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Disappearing in plain sight: An exploratory study of co-occurring eating and substance abuse dis/orders among homeless youth in Vancouver, Canada

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ABSTRACT

How are disordered eating and substance abuse embodied, experienced, and articulated within a context of multi-dimensional marginalization? Research on this topic is expansive, but 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. I conclude by offering suggestions for further research on co-occurring eating and substance abuse disorders among vulnerable populations.

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 often draw from clinical samples and overlook those for whom treatment is inaccessible due to structural constraints such as poverty. The under-representation 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, Hughes, Miller, Hipwell, & Theodore, 2009; Gard & Freeman, 1996; Mitchison, Hay, Slewa-Younan, & Mond, 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?"

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 & Pryor, 1996), but his claim has nonetheless expanded to include those with bulimia and substance abuse issues (Bulik et al., 1994; Carbaugh & Sias, 2010; Klopfer & Woodside, 2008), those with both anorexia and bulimia and substance abuse issues (Herzog et al., 2006; Kaye et al., 2013; Wiederman & Pryor, 1997), and those who first struggle with substance abuse but later demonstrate eating disorder symptoms (Cohen et al., 2010; Marcus & Katz, 1990; Suzuki, Higuchi, Yamada, Mizutani, & Kono, 1993). Although many of these studies suggest that eating and substance abuse disorders are inextricably linked (Holderness, Brooks-Gunn, & Warren, 1994; 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, Smith, & Cleland, 2005; Holderness et al., 1994; 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

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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 & Crisp, 2001; Nevonen & Norring, 2004; Sousa, Cipriani, & Ferreira, 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 (Calero-Elvira et al., 2009; Conason, Brunstein, & Sher, 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 Newman & Gold, 1992; Ram, Stein, Sofer, & Kreitler, 2008; Simioni & Cottencin, 2015) may fail 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, Murray, Walen, & Woolridge, 2016; Soban, 2006), as well as studies that highlight eating disorder symptoms among racial or ethnic minorities (Boisvert & Harrell, 2014; Chao, Grilo, & Sinha, 2016; Craig & Shisslak, 2003), by including youth of all backgrounds in my sample. How, I wonder, does multi-dimensional marginalization intersect with the deeply personal experiences of disordered eating and substance abuse?

A loud scream: concerns with traditional approaches and current approach

Although existing medical, psychiatric, and epidemiological studies have offered influential insights into precursors such as trauma (Blinder, Cumella, & Sanathara, 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, Presnell, & Bearman, 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 & 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 (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 & 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, Hollway, Urwin, Venn, & Walkerdine, 1984; Hoff, 1988; Hollway, 1983).

I thus proceed cautiously. Rather than endorsing humanistic beliefs about the self, wherein each person is viewed as "conscious, knowing, unified, and rational," 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" (Wardrope, 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 & Gammell, 1999; Wardrope, 2015).

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"