The interplay of substance misuse and disordered eating practices in the lives of young women

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Many young women struggle with problems of substance misuse and disordered eating practices. However, programs and ways of working when both issues are present are not common. This article explores the similarities and interplays of substance misuse and disordered eating, drawing on interviews with young women, and discusses some implications for therapy and residential programs.

Keywords: substance misuse, disordered eating practices, anorexia, bulimia, young women
INTRODUCTION

Psychotherapists commonly know that many young women struggle with problems of substance misuse and disordered eating practices (Brady, Back, & Greenfield, 2009). However, less commonly known is how a therapist can work with these problems when they occur simultaneously in a young woman’s life. This challenge attracted me to develop ways of working with young women who struggle with problems that threaten both themselves and challenge their helpers due to their complexity. My purpose in this article is to explore and illuminate the interplay and interrelatedness of disordered eating practices and substance misuse. Throughout the article, I give case examples from seven semi-structured interview conversations I conducted with young women who self-described as having personal experience with substance misuse and disordered eating practices. This article illustrates some of the practical and therapeutic applications of this approach for work with young women struggling with these problems, thereby opening space to explore the richness and complexity of this work.

OF PARADIGMS AND LABELS

A wide array of paradigms is used to describe substance misuse and disordered eating practices. It is, therefore, important to clarify the paradigms within which my own understandings of these two problems are located. I distinguish the term ‘substance misuse’ from the more commonly used terms ‘substance abuse/dependence’, which are rooted in the dominant addiction terminology and the ‘disease’ model of addiction. In a similar vein, I avoid using the term ‘eating disorders’, which I find conjures up and limits us to traditional and individualistic understandings of anorexia, bulimia, and compulsive eating. Instead, I choose the term ‘disordered eating practices’. I use this term 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’ (1993, pp. 53–54). Brown proposes that ‘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’ (1993, p. 54). My use of the term ‘disordered eating practices’ is an attempt to conceptualise the societal drive for thinness not as individual pathology, but as problems that are very much connected to their larger social contexts (see Brown, 1993).

Traditional discourses of eating disorders and addiction can also result in totalising labels of ‘anorexic/bulimic/alcoholic/addict’ being placed on or taken up by persons (Madigan, 1999; Sanders, 2007). While some people find these ‘labels’ helpful because they offer a way to understand their experience and a 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).

INSIDER-KNOWLEDGE AND THICK DESCRIPTION

This article is an attempt to privilege young people’s voices in a way that will invite them to let us – the professionals – know how we can be of more use to them. Their ideas for future therapeutic conversations with other young people who are also struggling to navigate this rugged and confusing territory are highlighted. I have paid specific attention to ensure that the voices of the young women I interviewed are highlighted by including quotes and snippets of our conversations throughout. Their voices held me accountable to highlighting their insider (Epston, 2000) or local knowledge (Geertz, 1973) and wisdom throughout the writing. This is important to me, as so often young people’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 pathologise them and separate them from so-called ‘normal’ or ‘healthy’ individuals. Foucault refers to these as ‘dividing practices’ (Foucault, 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 categorised as ‘well/unwell’, ‘normal/abnormal’, healthcare 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 healthcare professional and places the professional in a position of power over the individual.

This article 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 enquiries into gaining 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 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 (in other words, ‘all people who have these problems are like this’).

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, these can distract you from what you care about in life. As Ida explained to me, ‘I think that’s exactly the point’, referring to how the problems can act as a distraction from life and the need to participate in it. Even more difficult is when young women struggling with both problems describe both 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 specialise in one problem or the other. Reflecting on this idea in our conversation, Ida articulated how, ‘It’s almost like if they [counsellors] can only see them as separate from each other … they can’t really understand them, because their inter-relatedness is part of what defines them’.

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’ (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-medicalised and governed by 12-Step programs (Alcoholics Anonymous/Narcotics Anonymous), addiction counsellors, detoxification centres, recovery homes, and abstinence-based treatment programs. Eating disorder 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 compartmentalisation is incongruous with the ways in which people live their lives, and can lead one problem or the other to ‘go underground’, defying detection.
The above philosophies can also lead to very static ideas about treatment. Some of the following ideas are common:

- ‘Hitting rock bottom’ is a prerequisite for change.
- You have to want help to get better.
- Once you are an alcoholic or an anorexic then you will always be an alcoholic or an anorexic.²
- Addictions are progressive diseases which if left untreated can result in death.
- Abstinence is the only cure for addiction.

During the interviews I conducted, the young women often used the above ideas or other common deficit-based understandings to describe themselves. The language of deficit was often used by the young women as an explanation for their experience of substance misuse and disordered eating practices. As Beth described:

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

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

THE INTERPLAY BETWEEN DISORDERED EATING PRACTICES AND SUBSTANCE MISUSE

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. In my therapeutic conversations with young women, I have found that addressing the problems simultaneously creates a common space where the problems come alive in an entirely new way, thereby interrupting the tendency to dichotomise these issues, creating new possibilities for change. Addressing substance misuse and disordered eating problems collectively can be important; otherwise, these problems remain compartmentalised and separate – defined as ‘this’ (i.e. disordered eating practices) and ‘that’ problem (i.e. substance misuse). The problems’ interplay remains outside of any categorisations, its location hidden and silenced.

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. These relational features are the similarities between the problems and the ways in which these similarities interact to keep young women captive. 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 find freedom from the problems.

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, to cope 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 co-morbidity between disordered eating practices and substance misuse

The alternative diagram below illustrates the interplay between the two problems. I will describe the lower circle that represents the relational context shared by the two problems. The social context of the young women’s lives is always present when discussing the relational context.
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 the promises 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, 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 young women’s lives.

Ida described how the realisation that disordered eating was ‘making me anti-social’, led to her beginning to find freedom from disordered eating practices. She said, ‘That was part of the reason I started to get healthier – food is such a social cornerstone. The first summer I actually relaxed about what I ate, I had such an amazing time, I felt so carefree. I fell in love and met my husband’.

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 break-up, it might seem easier to ‘use’, or to binge and purge, as a way to cope with the barrage of emotions that one would experience when a relationship ends. 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 that the person is seeking. 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.

Ava said: ‘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 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 … And it’s like the problem just keeps getting worse and worse’.

SOCIAL ASPECTS OF SUBSTANCE MISUSE AND DISORDERED EATING

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 rite of passage for teenagers on their way into adulthood, with young men’s drinking often being strongly tied to discourses of masculinity (Nylund, 2007; Smith & Winslade,
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). Jill described how, ‘Like in advertisements, girls are drinking Captain Morgan [rum] 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’.

Problems are at times 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. Emma described how drugs, alcohol, and disordered eating practices tried to convince her that they could help her become the sort of young woman that society thinks she should be. She astutely described how, ‘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’.

The ‘relentless pursuit of thinness’ (Bruch, 1973, p. 555) and the generalised 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 body alteration. 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 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’ (1972, 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).

As Jill described:

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

Jill: Well the media is really bad for training women. Women should be blonde, skinny, have big boobs, a tight ass, and a small waist. They should be Barbie-ish. And like, they don’t have very important roles.

Ida clearly articulated the societal insidiousness of disordered eating practices and the difficulty this posed for her when trying to separate herself from them. She said, ‘I think drug abuse, at least for me, was a lot easier to leave behind, because the line between healthy/unhealthy isn’t so blurry’.

Disordered eating and substance misuse also support the notion of ‘special-ness’ among 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 with 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 get through certain periods in her life, ‘having 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 better able to see that the problems are anything but friends and how this façade isolated them from people who cared about them. Yet it is important to recognise how these problems can be ways to cope and, as Ida described, ‘I can still see the friend part’. Yet she went on to say this was not the ideal friend, or the friend she would choose at this point in her life given that she now has other options, choices, and ways to cope available to her.

MINIMISATION, RISKS, AND DIFFERENCES

At times, substance misuse and disordered eating is minimised as a problem. Young women often describe how they could ‘stop using at anytime’, or ‘it’s not really a problem’. For example, ‘When I lose X3 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'. 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.

Both substance misuse and disordered eating practices are associated with increased health risks and mortality rates. Mortality rates for persons with anorexia are higher than any other mental and psychiatric disorder (Herpertz-Dahlmann, 2009; Keel et al., 2003). 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 injecting drug users (Kerr, Tyndall, Lai, Montaner, & Wood, 2006). Hser, Hoffman, Grella, and Anglin (2001) followed people 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. Beth explained, ‘People think that if you use substances you can die, but if you get sick [purge] you don’t. I think a lot of people think like 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’.

As mentioned earlier, some fields of study consider anorexia/bulimia to be an addiction (Krueger, 1982), and 12-step groups such as Anorexics and Bulimics Anonymous (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 W.’, 1955).

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. Therefore, 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, or seeking pleasure (and/or transcendental and/or mood-altering experience), whereas people often begin ‘dieting’ as a way to lose weight.

THE WEB OF SUBMISSION

Following is a table that highlights the relational features that exist between the two problems. The chart also shows, by way of illustration, how in times when someone is vulnerable to one of the problems, it can be very difficult 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 endless submission. I have decided to break this table into two. Table 1 describes overall relational features between the problems, and Table 2 describes the promises that the problems offer young women. The categories and tables 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.

THE PROBLEMS’ INTERPLAYS IN THE LIVES OF YOUNG WOMEN

The following tables depict 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. Unfortunately, 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, and 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 could do in order to separate themselves from the problems.

Hannah gave an example of the problems’ interplay in her own life:

Christine: Do you think disordered eating practices and substance misuse share any of the same promises, or play off of each other in any way?

Hannah: Like how?

Christine: Like one kind of compliments the other?

Hannah: Well, like being skinny and having an eating disorder – if you do drugs it’s a lot less work and better results.

Christine: So how did you begin to figure that out?

Hannah: I wanted to do it, and then I saw what it did and I was like, ‘Whoa’.

Christine: When you saw what it did? On your own body or other people’s bodies?

Hannah: 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 skinnier too.

Other potential interplays include:

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. Or she might begin to imagine using substances for a week after she leaves the program in order to lose the weight she gained in treatment.

As a young woman tries to stop purging, she notices that her substance use begins to increase as a way to deal with the 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

Table 1: Relational features between the two problems

<table>
<thead>
<tr>
<th>Relational features</th>
<th>Substance misuse</th>
<th>Disordered eating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance misuse</td>
<td>Problematic relationship with substances (alcohol &amp; drugs)</td>
<td>Problematic relationship with substances (food)</td>
</tr>
<tr>
<td>Culturally supported</td>
<td>Social celebrations centre around alcohol</td>
<td>Normative expectations of thinness for women and a generalised fear of fat that exists in society</td>
</tr>
<tr>
<td></td>
<td>Glorification of alcohol and drugs in the popular media</td>
<td>Glorification of thinness and beauty in the popular media</td>
</tr>
<tr>
<td>Creates isolation</td>
<td>Removes people from their supportive/healthy connections</td>
<td>People are isolated as a result of disordered eating</td>
</tr>
<tr>
<td></td>
<td>People become preoccupied with using</td>
<td>People become preoccupied with eating or not eating, over-exercise, calorie counting</td>
</tr>
<tr>
<td>Patriarchy</td>
<td>Response to abuses of patriarchy</td>
<td>Response to objectification, self-surveillance, abuse</td>
</tr>
<tr>
<td></td>
<td>Drug use as a challenge of traditional females roles, a way to rebel</td>
<td></td>
</tr>
<tr>
<td>Promises</td>
<td>Substance misuse</td>
<td>Disordered eating</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lose weight</td>
<td>A young woman may use substances to help lose weight, or may lose her appetite because of substance use&lt;sup&gt;5&lt;/sup&gt;</td>
<td>A young woman may purge, restrict her food intake, over-exercise in order to meet the requirements of anorexia/bulimia</td>
</tr>
<tr>
<td>Help deal with memories/trauma/oppresion/violence</td>
<td>Feelings numbed by substance misuse</td>
<td>Feelings numbed by bingeing/purging/not eating</td>
</tr>
<tr>
<td></td>
<td>Euphoric sensations that substance use creates</td>
<td>Focus and distract self by thinking about or avoiding the above</td>
</tr>
<tr>
<td>Be social/belong</td>
<td>Feel more outgoing when under the influence, fit in, sense of community</td>
<td>As a way to meet social expectations of thinness</td>
</tr>
<tr>
<td>Have more energy</td>
<td>Get much more done; stay awake for longer periods of time (with stimulant use)</td>
<td>Feeling high as a result of not eating, more time in day if not eating to do other things</td>
</tr>
<tr>
<td>Perfectionism</td>
<td>Use substances in an attempt to be the perfect daughter/young woman, have more energy to get all demands of day done, schoolwork, sports</td>
<td>Be thin/perfect girl/perfect daughter. Meet parental, societal expectations regarding weight and appearance</td>
</tr>
<tr>
<td>Distraction from feelings; a way to self-soothe</td>
<td>Get intoxicated, forget for a while/numb out</td>
<td>Purging/restrictive eating keeps focus on food/body and away from thoughts/feelings</td>
</tr>
<tr>
<td>Sense of control</td>
<td>Able to control feelings, memories</td>
<td>Control food intake, body weight</td>
</tr>
<tr>
<td>Alleviates guilt</td>
<td>Makes you feel better</td>
<td>Makes you feel better</td>
</tr>
<tr>
<td></td>
<td>Temporary distraction</td>
<td>Temporary distraction</td>
</tr>
<tr>
<td>Intense focus</td>
<td>Preoccupation with obtaining drugs and alcohol, and using</td>
<td>Focus on avoiding food, or purchasing food/bingeing; counting and getting rid of calories</td>
</tr>
</tbody>
</table>
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.

CREATING A SPACE TO ENQUIRE ABOUT BOTH PROBLEMS

The above discussion illustrates the need to create space to enquire about the two problems. Without such enquiry, 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 specialise 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 problems work in their lives. Accordingly, practitioners need to develop ways that reflect and respect the complexities of their clients’ lives. As well, we need to understand how these problems can be so alluring that they tear people away from their values and preferences regarding how they wish to be in the world.

Below is an excerpt of a conversation in which Ida describes her rich and complex understandings of the problems and how, in prioritising her hopes, values, and preferences for her life, she began to find freedom from them.

I think both [substance misuse and disordered eating practices] can be ways of dealing with the world; it’s a distraction. If I prioritise being an unrealistic weight, I need to dedicate most of my energy to achieving that goal, which means I’m not paying attention to the fact that there are wars going on right now, where families are being slaughtered. There is oil leaking into the ocean and no-one is stopping it. Those problems are so overwhelming. It’s easier to distract by getting high or focusing on getting thin. I’m also aware it’s a waste of time and energy. I could be having fun, but instead I’m trying to lose weight when I don’t need to.

They both fill so many needs. As a youth and young adult, I also felt like I wanted people to know I was suffering, from just having to exist in a world where girls and women are routinely abused and exploited. And I still suffer, but I am better equipped to deal with it. I’m smarter, I can think more critically, I can challenge myself. I have an amazing husband who gives the support I need to make myself feel better. I ask myself what really matters? What do I want people to remember about me? When I’m 90, what do I want to think
In closing, I hope this article 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 article. How 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? How might the anticipation of a relationship between the two problems disable the potential interplay between them? Might young women then 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? I would love to hear how others are having these conversations with persons struggling with both substance misuse and disordered eating practices and look forward to continuing our conversation.

NOTES

1. This article is written from the research garnered from my PhD dissertation, The interplay of substance misuse and disordered eating practice in the lives of young women: Implications for narrative therapeutic practice. I interviewed twelve young women who were interested in sharing their experience with substance misuse and disordered eating practices. The young women 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.

2. These ideas use the static nature of personality to solidify their claims (Bird, 2000).

3. 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.

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

5. 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 which is also directly associated with weight loss.

REFERENCES


