DISAPPEARING IN PLAIN SIGHT: AN EXPLORATORY STUDY OF CO-OCCURRING EATING AND SUBSTANCE ABUSE DIS/ORDERS AMONG HOMELESS YOUTH IN VANCOUVER, CANADA

by

Nicole Marie Luongo

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in

The Faculty of Graduate and Postdoctoral Studies

(Sociology)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

April 2017

Abstract

How are disordered eating and substance abuse embodied, experienced, and articulated within a context of multi-dimensional marginalization? Existing studies that address this question emphasize medical influences and gather clinical samples, thereby overlooking those for whom structural constraints such as poverty make accessing costly and time-intensive treatment unrealistic. In this study, I fill methodological and empirical gaps in the literature by using qualitative methods to explore the co-occurrence of eating and substance use disorders among homeless youth. This study consists of two parts: (1) semi-structured interviews with youth and (2) structured interviews with key informants employed by low-barrier support services. Results show several indicators of co-occurring disordered eating and substance abuse among homeless youth. There is a strong link between conscious self-starvation due to body image concerns and compensatory substance abuse behaviours, while youth also engage in substance abuse to mitigate the effects of hunger related to food insecurity. Further, there is a significant disparity when comparing youths' eating disorder and food-related health literacy to their substance use disorder health literacy. Finally, patterned responses among youth and front-line workers suggest that while service providers have several supports in place to assist youth who are engaging in problematic substance use, there is a shortage of existing infrastructure to assist youth who are struggling with disordered eating. I conclude by offering suggestions for further research on co-occurring eating and substance abuse disorders among vulnerable populations.

Preface

This thesis is an original intellectual product of the author, NM Luongo. The interviews reported in Chapters 4.1 and 5 were covered by UBC Ethics Certificate number H16-01419.

Table of Contents

Acknowledgements

I offer my enduring gratitude to the faculty, staff, and my fellow students at the UBC, who have provided me with both scholarly and emotional support throughout the duration of this degree. I owe special thanks to my supervisor, Dr. Amy Hanser, and committee member, Dr. Dawn Currie, for their invaluable feedback during the preparation of this manuscript. I extend further thanks to Dr. Beth Hirsh and Dr. Amin Ghaziani, in part for their academic assistance but mostly for their empathy.

I thank the 2015 graduate cohort in sociology for bearing witness to the storm.

To my study participants: I do not pretend to Know you, but I See you and I will forever remember.

Dedication

For Duncan and Christine

"Suppose if you had been through something, like if you had been through something catastrophic. If you had been through like a storm or an earthquake together or something like, horrendous, you…it would bring you closer together?"

"So you think that people who suffer together would be more connected than people who are content?"

"Yeah, I do."

"But what if they are creating the disaster, within themselves?"

- Florence + the Machine.

CHAPTER 1. Another Conversation with No Destination: Introduction

The co-occurrence of eating and substance abuse disorders has been the focus of considerable research. However, existing studies draw largely from clinical samples and overlook those for whom treatment is inaccessible due to structural constraints such as poverty. The erasure of economically marginalized populations in the literature is troubling, particularly given emerging research suggesting that poverty is not protective against body image concerns and weight-altering behaviours such as binge-eating and purging (DeLeel et al. 2009; Gard and Freeman 1996; Mitchison 2014). With this study, I address this knowledge gap through a qualitative exploration of socio-cultural and institutional factors related to co-occurring eating and substance abuse disorders among homeless youth. Key research themes and questions include: "How are disordered eating and substance abuse embodied, experienced, and articulated within everyday contexts associated with extreme economic marginalization?" and "How do low-barrier service providers support homeless youth in addressing concerns related to disordered eating and substance abuse?"

CHAPTER 2. These Chains Never Leave Me: Study Context and Positionality

According to Sharon Craig (1997), the co-occurrence of eating and substance abuse disorders has been widely explored since the 1970's. It was at this time that professor of psychiatry Arthur Crisp noted that anorexic patients were more likely to abuse alcohol than patients of average or above-average weight (Crisp 1968 as cited in Craig 1997). Crisp's observation has since been contested (Krug et al. 2008; Wiederman and Pryor 1996), but his claim has nonetheless expanded to include those with bulimia and substance abuse issues (Bulik et al. 1994; Carbaugh and Sias 2010; Klopfer and Woodside 2008), those with both anorexia and bulimia and substance abuse issues (Herzog et al. 1992; Kaye et al. 2013; Wiederman and Pryor 1997), and those who first struggle with substance abuse but later demonstrate eating disorder symptoms (Cohen et al. 2010; Marcus & Katz 1990; Suzuki et al. 1993). Although many of these studies suggest that eating and substance abuse disorders are inextricably linked (Holderness et al. 1992; Nokleby 2012), the majority of existing research examines those who are first diagnosed with an eating disorder and later develop substance abuse problems. Clinicians who treat chemically dependent individuals may thus fail to inquire about patients' eating habits and body image concerns, leading to a lack of understanding and sensitivity about disordered eating among substance abusing populations (Courbasson et al. 2005; Holderness 1992; Killeen et al. 2011; Nokleby 2012).

This lack of understanding is something that I have intimate experience with, and is in part what prompted this study. Between the ages of 19 and 21 I was homeless on Vancouver's Downtown Eastside and, despite actively seeking out eating disorder resources while addicted to alcohol and crack cocaine, rarely encountered a support

service that could address my concurrent bulimia. Instead, I was frequently encouraged by front-line workers and psychiatrists to focus on addiction recovery, despite believing that my alcohol and illicit drug use was largely motivated by a desire to escape the obsessive thoughts and compulsions that drove my binging and purging. Many years later, the despair and helplessness I associate with that time remain viscerally painful.

I suspect that my experience was not wholly unique: At the youth homeless shelter where I often slept, there were many who explicitly displayed the signs and symptoms of disordered eating, as well as whispered confessions of self-induced vomiting or dieting from youth who were, by many accounts, too consumed by food-insecurity to be concerned with body image (McClelland and Crisp 2001; Nevonen and Norring 2004; Sousa Fortes et al. 2013). After attending addiction treatment and working for several years thereafter with youth in the foster care system, I also witnessed binge-eating, self-starvation, and purging with alarming regularity. Despite being stigmatized as substance abusers (Cheng et al. 2016; Hepburn et al. 2016; Xiang 2013), however, homeless youth are rarely the topic of scholarly inquiry among eating disorder researchers, and I have yet to locate a single study that examines the interaction between eating and substance abuse disorders that includes this population. Instead, much research draws from clinical samples that require participants to have been formally diagnosed with anorexia, bulimia, or alcohol or drug addiction (see Blinder et al. 2015; Calero-Elvira et al. 2009; Conason 2006), thereby omitting those for whom structural forces such as poverty make accessing costly and time-intensive eating- or substance abuse disorder treatment unrealistic.

The dual purposes of this study are thus to explore factors related to health and well being that are linked to complex but overlooked combinations of social and economic dynamics, and to generate further academic interest about disordered eating among economically marginalized populations who abuse substances. I take up Heid Nokleby's (2012) suggestion in a recent review to fill a methodological gap in the literature by adopting a qualitative approach to data generation, as quantitatively-oriented research (see Ram et al. 2008; Newman and Gold 1992; Simioni and Cottencin 2015) often fails to illuminate the underlying attitudes, perceptions, and structural influences that motivate co-occurring disordered eating and substance abuse. I also draw from emerging research that challenges the myth that males and gender-fluid individuals are unlikely to experience disordered eating (Calzo et al. 2016; Cohn et al. 2016; Soban 2006), as well as studies that highlight eating disorder symptoms among racial or ethnic minorities (Boisvert & Harrell 2014; Chao et al. 2016; Craig and Shisslak 2003), by including youth of all backgrounds in my sample. How, I wonder, does multi-dimensional structural marginalization intersect with the deeply personal experiences of disordered eating and substance abuse?

CHAPTER 3. A Loud Scream: Theoretical Orientation

Although existing medical, psychiatric, and epidemiological studies have offered influential insights into precursors such as trauma (Blinder et al. 2006; Cohen et al. 2010; Dohm et al. 2002; Killeen et al. 2015) and neurological risk factors (Castro-Fornieles et al. 2010; Franko et al. 2008; Stice et al. 2001) of co-occurring eating and substance abuse disorders, a preoccupation with generalizability requires researchers to employ standard diagnostic criteria for statistical modeling purposes. However, the underlying assumption that mental health conditions can be diagnosed by an atheoretical guidebook studied by objective professionals without considering personal, social, and institutional contexts has been scrutinized (Fredrickson and Roberts 1997; Guilfoyle 2013; Wakefield 1992). The Diagnostic and Statistical Manual of Mental Disorders (DSM), with its "relentless commitment to its own knowledge" (Guilfoyle 2013), ignores many of the extraneous factors that contribute to what even the most well-intentioned clinicians may deem "pathological" thoughts and behaviours. This is particularly relevant when one considers the "relations of ruling" (Smith 1990) between homeless youth, practitioners, and researchers, as practitioners and researchers may be highly educated but implicated in bureaucracy and far removed from lived realities of oppression.

Beyond this, even conventional qualitative approaches have been criticized for problematic philosophical underpinnings that reify biomedical understandings of health and illness (Arslanian-Engoren 2002; Bendelew 2004; Crowe 1998). Specifically, the notion that language – unstable, incoherent, and historically situated – conveys an "authentic voice" when describing one's lived experience of mental health is suspect (Ceci 2003; Grant 2014; Gone 2008). Rather, language can be viewed as a cultural

system that, while ostensibly expressing "truthful" narrative identities, works to (re)configure and (re)produce dominant power relations (Adams St. Pierre 1998; Grant 2014; Stevenson & Cutliffe 2006). Language tacitly accepts the reasonableness of the self-knowing subject - the "metaphysics of presence" (Derrida 1976) – whose essence can be uncovered by clinicians and disseminated by researchers. This proposition is questionable, however, when one considers the cacophony of shifting discourses (Foucault 1976) transmitted through families, peer groups, and institutions such as the media and medical profession. These discourses inevitably shape research participants' subjectivities and subsequent responses to interview questions about mental health (Henriques et al. 1984; Hoff 1988; Hollway 1983).

I thus proceed cautiously. My theoretical approach may loosely be described as feminist poststructuralist. I adopt these sensibilities in that I do not claim total scientific objectivity, and I do not wish to label youth participants as either "healthy" or "disordered." I further understand that participants' "medicalized subjectivities" (Wardprope 2015) – that is, their self-conceptions of themselves as disordered - may be influenced by social norms that stigmatize homelessness. I do, however, treat participants as "experts," in that I view their pain, independent of its social and political antecedents, as "real." Finally, I treat the social world as a site of (re)constitution: I do not attempt to reify existing perceptions of "reality" but rather interpret reality – and the language deployed to discuss it - as a product of historic and discursive conflict wherein economic marginalization, young adulthood, and womanhood are pathologized (Piran 2010; Stoppard and Gammell 1999; Wardrope 2015).

CHAPTER 4. Trying to Cross a Canyon With a Broken Limb: Methods

Data were generated through 11 interviews, 7 semi-structured with youth and 4 structured with front-line workers, conducted between December 2016 and March 2017 in Vancouver, Canada. Initially, I met with the executive directors of one homeless shelter and one outreach organization to obtain permission to post recruitment flyers welcoming youth with "food-related or body image concerns who currently or formerly used alcohol or drugs" to contact me by telephone or e-mail. I also offered a $15 honorarium for participation. Mid-way through data generation, I attended the outreach organization's youth advisory committee meeting to invite further participation. While several youth approached me afterward to ask whether I considered some of their eating-related thoughts and behaviours problematic, I could not ethically offer feedback beyond sharing my own experience and suggesting they seek further support. Although this generated what appeared to be much interest among potential participants, I arrived several times after scheduling interviews to find that youth did not appear. I attribute this to the transient nature of homelessness and to the multiple, competing factors that may influence a youth's decision to prioritize one commitment over another. There is also the possibility that youth, despite speaking with me first, were suspicious of my position as an "expert" and the opportunity this afforded me to influence outsider perception of their lives.

Ultimately, snowball sampling (Seymour and Graham 1986) was a more effective recruitment tactic. One youth, whom I had known while a front-line worker and remain in casual contact with, offered to participate and told members of her group home about my study. After conducting interviews with youth, I decided to include a key

informant sample by speaking with employees of local support services. I did so primarily to discern whether these employee's perceptions of client need matched the concerns described by youth. In this context, "front-line worker" is defined as a formal employee of a support organization who interacts directly with youth and is tasked with providing them with necessities such as food and clothing in addition to offering counseling and educational resources.

Youth participants ranged in age from 18 to 28 years old, the latter being the cut-off age for accessing many local youth support services. During recruitment and data generation, I was hesitant to adopt the terms "eating disorder" and "substance use disorder," as each indicates that one has received a formal diagnosis and further suggests that the symptoms of these "disorders" are inherently problematic: I know all too well that that rather than being maladaptive, they may in fact be self-protective mechanisms employed to stay alive. I thus use "eating disorder" and "disordered eating," as well as "substance abuse" and "substance abuse disorder" interchangeably throughout this article, though this may be a point of contention among researchers who remain invested in the DSM.

4.1 Ethical Concerns and Sample Composition

All research was approved by the University of British Columbia's Behavioural Research Ethics Board. Before data generation, I went through three rounds of ethics review to amend my interview guide and consent form due to the sensitive nature of questions and vulnerability of my study population. I further offered a list of local, low-barrier counselors to youth after conducting interviews in consideration of the fact that interviews could be emotionally distressing. Youth consistently declined this list, as most

were well connected with support services and were eager to discuss my study topics. I also engaged in an extensive process of writing analytic memos after interviews, both to discern themes I saw emerging and to document feelings of anxiety, surprise, or doubt that arose. As someone who avidly participated in survey research while homeless to obtain honoraria, I did not want to evoke feelings of exploitation among youth participants. At no point did I sense that ceasing the study was warranted.

Youth of all genders, sexual orientations, and racial/ethnic backgrounds were invited to participate due to the underrepresentation of those who are not female, white, and heterosexual in the eating disorder literature. One unanticipated result was the number of youth in my sample who had Aboriginal heritage. Of my seven youth participants, five stated that their racial or ethnic background was partially or fully Aboriginal, a significant number given that Aboriginal people make up less than 5% of British Columbia's total population (Statistics Canada 2006). Though my sample could be skewed in favour of including Aboriginal participants due to the overrepresentation of Aboriginal youth who grow up in Canada's child welfare system and subsequently become homeless as they "age out" of foster care at age 19 (Duff et al. 2014; Smith 2009; Trocme et al. 2004), my demographic composition may also be related to systemic discrimination experienced by Aboriginal people when accessing health-care. Specifically, prior studies suggest that Aboriginal populations are more likely to encounter difficulties entering addiction and eating disorder treatment (Barker et al. 2015; Philips et al. 2014; Wood et al. 2004), and that the ongoing legacy of colonization, residential schools, and institutional racism has generated distrust of service providers

among Aboriginal people (Baskin 2007; Krusi et al. 2010; McBain-Rigg and Veitch 2011).

One formerly homeless 28-year old participant echoed these concerns while recalling the perceived hostility she felt from support services while struggling with both substance abuse and binge eating. She stated, "It was really painful…I always thought people were judging me 'cause I was like, either Native or young." The ethnic composition of my sample could thus reflect that rather than being more likely to have eating and substance abuse issues, doubly- or triply-marginalized Aboriginal youth in Canada receive suboptimal health care and are consequently left with few options when attempting to address these issues. I took this into consideration while conducting interviews. Though I could not, as a Euro-Canadian, explicitly modify my interview questions to adopt Aboriginal ways of understanding, I remain conscientious of the fact that western mental health discourses can be viewed as a form of surveillance (Gore 2008) of Aboriginal people in a settler-colonial state. My sample may underscore the need to provide accessible, affordable, and culturally competent treatment options for Aboriginal youth struggling with co-occurring disordered eating and substance abuse, as well as a need for greater representation of Aboriginal people in the eating disorder literature.

4.2 Data Generation and Analysis

My interviews averaged twenty-eight minutes but ranged from twelve to sixty-four minutes. I first obtained written informed consent and assured participants that identifying information would be removed from my study. Interviews were conducted individually, and I met six of the seven youth participants at a coffee shop or park of their

choosing. One participant had recently moved into subsidized housing and asked that we meet at her residence. While conducting interviews with front-line workers, I followed a similar protocol and met three at a coffee shop. One worker was a relative and instead opted to meet at my home. With consent, interviews were audio recorded. I transcribed interviews verbatim within two hours after they ended, including pauses, laughter, and voice inflections.

Before beginning interviews, I described my purpose of inquiry as an exploration of "disordered eating, body image concerns, and substance abuse issues among homeless youth." In accordance with the tradition of feminist poststructuralism (Gavey 1989; Weeden 1987), I was transparent about my own positionality and briefly articulated being formerly homeless with both diagnosed eating and substance abuse disorders. I did not, however, attempt to conceal the fact that my struggles are ongoing: Though no longer socioeconomically marginalized, I continue to contend with internal dialogues that are painful, exhausting, and may be considered far from "healthy." During the interview process, I felt this mitigated some of the hierarchical researcher-subject dynamic and built rapport with participants. I also viewed the interviews as a transmission of inherited language that is located within the shared social context through which it is exchanged (Hardin 2003; Wetherell 1986). Here, my experience was once again useful: While I did not want to make assumptions about my youth participants' psychiatric or medical knowledge, I anticipated that their social context - once my own - of extreme economic marginalization and street-involvement may have limited their access to medicalized discourses deployed in the DSM. I was also not concerned with categorization or even of trying to "know" my participants as "rational selves" (Smith 1993) beyond what they

conveyed through language. I thus avoided questions that included the terms "anorexia," "bulimia," or "substance abuse disorder" and instead invited a plurality of meanings about these issues that I interpreted as being "socially, historically, and culturally specific" (Gavey 1989).

I began with general questions about age, self-identified race/ethnicity, education level, and length of homelessness. Those some poststructuralists eschew categorization entirely, I felt these forms of self-identification could influence participants' subjectivities and may thus be relevant considerations during data analysis. I moved on to asking youth participants to describe what they ate in a typical day, their habits around alcohol and illicit drug consumption, and questions related to economic marginalization such as, "does the cost of eating ever interfere with important purchases?" Over the course of the interviews, I extended the discussion to include specific body parts the youth liked or disliked, their motivations for using substances, and how supported they felt by front-line workers in addressing their eating or substance-related concerns. Throughout, most youth were keenly engaged and offered suggestions for how support services could improve, particularly with regards to disordered eating. I often had to modify the planned interview format in concert with stories participants shared, at times of overdosing or of friends' deaths, and the slang they employed.

I offered a very similar explanation of my study to front-line workers, but emphasized that I was primarily interested in organizational supports. I again began with general questions, and then moved on to beliefs about both eating and substance abuse disorders. I asked participants to describe the signs and symptoms of these disorders and how they felt each originated, as my experience has taught me that front-line workers are

often responsible for identifying and addressing potentially problematic behaviours in lieu of family involvement. Although questions directed toward my youth sample were largely conceptual, here I was more direct when inquiring about how participants would respond if a youth approached them about struggling with eating- or substance-related concerns. I concluded by asking about institutional capacity to address these issues, such as whether organizations were equipped with addictions specialists or eating disorder counselors. Each participant acknowledged that the latter were absent.

Drawing from poststructuralist conventions that challenge traditional methods of data analysis (Jackson and Mazzei 2013) I considered the influence that dominant cultural discourses about disordered eating and substance use have on the articulation of individual correspondence (Hardin 2003). That is, I accepted that data may be partial, contradictory, and heavily influenced by the narratives to which my participants had access (Allen and Hardin 2001). I was further cognizant of the potential "conversational moves" (Atkinson and Heritage 1984; Sacks 1992) that both my participants and myself made throughout the interviews, and took into account the influence that my presence as a researcher had on what participants felt may be a preferred response (Hardin 2003). Due to the broad and exploratory nature of my research questions, I did not anticipate *a priori* codes but instead immersed myself in the data to "comprehend its meaning in its entirety" (Crabtree and Miller 1999) by reading interview transcripts several times before coding. I assumed that participants constructed context-specific meanings and that I, as the researcher, may unintentionally interpret these meanings based on my own beliefs and values (Charmaz 2006). I also practiced an iterative process of reviewing my findings

and refining my interview questions to better suit themes I saw emerging as interviews were conducted.

I divided the coding process into two distinct phases (Massengill; Ryan and Bernard 2003). I first analyzed my data line-by-line during initial coding so as to not overlook any ideas, themes, and concepts that emerged. While doing so, I kept in mind that themes would be overlapping and far from concrete (Vandermause 2008). I then engaged in a process of focused coding, during which I organized initial codes into groups of codes that I felt were particularly relevant given my research questions. I did so using NVivo software, a qualitative software program that that is useful for researchers who work with rich, text-based data and require deep levels of analysis on small or large datasets. Although NVivo is a powerful analytic tool, I continued to hand-write reflective memos to note inconsistencies and contradictions in participants' responses. I took these into consideration while building codes into hierarchies of importance and grouping them into thematic elements (Ryan and Bernard 2003).

I now turn to my results, which I organize into four major sections. I begin by discussing body image concerns, restrictive tendencies, and compensatory substance abuse among youth. I follow this with a description of food insecurity and substance abuse, with an emphasis on the implications of food insecurity for youths' body image concerns. I then explore youths' eating disorder and food-related healthy literacy compared to their substance abuse disorder health literacy. Finally, I relay both youths' and front-line workers' perceptions of institutional capacity to address these issues, noting the consistency with which participants from both samples felt that eating disorder resources were scarce.

CHAPTER 5. All That's Left is Hurt: Results

Results show several key indicators of co-occurring disordered eating and substance abuse among street-involved youth. Specifically, two main themes emerged: a strong link between conscious self-starvation due to body image concerns and compensatory substance abuse behaviours, and engaging in substance abuse to mitigate the effects of unintentional self-starvation. Further, my data indicated a significant disparity when comparing youths' eating disorder and food-related knowledge to their substance use disorder knowledge. Finally, both youth and front-line workers confirmed that while low-barrier service providers have several supports in place to assist youth who are engaging in problematic substance use, there is a shortage of existing infrastructure to assist youth who are struggling with disordered eating.

5.1 Theme One: Body Image Concerns, Restrictive Tendencies, and Substance Abuse

A prominent theme that emerged was substance abuse and self-starvation as a means to achieve or maintain a low body weight. Several participants described being strongly affected by social norms surrounding thinness and subsequently facilitating weight loss through substance use, an important finding given homeless youths' erasure in the eating disorder literature. Many youth noted their susceptibility to being influenced by the images featured in popular magazines. One 21-year-old participant claimed, "I always picture the girls in magazines" when asked to describe her perception of an ideal body, and another acknowledged, "my thinking is a bit twisted because of the media and our culture and stuff." A third, male youth, who is immersed in Vancouver's gay community and consistently described feeling overweight, acknowledged, "in our culture and society we keep getting bombarded by media and TV shows and movies and books

saying you have to be super skinny to be attractive and for men to be like, muscular and sexy. Especially in the gay community…the media there is like, awful, because it's just about sex, sex, sex - like you have to be muscular in order to be happy, and you have to like, eat a certain way in order to be gay."

My participant's body-image concerns were frequently related to their substance use. One 28 year-old who has since entered addiction recovery recalled "struggle[ing] with this [eating while drinking] a lot. It was like, ok, I'm going to drink, and that's a lot of calories, so I guess I'm not going to eat dinner. Like I would prefer to drink over eating because I figured that's a way to balance things out." This participant also had a history of cocaine abuse, and described how the drug "would curb her appetite" so that she "did not eat frequently to become thinner." Instead, she "would go out all night partying and felt like [she] lost weight because [she] was out dancing." Similarly, another participant, who has also entered recovery, stated that prior to becoming sober she "would literally not eat food on purpose and just drink" and that she "associated drinking with losing weight" because she was able to more effectively skip meals while intoxicated. These youths' actions were thus in alignment with those separated by research on middle- and upper-class participants who intentionally restrict their caloric intake as a compensatory behaviour prior to or after consuming alcohol (Barry and Piazza-Gardner 2012; Burke et al. 2010; Root et al. 2010). My results suggest that homeless youth whose restrictive tendencies manifest at sub-clinical levels or remain undiagnosed may abuse alcohol and other substances to conform to broader culture values in which women and gay men are judged based on physical appearance. Service providers and clinicians may want to inquire about these youths' body image concerns

when attempting to address substance use, as these concerns appear to motivate a portion of youths' alcohol and illicit drug consumption.

Some of my participant's eating habits and body image concerns improved as they entered recovery from substance abuse. One participant, who now uses moderate exercise rather than illicit drugs to reduce her anxiety and depression, stated, "I've come to realize that you have to eat to exercise…I don't want to go back there [to her eating disorder] so I'm going to have a cookie, just in moderation." Another sober, formerly bulimic participant noted that a primary benefit of entering addiction recovery has been "the ability to afford healthy food." This counters previous claims that people are inclined to replace one coping mechanism with another (Baker et al. 2010; Nokelby 2012). It instead suggests that the cessation of alcohol and illicit drug use contributes to an enhanced sense of confidence and well-being that can prompt renewed interest in other health-promoting behaviours. Future research is needed to investigate whether this phenomenon is apparent only among homeless populations or whether it is found in members of other social classes, who have less to lose, so to speak, when it comes to getting sober[1]

5.2 Theme Two: Food Insecurity and Substance Abuse

Another finding that is perhaps unique to street-involved populations and is widely ignored in the literature was the relationship between food insecurity, substance abuse, and body image concerns. When prompted, all of my participants noted that they were formerly or currently food-insecure. One who was being raised in the child welfare

[1] Here I refer to the fact that those who are not at risk of losing temporary housing that mandates abstinence, as with many youth homeless shelters and social housing, may not feel the same urgency – and subsequent accomplishment – to stop using illicit drugs.

system stated that she had to "go to [her] group home" when hungry, while another, who has recently "aged out" of foster care, mentioned that she would "spend all [her] money on drugs and alcohol" and thus could often not buy food. Another, 28-year old male participant, noted with some disdain that he needed to access free outreach programs to eat but that these programs required "putting on a little green bowtie and dancing" in order to access food. Though the myriad complications associated with the non-profit industrial complex are relevant given my participants' responses and require further investigation, they exist beyond the scope of this study.

In some instances my participants consciously used substances to mitigate the effects of unintentional, prolonged starvation, while others demonstrated a reliance on substances without explicitly conveying that usage was connected to an inability to afford food. When asked what he ate in a typical day, one male participant described consuming on average only two pizza pops and stated, "if I don't eat my stomach is completely like, growling so hard I feel like a goddamn pitbull is going to burst out of there [but] alcohol numbs the pain." This participant had been street-homeless for several years and though he had developed a complex cognitive and behavioural system to meet his basic needs, also emphasized that he would "not eat for days at a time, [and would] just drink cider" due to its relative cost-effectiveness when compared to healthy food.

Although self-starvation due to poverty is not commonly reflected in the literature as a form of disordered eating, it is interesting to note that an effect of food-insecurity – namely, reduced body weight and shape – was framed by some participants as its positive consequence. One youth, for instance, discussed the pleasure she felt at being "way too thin" because she opted to spend her limited resources on alcohol and drugs rather than

meet her nutritional needs. Others noted that although they often channeled funds to substance use and could only afford free meals offered by support services, some of these meals were "basically all carbs and fat" and were to be avoided due to body image concerns. Future researchers may want to consider including homeless youth in studies that explore how young adults are influenced by the stigmatization of fatness, as extreme economic marginalization does not appear to protect one against internalizing hegemonic discourses that reinforce the value of thinness.

5.3 Theme Three: Knowledge of Eating Disorders Versus Substance Abuse Disorders

There was a significant disparity among my youth sample between their understanding of eating habits and eating disorders versus their understanding of substance abuse. While all of my participants were able to name and describe multiple variations of substance abuse, including the short- and long-term effects of specific substances, the psychological and physical ramifications of being physiologically addicted to these substances, and potential precursors to addiction, only two could name and define at least one eating disorder. One 21 year old participant, who discussed "making herself puke" in elementary school, could not identify this behaviour as purging and had never heard the word bulimia. Another 18 year old, when asked if she knew what anorexia was, responded "not really, I've read a book about it but it didn't fully explain it and I've never taken classes on it."

It is noteworthy here that economic status has been linked to various forms of health literacy, with those who are less educated and generate less income generally being less aware of health-promoting behaviours and demonstrating attitudes and beliefs that are linked to poor mental and physical health outcomes (Gibson and Williams 1994;

Howard et al. 2006; Kim et al. 2015). Sociologists have often drawn from the work of Pierre Bourdieu to explain this phenomenon, with some suggesting that cultural capital – that is, culture-based resources such as knowledge, books, and education as well as the norms and values that one accrues through socialization (Bourdieu 1986) – play a significant role in the unequal distribution of health literacy and illness (Kickbusch 2001; Paasche-Orlow et al. 2005). Bourdieu's cultural capital does not fully explain the discrepancy between my participants' beliefs about eating disorders versus those of substance abuse, however. Rather, I suggest that the frequent stigmatization of street-involved youth as substance users within institutional environments such as homeless shelters, combined with the normalization of substance abuse among this population within their families and peer groups, has lent itself to an unusual degree of health literacy when it comes to the signs and symptoms of alcohol and illicit drug abuse. Simultaneously, these youths' lack of formal education, as well as the transmission of disordered eating and poor nutritional habits through their families, has contributed to a vast knowledge gap that may render them vulnerable to untreated eating disorders.

5.4 Theme Four: Service Provider Gaps in Addressing Eating Disorders

Finally, my interviews with both youth and service providers revealed a significant lack of existing infrastructure designed to assist those struggling with an eating disorder. While every front-line worker could describe supports such as addictions counselors that their organizations had in place for youth who were engaging in problematic substance use, all were uncertain about where to direct youth who were demonstrating disordered eating. One youth worker, who has been employed by three local outreach organizations, claimed she has observed behaviours such as binging and

purging or self-starvation among "100 percent" of the youth she has met. Yet she stated, "we talk so much in our field about mental health and addictions…[but] eating disorders don't have a voice…it's crazy." Another, whose family member had formerly been diagnosed with anorexia and was thus very sensitive about disordered eating in the clinical sense, noted, "I used to volunteer with groups of girls and it was almost like, every session things would come up about restricting food or about how calories are bad…having lived with someone with an eating disorder it was quite shocking." When prompted to explain how she would support a youth who approached her with food- or weight-related concerns, she admitted, "It's tough…we'll pass the message on to a school counselor, maybe, but we never really know if it's being addressed." Finally, when asked if it was her perception that there is a disparity between institutional supports in place for those struggling with a substance abuse versus eating disorder, one employee of an Aboriginal youth organization replied, "yes, definitely. I can't think of one place that you might be able to go to for an eating disorder, [but] I can think of at least five or six places just off the top of my head for drug and alcohol addictions."

Not only were front-line workers concerned about the lack of supports in place for those with disordered eating, the youth themselves, despite often having spent years accessing support services, were similarly uncertain about where to seek guidance about food or body image concerns. When asked if she would know who to approach if she witnessed a friend engaging in self-starvation, one youth, who had spent three years at a local homeless shelter, responded, "No, I don't find that there's too much out there about that." When prompted to answer the same question, another, 18-year-old youth who was in recovery from both bulimia and substance abuse and had spoken positively about

addictions counselors stated, “Um…I don’t know.” A third, male youth, when asked whether he believed staff at a local homeless shelter would be able to address his concerns about binge-eating responded, “No I don’t think they would…like they’re very helpful people and I kind of go talk to them if I have like, legal problems or stuff like that but I never really go to them for a problem like overeating.” In contrast, each of these youth could name and describe several organizational supports they were aware of and had accessed for assistance related to drug and alcohol abuse. My results highlight the need for service providers to evaluate existing infrastructure and implement eating disorder-specific supports, while suggesting that service providers may want to consider incorporating eating disorder-related training into their mandates. As one youth succinctly put it, “They can spread awareness about it [food and body image concerns]. I don’t think they do enough.”

CHAPTER 6. As Far as I Could Get: Conclusion

The purposes of this study were to explore how extreme economic marginalization influences disordered eating and body image concerns among homeless youth, and to assess the extent to which these concerns related to youths' substance use. I further sought to identify gaps in service provision related to disordered eating and substance abuse. My results show that poverty does not render youth immune to cultural discourses that stigmatize fatness, and illuminate that food insecurity may in fact exacerbate youths' restrictive tendencies and substance consumption. Despite being influenced by popular media's depictions of normative bodies, the youth I spoke to faced unique structural constraints that rendered them vulnerable to misidentifying disordered eating while reducing their formal capacity to seek help for an eating disorder.

Further research is needed on these phenomena. Due to my small sample size, I cannot make concrete recommendations to address disordered eating among homeless youth, despite youths' avid suggestions that improvements be made with regards to eating disorder-related service provisions among support services in Vancouver. All but one of the youth I spoke to confirmed that they were relatively comfortable accessing charitable assistance programs and had fostered meaningful relationships with front-line workers, with one stating, "[organization name] is like one of my main favourite places because I feel like they're not there for just the job, they're actually there for the youth too." Another, when asked if she ever felt embarrassed about having to approach outreach programs for food, responded, "No, because I think everybody has their moments when they need help and [employee name] is like the nicest guy." This suggests that for some street-involved youth, front-line workers play an important role in

addressing youths' emotional needs in addition to meeting their more concrete needs such as clothing and shelter. This is not surprising, given the empathy and sensitivity displayed by each front-line worker as they discussed their client base.

I acknowledge that my own positionality may have unintentionally contributed to biases during study conceptualization, data generation, and data analysis. That said, I also suggest that it may have also offered useful insights into youths' concerns that would have otherwise remained unexplored. I recommend that my study topics be taken up by other researchers, particularly through adopting Dorothy Smith's (2005) suggestions for institutional ethnography as a means of more closely examining the "translocal relations" that coordinate people's activities within institutions. Doing so will not eradicate the multiple structural factors that render youth homeless and food-insecure in the first place (a topic that is beyond the scope of this study but that certainly warrants intervention), but may offer insight into how youth's activities, including their eating- and substance-related behaviours, are cared for and managed within institutional environments.

Bibliography

Adams St. Pierre E. 1998. Poststructural feminism in education: An overview. *International Journal of Qualitative Studies in Education,* 13(5): 477-515.

Allen D. & Hardin P. 2001. Discourse analysis and the epidemiology of meaning. *Nursing Philosophy,* 2: 163-76.

Atkinson J. & Heritage J. (eds). 1984. *Structures of Social Action: Studies in Conversation Analysis.* Cambridge University Press, Cambridge.

Baker J., Thornton L., Strober M., Brandt H., Crawford S., Fichter M., Halmi K., Johnson C., Jones I., Kaplan A., Klump K., Mitchell J., Treasure J., Woodside B., Berrettini W., Kaye W. & Bulik C. 2013. Temporal sequence of comorbid alcohol use disorder and anorexia nervosa. *Addictive Behaviors,* 38(3): 1704-09.

Barker B., Kerr T., Nguyen P., Wood E. & DeBeck K. 2015. Barriers to health and social services for street-involved youth in a Canadian setting. *Journal of Public Health Policy,* 36(3): 350-63.

Barry A. & Piazza-Gardner A. 2012. Drunkorexia: Understanding the co-occurrence of alcohol consumption and eating/exercise weight management behaviors. *Journal of American College Health,* 60(3): 236-43.

Baskin C. 2007. Aboriginal youth talk about structural determinants as the causes of their homelessness. *First Peoples Child and Family Review,* 3(3): 31-42.

Bendelew G. 2004. Sociology and concepts of mental illness. *Philosophy, Psychiatry, and Psychology,* 11(2): 145-46.

Blinder B., Cumella E. & Sanathara V. 2006. Psychiatric comorbidity of female inpatients with eating disorders. *Psychosomatic Medicine,* 68: 454-62.

Boisvert J. & Harrell A. 2014. Ethnicity, socioeconomic status, and eating disorder symptomology in Canada: Implications for mental health care. *Ethnicity and Inequalities in Health and Social Care,* 7(4): 158-77.

Bourdieu P. 1986. *The Forms of Capital,* In: Richardson G (Ed). *Handbook of Theory and Research for the Sociology of Education.* Connecticut: Greenwood Press. 1986.

Bulik C., Sullivan P., McKee M., Weltzin T., Kaye W., Dahl R. & Weltzin T. 1994. Characteristics of bulimic women with and without alcohol abuse. *American Journal of Drug and Alcohol Abuse,* 20: 273-83.

Burke S., Cremeens J., Vail-Smith K. & Woolsey C. 2010. Drunkorexia: Caloric restriction prior to alcohol consumption among college freshmen. *Journal of Alcohol and Drug Education,* 54: 17-34.

Calero-Elvira A., Krug I., Davis K., Lopez C., Fernandez-Aranda F. & Treasure J. 2009. Meta-analysis on drugs in people with eating disorders. *European Eating Disorders Review,* 17: 243-59.

Calzo J., Horton N., Sonneville K., Swanson S., Crosby R., Micali N., Eddy K. & Field A. 2016. Male eating disorder symptom patterns and health correlates from 13 to 26 years of age. *Journal of the American Academy of Child and Adolescent Psychiatry,* 55(8): 693-700.

Carbaugh R. & Sias S. 2010. Comorbidity of bulimia nervosa and substance abuse: Etiologies, treatment issues, and treatment approaches. *Journal of Mental Health Counseling,* 32(2): 125-38.

Ceci C. 2003. Midnight reckonings: On a question of knowledge and nursing. *Nursing Philosophy,* 4: 61-7.

Charmaz K. 2006. *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* Sage: Thousand Oaks, CA.

Chao A., Grilo C. & Sinha R. 2016. Food cravings, binge eating, and eating disorder psychopathology: Exploring the moderating roles of gender and race. *Eating Behaviors,* 21, 41-7.

Cheng T., Kerr T., Wood E., DeBeck K. Johnston C. & Nguyen P. 2016. Substance use patterns and unprotected sex among street-involved youth in a Canadian setting: A prospective cohort study. *BMC Public Health,* 16(4).

Cohen L., Greenfield S., Gordon S., Killeen T., Jiang H., Zhang Y. & Hien D. 2010. Survey of eating disorder symptoms among women in treatment for substance abuse. *The American Journal on Addictions,* 19(3): 245-51.

Cohn L., Murray S., Walen A. & Woolridge T. 2016. Including the excluded: Males and gender minorities in eating disorder prevention. *Eating Disorders*, 24(1): 114-20.

Conason A., Brunstein Klomek A. & Sher L. 2006. Recognizing alcohol and drug abuse in patients with eating disorders. *QJM: Monthly Journal of the Association of Physicians,* 99(5): 335-39.

Courbasson C., Smith P. & Cleland C. 2005. Substance abuse disorders, anorexia, bulimia, and concurrent disorders. *Canadian Journal of Public Health,* 96(2): 102-06.

Crabtree B. & Miller W. 1999. *Doing Qualitative Research,* 2nd Edition. Newbury Park, CA: Sage Publications.

Craig, SE. "The Comoribidy of Eating Disorders and Substance Abuse and Their Relationship to DSM-IV Personality Disorders." Thesis. Seton Hall University, 1997.

Craig M. & Shisslak C. 2003. Ethnic differences in dieting, binge eating, and purging behaviors among American females; A review. *Eating Disorders,* 11(4): 289-304.

Crisp A. Anorexia nervosa. *Hospital Medicine,*1: 713-18.

Crowe M. 1992. The power of the word: Some post-structural considerations of qualitative approaches in nursing research. *Journal of Advanced Nursing,* 28(2): 339-44.

DeLeel M., Hughes T., Miller J., Hipwell A. & Theodore L. 2009. Prevalence of eating disturbance and body image dissatisfaction in young girls: An examination of the variance across racial and socioeconomic groups. *Psychology in the Schools,* 46(8): 767-75.

Derrida J. 1976. *Of Grammatology*. (trans. Spivek G.). John Hopkins University Press, Baltimore MD.

Dohm F., Streigel-Moore R., Wilfley D., Pike K., Hook J. & Fairburn C. 2002. Self-harm and substance use in a community sample of black and white women with binge eating disorder or bulimia nervosa. *International Journal of Eating Disorders,* 32(4): 389-400.

Duff P., Bingham B., Simo A., Jury D., Reading C. & Shannon K. 2014. The 'Stolen Generations' of mothers and daughters: Child apprehension and enhanced HIV vulnerabilities for sex workers of Aboriginal ancestry. *PlOs One,* 9(6): e99664.

Franko D., Dorer D., Dell P., Jackson S., Manzo M. & Herzog D. 2008. Interactions between eating disorders and drug abuse. *The Journal of Nervous and Mental Disease.* 196(7): 556-61.

Foucault M. History of Sexuality, Volume 1. Pantheon Books. New York, NY: 1976.

Fredrickson B. & Roberts T-A. 1997. Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly,* 21: 173-206.

Gard M. & Freeman C. 1996. The dismantling of a myth: Eating disorders and socioeconomic status. *International Journal of Eating Disorders,* 20(1): 1-12.

Gavey N. 1989. Feminist poststructuralism and discourse analysis: Contributions to feminist psychology. *Psychology of Women Quarterly,* 13: 459-75.

Gibson S. & Williams S. 1999. Dental caries in pre-school children: Associations with social class, toothbrushing habit and consumption of sugars and sugar-containing foods. *Caries Research,* 33(2): 101-13.

Gore J. 2008. Mental health discourses and Western mental health proselytization. *Ethos,* 36(3): 310-15.

Grant A. 2014. Troubling 'lived experience:' A post-structural critique of mental health nursing qualitative research assumptions. *Journal of Psychiatric and Mental Health Nursing,* 21: 544-49.

Guilfoyle M. 2013. Client subversions of DSM knowledge. *Feminism and Psychology,* 23(1): 86-92.

Hardin P. 2003. Constructing experience in individual interviews, autobiographies, and on-line accounts: A poststructuralist approach. *Journal of Advanced Nursing,* 41(6): 521-630.

Henriques J., Hollway W., Urwin C., Venn C.& Walkerdine V. 1984. *Changing the Subject: Psychology, Social Regulation, and Subjectivity*. London: Methuen.

Hepburn K., Barker B., Dong H., Wood E., Kerr T., DeBeck K. & Nguyen P. 2016. Initiation of drug dealing among a prospective cohort of street-involved youth. *American Journal of Drug and Alcohol Abuse,* 42(5): 507-12.

Herzog D., Franko D., Dorer D., Keel P., Jackson S. & Manzo M. 2006. Drug abuse in women with eating disorders. *International Journal of Eating Disorders,* 39(5): 364-68.

Hoff LA. 1988. Collaborative feminist research and the myth of objectivity. In K. Yllo and M. Bograd (Eds.) *Feminist Perspectives on Wife Abuse* (pp. 269-81). Newbury Park, CA: Sage.

Holderness C., Brooks-Gunn J. & Warren M. 1994. Co-morbidity of eating disorders and substance abuse review of the literature. *International Journal of Eating Disorders,* 16(1): 1-34.

Hollway W. 1983. Heterosexual sex: Power and desire for the other. In S. Cartledge & J. Ryan (Eds.), *Sex and Love: New Thoughts on Old Contradictions* (pp. 124-140). London: Women's Press.

Howard D., Sentell T., Gazmararian J. 2006. Impact of health literacy on socioeconomic and racial differences in health in an elderly population. *Journal of General Internal Medicine,* 21(8): 857-61.

Hudson J., Weiss R. & Pope H. 1992. Eating disorders in hospitalized substance abusers. *American Journal of Drug and Alcohol Abuse,* 18: 75-85.

Jackson A. & Mazzei L. 2013. Plugging one text into another: Thinking with theory in qualitative research. *Qualitative Inquiry,* 19(4): 261-71.

Kaye W., Wierenga C., Bailer U., Simmons A., Wagner A., Bischoff-Grethe A. 2013. Does a shared neurobiology for foods and drugs of abuse contribute to extremes of food ingestion in anorexia and bulimia nervosa? *Biological Psychiatry,* 73(9): 836-42.

Kickbusch I. 2001. Health literacy: Addressing the health and education divide. *Health Promotion International,* 16: 289-97.

Killeen T., Greenfield S., Bride B., Cohen L., Gordon S. & Roman P. Assessment and treatment of co-occuring eating disorders in privately funded addiction treatment programs. *American Journal on Addictions,* 20(3): 205-11.

Kim S., Knight S., Tomari C., Colella K., Schoor R., Shih L., Kuzel T., Nadler R., Bennett C. 2015. Health literacy and shared decision-making for prostate cancer patients with low socioeconomic status. *Cancer Investigation,* 19(7): 684-91.

Klopfer K. & Woodside DB. 2008. Substance abuse in women with bulimia nervosa: Prevalence of comorbidity and therapeutic approaches. *Psychiatric Times,* 25.SE1: 22.

Krug I., Treasure J., Anderluh M., Bellodi L., Cellini E., di Bernardo M., Granero R., Karwautz A., Nacmias B., Penelo E., Ricca V., Sorbi S., Tchanturia K., Wagner G., Collier D. & Fernandez-Aranda F. 2008. Present and lifetime comorbidity of tobacco, alcohol, and drug use in eating disorders: A European multicenter study. *Drug and Alcohol Dependence,* 97(1-2): 169-79.

Krusi A., Fast D., Small W., Wood E. & Kerr T. 2010. Social and structural barriers to housing among street-involved youth who use illicit drugs. *Health and Social Care in the Community,* 18(3): 282-88.

Marcus R. & Katz J. 1990. Inpatient care of the substance-abusing patient with a concomitant eating disorder. *Hospital and Community Psychiatry,* 41: 59-63.

Massengill R. "Chapter 6: Data Analysis." Pp. 35-42 in *Writing Sociology* (Princeton University Student Guide).

McBain-Rigg K. & Veitch C. 2011. Cultural barriers to health care for Aboriginal and Torres Strait Islanders in Mount Isa. *Australian Journal of Rural Health,* 19(2): 70-74.

McClelland L. & Crisp A. 2001. Anorexia nervosa and social class. *International Journal of Eating Disorders,* 29(2): 150-56.

Mitchison D., Hay P., Slewa-Younan S. & Mond J. 2014. The changing demographic profile of eating disordered behaviors in the community. *BMC Public Health,* 14: 1-9.

Piran N. 2010. A feminist perspective on risk factor research and on the prevention of eating disorders, *Eating Disorders,* 18, 183-98.

Nevonen L. & Norring C. 2004. Socio-economic variables and eating disorders: A comparison between patient and normal controls. *Eating and Weight Disorders – Studies on Anorexia, Bulimia and Obesity,* 9(4): 279-84.

Newman M. & Gold M. 1992. Preliminary findings of patterns of substance abuse in eating disorder patients. *Journal of Drug and Alcohol Abuse,* 18(2): 207-11.

Nokleby H. 2012. Comorbid drug use disorders and eating disorders – a review of prevalence studies. *Nordic Studies on Alcohol and Drugs*, 29(3): 303-14.

Paasche-Orlow M., Parket R., Gazmararian J. The prevalence of limited health literacy. *Journal of General Internal Medicine,* 20: 175-84.

Philips M., Richardson L., Wood E., Nguyen P., Wood E., Kerr T. & DeBeck K. 2015. High-intensity drug use and health service access among street-involved youth in a Canadian setting. *Substance Use and Misuse,* 50(14): 1805-1813.

Ram A., Stein D., Sofer S. & Kreitler S. 2008. Bulimia nervosa and substance use disorder: Similarities and differences. *Eating Disorders: The Journal of Treatment and Prevention,* 16(3): 224-40.

Root T., Pisetsky E., Thornton E., Lichtenstein P., Pedersen N., Bulik C. 2010. Patterns of comorbidity of eating disorders and substance use in Swedish females. *Psychological Medicine,* 40(1): 105-15.

Ryan G. & Bernard H. 2003. Techniques to identify themes in qualitative data. *Field Methods,* 15(1): 85-109.

Sacks H. 1992. Experience. In *Feminists Theorize the Political* (Butler J. & Scott J., eds), Routledge, New York, pp. 22-40.

Seymour S. & Graham K. 1986. New developments in the sampling of special populations. *Annual Review of Sociology*, 12: 401-29.

Simioni N & Cottencin O. 2015. Resurgence of anorexic symptoms during smoking cessation in patients with a history of anorexia nervosa: An unseen problem? Report of two cases. *International Journal of Eating Disorders,* 48(6): 798-801.

Smith D. 1990. *Texts, Facts, and Femininity: Exploring the Relations of Ruling.* London, New York: Routledge.

Smith S. 1993. *Subjectivity, Identity and the Body: Women's Autobiographical Practices.* Indiana University Press, Indiana.

Smith D. 2005. *Institutional Ethnography: A Sociology for People*. Lanham: Alta-Mira Press.

Smith A. 2009. Aboriginal adoptions in Saskatchewan and British Columbia: An evolution to save or lose our children? *Canadian Journal of Family Law,* 25(2): 297-367.

Soban C. 2006. What about the boys? Addressing issues of masculinity within male anorexia nervosa in a feminist therapeutic environment. *International Journal of Men's Health,* 5(3): 251-67.

Sousa Fortes L., Cipriani F., Ferreira M. 2013. Risk behaviors for eating disorders: Factors associated in adolescent students. *Trends in Psychiatry,* 35(4): 279-86.

Statistics Canada. 2006. Aboriginal Profiles of British Columbia: 2006

Stevenson C. & Cutliffe J. 2006. Problematizing special observation in psychiatry: Foucault, archeology, genealogy, discourses and power/knowledge. *Journal of Psychiatric and Mental Health Nursing,* 13(6): 713-21.

Stice E., Presnell K. & Bearman S. 2001. Relation of early menarche to depression, eating disorders, substance abuse, and comorbid psychopathology among adolescent girls. *Developmental Psychology,* 37(5): 608-19.

Trocme N., Knoke D. & Blackstock C. 2004. Pathways to the overrepresentation of Aboriginal children in Canada's child welfare system. *Social Servie Review,* 78(4): 577-600.

Stoppard J. & Gammell D. 1999. Women's experiences of treatment of depression: Medicalization or empowering? *Canadian Psychology,* 40(2): 112-28.

Suzuki K., Higuchi S., Yamada K., Mizutani Y. & Kono H. 1993. Young females with and without eating disorders: A comparative study in Japan. *American Journal of Psychiatry,* 150: 1053-58.

Vanderause R. 2008. The poiesis of the question in philosophical hermeneutics: Questioning assessment practices for alcohol use disorders. *International Journal of Qualitative Studies on Health and Well-Being,* 3: 68-76.

Wakefield J. 1992. Disorder as Harmful Dysfunction: A Conceptual Critique of DSM-III-R's Definition of Mental Disorder. *Psychological Review,* 99(2): 232-47.

Wardrope A. 2015. Medicalization and epistemic justice. *Medicine, Health Care, and Philosophy,* 18(3): 341-52.

Weedon C. 1987. Feminist practice and poststructuralist theory. Oxford: Blackwell.

Wetherell M. 1986. Linguistic repertoires and literary criticism: New directions for a social psychology of gender. In Wilkinson S. (Ed.), Feminist Social Psychology: Developing Theory and Practice (pp. 77-95). Philadelphia: Open University Press.

Wiederman M. & Pryor T. 1996. Substance use among women with eating disorders. *International Journal of Eating Disorders,* 20: 163-68.

Wiederman M. & Pryor T. 1997. The relationship between substance use and clinical characteristics among adolescent girls with anorexia nervosa or bulimia nervosa. *Journal of Child and Adolescent Substance Use,* 6(1): 39-47.

Wood E., Spittal P., Li K., Kerr T., Miller C. & Hoggs R. 2004. Inability to access addiction treatment and risk of HIV infection among injection drug users. *Journal of Acquired Immune Deficiency Syndrome,* 36(2): 750-54.

Xiang X. 2013. A review of interventions for substance use among homeless youth. *Research on Social Work Practice,* 23(1): 34-45.