems.

Learning to Keep the Problems at Bay

The young women described learning how to get free and stay free from substance misuse and disordered eating practices by piecing together what worked and what didn't. As therapists we can support people in their journey away from problems by enquiring about the times they feel farthest away from these problems, the moments the problems are not around, the times that the problems feel the closest, and about the people who they feel safest around and who support them in staying free from disordered eating practices and substance misuse (Berg & Miller, 1992). Therapists can also inquire about the feelings that disordered eating practices and substance misuse are most likely to take advantage of, and learn with the young women about the details of just how it is that the problems try to make a comeback in their lives. In this way we can support people in making safer choices with these problems and to be safer with themselves.

Below Emma has conceptualized 'relapse' as existing outside of black and white notions of 'you are clean' or 'you are not clean.' When young women think that relapse equals failure, problems can take advantage of this and convince them that they might as

well keep drinking or purging. However, if we can slow this discourse down we are able to find movements away from the problem, which can develop into a rich storyline for what it is that they want and prefer for their lives, and the ways that they are taking steps towards this. 'Relapse' within this framework is seen as normal, predictable and part of the learning process.

Emma:

C: You know as you say that I have this image of someone deciding to walk off a cliff.

A: Yeah, that's what it is. Yeah. That's exactly the best way to imagine that, because that's what it is.

C: And I'm also thinking about what you have been doing and what you can continue doing to slow down. So that you have a guardrail to catch you before go over the cliff?

A: Yeah. Once you relapsed enough, you kind of get to the point where you have—well, you have that moment of maybe this isn't the best idea, and every time that happens and you do you know, the first time it happens you struggle and struggle and struggle and struggle and work so hard to get back up. The second time you're just like, 'My God, did I do this again?' and it's still really hard. And the third time, like, okay, I know how to do this. It's going to be difficult but I can do it. I've done it before. And then the fourth time it's almost like you've built yourself a little roadblock.

C: Nice, something to slow yourself down.

A: Exactly.

What follows is a list of some of the strategies that the young women described in the interviews as having been helpful in finding some freedom from the problems, as well as strategies that they have used to keep some space between themselves and the problems. These answers were in response to the question, 'Are there things that you do to keep some distance from the problems and/or strategies to catch the problems re-appearance?'

Strategies that Young People Described as Helpful

- Not comparing yourself with others
- Reminding yourself that you are healthier than you were before
- Not glorifying substance misuse or disordered eating practices, and throwing out pictures that do
- Not isolating your body into parts and picking it apart
- Keeping busy and having a schedule
- Distracting oneself when thoughts /ideas of substance misuse or disordered eating practices appear (for example, reading, listening to music, going for a walk with a supportive person)
- Keeping on top of things so that it doesn't lead to feeling overwhelmed
- Writing positively in a journal
- Building important things into your life, so that you have things that you don't want to loose
- Remembering where substance misuse and disordered eating practices took you, playing the tape through, and reminding yourself where it will take you again
- Surrounding yourself with a solid community of supportive people

- Staying away from friends who misuse substances or are preoccupied with weight
- Giving away clothes that no longer fit
- Looking at pictures that remind you of where you don't want to be again
- Remembering everything you are getting back in your life
- Making connections between the ways the two problems work together and how one can use the other to sneak back in

Questions to Address Movement Away and the Communal Solutions that these Problems Can Share

These questions are focused on helping the young women begin to recognize the ways that the problems may be similarly operating in their lives and ways that they may be able to use the strategies that they used to get free from one problem to begin to get free from the other. Some young women may prefer to find freedom from one first and then the other; others may choose to address the two simultaneously.

- What did you have to learn to begin to break free from substance misuse and/or disordered eating practices?
- Are there strategies you have been using to get free from one problem that might help you get some space from the other? Or, Are there strategies that you may have used to get free from one problem that you are finding helping in gaining some freedom from the other?
- Since getting free from disordered eating practices or substance misuse what have you learned about yourself (skills, preferences, abilities) that may assist you in finding freedom from the other problem?

- With drugs and alcohol and disordered eating practices are there times when you might be more or more or less vulnerable to the teaming up? Are there certain times of the day, people or places that you need to be careful around?
- Are there things that the problems may try to use to their advantage to try to sneak back in your life? How might they use the other problem to help them sneak back in?
- What are the things that you do to help catch the problem's reappearance? Are these the same for both problems? Different?
- Are there things that you do to keep some distance from substance misuse and disordered eating practices? What do you do? Are they the same strategies or different strategies?
- What did you have to do or have to learn, in order to break free from substances or disordered eating practices so that it didn't have the same kind of power over you? How did you begin to figure this out? Did anyone help you in this?
- If you continue to gain freedom from these problems where do you imagine being in a months time? In 3 months time?

What Family Members/Important People in Their Life Did

This section stands against mother blame and individualism. It also supports my argument against individualist notions of self: people need people to live and create change in their lives. As therapists, an important part of our work is to create audiences and communities for the witnessing of new meanings, practices, and understanding. It is through this process that a preferred or re-remembered performance of self can emerge.

People come to know what they know and to know themselves through community and connection with others.

This also speaks to the importance of having support in women's lives in order to find and maintain freedom from substance misuse and disordered eating practices. Sometimes this is difficult, as disordered eating practices and substance misuse can rip through families and cause huge divides. Its difficult for families members to hold onto their memories and knowings of 'their little girl' when their daughter is acting in ways that they could never have imagined possible. Disordered eating practices and substance misuse gain even more strength when they manage to turn the young women against their families and their families and friends begin to lose hope that they will ever see their daughter or friend again. Disordered eating practices and substance misuse also work hard to turn family members and friends against the young women. Yet the people in the young women's lives are important resources and can act as memory keepers (Maisel, Epston & Borden, 2004); gently reminding them of who they are, until the fog of drugs and alcohol and disordered eating practices begins to clear and they can see themselves again. Therapists can work to create a community of concern (Madigan & Epston, 1995) to stand alongside them as a way to begin to break up the isolation and disconnection from community and families that substance misuse and disordered eating practices strongly try to impose. People need connections and support to stay free from substance misuse and disordered eating practices. Countless other therapists have written about the importance of having an audience and a community to witness and hold a person's memory. Tom Andersen (1987, 1991), Barbara Myerhoff (1982, 1986), Michael White & David Epston (1990), Stephen Madigan (1999), The Just therapy

Team (2003), all work hard to connect and reconnect people with important community and family members in their lives and 'back with themselves.' Letter writing campaigns can act as counter-documents to the words/voices/lies of drugs and alcohol and disordered eating practices (Madigan & Epston; White & Epston).

Family members and other supports offer a different perspective than the perspective that substance misuse and disordered eating practices give. So it seems that when people become self-reflexive, they can start to change, and take steps away from the problems they are faced with. This is good 'evidence' that the modernist, individualist discourse, which tends to be unreflexive can generate further pathology (S. McNamee, personal communication, August 23, 2009). Given that the modernist notions of psychology locate problems internally there is little space for the generation of new knowledges that relational externalizing allows for (Bird, 2000).

In the interviews it became apparent that the problems worked hard and often succeeded in ripping the young women away from their support and turning them away from the people that loved and cared for them. When this occurred, the problems appeared to gain more strength. Below I have included examples from our conversations that describe the importance of connection and community as an antidote to the problems of disordered eating practices and substance misuse.

Family, Friends and Community Members as Allies

Families and friends can act as allies to support young women in getting their lives back from substance misuse and disordered eating practices. They are memory keepers, supporters, and helpers in the process. If family members engage with the idea that disordered eating practices and substance misuse are external intruders, they can

leverage themselves against the problem. Family members can be instrumental in helping young women question the impact that these problems have in their lives and in getting them to a counsellor or treatment program. Hannah and Rachel both reflect on the importance of support in helping them get to Peak House.

Hannah:

C: In order to break free from this view of yourself what did you do, did anyone else help you break free from that view?

A: Paul

C: What did he do to help you?

A: And his mom. I don't know, just gave me like support to get help. Like he didn't force me to do anything. They let me live with them and they were like well maybe you should go to treatment because that would be the best thing to go and if you don't like it you can come home. I wasn't being told, like I had to come to the conclusion I wanted help. But just having people being there to support me no matter what I did.

Rachel describes her friends and family as instrumental in getting her to Peak House. She describes how her mom thought she was 'getting really depressed and stuff' so she got her to see a counsellor.

C: Were there times when alcohol and drugs and eating disorders have been less of a problem in your life, and if so what actions did you take to make this possible.

A: Being here. And being with certain people.

C: Were there certain people that lessened the strength of the problem?

A: My friends, my family, and I went camping, and I remember I broke down before we left and I didn't want to go back. I told my family that I was scared that I'll start using again and having this time away from drugs and being here with you guys like, just changed everything so much I don't want to leave because things will go back to the way they were. And they said, you know, its up to you to change; 'we can't live here forever, this isn't our house.' So we went back and things did go right back to where they were, but it really did like—I think that going there that time, after trying to clean up so many times really made a difference and like I remember shortly after that I was cleaning my room and I found the Peak House flyer that the drug and alcohol counsellor gave me and I just found it and actually read it and that really helped me.

In the time that Rachel had away from the problems she was able to see a different perspective on how things could be if the problems were no longer in her life. Counsellors can plant seeds of information (H. Elliott, personal communication October 3, 2006). Perhaps young people are not ready to act on the information now but they might at a later point, as Rachel describes her counsellor had previously given her a flyer for Peak House but it wasn't until later that she entertained the notion of attending.

Given the power that substance misuse and disordered eating practices have to rewrite people's identities, families and friends can act as allies against this (Maisel, Epston, & Borden, 2004). Families can refuse to side with the view that the problems are trying to have them see.

Jill:

C: In order to break free from this view of yourself, what did you do or did anyone else help you do in order to break free from that view of yourself.

A: My guardian helped me get through it, and see who I am, he reminded me of who I am. He's known me most of my life and he kept reminding me of who I am.

Megan explains the importance of her mother having held on to her memory when Megan was under the influence of the problems.

Megan:

C: So how or did anyone help you take that serious look at yourself and recognize this isn't what I want; I don't want to be that girl in the bathroom?

A: My mom. Because she was really close to me my whole life. She saw the changes and I didn't want to see them. She kept pointing them out slowly and making me look at myself even if I didn't want to. She kept making me look at what I was doing and saying this isn't you. I don't know who you're trying to be but it's not you.

C: What did she help you see?

A: She made me feel like—like the daughter who she knew, like the daughter I was—who a few months ago, was always prepared for school, always organized and just like on top of everything, and then looking at who I was then, I didn't have anything organized because I was too busy worrying about how I looked or how other people were seeing me. But not important people like the teachers.

Friends, Family and Community to Help Keep some Distance from Substance Misuse and Disordered Eating Practices

A supportive community of concern (Madigan & Epston, 1995) can act as an antidote or barrier to the empty void that problems attempt to drown people in.

Ava:

C: So are there any things that you do to help keep some distance from eating disorders, drugs and alcohol or any strategies that you use to catch the problems reappearance?

A: There are meetings for substance misuse and meetings for eating disorders as well so, meetings and being around people. And one of the big things is knowing you are not alone and knowing that I can say anything at a meeting. Feeling alone is such a bad shitty feeling 'Oh I'm alone and I'm the only one going through it'—but really you aren't. So being unable to say it feels like no one else in the world knows what I feel—and just being able to share that emotion with someone kind of helps to take it away. It kind of helps when you're having a hard time and you see someone who's gone through it and they are happy now, that gives you hope.

Hope that change is possible is such an important part of change. As therapists, part of our job is to hold onto hope when others' hope is thinning. The possibility of hope is often what keeps people moving forward, and refusing to give up. The young women all described how their hope expanded in connection with others.

Megan:

C: Are there things that you do that help you keep some distance from disordered eating practices and drugs and alcohol or are there strategies that you use to catch the problems from reappearing?

A: Being around people who don't—like who aren't using and people who want to have lives free of drugs and alcohol and disordered eating practices, people who aren't—who you know aren't using behind your back right.

C: Why is that important? How does that keep drugs and alcohol far from you?

A: Because it's not—like it's not in your life. It's not in your life at all.

Below Megan offers her observations on the ways that strong relationships not only helped her get free from problems they are also what continue to keep her from problems.

Megan:

C: Are there strategies that you use to catch the problems from sneaking back in?

A: Mmm, I haven't really put that to the test yet so I don't really know.

C: What do you imagine doing?

A: If I have strong relationships with my family, I know that I don't want to hurt them anymore. Also like I don't want to lose their support, so I keep that in mind. And my supportive friends I don't want to let them down. Just keeping them and my health in mind.

When a young woman begins to take steps or even begins to contemplate the possibility of freeing themselves from disordered eating practices and substance misuse this is a huge feat. Family, friends and therapists can act as important resources in

helping people remember who they were prior to alcohol and drugs and disordered eating practices making an appearance in their lives. In our work as therapists we can invite others to stand with the person against the voice of disordered eating practices and substance misuse. Connecting and reconnecting people with others helps make real the support–it is an embodied connection with others. It helps take the power away from disordered eating practices and substance misuse if someone is standing with them.

Ava:

A: You're less vulnerable when you're happy.

C: How is happiness an antidote to the teaming up?

A: I think when I'm truly happy I'm being supported—and I can see clearly. I can see that drugs won't make me better and it's not going to make me look any better or be any better or be any cooler, and certainly not like any eating disorder.

Ava continues,

C: Did it make a difference having other people around you helping you quit?

A: Yes. Because you know, people think they can do it on their own but you can't. The drugs in your brain, they're making you think you can, but you can't.

Family members, parents, and friends, can hold onto their knowing of a young women until she is able to join them in this (Maisel, Epston & Borden, 2004). Just as problems counter the words of loved ones, loved ones can counter the words of the problems. For example, parents can speak to their concern that the problems are causing in the young persons life, and can express their worry about the

ramifications this is having. They can ask questions about how these practices might be interfering with the young women's dreams or hopes.

For example, I was working with a young person struggling with disordered eating practices and she was describing a party that she was invited to go to on the weekend. In a very anti-anorexic move she was planning on attending, but was noticing that since she had made up her mind to go, anorexia had been ramping up its strategies to keep her from going. Anorexia had given her permission to go if she didn't eat for four days before the party. Anorexia was also trying to convince her that she had nothing to wear, telling her she was too fat to fit into any of her clothes. She described the painful process of trying on many outfits none of which met anorexia's requirements. As she described in detail her agony over getting dressed for the party she was invited to imagine her best friend standing alongside her as she was getting dressed. We discussed what her friend would say about how she looked, and what anorexia would be telling her about her friends opinion of her. I asked her what her friend would say back to the voice of anorexia if she was able to speak on her behalf. What would her friend think about the way that anorexia was talking to her? Would she be okay with this? Would her friend agree with what anorexia was saying or would she have a different opinion? The young women's friend was an important voice to counter the all-powerful voice of anorexia, and supported her in not having to be alone with anorexia, thus beginning to build a community of concern (Madigan & Epston, 1995).

Questions to Enquire About What Family and Friends Did That Was Helpful

- Have there been ways that your family and friends have been supporting you in getting some distance from substance misuse and disordered eating practices?
- Who in your life do you think would have known that you would have been able to find some space from these problems? What do they know about you that would have them knowing this?
- What person, place or thing has most supported you in finding freedom from substance misuse and disordered eating practices?
- What would you like the person's in your life to know about how they can best support you in moments when you are struggling?

What Therapists Did That Was Helpful and/or What Young Women Would Like Them to do

This section highlights the intimate *local knowledge* (Geertz, 1983) or *insider knowledge* (Epston, 1999) that the young women have regarding their lives and their experience of the problems of disordered eating practices and substance misuse. It speaks to the importance of listening and honouring the young women's wisdom and the direction they wish therapy to go in (Anderson & Goolishian, 1988). In the preface to their book, Insoo Kim Berg and Scott Miller (1992) write, "this book is based on our faith that all clients have the resources and strengths necessary to solve their own problems, that they know and want what is good for them, and that they are doing the best they can" (p. x). I wholeheartedly agree with that. In fact, this dissertation is a testament to that statement. During the interviews I asked the young women what their

experiences with therapists was regarding what they had found helpful and or unhelpful when addressing the problems of substance misuse and disordered eating practices. The young women had many ideas about what was helpful and unhelpful for therapists to do. These ideas are 'not truths' pertinent to all young women experiencing these problems. Rather, they suggest some potential avenues for conversation regarding the interplay between substance misuse and disordered eating practices.

Communal conversations

Part of what motivated the interviews was my curiosity to hear the young women's ideas about how the problems may have worked together in their lives and their ideas regarding how to use the interplay between the problems to gain some freedom from them. As all of the youth I spoke with noticed and described some sort of interrelatedness, I became curious about how therapists could have been more adept at enquiring about this interplay, and if they did what difference might this have made.

Beth:

C: How could therapists have been more helpful to you when you were struggling with these problems? Are there things they could have done or asked?

A: Just talk about how they do go hand in hand and how a lot of people struggle with it. Because I honestly didn't think that many people struggled with it.

C: When did you figure out that more people struggle with it than you thought?

A: Just talking with people and sitting down and talking with your crewmates. I found that so helpful having crewmates coming and asking me questions. At

first I was overwhelmed but then I realized I can actually help someone and that's cool.

Problems thrive in isolation, and they flourish when people are convinced by the problem that 'they are the only person experiencing this problem.' In isolation, the problems can convince people that 'If other people knew they'd … (fill in awful consequence here).' The problems grow in silence, and often as the problem grows, the young women's shame grows as well. When therapists wonder out loud, 'other young women have mentioned that they have found that disordered eating practices and substance misuse sometimes have a way of teaming up together. Has that been your experience?' they can contribute to a young persons experience of 'I'm not the only one….' This development could then lead to a person unmasking some of the other 'lies' that the problems have told them, because if the problems lied to them once they may begin to wonder, could they have told other lies?

A few minutes later in our conversation Beth adds:

C: What difference would it have made if both were addressed at the same time versus addressing the eating disorder first and substance misuse second or, alcohol and drugs first and then the eating disorder?

A: I think it would have made a huge difference to do them both at once because then you're able to actually do all your work instead of you're still like running away from doing one or the other, right. But if you're just addressing both problems at the same time, then it gives you a lot more headspace, and like a lot more time to like make realizations about things right. It's much easier to do both at the same time than one at a time. Because the more you get sick [purge]

and stuff you realize you don't loose as much weight as when you are doing drugs and then you want to do drugs or vice versa, right.

C: Would it be difficult to deal with both at the same time do you think?

A: Well, it's not easy to do in the first place.

C: Good point!

A: I think it would be easier to do them both at once. Although you may think it seems harder at first because you know that's just like quitting smoking, and quitting drugs, they're both two hard things but still if you do them together, it's a hell of a lot easier.

It is interesting that Beth wants to address them both at once as for her this would be easier. If young people had previously been having conversations about the interplay between the two problems and were 'prepared' for the problems to ramp up their tactics in order to get them back, they might not be so vulnerable to the teaming up of the problems. As Beth described above, knowing that drugs can take advantage of ideas like 'I can make you thin again' could be advantageous for her, and she could in a sense be prepared for this should it happen. If the silence and secrecy that these two problems flourish in is unveiled then young women might be more prepared to speak about it, as shame might not weigh so heavy into keeping them silent about one problem or the other.

Rachel describes wanting therapists to start talking about the connections more as well.

Rachel:

A: I don't think people really realize the connections between the drugs and eating disorders.

C: So should therapists and young women be having more conversations about the connections?

A: Yeah.

C: What difference do you think that would make if that were happening?

A: I don't know. I think it would be easier to help ourselves.

C: How come?

A: Well, we can't help something that we don't understand, that we don't know about.

C: Now that you know what the connection is between the two.

A: Yeah.

C: What difference does that make for you?

A: Well, it's easier for me to stay away. Knowing that it'll just lead me right back to where I was.

Michelle further articulates this concept.

Michelle:

C: Do you think that it is always important if there are both going on to talk about the connections and about the overlap?

A: Yeah.

C: Rather than just saying okay, you take care of your alcohol and drugs at this place and then go deal with the eating disorder?

A: No, that's no good.

C: How come?

A: Because once they overlap, they're not separate problems, they're a problem.

C: Can you say more about that?

A: Like, it's not like you're eating is a problem and your drugs are a problem. They're a problem together and it's once they overlap its not just drugs getting in the way or eating getting in the way. It's both of them in your way right now. Just because you get one out of the way doesn't necessarily mean you'll get both.

C: Okay.

A: And then like what if we were at a treatment that was only for drugs and then we get out and we don't go in [to a program to address disordered eating] for two or three days, there's pretty small chance we'll be able to cause the eating's still there, eating away at us. So right away we're going to want to go back and do drugs [as a way to lose weight]. And then we jilt our eating because we just went on a drug binge and so shit out of luck again for the next one [being able to enter the program for eating disorders].

Michelle mentions an important aspect of the risks involved with the time delay that often occurs when entering a treatment program. She says that even in two or three days if the 'eating' hasn't been dealt with that drugs could show up as a way to lose weight which then could lead to a drug binge. This leads to an important aspect of care that therapists can provide, prior to a person entering a treatment program. Other young women also describe how both problems often show up in a huge way before they are scheduled to enter a treatment program. Drugs can try to convince them to have 'one more binge' as 'this is the last time they will *ever* be able to use.' Disordered eating

practices can also take advantage of this perhaps by telling a young woman that she is not thin enough to enter a treatment program, no one will think she has a problem unless she loses more weight. The problems will use whatever they can to interrupt a person getting help. Michelle continues,

C: So together is better?

A: Yeah.

C: Do you think it would be difficult to address both at the same time?

A: It can take a lot of work. I don't think –like, it's not impossible but it takes a lot more work than just working on one problem.

C: How much work has it taken for you to be able to work with both?

A: I haven't really done the work for both, but just staying away from drugs, has made me realize that not eating isn't healthy and that isn't the way to go and so like eating properly. Like just, I don't know. For me there is so much to like not eating, it's almost like a high you get when you don't eat because you have that happiness and attitude like, 'Yeah, I did it again. Another day gone.' But I found like without the drugs I've been eating properly because I haven't been getting guilt trips, and I haven't been high all the time, so I wanted to eat. My hunger is there so I eat when I'm hungry. But otherwise eating properly makes me not want to do drugs because I feel better from not doing drugs and so it's just, like, together. It's like I have been working more on the drugs part but at the same time eating's following it.

It appears that when people start to get their lives back from drugs an attitude of care for oneself can begin overflow into other aspects of their life. If therapists can find

ways to harness this care, and talk about what might be some potential threats to their newly found care (for example, disordered eating practices), it might help to keep the other problems at bay.

Interrupting neat and tidy categories of problems

The concept of compartmentalizing people and their problems is an idea that is incongruous with the way we live our lives, yet it is the way that science is structured Kutchins & Kirk, 1997). As described in chapter three, as way to make sense of illness, people's experiences were categorized and coded into "medical classification of diseases" (Caplan, 1996, p. 38) Yet these categories that were once set up as a way to help physicians have a common language has resulted in these categories being used as "an explanation of people's lives" (Peele, 1995, p.3). Placing persons and problems into fixed categories may result in our missing the connections between people's lives and the problems that plague them, as well between problems and problems.

Decontextualizing people makes space for quick cures and treating people as if they were machines, by which I mean that if you can find the piece that's broken then you can fix it and the machine will run smoothly again. Unfortunately (or fortunately) people are not like that. If we can expand our thinking away from the binary and categories of this or that, we are better able to contextualize people's lives and look at problems contextually and as interrelated to each other. Cushman (1995) writes,

> The individual's feelings and thoughts, because they were located by psychotherapy *inside* the bounded, masterful self, were considered to be products of intrapsychic processes, and not the products of culture, history, or interpersonal interactions. Psychological problems have been interpreted as

illnesses that are conceptualized as residing within the person and caused by intrapsychic conflicts or malfunctions (p. 157).

Emma discusses her reasons for why she thinks a program that addresses both problems would be a good idea.

Emma:

C: Okay. If you were asked to design a perfect program or group for people struggling with both problems, what would it look like? Like, what kind of things would you include? What that be a good idea, a bad idea?

A: I think that is a good idea. I would be really happy to see that happen one day where both of those things would just be treated as addiction, and that was that. It wouldn't matter if you had anorexia, bulimia or alcohol dependency or substance abuse, you know. If it was all put together on the same plate as addiction that would be a lot easier for a lot of people to deal with.

C: What makes you think that that would be the case?

A: It's a lot easier to – to explain addictions, you know, you're doing something that's bad for you, that you feel like you can't stop.

C: You're eating, drinking, drugging?

A. Anything, yeah. Then sit back and address one problem solely and try to nit pick through all the things that it could be or it could stem from.

Emma:

C: Would it have made a difference to you when you were in a program for disordered eating practices to have been able to talk about your struggles with substance misuse?

A: Yeah, it would have. It really, really would have.

C: What difference do you think it would have made?

A: It would have made the problem real.

C: Can you say more about that?

A: It would have made my drug problem real, just as real as the eating disorder.

C: Okay. And if the drug problem had been as real what difference would that have made?

A: It would have been easier to deal with. And I don't think it would have been as severe, had it not have been pushed back. Like I kinda had to hide it and pretend that it wasn't a big deal.

C: Okay.

A: Yeah. It's really funny. In that program I learned how to be a really good liar. Yeah. That was actually like the biggest thing that program taught me. Yeah. That just really paved the way for drugs.

When programs don't create space for both problems or multi-problems to be discussed, problems can go underground. For Emma, 'this taught her to be a good liar.' Of course this is not the intention behind these guidelines, but a young person may think that she will be asked to leave the program if they talk about their struggles with the other problem (especially if these other problems are currently active). The tactics the problem uses can exasperate this sense of secrecy, which serves to isolate and alienate young women from therapists and support staff. The problems might try to convince the young women, 'you have too many problems, you are unfixable,' 'you are so screwed up, no one will ever be able to help you,' or 'here you are throwing up everyday and

talking about how happy you are and how good you feel since giving up drugs, you're such a liar.' Those tactics can all contribute to a person's sense of 'falseness' or lying which substance misuse and disordered eating practices can use to their benefit when they are trying to entice a young woman back to them.

Beth describes why she thinks addressing the two problems together is useful for her,

C: What do you think that might have happened when you left here, if you hadn't dealt with the bulimia while you were here?

A: I don't know. I think I would be more tempted to do drugs.

C: How so?

A: Because then I would still be purging and I would still be having major weight issues and body issues and emotional issues right. And when that doesn't work anymore, then there comes drugs right back in. I wouldn't have really been learning how to deal with my problems when I was here cause I would have been purging.

Megan echoes the above,

C: If you've had done that. Lets say you purged the entire time you were here, would that have influenced your thinking about how successful you had been at Peak House?

A: Yeah. I would have felt like I was lying to everybody and kept that addict part of me- the lying, the manipulating.

C: And do you think that drugs could have turned that and twisted that around once you were done this program and used it to its advantage in anyway?

A: Probably just that you gained back trust from a lot of people and you have a lot of people who have trust and faith in you now, so they have faith that your not gonna go use, and no one's gonna be drug testing you once you are gone. So knowing that it'll still be there when you get out. So it would have kept that thought running the whole time, 'that once you get out, I'll still be there to help you.'

Creating space for both problems to be addressed

Every young woman who consults us has different ideas about counselling and how it can be effective. As therapists we need to collaborate with young women about the therapy and whether it is helpful. Stepping away from an expert stance and seeing the client as an expert in her own life helps us to become curious about the young women's ideas. Some of the young women spoke about addressing the problems separately at first, beginning with the problem that is most concerning for them, and then exploring the interplay between the two problems. We can still work on one problem at a time while becoming curious about the ways various problems may work together. Jill brings up an important point: the possibility that we miss the details if we don't spend enough time talking about one problem first. It's often in the details that we learn how problems stay alive and thrive in a young woman's life so going slow and really becoming curious about just how these problems work and manoeuvre themselves through a person's life is very important.

C: Would it make a difference if both were addressed at the same time or would you address one first and then the other one?

A: Different. You might miss the detail about one or the other things while talking about both.

C: So if you were not going to address them in detail, together, would it be useful at least to kind of make some kind of link or ask them about the ways they work together?

A: I think that's a good question. How do they work together? Yeah or how do they feed off each other? Yeah. Good question.

Given that the young women described that space should be created for both problems to be addressed if this is relevant to the young person seeking therapy, I was curious about their ideas about how this could look and how therapists could bring it up in conversation.

Rachel:

C: Would it have made a difference if both problems were addressed at the same time verses eating disorders first and alcohol and drugs second or vice versa?

A: Well, it depends on what the person comes to you with.

C: How about for you though?

A: Okay. Well for me I guess addressing the drug problem first and then showing the link.

C: Why would you want the drugs addressed first?

A: Well if you were just like, 'Rachel you have an eating disorder.' I'd be like what is wrong with you? So introducing the one you already know about then how they prey off each other and then maybe addressing the other ones separately, kind of like phasing it in.

C: And why do you think those links need to be brought in?

A: Because if you just start talking about eating disorders they'll think, 'what are you talking about'?

C: Why do you think they should talk about it anyway? Why not ignore it? Why not talk just about the drugs?

A: Because some people don't realize it.

C: And what difference does it make if you do?

A: Then you might realize when you're doing it and try to help yourself or help other people help you. But if you're not aware of what is going on then nothing can be done about it. Unless like you're captured and force-fed every day.

In regards to disordered eating practices Megan later adds,

A: But I never really thought that it was a problem. I guess, like that could be a danger with leaving it up to people to address when they have a problem cause some people might not.

Some of the young women just wanted therapists to bring it up, ask about it, be curious and talk to them about it.

Megan:

C: What could therapists have done to bring it up in order to have more conversations about it?

A: Like if they bring it up, to be up front with it. Like to actually ask. Like straight out.

Jill concurs,

C: What would you like therapists to know about the two problems? Like how could someone have brought it up, or made the connection back when you were using say three years ago in a way that might have made a difference for you.

A: Somebody could talk to me about my weight because I got really skinny for a bit, like it was extremely unhealthy how fast I got skinny and how skinny I was. You know what I mean. Like maybe somebody could have talked to me about like why have you lost so much weight like ask me if I wanted to talk about it—all I really wanted to do was talk to somebody about it but it never really came up.

Jill's wanting to talk to someone about her weight highlights once more how these problems flourish in secrecy. As therapists we can help with the naming of the problems in a tentative way, so that young women don't have to be alone with these problems.

The power of a community

The strong cultural push towards individualism and the internalization of problems serves to further isolate and divide people from each other and their surrounding community (Gergen, 1991) and contributes to the sense of keeping struggles private as 'we should be able to deal with things ourselves, and if we were stronger we would be.' Group therapy can be a way to interrupt this isolation. Many of the young women expressed an interest in having conversations with other young people about the interplay between these problems.

Megan:

A: At Peak House we talked about it in gender group.

C: Was that useful?

A: Definitely. Just knowing that other people here went through the same thing, too, and I didn't think that disordered eating practices and drugs and alcohol can go hand in hand for a lot of people.

C: What difference did it make when you did realize that it went hand in hand for a lot of people?

A: Just knowing if I needed help I could talk to them. Like with a past resident, hearing about what happened with them and being like, 'Oh my gosh, that's almost the same as me,' kind of thing. And seeing how she got through things and her strategies and kind of taking them and applying them in my own life, that really helped.

C: How do you make sense with that? The fact that they do go hand in hand for so many young women?

A: I don't have a worse problem than anyone else. It's something that is just like, drugs and alcohol can be dealt with and disordered eating practices can be dealt with. Not easily but you know what I mean, it can be dealt with.

It appears that the tactics that problems use do not vary much from person to person. Problems it seems are not that creative. Fortunately, this works to our benefit, as we can see Megan describes having a moment of 'Oh my gosh, that's almost the same as me.' In this moment the problems loose some of their power, and the sense of isolation that young women may be experiencing is interrupted. This demonstrates the power of group therapy when working with these problems as group therapy can help break the isolation and secrecy that these problems are fuelled by, and can even give

young women ideas for how to break free from the problems. As Megan said above she borrowed from the strategies of others.

Beth:

C: What about if it was talked about as these two problems often show up together? They can be really sneaky.

A: I think that would be awesome.

C: Really?

A: I think you should do a group on that. I think that would help people, it'd help everybody. Cause we do groups on how drugs piggyback on friends and relationships. But we have never done it with like bulimia or anything.

Beth later goes on to say how if we had done groups on the two problems or even included it as part of their orientation to the program it would have made it easier to have said something about her own experience of struggling with both problems. Its important to mention that in any group therapy conversation we want to be mindful of the ways in which problems can show up in these spaces, and use what is being discussed to their advantage. For example, young women have spoken to me about comparisons that can leave them wondering if 'they have enough of a problem.' For example, disordered eating practices can have someone questioning if they are thin enough, bingeing enough, or purging enough to warrant help from others. In the same vein, drugs and alcohol can have a young woman wonder if her problems with marijuana are in the same realm of the problems of a young woman sitting next to her describing where intravenous heroin use has taken her. Drugs might work hard to convince her that she doesn't have a problem, and that she is taking up a space from

someone who deserves it more than she does. All these tactics could result in her leaving a treatment program. Then the problem can take this one step further and convince her that 'they are such a failure—you couldn't even stick out rehab!'

Ava's comment below emphasizes how a dialogic space of openness and curiosity opens doors to new possibilities for everyone (Anderson & Goolishan, 2000).

> A: Like just discussion. Like learning—you learn from each other, you come to realizations and epiphanies together. Well you know the bottom line pretty much and I think the guys and girls could do more sessions together. You know because we learn from each other and girls learn from each other in groups. We should have more discussions to get everyone talking.

The difficulty involved

So many of the young women mentioned wanting therapists to be aware of the difficulties involved in trying to get their lives back from the two problems. They wanted therapists to have a sense of just how hard it was, and how hard they were working to get some space from these problems.

> Ava:
>
> C: Is there anything specifically about eating disorders and drugs and alcohol that you want therapists to know about how to work better with the two problems?
>
> A: That we're definitely struggling, and we're trying.
>
> Aimee:

C: For therapists working with people who struggle with eating disorders and drugs and alcohol, what would you like therapists to know about these two problems?

A: That it's not an easy thing to get over.

They also wanted therapists to be aware of the shame that the problems can bring with them. Michelle articulates how therapists need to be sure that they are not being judged as this can only build the sense of shame.

Michelle:

C: For therapists working with young people struggling with eating disorders and drugs and alcohol, what would you like the therapists to know about these two problems and how they've could possibly have been more helpful to you in your struggle with both problems?

A: A lot of the times we're really ashamed of being addicted to drugs and having an eating disorder. I find that we always think people will judge us right away and to, like if the therapist showed us that we're not being judged and it makes it easier for us to talk. I know that I always thought that I was, like, I was always ashamed of not eating. But I always, like, I still didn't eat and I still, just like I, what is the word I'm looking for? I don't know. Denied that I had theproblem to everyone because when I did ask for help, I was told that I didn't have a problem. So like any therapist or counsellor out there, if the kids know they're not being judged then it's a lot easier for to us talk, which makes it easier for us to get better.

Below Emma describes the art of having a conversation about the two problems. She speaks of the need for delicacy, for the conversation to be gentle and for things to be slowly teased out together. She describes how it can be confusing and how the problems can end up arguing as a result of addressing them in conversation together which is not helpful.

Emma:

C: So like was there ever a therapist who you were able to discuss both eating disorders and alcohol and drugs at the same time?

A: Yeah, but it's so difficult to do it, it's like this is really confusing.

C: What's confusing about it?

A: Cause I have always thought of them as completely separate issues and when you put them into the same—the same conversation it's like—it's almost like they're arguing in my head. 'I'm more important, no I am.' You know.

C: Okay.

A: They help each other out cause they both want to be active. But if one of them—if the attention is on one of them right away then, one of them wants it more, you know. Like I'm the one that defines you.

Talk About the Pain

In therapeutic conversations, it can sometimes feel like there is not always enough time to 'talk about everything.' Fear for our clients, session limits and trying to sift through so many issues can overwhelm even the most seasoned therapist, and keep their attention on the immediate. This can be increased when we are concerned that

these 'problems' may kill our clients.[28] The problems of substance misuse and disordered eating practices also try to ensnare therapists in their webs using tactics of distraction, which can leave the therapist feeling incompetent, under-knowledged, and in need of more training. This sense of 'I don't know what to do' from a therapist can elevate the problem's status, and perhaps leave a young women wondering if anyone can help her. When someone is medically stable and the drug and alcohol fog and spell of disordered eating practices may have lifted (even just for a bit) the young women may feel ready-enough to talk about the 'pain' behind the use, and the 'pain' that these practices have caused in the young women's lives. Talking about reasons behind the use, and what 'purpose' these ways of coping through substance misuse and disordered eating practices served can be an important part of the work. We can begin to story young women's experiences of what is unsaid yet spoken through their bodies (Bordo, 2003) as a way to support them in freeing themselves from these practices. Brown (2007) writes:

> If we respect that symptoms of eating problems are meaningful clues to women's and girls' subjugated stories, we can begin to unpack their displaced meaning. Giving space to these stories, making them visible, and hearing them are likely to make body talk of eating 'disorders' and weight preoccupation unnecessary.

[28] I am not referring to cases where a young woman needs to attend detox or be admitted to a hospital for re-feeding. I am referring to situations where they are nourished enough and have enough time free from substances to participate in therapeutic conversations. Even in these moments the problems can seem so overwhelming that they keep the therapist focused on the immediate and doubting themselves. This I believe is a tactic of the problem that serves to keep the therapist second guessing themselves and feeling incompetent in their work.

Focusing on changing behaviour without making space for unheard stories is unlikely to entrench the need for such body talk (p. 280).[29]

Ava astutely describes that the 'problem' is not simply just about substance misuse and disordered eating practices, something else is occurring.

Ava:

C: What do therapists need to pay attention to when working with people who struggle with both problems?

A: That it's not just the drug use and the eating disorders, there's something underlying it. There is some kind of childhood emotional pain, there is something behind it and like it's those things that need to be dealt with, not the, not the addiction. Once that's healed, it'll make it a lot easier to get rid of the addiction and stuff once you've dealt with the underlying problem. If your wrist breaks, you don't just go and take a temperature—there is an underlying problem right, if you don't fix it your wrist is gonna break again you know, same with everything. Everything on earth so fix the underlying problem and figure out what it is, heal it, somehow and then once you have this shit dealt with its 'oh, that's why I do this, that's why this is happening.' And it stops you wanting to use those drugs.

C: What does that understanding do? How does it get you wanting to stop using those drugs?

[29] Catrina Brown (2007) defines 'body talk' as "*Body talk* refers to the culturally specific ways that women speak or communicate through their bodies. Body talk begins to speak the unspoken, or *yet to be spoken*, through with preoccupation struggles. It has begun to draw attention to women's struggles at a cultural level and to make them visible" (p. 269-270).

A: Self-awareness. And understanding it's normal. And that there is a way to deal with it besides drugs. And like permanently though.

If as counsellors we start with the assumption that all people seeking therapy have the knowledge and wisdom needed to solve their own problems then we need to create the space for young persons to address what is important to them. Everyone makes different meaning of their experience, and we need to work with the people consulting us, and travel along the paths they wish us to walk alongside them on. Weingarten (1998) refers to a therapist as a 'fellow traveller' in this regard. Should young persons wish to address the pain behind the use, we are looking at the context in which the problems arose, and how it might make sense that it showed up at that particular time. Talking about the context of the use takes us farther away from internalized notions of problems, and problems residing inside of people and closer to people's experience and knowledge of how to become free of problems. Tom Andersen (1998) borrows from and builds on Wittgenstein's idea of "Now I know how to go on" (p. 79) and applies it to therapeutic conversations, where the hope for therapy is that it, if successful, gives people a sense of knowing 'how to go on.' So together therapist and young woman can have conversations about the pain in a way that might dissolve it, allow new meaning to be made, or just help people come to a place where they can say, they know what they need to do in order to move forward.

Insiders as Consultants: Program Design

Given that the young women have first hand knowledge of these problems, I was curious about their ideas specific to program development, and I asked them what they

thought would be important to included in a program that addressed both substance misuse and disordered eating practices. Some of their ideas were:

- An all-young-women live-in program
- Increase the length of time of the program (longer than 10 weeks)
- Having conversations that link up the problems
- Having structured groups/programs after meals (to help alleviate ideas and practices of purging or over-exercising after meals)
- Making sure there is no talk that glorifies alcohol and drugs and disordered eating practices
- Flexibility
- Treat people with respect
- Provide education about substance misuse and disordered eating practices
- Include the medical aspects of how these problems impact your body
- Have good healthy food for people to eat balanced and nutritious meals
- Including different activities, people are able to try different things and learn new hobbies
- Offer certification programs
- Offer fun exercise programs like rock climbing, kayaking (exercise that is not focused on burning calories, rather focuses on fun and moving your body)
- Work with what the person loves to do
- Normalize and explain why people might be gaining weight, especially when getting free form substance misuse and disordered eating practices (makes it less scary for people)

- Talk about overall lifestyle changes
- Have pets around for their therapeutic value
- Giving people space to say 'I'm in a struggle right now' and having people available for them to talk to
- Learning how to pay attention to what your body needs
- Not weighing yourself, no scales, and no practices of measuring food and/or body
- No magazines or speaking in ways that glorify alcohol and drugs, beauty, thinness, or objectify and stereotype women
- No television

Questions to Ask About the Interplay Between Substance Misuse and Disordered Eating Practices

- Have you noticed that these two problems often show up together?
- Have you noticed any similarities between the two problems?
- Other young women have described disordered eating practices and substance misuse as being very sneaky. Have you noticed this as well?
- How might substance misuse piggyback on disordered eating practices, or how might disordered eating practices piggy back on substance misuse?
- Are there ways that you have noticed that the problems can work together at times?
- How do they feed off each other?
- What do you imagine you'll need to learn in order to break free from disordered eating practices and substance misuse?

- Since you've stopped using substances or disordered eating practices have you noticed that the other problem has been lurking in the background? If so why do you think this is?
- Are there things that you do to keep some distance from drugs and alcohol and disordered eating practices? Do you use the same strategies for both or are they different strategies?
- How might what you want for your life and what disordered eating practices and substance misuse want for your life differ?

Insider Knowledge: Advice for Other Young People and Therapists Working with People Who are Struggling with Similar Problems

During the interviews I asked the young women what insider knowledge they had for other young people struggling with these problems. What would you want them to know? What support, advice or insider knowledge might offer them? I also asked them, what advice would they give to therapists, working with young people struggling with eating disorders and alcohol and drugs? What they would like therapists to know about these two problems? What follows are their responses to the questions.

Emma:

A: [to therapists] That they're the same. Actually, I just remembered an incident here, one time with one of the staff members, and I tried to talk to him about the eating disorder problem that was coming up and he even said, 'Well, like, I just don't understand it,' and I was like 'you've been through substance abuse. It's the same thing.'

Beth:

A: [to young women] Definitely, I know it's hard, but try to be more accepting of your body.

C: How did you deal with that? How did you start to gain more acceptance of your body?

A: I think just getting away and realizing that it's not what is on the outside that what matters is on the inside. Beauty's on the inside it's much more than skin deep. It's totally your inner beauty that counts and it outweighs the outer beauty by far. Like, you can be totally gorgeous but just a nasty person, you know. Like, would you rather be like this nasty person that looks absolutely gorgeous or an average looking person that has a gorgeous personality?

Hannah:

A: [to young women] That everyone is beautiful, that you don't need to put something in your body or like inflict pain on yourself to make yourself beautiful or love yourself, make that guy want you. Like if he doesn't like you for who you are, then it's not worth it.

Later she adds,

A: Don't look in the mirror and pick out whatever is wrong with you. Just know that what you're doing is better for you in the long run and you don't have to be sick all the time.

Michelle:

A: [to young women] There is help. It's not impossible to get better and it's just a matter of admitting that you're powerless over it and once you do that you can see that help is there.

C: Okay.

A: I find if you're still in control a bit there is no way you can get help. Once I admitted, admitted that I was powerless I could not only ask for help, but like take the advice that I was given and I didn't take it all. I mean there is no way you can take all the advice that you're given but it definitely made it easier for me to like talk about it and to want to get better, once I realized I couldn't control it.

Savannah:

A: [to young women] keep going and keep trying, if you fall back into it, know it's okay. The importance of building a support network of friends who don't use. Meet people who've been through it. Build connections with others, and have good supportive people around.

Alexa:

A: [to young women] It gets better and to know that you're not alone. That people are not jealous of you as much as you think it, they're not. Sometimes you need a harsh reality check. You're thinking crazy. The drugs are getting to your head. This is not who you are.

Megan:

A: [to young women] That it's not normal. It's not healthy. Not the whole kind of school bit they give you, it causes this and this and this. But just saying like you're not going to feel good about yourself no matter how thin you get. No matter how much you use or how long you can go without eating, you won't feel healthy. You're not going to gain popularity by the positive people, you're

going to get the negative attention and negative friends at school, who all think that using and like disordered eating practices is okay and that they would support it. And those aren't people you want to hang around for the rest of your life because they won't help bring you up to where you should be, and they're not gonna help you get farther in life.

C: So if you had got that kind of advice, what difference might that have made for you?

A: If I was just starting here, it would be different I might hear it, but if I was still out in the community, there I'd be 'like what are you talking about.' Like when people's minds are clear it's easier to take things in. So if I was here I would probably hear it and relate it to my own life. Like yeah that's true and that would stop me from or make me think twice before I go do something. It might not have stopped me right away but eventually it builds and grows when you keep hearing it.

Ava:

A: [to young women] Consequences for sure, but I know everybody thinks that they are the one that can prove them differently, even I do that, right. I'd say, oh god there is so much I would say. There's some much to say I don't even know where to start. I would say find your self-worth. That's really important. We had this epiphany in gender group one day like self-worth; everything leads back to it. That's the beginning. Knowing your worth and knowing you're worth it and you're not dirt and drugs won't make it better. You alone will make it better no matter what cards you're dealt in your life or the environment you grew up in.

You make your own future, don't fuck with it and don't let some kinda substance control you. Take control.

C: So if you had been offered this information that you just shared, what difference might it have made for you?

A: Well no one can change my mind, and I can't change anyone's mind but the more awareness you have, like with smoking, the more I know about that the more and more stupid I feel when I'm doing it you know what I mean?

C: If someone told you what you had said like, 'find your self-worth, it all stems from there' would that have made a difference for you growing up?

A: When I was younger, yeah. When I was in my bad days. Fuck you, right? You can't help someone that's in it until they want to help themselves, until they find their own self-worth until they come to the same realization. But if I was really young and I had been told that I think I would have made smarter decisions. I can't say I may never have tried anything but I think I would have made smarter decisions and not put myself in certain situations and not have been so stupid. But you know you learn, you learn. You learn from it and you have to go through the fire to be better and your experience will make your future different and better.

Questions to Highlight Insider Knowledge

- So for other young women struggling with disordered eating practices, or substance misuse what would you want them to know? What support or advice or insider knowledge might you offer them?

- If you had been offered this same advice that you just mentioned, what difference do you imagine that it might have made?

Section 7. Recursiveness

I sought to know more about the ways in which the problems worked in young women's lives rather than trying to discern 'what was wrong with them' or 'why they had these problems.' This position distinguishes postmodern social construction practices from more modernist ways of knowing and working. I consider the aforementioned practices having contributed to a foundation from which to move forward, and this foundation contributed to the richness of our interviews, and what was possible for the young women to speak with me about. And importantly, our conversations made space for the young women to reflect on and consider practices of disordered eating practices and substance misuse that were relevant and important to them at this time in their lives. I credit these practices to the young women's descriptions of our interviews as being useful to them. This section speaks to the ideas of research as being recursive, and being of use to the participants involved. The young women described the interviews as being useful for them, and they were tremendously useful for me. My hopes are that other therapists and young women will benefit from these conversations and subsequent understanding of the interplay between these problems.

What follows are the young women's descriptions of the ways in which they found the interviews to be of use to them.

Emma:

C: Yeah. What did they need to convince you to become part of your life in the way that they did?

A: That's a really good question. Can you say it one more time?

C: What did drugs and alcohol and eating disorders need to take advantage of or convince you of in order to become part of your life in the way they did?

A: And this is exactly for me, right?

C: Yeah, just for you.

In the above example, Emma says 'that's a good question' and clarifies that this is 'exactly for me, right?' I attempted to centre the youth in the interviews; I wanted to know what 'their' experience was like and their ideas about the ways that these problems worked in their lives. There were no right or wrong answers.

I checked in with the young women throughout the interviews, asking how they were doing and how the interview was going. During one of the interviews I noticed that Alexa was yawning, so I asked her how she was doing, and she let me know that she was tired and would like to stop the interview and complete it the next day. At the end of each young woman's interview, I enquired as to how each was doing and how each person felt about what she had said. The following is an example of this, and of the youth's description of this being a useful experience and her ideas that this will also be of use for other youth.

A different kind of talk

The young women described the interviews as being a good experience. Not only did they speak of the interviews as having some therapeutic benefit, many young

women described having garnered new ideas as a result of our conversation about what it will take for them to stay free from both problems.

Jill:

C: We've finished all my questions. How was it?

A: Cool. I like this.

C: What was cool about this?

A: Just things I never talked about with anybody before or thought about and there were some really insightful questions and I think if you asked other people those questions, like it would get them thinking.

C: Given that you said you talked about things you never talked about before.

A: Yes.

C: Or even thought about. How are you doing having had thought about and talked about them?

A: They're not affecting me because I'm not like that anymore you know what I mean. Like, I'm not using drugs and I'm sober so I can talk about them. [Laughing] It's good to talk about it, that's all.

As Jill shared, this was the first time she had ever talked about this with anyone before; it was important that I follow up with her to see how she was doing after having given voice to new ideas. Ethically, as a therapist/researcher, it is my job to follow up with her to help ensure that she is doing well enough to end the conversation and that she will be okay afterwards. If she mentioned feeling unsure of how she was doing, or having painful memories, together we could make a plan for how she could take care of

herself for the evening, who could support her in taking care of herself, and check out how safe she feels with herself.

In the excerpt below, Emma articulates how our conversation was different than other conversations she has had regarding disordered eating practices and substance misuse. I believe that stepping into a new conversational space is central to the process of creating change in therapy. Putting a fresh perspective and taking a closer look at old and familiar problems in a new way supports people in renegotiating their relationships with and knowings of these problems. As McNamee (2004a) describes, "Social construction, as a therapeutic stance tunes us into the interactive moment where therapeutic change might be possible" (p. 269). In the example below it appears that new meaning was made together in our conversation and that as a result Emma now has a different way to understand these problems, and move forward in her life.

Emma:

A: I was just saying how, how this interview was really difficult. It's so interesting because although both problems have been acknowledged at once, never to this degree. Never. And I'm 18 now and I started treatment when I was 12. This is the first time that anyone has given the attention to both issues.

C: So what difference do you think this type of attention to those issues might make for you in your life?

A: I think it's good. I think it's very good and that I'm going to see positive changes from actually noticing the feelings and thoughts that this specific interview has brought up.

Above Emma mentions how 'this is the first time that anyone has given attention to both issues' and that as a result of our conversation that she is 'going to see positive changes' as a result of our conversation together.

Emma continued,

C: I'm really glad that this has been useful to you because it's been really useful to me.

A: Yeah, this is really cool. Now I feel like I am better equipped. Wow. Like I feel so much relief, already.

The above section highlights the way that research can be beneficial for both 'researchers' and 'participants.' Emma is walking away from the interview with new ideas about how to navigate these problems should she be faced with them in the future. She is also fully engaged in the conversation, her energy demonstrating that she is really connected to the above ideas and that they resonate for her.

During our conversations there were many instances of the young women exclaiming, 'Wow so they really do go together!' New realizations were made and they described thinking that these realizations would be 'stuck in their heads.'

Aimee:

C: How was this for you? Was this useful?

A: Yeah good. I realized a whole bunch of stuff; I kept catching myself like, 'Oh my God.'

C: What did you realize?

A: Just thinking how tiny I was and one thing I said about how drugs and eating disorders are together. Sort of like, well, its hard to quit drugs because you have

fun with it and it makes you skinny but you don't want to lose the skinniness, so that was like whoa.

C: Do you think this conversation in itself might help you when you leave Peak House?

A: Probably. Because now I know like, now that I've said this stuff out loud, what to do or how it happened, it's stuck in my head now.

Aimee mentions that 'it's stuck in my head now.' One of the useful aspects of therapy is that in speaking aloud ones hopes for oneself, young woman begin to know what it is that they want for themselves and for their lives.

Some youth such as Beth and Ava (mentioned below) had new realizations, which is exciting as it suggests that together in dialogue we have co-created something that is of use to them. Ava was able to hear perhaps the familiar in an unfamiliar way, or speak something that she did not yet know.

A: Like I just made a lot of realizations doing this.

C: What did you realize?

A: Like things like I didn't even realize when I was using the drugs.

Beth:

C: Was this useful?

A: Yes.

C: Yes. So what was useful about it?

A: I don't know. Just being able to talk about stuff. The more I talk about it the more realizations I get for myself and even though I've said it a million times the more I hear it the more it sticks.

C: As a result of this conversation is anything sticking a bit more?

A: Well yeah cause today I felt pretty depressed about my body and right now I feel absolutely great! [laughter]

C: What was it you heard yourself say that's making you feel so great? Cause your body hasn't changed in the last hour. So what is it that you heard yourself say that's got you feeling absolutely great?

A: That it doesn't matter. I just have to get that through my head. Like people aren't gonna love you for what you look like. And if they do just love you for the outside than that's really bad.

C: Okay. How can you hold on to this remembering right now? This feeling?

A: I don't know. I talk to Shawn usually that helps me hold onto it, that's true love. I just gotta remember the good things in life.

In the above piece, others are invited into our conversation adding to its richness and usefulness. Beth mentions that her boyfriend helps her to hold onto these knowings. In this example I am inquiring as to who can help her remember this knowing. This practice helps build and create communities of concern (Madigan & Epston, 1995) to stand as allies with them and against problems.

The following quote is an example of the benefits of having these types of conversations and how they can in a sense insolate people from the problems of disordered eating practices and substance misuse. Demonstrating the importance that talking about the interplay between the two can make in peoples lives.

Hannah:

C: Had you not talked about the connection between disordered eating practices and substance misuse and left treatment without even acknowledging disordered eating practices, do you think your stay here would have been different? Would you be leaving with that still lingering in the back of your head?

A: Yeah, I would probably go home and stop eating.

C: Really?

A: Yeah.

C: Okay. And then what would have happened?

A: I would be sick. Unhealthy. Well old behaviours would have showed up.

C: Do you think drugs could have shown up at some point?

A: Yeah.

C: What difference did it make to talk about it then?

A: Knowing that they're linked and that one can bring, like bring on the other.

C: Um-hmm.

A: That's the way for me that it's worked in the past and like if I don't pay attention to it, then, you know, they can come back without me even noticing at first.

Michelle:

C: Was this useful for you?

A: Yeah.

C: What difference does it make might this conversation make in terms of you getting free from both problems?

A: I've never, up until now I haven't completely thought about them being together. I have to a point, but like I don't, it made me realize more that the drugs and the eating does go hand in hand. I never really looked at it like that before.

C: Now that you do?

A: It's going to be easier to stay away from both.

C: Interesting.

A: And I'm still not going to be able to walk out the door right now and stay away from either. But by the end of my stay, I think just realizing that together they're going to destroy me.

Questions That Can be Used to Explore the Idea of Recursiveness/usefulness With Young Women

- How is this going for you?
- How was this conversation for you? Did you experience any new or re-remembered ideas/thoughts/feelings that you did not have when we first began this conversation?
- Did you hear yourself say anything new or anything that you were intrigued by?
- Is there anything from this conversation that you want to hold onto, or take with you as you leave the room?
- How will you hold onto these ideas/thoughts/ practices? Who can help you hold onto this experience/knowing?
- After this conversation how might these ideas/practices begin to show up in your life?

- Who can you share some of these ideas that we spoke about today with as a way to further strengthen them?
- [for therapists] How have you been "moved" (White, 2007, p. 191) as a result of this conversation?

CHAPTER 7 DISCUSSION

In this dissertation, I examined the interplay between substance misuse and disordered eating practices in the lives of 12 young women and the ways that helpers can use this understanding to their advantage. A review of related literature, supplemented by conversations with seasoned therapists working closely with these problems indicates that disordered eating practices and substance misuse often occur together. However, what has not been as clear is how to best approach these problems when they co-presented in a young women's life.

Drawing on the ideas of co-research as developed by family therapist David Espton (1999), I embarked on this project alongside a small group of young women to gain a better understanding of their insider knowledge about the intricacies and interplay between the problems of substance misuse and disordered eating practices. I specifically looked at (1) the ways these problems can be supported culturally, (2) how these problems are often individualized, thereby supporting the development of an ensuing vocabulary of deficit, (3) the conditions and requirements of the problems for their survival, (4) the ways that young women are recruited and ensnared by these problems, (5) the similarities between the problems and the ways they can act as 'tools' for each other, and (6) actions that the young women have taken to find some freedom from the problems, with specific examination of the actions that young women have found helpful with both problems. Finally, I explored how this research can be of use to others - not only does it appear to be helpful in liberating those ensnarled by these two

powerful problems, but it may also be beneficial to practitioners looking to find a way to be of use to those suffering in the grips of these problems.

In this final chapter I will describe the contributions that this particular narrative therapeutic approach to working with the problems of substance misuse and disordered eating practices offers to therapists. I will also discuss how a research inquiry can invite participants to become reflexive about their own experience (Tomm, 1987). I also explore how the idea that these problems are in relationship with each other appears to be new to the therapists, yet not necessarily new to the young women. Then I briefly describe the importance of co-research practices. Finally, I discuss possible limitations of this study and recommendations for future use of this research.

Specific Contributions for Therapists

The descriptions offered by the young women illustrate the relational features and similarities that the problems of substance misuse and disordered eating practices share. The questions that I formulated (often in the presence of the young women) elicited generative and detailed accounts of the problems' interplay. These questions led to exciting co-discoveries regarding the similarities and interplay between the problems, the tactics that problems both use, and the ways that substance misuse and disordered eating practices can work together to devastate a young woman's life. The results section was replete with interesting suggestions for how therapists can provide more adequate therapy for persons struggling with both substance misuse and disordered eating practices. In this section I will summarize these suggestions.

In the interviews, the young women and I unpacked the many ways that substance misuse and disordered eating practices had been supported in their lives

(inadvertently or otherwise) by the media, society at large, family and friends. Commonalities in their experiences suggest that the pressures to look a certain way and 'fit in' permeate their lives on a daily basis. They described these pressures existing at times in very subtle ways. For example, they identified nuanced messages to maintain a particular body image in advertising, gestures, glances, and comments; all suggesting that there is a certain way to be a young woman. They also described the power of discourse, specifically of folk psychology. They described these influences leading them to believe that they are responsible for the creation of their problems and, subsequently, to see themselves as labelled with the identities of 'addicts,' 'alcoholics,' bulimics' or 'anorexics.' Conversations that deconstruct the above ideas appear to relieve some of the guilt, blame, shame, and hopelessness that this pathologizing discourse can place on persons, making space for the co-construction of preferred stories to be developed thereby creating hope that there will be freedom from these problems.

The young women astutely described the conditions that support the flourishing of these problems in their lives, as well as the strategies that the problems used to recruit young women. For example, they described how the problems flourish in secrecy, attempting to isolate young women. The young women also described commonalities in the ways that the problems worked to maintain a close relationship with them by offering, for example, empty promises, coping strategies, and tools for forgetting 'who they are' and what is important to them in life. These conversations supported the young women in gaining a clearer sense of just how these problems worked in their lives, which can contribute to their having a sense of what they need to do to find freedom these problems. We also discussed the times, places, things, and people that

may contribute to the young women's vulnerability to the problems' appearances or re-appearances. The young women described these questions as being especially useful to consider in order to avoid the problems' attempts to make a comeback in their lives. For practitioners, these questions could be useful when developing relapse prevention plans and plans for staying free from substance misuse and disordered eating practices.

The young women's accounts of their experiences with both problems demonstrate a need for therapists to enquire about the presence of the other when working with young women struggling with substance misuse and/or disordered eating practices. Further, their accounts speak to the importance of having conversations about the interplay between the problems of substance misuse and disordered eating practices. Throughout chapter six, potential ways of having these conversations were demonstrated. In particular, emerging common descriptions included how:

- One brought on the other and it feels like they fed off each other
- They unconsciously lead you to one another whether you know it or not, its linked because it all has to do with some sort of image
- Being skinny and having an eating disorder and if you do drugs it's a lot less work and better results

From the interviews, it became clear that young women quickly learn that drugs can intensify the thinness they may be looking for, and in this way, drug use becomes a tool of disordered eating practices. They also described how the problems can work together. For example, drug use can give a young woman the energy that she is lacking as a result of not eating. Therapeutic questions to address specific aspects of the problems and their interplay were also offered. These questions can act as resources for

therapists when having therapeutic conversations with young women struggling with these problems.

I found it interesting that some young women wanted the problems to be addressed together as they described them as becoming 'a problem' when they occurred in their lives together. Yet other young women wanted the problems to be addressed separately, as they thought the process of navigating the ways they work together would be difficult or confusing. Regardless of the ways in which these conversations were to be navigated, all young women who were interviewed spoke to the need for both problems to be discussed and their connection highlighted and addressed.

The young women's comments suggest that treatment programs for both disordered eating practices and substance misuse should consider making space for these conversations to occur. This could take place in a variety of ways: individual conversations, group therapy conversations, and psycho-educational presentations, to name a just few. The young women all described the importance of connecting with other young women who have experienced similar problems, as this helped them to know that 'they are not alone.' They described this connection being important for two reasons. First, it supported them in moving away from the problems as they described no longer feeling isolated and alone with the problems. Second, they could then borrow from the knowledge and strategies that others had used and found helpful in gaining some freedom from these problems. The young women also described conversations with others as aiding them in developing a supportive community of concern, which they described as necessary in order to find lasting freedom from these problems. This research also suggests that treatment providers working in these settings need to be

educated about both problems and have an understanding of the tactics and strategies that the problems use in a young woman's life as well as how the two problems can work together to create their own problems.

Reflexivity

This dissertation highlights the utility of therapeutic approaches and research practices that invite participants to become more reflexive about their experiences. In order to invite participants to become reflexive, particular questions can be utilized. Karl Tomm (1987) defines reflexive questions as:

> …questions asked with the intent to facilitate self-healing in an individual or family by activating the reflexivity among meanings within preexisting belief systems that enable family members to generate or generalize constructive patterns of cognition and behaviour on their own (p. 171).

The questions I asked placed young women in a reflexive position as I invited them to look back on their experiences with substance misuse and disordered eating practices.

Looking back in this way made space for young people to articulate and make connections between the two problems in ways that they had previously not seen. The questions asked also invited the young women to look towards the future, for example, imagining what difference this conversation might mean for them in staying free from substance misuse and disordered eating practices. Both past-focused and future-focused questions positioned the youth as having important insight into the ways that these problems worked in their lives.

During the interviews I was offering a new idea about the interplay between disordered eating practices and substance misuse. Initially the young women had to take some time to think about the shared relational features or interplay between the two but once the connections were made, and once the women started using examples of the ways that they had experienced the problems working in their own lives, there was always an expression in some form of 'Wow, so they really do go together.' The young women had previously lived and experienced the interplay, but had not yet voiced or articulated their experiences. The ideas were new, but yet not new or familiar, at the same time.

When the young women and I were talking, I was offering a new idea, yet the young women responded as if they had known this all along. There was a familiar knowing to the content of our conversation, as if bumping into an old friend, 'Hey, I know you from somewhere.' Asking the young women questions about the interplay in ways that they had perhaps not yet been asked allowed them to hear what they may have sensed, or known, but not yet articulated. Once it was voiced or in hearing their experience reflected in the words of another young women, clients often exclaimed, 'that's the same as me.' They were no longer alone with their experience and had the words to describe it. The therapeutic conversations I had with the young women supported them in seeing connections (Wittgenstein, 1953) between their experience and our conversations.

The Importance of Co-research

As previously mentioned, this study is, to my knowledge, the first study that has been done that focuses on young women's experiences with both substance misuse and

disordered eating practices and on their ideas about how to address these problems. Interviewing young women was my attempt to address the silence from youth in professional literature about their personal experiences and their ideas for simultaneously addressing the problems of substance misuse and disordered eating practices.

By positioning the young women as co-researchers during the interviews, exciting and generative possibilities for addressing these two problems were created. During the interviews I was struck by the idea that the young women had previously lived the interplay between substance misuse and disordered eating practices so it was a familiar idea. On the other hand, for some therapists, this was a new idea. This led to my questioning some of the traditional therapies and research practices that I addressed throughout this dissertation.

The examples of the young women presented in chapter 6 illustrate that young women have definite accounts about how disordered eating practices and substance misuse worked together in their lives. But this raises questions. If there is a general consensus among the young women about the interconnections between the problems, then how is it that there is a void of information regarding therapeutic practices to address the interplay in clinical and professional work and literature, especially research literature that includes the clients' voices and preferences for the direction of therapy? The thoughtful and insightful contributions that the young women have offered to the field of substance misuse and disordered eating literature and therapeutic practice suggests that researchers and/or therapists should seek to position clients as co-researchers and consultants whenever possible.

Hannah:

Christine: For therapists working with people who struggle with eating disorders and anorexia and bulimia or eating disorder, alcohol and drugs. What would you like therapists to know about these two problems? Do you think they think about the link?

Hannah: I don't know. Do they?

Christine: I think some people do but I don't know if a lot of people do.

Hannah: They should know that.

Christine: Yeah?

Hannah: Yeah.

Of particular interest was how the young women reported feeling better or more hopeful, often in relationship to their body or in regards to staying free from substances after the interviews. This demonstrates the utility of these conversations and the potential benefit of incorporating these conversations into eating disorder or substance misuse programs. This also demonstrates the therapeutic benefits that co-research practices can offer when conducted in ways that are respectful, ethical, and honouring of the voices that consult us. As researchers, it is important that we begin to create space for 'insiders' to document their experience and their ideas for how to best move forward in their lives. Their ideas, practices and insider knowledge should be written about and circulated widely and legitimized in order to open up new therapeutic possibilities for persons trying to free themselves from problems.

The dynamics of this co-research practice has also benefited me in ways other than as a researcher. In other words, I have been moved by it in the way Michael White

(2007) describes being moved and transported by the stories to which we are witnesses. Michael White commonly described being "moved" (p. 191) and changed by the people with whom he met. I too wish to touch on how I am no longer the same since the initial conception of this writing and my conversations with the young women. I felt honoured to be trusted enough with these young women's stories of strength, hope, courage, and protest. I was reminded of the strength it takes to re-claim one's life from problems and of the importance of having a supportive community to stand alongside you as you embark on this journey. Since these initial conversations, I have carried these young women's voices with me. Their voices and insider knowing accompany me in the work that I do with other young persons struggling with similar problems. I have also become attuned to the liberating effects of a narrative co-research approach to therapy, in that it challenges the silencing and oppression that can occur when persons consult with 'experts' (therapists) for help.

As a result of hearing these young women's stories, I have been reminded of why I stepped out and stayed out of the box of traditional therapy approaches that often view persons as complicit with problems, see problems as the result of defective genes or that can be explained by biochemical explanations. Therapy, in itself, is political work that provides a space for us to take a stand with our clients about the injustices they experience, exploring the ways the problems may be supported in larger society. As demonstrated in this writing, narrative therapy offers us a platform to protest the injustices and indignities to person's lives as well as offering a compassionate, respectful and transformational way to engage with the persons who consult us.

Limitations

In the concluding chapter of his dissertation Alan Wade (1999) writes that he has made claims, yet,

> …provided no empirical proof in support of this claim. Rather I have presented a small number of illustrative cases, mostly from my practice as a therapist. The reader is right to remember that I have inevitably interpreted the examples and could have misrepresented the individuals and their circumstances to support my claims (p. 359-360).

One could say that this is also true and a limitation of my dissertation. I created categories based on common themes described by the young women; themes that struck me. However I did my best to ensure that these categories made sense to others and examined my own biases by engaging three colleagues in a forced sort (Stainton Rogers, 1995), described in the methodology chapter. Another limitation of this study has to do with the method of co-research that I employed. It could be argued that due to issues of power, the young women were simply answering the questions in the way they believed I wanted them to or, that I was feeding them or suggesting the answers I wanted to find in the questions I was asking. During the research process I addressed this to the best of my abilities. I had them put their own name on their experience of disordered eating problems, I asked the young women to describe their own experiences of the problems, and clarified that the answers were to be based in their experiences. For example in an interview with Emma, she says:

> C: What did like drugs and alcohol and eating disorders need to take advantage of or convince you of in order to become part of your life in the way they did?

A: And this is exactly for me, right?

C: Yeah, just for you.

Another limitation of this study and the use of co-research is that it is not easily replicable. The context of this study would be difficult to reproduce since interviewing 12 young women with similar experiences may produce different results simply based on the dynamics between the interviewer and interviewees. Additionally, the interviewer's knowledge of the interplay of substance misuse and disordered eating practices as well as the interviewees' experiences with these problems could produce different results. In the methodology section I attempted to clearly articulate my role as researcher so that the readers could have some trustworthiness in my attempts to produce a useful and reasonable piece of work

Another limitation of this study is generalizability. The study had a small sample size as I only interviewed twelve young women. The young women were all close in age (15 to 21) and were currently in or had attended the Peak House program for substance misuse, and self-described as struggling with disordered eating practices. As a result, the findings of this present study may not be widely generalizable to other populations. For example, the results of this study might not apply to young men or to adults participating in similar substance misuse programs who also self-report as struggling with disordered eating practices.

Another limitation of my dissertation could be the criteria that determined whether the young women could participate in the study or not. As mentioned in chapter five, the requirements for inclusion in the study were that the young women had attended or were attending Peak House and that they self-described as struggling with or

having struggled with disordered eating practices. This criterion was selected rather than including them only if they met the diagnostic criteria for substance abuse, dependence or eating disorders as defined by the DSM-IV-TR (APA, 2000). I also did not make direct correlations between the substance(s) that the young women were using and their specific type of struggle with disordered eating practices, for example anorexia, bulimia, or compulsive eating. For example, given that cocaine can act as an appetite suppressant, it would be a drug that would make a young woman lose a lot of weight in a short amount of time.

Furthermore I limited my study to Peak House, an inpatient co-ed treatment centre for substance misuse problems. Studying similarities and differences between young women's responses in different treatment settings would also have been very interesting. For example, interviewing young women attending inpatient treatment centres for disordered eating about their experiences with substance misuse problems would have been fascinating. Similarly, it would have been fascinating to conduct the study with young women attending individual or group outpatient therapy for substance misuse or disordered eating practices. This would offer therapists insight into therapeutic practices unique to specific treatment settings.

Future Directions

There are always things we wish we had done differently, and if I was given the opportunity to do this study again there are a few things I would do differently. I would have liked to have had the opportunity to go over the transcripts with the young women once they were transcribed, asking questions about their experience of the interviews, what changes they may have noticed since our interview, and allowing them to question

me about my experience. It would also have been interesting to have had lead a reflecting team[30] with a new group of young women either in a treatment centre for disordered eating practices or substance misuse after they read the results section of this dissertation (Andersen, 1991, 1992a; Katz, Siegal, Rappo, 1997). I would be curious to hear their responses to words of the young women, their responses to my interpretations of the results, and their own ideas about the interplay between substance misuse and disordered eating practices.

I hope this research will stimulate discussions regarding how therapists and treatment programs can best serve the needs of young women struggling with disordered eating practices and substance misuse problems. I hope that young women are included in these conversations. Other questions have emerged during the writing of this dissertation. Can traditional alcohol and drug and eating disordered treatment practices begin to be more inclusive and reflective of the experiences of young women experiencing both problems? And how might this research potentially inform new therapy practices? Building on this question I have included in the Appendix (Appendix E) a potential outline of a six-week therapy group for young women struggling with both substance misuse and disordered eating practices. I am also curious if the anticipation of a relationship between the two problems might disable the potential interplay between them, since young women might begin to predict the ways that the problems could appear or re-appear and the ways they work together in order to keep them ensnared. Questions regarding how this work might also be preventative emerge.

[30] For a detailed explanation and description of reflecting teams please see Tom Andersen's (1991) book The reflecting team. New York: Norton.

The main thing I think this dissertation offers regarding future directions is the need to expand our horizons of research inquiry to position 'insiders' (research 'subjects') as co-researchers. By positioning the young women as co-researchers, an interplay between my world and theirs occurred which opened up space for new possibilities and connections to unfold. In this opening, both the young women and myself made connections between disordered eating and substance misuse that we had not seen or known before our conversation together. In this way, the interview became a process of co-construction for both the participants and myself. With each interview, a different level of depth and richness was added to my understandings of the ways in which disordered eating practices and substance misuse can work in a young women's life, and the ways in which young women can begin to find some freedom from these problems. I hope that this research inquiry can open up space and lend credence to young women's voices within the field of therapy research. As well, I hope that voices of other 'clients' struggling with problems are added to the breadth of therapeutic literature in the hopes of offering new possibilities and new ways to go on (Andersen, 1998).

APPENDIX A THERAPIST INTERVIEW QUESTION

1. Will you please describe your work and ideas in terms of education, experience, theoretical orientation, and any other points that are significant to you as a professional?
2. In your work with people that struggle with problems of disordered eating have you come across people who have also struggled with problems of substance misuse?
3. If so, did both problems present at the same time or at different time periods?
4. In your experience is there a difference for people experiencing both problems or a difference in their experience of the problems, compared with someone who experiences one problem or the other (disordered eating practices or substance misuse), and can you speak to that difference?
5. Did you notice any similarities in the ways the problems effected people's lives?
6. In your experience are there ways that alcohol and drugs might become appealing to someone struggling with disordered eating, or in your experience are there ways that disordered eating might become appealing to someone with a substance misuse problem?
7. What are your ideas about the interconnectedness or the points of convergence between alcohol and drugs and substance misuse?
8. In your own work have you developed ways to address both problems together? If Yes, how do you do this, and what led you to doing this. If No, what led you to choose to work with only one of the two problems? Do you have a way of prioritizing which problem you work with initially? What guides these decisions for you? If the program did not mandate this what do you think you would do if you were confronted by both problems?
9. What potential benefits/difficulties might arise when addressing the two problems together - what about when addressing the two separately?
10. Are there any readings that you would recommend?

Thank you for your time.

APPENDIX B QUESTIONS FOR INSIDERS[31]

What would you call/name your experience with disordered eating practices?

1. What are some of the pressures that young women face about how they should be and how they should look? Did you ever experience 'pressure' to look a certain way or fit in and did substances or disordered eating practices ever try to convince you that they could help you 'fit in'? If so how did they do this?

2. Are there ways that the media, our family, and friends might inadvertently support disordered eating practices and substance misuse?

3. Some young women struggle with both eating disorders and substance abuse, why do you think this is? Why might some people struggle with both problems and some do not?

4. Have there been times when alcohol, drugs, and disordered eating practices have been a problem in your life?

5. Were there things going on in your life that made the problems look like a good option?

6. Were there any promises that substance misuse or disordered eating practices offered you to convince you that they would help you out?

7. Were there any differences in the ways that substance misuse or disordered eating practices 'helped' you out?

8. If they did 'help,' what have YOU had to do or learn in order to break free? What do you know now about their 'promises'?

9. In regards to timing, was there ever a time that disordered eating practices and substance misuse overlapped in your life or did they appear at separate times. Did one ever use the other to sneak back into your life?

[31] Questions 1, 2, 6, and 20 are adaptations inspired by Helen Malson's questions from the book *The Thin Woman: Feminism, poststructuralism and the social psychology of anorexia nervosa* (1998, p. 194-196).

10. Have you found that these problems have a way of 'teaming up' together? Can you describe these times be? Do they share any of the same tactics, or fulfil the same purposes? How do you understand/explain this? How did you figure this out?

11. Are there times when you might be more or less vulnerable to the 'teaming up'?

12. How would you describe the meaning or link between alcohol & drugs and disordered eating? What did it need to do (take advantage of, convince you of) to become part of your life in the way that it did?

13. How would you draw/or what would a diagram look like for they way that they interacted in your life?

14. Are there any thoughts, feelings, times, situations that have made you more vulnerable to their appearance either in the past or presently?

15. Were there times when disordered eating practices and substance misuse might have been less of a problem in your life? When? What actions did you take to make this possible?

16. Are there any things that you do that help keep some distance from disordered eating practices and substance misuse's strategies that you use to catch the problems' reappearance? Are the strategies that you use the same for both problems?

17. Were there times that disordered eating practices and substance misuse defined your identity, did they do this separately or together? What qualities did they try to get you to forget?

18. Was this a useful way to see/think about yourself? Why or why not.

19. How would you prefer yourself and others to see you?

20. Did disordered eating practices and substance misuse ever have you questioning this way of seeing yourself? Or did it affect your relationship with yourself in anyway?

21. In order to break free from this view of yourself what did you do, did anyone else help you to break free from that view? Were there certain qualities that you needed to remember?

22. When you were working with therapists or in a treatment program did you ever experience having to hide one problem or the other? If so how did that come about? If not what did you or the therapist do to be able to discuss both disordered eating practices and substance misuse at the same time. Was it important that you were able to do so?

23. If you were asked to design the 'perfect' program/group for people struggling with disordered eating practices and substance misuse what would it look like. Would there be things that would need to be included?

24. For other young people struggling with disordered eating practices and substance misuse what would you want them to know? What support, advice or insider knowledge might you offer them?

25. If you had been offered the same information that you just shared, what difference might this have made for you?

26. For therapists working with young people who are struggling with disordered eating practices and substance misuse what would you like therapists to know about these two problems? How might people have been more helpful to you when you were struggling with both problems?

27. What do therapists need to pay attention to when working with people who have struggled with both? Would it have made a difference if both were addressed at the same time vs. addressing disordered eating practices first and substance misuse second or vice versa? Would it be beneficial when working with a counsellor to have these issues addressed simultaneously? What might be difficult about doing this? How would this look? Are there ways that therapists can help when you have stopped either substance misuse or disordered eating practices and you are starting to notice changes in your body (what could they say/do, etc…)

28. Are there things that we have not yet talked about that you feel are important? Or are there any other questions that you were hoping that I would ask?

Thank you very much for participating in this interview.

If you would like a copy of our interview please give me your email address and I will email a copy to you.

APPENDIX C CONSENT FORM FOR INSIDERS

You are being invited to participate in a study focused on Substance Misuse & Disordered Eating that is being conducted by Christine Dennstedt. The study is part of a Ph D thesis in Social Sciences, under the supervision of Dr. Sheila McNamee.

You are being asked to participate in this study because, in today's society, young people are constantly bombarded with information concerning substance misuse and disordered eating. In a way, this makes you an expert on these topics. If you agree to voluntarily participate in this research, you will be asked to participate in an interview approximately one hour long that will be audio recorded by Christine Dennstedt. I will be meeting participants at Peak House or at a location that is most convenient to them.

The purpose of this study is to explore ways to tease apart the complexities that arise when the problems of alcohol and drugs and disordered eating issues work together. I am inviting you to look at the complexities of this problem and to begin explore the ways in which the two problems work together.

Your participation in this study is entirely voluntary, and if you do decide to participate, you are free to withdraw at any time without any consequences or any explanation. Your continued participation should be as informed as your initial consent, so feel free to ask

for clarification throughout the interview. You may also choose to decline any questions with which you are uncomfortable or do not wish to answer.

The audiofile of the interview and my interview notes will be kept in a locked cabinet for five years, as per BC PIPA standards. The only people with access to the interview notes and audiofile will be myself and my dissertation advisor.

It is possible that the results of this study will be shared with others in the form of published articles and presentations at Scholarly meetings and conferences. However, your anonymity, will be maintained.

There are always risks and benefits of participating in a research study. A possible benefit to participating in this study is a thoughtful review of your own ideas. There are certain risks associated with revealing personal information about your experiences. It is not possible to identify all potential risks in any research process but all reasonable safeguards have been taken to minimize risks. For example, you need not answer any question you choose not to, and you can decide to end your participation in the interview at any time. Due to issues pertaining to confidentiality, your identity will be kept strictly anonymous by way of a pseudonym and your name will not be included in the published results.

I, (please print your name) _____ agree to

participate in this research under the following conditions:

1) That a pseudonym is used to identify any contribution/information I provide.

Contact and Questions:

At this time you may ask me any questions you may have regarding this study. If you have questions later, you may contact me at c_dennstedt@yahoo.ca, or 604.505.9183. Any questions or concerns about institutional approval should be directed to Sheila McNamee my Taos/Tilburg thesis advisor. Should you wish to contact her please email her at sheila.mcnamee@unh.edu.

Your signature below indicates that you have read and understand the above conditions of participation in this study Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in this study, that you agree to participate as a research participant, and that you have had the opportunity to have your questions answered by Christine Dennstedt and/or Sheila McNamee.

_____	_____	_____
Name of Participant	*Signature*	*Date*

Name of Legal Guardian	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be taken by Christine Dennstedt.

APPENDIX D CONSENT FORM FOR THERAPISTS/RESEARCHERS

You are being invited to participate in a study focused on Substance Misuse & Disordered Eating that is being conducted by Christine Dennstedt. The study is part of a Ph D thesis in Social Sciences, under the supervision of Dr. Sheila McNamee.
You are being asked to participate in this study because of your expertise/knowledge of substance misuse and/or disordered eating and if you agree to voluntarily participate in this research, you will be asked to participate in an interview approximately one hour long that will be audio recorded by Christine Dennstedt. I will be meeting participants at their workplace or at a location that is most convenient to them.

Your participation in this study is entirely voluntary, and if you do decide to participate, you may withdraw at any time without any consequences or any explanation. You may also interrupt the interview at anytime and ask the interviewer any questions you may have, and/or refuse to answer any questions with which you are uncomfortable. As an accountability measure all of your ideas will be quoted to you. After the interview, I will conduct a theme analysis of our conversation. The audiofile and my interview notes will be kept in a locked cabinet for five years, as per BC PIPA standards. Only myself and my dissertation advisor will have access to the interview notes and audiofile.

It is possible that the results of this study will be shared with others in the form of published articles; and presentations at Scholarly meetings and conferences.
I do not see any known or anticipated risks to you by participating in this interview the cost will be your time. A possible benefit to participating in this study is a thoughtful review of your own ideas.

Contact and Questions:

At this time you may ask me any questions you may have regarding this study. If you have questions later, you may contact me at c_dennstedt@yahoo.ca, or 604.505.9183. Any questions or concerns about institutional approval should be directed to Sheila McNamee my Taos/Tilburg thesis advisor. Should you wish to contact her please email her at sheila.mcnamee@unh.edu.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by Christine Dennstedt and/or Sheila McNamee.

_____	_____	_____
Name of Participant	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be taken by Christine Dennstedt.

APPENDIX E GROUP OUTLINE

A 6 week support group for young women struggling with substance misuse and disordered eating practices

Week 1: Creating Community

Introductions
Setting norms for the Group
Safety and the Limits of Confidentiality
Talking about language practices that don't support the problems
Ways of connecting with group members that stand outside of the problem (no glorifying substance misuse and disordered eating practices).
Introduce the idea of the continuum of substance misuse, the body image continuum and externalizing practices.
Introduce the idea of Michael Whites' journey metaphor. Discuss what types of preparations are needed as people begin on their travels. Where going to, what they need to bring with them on their journey, what they need to say goodbye to? Also discuss ideas of identity migrations (White, 2007)
Journaling Homework: How did they prepare to take the step of attending the group, what developments have happened that have them coming to the group. What helped them become ready-enough to attend? What actions were most helpful for them and perhaps others in getting them to this group? What ideas/voices did they have to resist in order to attend this group. Or perhaps it is the hope of what may happen. Also write about what they need to bring with them on this journey as discussed in group today.

Week 2: Getting to know the tactics of the problems

Brainstorming the promises of substance misuse
Brainstorming the promises of disordered eating practices
Looking at the ways the problems may have been an attempt to solve problems/feel better/cope
Looking at the ways these promises are actually empty promises (lies) and at the real impact they have been causing in persons lives.
Looking at what feeds the problems and things/events/contexts that the problems can take advantage of
Journaling Homework for week 2: each person picks three 3 ways that the 2 problems are most influential in their lives. Write about what feeds the problems, what makes them bigger. Then what makes them smaller, takes away their power. Actions, specific people, things, and places that support them in this.

Week 3: Looking at the interplay between the two problems

Revisiting the promises of the two problems
Exploring the similarities between the two problems
Exploring the possible interplay between the two problems: the ways that substance misuse and disordered eating overlap/connect, for example the similar promises they may tell, similarities in the ways they work in peoples lives
Journaling Homework for week 3: Each person draws the interplay between the two problems (Discuss ideas about how perfection may sneak in and try to wreck this exercise, and ways to keep it at bay). Notice and journal anti-anorexic/ anti-alcohol and drug actions that you may have begun taking or that you would like to imagine yourself taking.

Week 4: Movement Away

Discussing the pictures of the interplay
Reflecting team group: Have someone come in and be interviewed who is now free from the problems- discuss the history of this development, what they had to learn, ways they keep moving forwards.
Building a community- places ways to find support for these ideas outside of the group.
Journaling Homework for week 4: Begin to imagine other possibilities ways to move through pain/cope. What you would like to begin to fill up your life with when these problems are no longer around in this way. Continue to notice and journal anti-anorexic/ anti-alcohol and drug actions that you may have begun taking or that you would like to imagine yourself taking.

Week 5: Moving towards new possibilities

Discuss homework
Talk about moments/places/spaces where you have felt free from substance misuse and disordered eating practices. Actions that they have been taking that support these developments. People and places in their lives that support these moments.
Set backs & slip ups- how to move forwards after a setback- what you learn about making change in these moment.
Witnessing of personal qualities that cannot be measured by appearance.
Journaling Homework for week 5: Journal about the moments/places/spaces/persons where you have felt most free from substance misuse and disordered eating. What is it about these persons/places/moments that contribute to this development? How are you different in these moments?

Week 6: Noticing & Holding onto Moments of Freedom

Noticing Change. What changes have happened over the course of the last 6 weeks, what helped prepare you to make these changes? Was there a significant person, place

or thing that helped you make or begin to make these changes? (Epston, D., Workshop, October 14, 2009. Vancouver, BC)
What developments are important for people around you know? Videotape or write comments down for people in their life to be a witness to the changes, and the ways they can help you hold onto these changes.
Witnessing/Reflecting Group. What others can do to support them in finding and holding on to freedom from the problems.
Everyone in the group discusses where they would like to be, and what their relationship with the problem will look like. 'Imagine in 6 months from now…' Take it with them when they leave.
Journaling Homework for week 6: Finding freedom from the problems- how to continue holding on to the changes that you have made and continue moving forward.

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