Solidarity conversations:

A feminist narrative lens on bulimia and abuse

by Kassandra Pedersen

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Abstract

Literature often frames bulimia through biomedical models of disease, emphasising biological, psychological and behavioural deficits, and treatments focused on symptom reduction. This paper reimagines so-called "bulimic episodes" as potential acts of testimony or protest against multiple structures of oppression. Drawing on feminist, narrative therapy and anti-oppressive frameworks, I propose an alternative language to bulimic episodes, using the metaphor of tides as a way of redefining bulimia. Application of this metaphor demonstrates how stepping away from conventional conceptualisations affects what is possible in therapeutic conversations. Through my own lived experiences with bulimia and in vitro fertilisation, I examine how medicalisation can reduce agency by centring body-focused narratives, particularly those emphasising weight policing and body image regulation. I also argue that prioritising externalising conversations when bulimia raises its tides can unintentionally replicate neoliberal discourses of food and body management. By expanding the ethics of externalising practices, I propose a nuanced, justice-informed approach that incorporates the "absent but implicit". This perspective moves away from battle metaphors and from dichotomies of "oppressor" and "survivor", which dominate traditional recovery narratives, including some feminist cultural models of eating disorders. Instead, I invite possibilities for navigating people's fluid and varying relationship with bulimia while engaging with other meaningful aspects of their lives. Through a detailed story of practice, this paper offers alternative therapeutic pathways to respond to bulimia's tides. These are grounded in feminist ethics, encouraging agency, solidarity and multi-layered understandings of bulimia.

Key words: bulimia; eating; feminism; absent but implicit; lived experience; co-research; solidarity; narrative therapy; narrative practice

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I write from a place where lived experience, therapy and supervision converge – where personal stories become political and intersect with broader structures of oppression (Reynolds, 2013). My approach is shaped by:

- my own experience with bulimia and finding solace through receiving narrative therapy responses crafted to my specific context and location of experience[1]
- my role as a narrative practitioner working with people reclaiming their lives from bulimia
- my work as a supervisor supporting practitioners who respond to people's eating concerns.

My use of "I" in this paper acknowledges the partial and subjective nature of my perspective, shaped by my lived experience, supervision and feminist praxis (Hanisch, 1969). When I use the term "we", this is not to overlook differences among practitioners but to highlight the shared values I treasure in narrative therapy, including social justice, feminism and intersectional principles. This collective stance is held with awareness of the complexity, uncertainty and diversity within both counselling and lived experiences.

Lived experience of bulimia, in vitro fertilisation and the medical gaze

After 15 years of living with bulimia[2], I dove into the world of in vitro fertilisation (IVF) with the excitement of a child opening a birthday gift, only to find my identity reduced to a collection of data points and rigid standards, especially the body mass index (BMI). The medical gaze, as described by Foucault (1973), turned me into a walking chart, aligning my worth with physical criteria and numbers. This scrutiny had me questioning the very definition of "good health", especially at the intersection of fertility, eating disorders and mental health. My IVF consultations felt like a never-ending game of "fix my body", ignoring the nuanced relationship between bulimia and motherhood.

Much of my work takes place in Greece, where culture often idealises motherhood as involving unceasing devotion to the role. Yet beneath the surface, these ideals carry undercurrents of strain and contradiction. In therapeutic conversations, bulimia's tides often draw these tensions into sharper view, revealing the complexity of what lies beneath the idealised image. Through its shifting movements, bulimia repeatedly claims time, energy and space, disrupting life's rhythms and challenging normative ideals of motherhood. Bulimia thrives on dichotomies that position femininities as either destined for motherhood or not, sowing doubts about identity, capacity and purpose – doubts I have deeply felt myself. As a result, I encountered bulimia raising its tides in my life in ways I had never seen before.

The concept of gender performativity[3] was introduced by feminist theorist Judith Butler (1990). In my experience, reproductive normativity – framing maternal success as central to a woman's value – added an extra layer of discursive labour as I felt compelled to continuously "perform" my worth beyond the narrow confines of maternal success. This intersection of health, gender and reproduction highlights how societal norms both shape and constrain women's experiences in ways that are deeply personal yet politically significant.

Medicalised ideas of "healthism", which define wellbeing through health metrics (Crawford, 1980; Hamann, 2009), recruited me into treating my body like a do-it-yourself project. I've never been one to do things halfway, so this perspective led to a single-storied account of my relationship with my body, primarily focused on control.

Thrown deep into the medicalised ocean, I found myself searching for the feminist ideas I treasure and have worked with for years. How is it that we become disconnected from such meaningful knowledge? Even as I share my lived experience in this paper, I find my language occasionally drifting into medicalised culture. This reflection led me to reconnect with supportive feminist spaces and voices (e.g., Braidotti, 2006; Hanisch, 1969; hooks, 1984), which continue to remind me that solutions are not solely an individual's responsibility (Denborough, 2008).

In this writing, I carry the stories of many women, from both counselling and my communities, whose insights have shaped and inspired this paper.[4] Having faced front-on the intersection of medical encounters and bulimia, I aimed to become more attuned to those moments when bulimia raises its head and how we might resist replicating medicalised responses in our conversations. This journey reaffirms that personal experience deeply informs professional practice (C. White & Hales, 1997).

Navigating externalisation with special care

I am profoundly appreciative of narrative practitioners (including Epston et al., 1995; Lainson, 2016; Madigan & Epston, 1995; Maisel et al., 2004; M. White, 2011; M. White & Epston, 1990) for their robust framework for addressing eating concerns. Their detailed descriptions of narrative practices offer valuable insights into the complexities and political dimensions of this work. Michael White and David Epston's concept of externalisation – viewing the problem as separate from the person – has been revolutionary in addressing bulimia by shifting focus from the individual to the problem. Bulimia has its own history of how it becomes established within a person's life, and externalising conversations, along with deconstruction, can create space for co-researching this history and exposing related abuses of power and privilege (M. White, 2007). However, I approach this practice with special care specifically when people describe critical moments of bulimia's tides receding.

Relationships with bulimia are multi-storied, multi-layered, fluid and complex. A unique aspect of bulimia, distinct from anorexia, is its cyclical nature: it is marked by waves of intensity often tied to specific moments in time. Bulimia is not a fixed, singular story but resembles a turbulent tide: sometimes crashing in with overwhelming force, other times quietly receding, leaving us to grapple with its aftermath.

At their highest surge, these so-called "bulimic episodes" resemble a tidal wave, sweeping across the landscape of life and disrupting nearly everything in its path. By suggesting the metaphor of tides in this paper, I hope to acknowledge the ongoing movement of these waves – an aspect often oversimplified or overshadowed by symptom-focused improvement discourses.

Through therapeutic conversations with people living with bulimia, I have noticed that relationships with bulimia are not static. Even when we are not fully immersed by bulimia's waves, we remain aware that we are swimming in the same waters. Bulimia is not something we either "have" or "don't have". This understanding has deepened my interest in therapeutic conversations that go beyond responding to bulimia's explicit operations. Instead, I'm interested in understanding how people ascribe meaning to their experiences while navigating the changing and subtle tides of bulimia.

This paper focuses on a specific moment: when the tide is just beginning to recede.

The aftermath of a wave of bulimia can feel like standing amidst the wreckage of a tsunami: physically, emotionally, mentally and spiritually overwhelmed by the sheer intensity of the experience. Being stuck in the aftermath of bulimia's tempest often involves grappling with its far-reaching implications, such as weight concerns, health issues, bodily dislocation or displacement, and feeling like hostages in our own bodies (Pedersen, 2016). These challenges can intertwine with struggles in relationships, heightened anxiety, suicidality and an overwhelming sense of powerlessness, hopelessness and failure. Many describe feeling trapped in a "liminal space" (M. White, 1997) in which the familiar sense of self and body is disrupted and meanings are in flux. This concept draws on Michael White's use of rites of passage to describe a migration of identity – an anthropological metaphor inspired by Turner (1969) and van Gennep (1909/1960). White applied this idea in his work with women leaving relationships marked by violence and control and in supporting individuals transforming their relationships with alcohol or drugs (Hegarty et al., 2010; M. White, 2000). Central to a rite of passage is the liminal phase – a transitional state between separation and reintegration – in which one is neither entirely anchored in an old identity nor fully integrated into a new one. For those of us navigating bulimia's surges, imagining these as a liminal phase can resonate deeply. They represent a period of turbulence, confusion and even despair as we adjust to the overwhelming effects of bulimia's rise. In my practice, I invite individuals to map their journey through this migration, recognising that their relationship with bulimia is neither singular nor linear but shaped by multiple movements – both chosen and imposed – that range from significant life transitions to momentary shifts. This mapping emphasises the fluidity of the journey, highlighting the interplay between personal transformation and bulimia's relentless changes. In doing so, despair is reconceptualised not as an endpoint, but as part of a complex, spiralling process of moving from how things are to how they might be – from *being* to *becoming*.

An externalising understanding (on the therapist's part) is foundational for receiving and responding to these experiences of despair and displacement. Yet, I have noticed that externalising questions that focus on the immediate effects of bulimia's wave can intensify scrutiny of a person's relationship with food, the body and health. Pathologising biomedical

discourses, particularly in the context of neoliberal mental health services, often invite individualised notions of self-care. The urgency to "amend" can also subtly enter the conversation, bringing self-blame and shame into the room. Suddenly, it feels too crowded!

In my own experience of receiving therapy, I recall that questions such as "What has bulimia tried to convince you of?" or "How have you resisted bulimia?" – while theoretically grounded – had unexpected effects. It felt as though my timing and the therapist's were out of sync. While I was still grappling with the shock of bulimia's sudden rise and its embodied effects in the present moment, such questions felt like a push to take a position before I had made sense of how I had arrived in the conversation. This unintentionally created a divide, leaving me torn between aligning with the therapist or with bulimia. When those sorts of questions were asked, bulimia watched me closely on one side, the therapist stood on the other. In those moments, it felt far less risky – though no less painful – to align with bulimia. Quietly, I would turn away from the therapist, so subtly that they might not even notice, as I charted a course through the conversation that kept bulimia from feeling alienated. In doing so, the connection with the therapist would strain almost imperceptibly until it eventually frayed, and I was left alone once again, with only bulimia.

The women I have worked with have taught me that jumping into the statement of position maps during bulimia's rising tides is like stepping on to a tightrope without checking the safety net first. Without full permission and a thoughtful approach, our co-research risks replicating the very power relations we aim to challenge. Informed by the effects of my practice and what people shared with me, I began to reflect on what adjustments to narrative practice might be needed to better fit the particular context of work with bulimia. What new possibilities might arise from adaptations in navigating bulimia crises or feelings of entrapment within one's own body?

My approach to narrative practice maintains that the theoretical approach and direct practice need to be conceptualised in relation to each other. The most meaningful moments of co-research in my own experience of receiving narrative therapy were those that created space to contextualise bulimia's recent tides.

Michael White encouraged us to situate problems within broader cultural contexts such as race, gender and class (M. White, 2007). These conversations helped me to notice how gender expectations and medicalised discourses were shaping my own life, and to consider actions that could reclaim territories that had been taken away from me. In my practice, women have also taught me that while bulimia is often described as the outcome of such structural pressures and injustices, it can sometimes be experienced as something more: a response to the ways these contextual forces are lived out in immediate contexts and relationships – for example, through family pressures, intimate partnerships, or experiences of displacement from safety, identity or rights.

Attending in this way has profoundly influenced how I join with others in conversation. Rather than focusing solely on mapping bulimia's effects and unpacking the contexts in which it has taken hold, I have learnt to pause and wonder, together with the person, what the tides might be responding to in the particular circumstances of their life, and what this understanding might make possible for them to discern.

Women have also shown me that alongside the force of bulimia's tides there are small, careful and creative ways they find to endure and move through them. These can be understood as acts of survival. At the same time, I have noticed a risk in framing bulimia only as an enemy or an invading force. When conversations settle into this single-storied view, they can inadvertently reproduce a battle-like orientation that leaves little space to notice what else bulimia might be speaking of. An alternative possibility I have been drawn to consider, shaped by these conversations, is whether bulimia itself might sometimes be understood as a form of testimony: a turbulent expression of protest or witness to what has been unjust, violated or silenced. Through conversations with women, I have explored attending to what is "absent but implicit" in bulimia's tides within the intersecting contexts of their lives. I have noticed that this way of working can open space for multiple understandings to emerge, such as viewing these tides as possible protests against oppression or trauma.

When engaging with what is absent but implicit in people's experiences of bulimia's tides, we can focus on determining which aspects of a person's experience to highlight amidst intersecting oppression. This approach, shaped by my work with women across diverse contexts, is demonstrated the following section in which I draw on an example from the overlapping practice areas of trauma/abuse and bulimia.

Story of practice: Bulimia's rise as a testimony or protest

My work with Maria, a woman navigating bulimia, has deeply shaped my approach to working with the absent but implicit in response to bulimia's turbulent tides. One session stands out. Maria described feeling like the "snake" – her name for bulimia – had swallowed her whole. In previous sessions, we externalised the snake, placed it in context, and explored the steps Maria had already taken to avoid its venom, recognising her skills and values (M. White, 2007). Although I thought we were really hitting our stride, then came the curveball! I checked in with Maria about her experience of the conversation so far. I am deeply grateful for her honesty – she expressed her frustration, catching me completely by surprise.

The snake, always lurking, had been striking with its "poisoned bites" more often lately, leaving her wanting to hide from her own body. She explained that our externalising conversations felt like an unwelcome magnifying glass on the snake that reinforced the urgency to "do something" while she was still grappling with the shock of its recent bites. Reflecting on this had me wondering whether it was the deconstruction part of externalising or asking Maria to take a position or something else that felt overwhelming. This reconnected me to my own experience: the more the therapy I was receiving focused on bulimia during times of raising tides, the more it seemed to puff up its chest and thrive on that attention, almost as if it got bolder the more we talked about it. This was when I felt a need to shift my approach, moving beyond externalising conversations to something more expansive, where attention could be given to the nuances of Maria's experience, without reinforcing the feeling that bulimia was the dominant force in the room.

I asked Maria about the direction she'd prefer for our conversation, but she expressed uncertainty, mentioning that she had assumed the session "should" focus on her bulimic episodes. This tension underscores the importance of maintaining a co-research stance (Epston, 1999; Epston & White, 1992; M. White, 1995) and resisting the idea that narrative therapy can be "rolled out" as a series of maps. What might initially seem like a dead end in conversation can, instead, become an opportunity to explore the very process of the co-research itself.

Instead of pushing the conversation forward, we slowed down to "loiter with intent" (Epston, 1999) around Maria's experienced location within the conversation. I asked Maria, "As you mention that focusing on the bites of the snake isn't helpful today, what do you notice? What's it like to bring that into our shared space? What emerges for you in this particular moment?" By staying with how people arrive in the present moment, we can always find potential avenues for co-research (Braidotti, 2006).

Bringing the focus back to the present ensures accountability to co-research by positioning both of us as active, collaborative participants moving "from the known and familiar to what is possible to know" (M. White, 2007, p. 263), rather than making decisions in isolation. In this context, slowing down was an intentional and politically significant practice, as this shift in pace disrupted the pressure for immediate action – a crucial stance, especially when healing from the aftermath of bulimia's tide might require time and special care.

Shifting our focus away from the snake allowed other aspects of Maria's life to come forward. She shared that the snake had been present throughout the abusive relationship she was enduring, but it became even more prominent whenever she prepared or attempted to leave. I asked, "What was happening in your life in the months leading up to your decision to leave the relationship? Who has been alongside you during these hard times?" Maria said that no-one was aware of her experience of abuse, and this often invited feelings of despair and isolation. We discussed Maria's experience of this despair and isolation, and how they manifested in her life. We talked about the contexts of this despair, which included socioeconomic conditions that kept her entrapped in the abusive relationship and silenced her voice. This had me interested in what was absent but implicit in Maria's despair. I asked, "When you speak about the despair of being silenced in the abuse, is there anything that you feel is important to have witnessed, to be acknowledged in your decision to leave?" Maria expressed that having "no-one knowing" seemed to disqualify her survival skills and knowledges. She wished to be seen for what she had endured and acknowledged for what it takes to leave. She also wished she didn't have to make risky life-changing decisions on her own.

Vikki Reynolds (2013, p. 33) pointed out that women's trauma is often framed as a medical issue rather than a systemic one. In the conversations

I am part of, connections between trauma and bulimia frequently emerge, reflecting broader systemic forces at play. Given that bulimic episodes increased as Maria prepared to leave the relationship, I grew curious about the role the snake played in her experience of living in silence. I asked, "Was the snake present in moments of fear? Has it witnessed the oppressive practices and attitudes you faced?" In this way, the snake – as a metaphor for bulimia – was repositioned not only as a force of disruption but also as a witness to Maria's struggles. Maria confirmed that the snake had indeed been present, seeing her through experiences of violence and threat and deeply aware of what it means to survive those moments of despair. Positioning the snake in this way created space for Maria to consider that its presence might not only bring harm, but also speak of her endurance and her refusal to remain silent in the face of violence. I have since found that this repositioning, from adversary to witness, can also open possibilities in other conversations where women describe living with both trauma and bulimia.

Since no-one else knew about her experiences of abuse, I asked Maria what it meant for her to have a witness to her survival skills in moments of fear and uncertainty, even if that witness was non-corporeal – such as the snake in this case. I then wondered aloud, "If I asked the snake directly, what might it testify about your experience of violence? What aspects of your being have been violated, and which beliefs or values have been transgressed by ongoing oppression?" Reynolds (2013) suggested that what is often labelled as "depression" might be more accurately understood as "oppression". This perspective helped bridge gaps in my work with Maria, resonating with the feminist view that personal issues frequently have political roots (Hanisch, 1969).

I deliberately maintained the focus of my questions on the immediate context of violence, rather than retracing the history of bulimia in Maria's life. When we meet with people facing the aftermath of bulimia's turbulent tides, it is not always necessary to engage in a full unpacking of the person's history with bulimia or a broader deconstruction of bulimia. Instead, focusing on the present creates space for response-based practice, without delving into multiple timescapes unless this becomes relevant or warranted.

Maria described how the snake seemed to resist the invisibility of the oppression it had witnessed. The snake refused to remain silent about the violence Maria had endured. This refreshed understanding began to loosen the totality of bulimia's domination. From here, we could ask further questions: if the snake was acting in protest, what exactly was it protesting against? And, equally, what might it have been protesting *for*? These reflections opened space for Maria to begin seeing the snake not only as a witness but also as participating in her protest against the violence and control she had suffered. In this light, the snake could be seen as a testament to what had been precious to Maria and violated (M. White, 2003).

Although the snake brought Maria frustration and despair, Maria noticed that, within the high-risk context of the abusive relationship, the snake often held a position of power that she herself could not safely access. While Maria was working "in the shadows" to escape violence, the snake seemed to embody a protest that Maria, for safety's sake, could not yet express fully and openly. I was deeply moved when Maria described looking at herself in the mirror, noticing the physical effects of a recent bulimic episode, such as weight gain, and feeling as if she could actually hear the snake within her body crying out against the violence: "enough is enough!" We explored how sitting with bulimia's impact on her body – at least for a while – could be understood as a physical statement of position: a stance against gender oppression.

In unpacking with Maria what bulimia exists in the face of, I found thinking about the absent but implicit particularly relevant. Together, we explored how she was able to discern what bulimia might be advocating for, even amid feelings of frustration and despair. Maria noted that she understood a bit about advocacy. She recalled her dear cousin whom she often witnessed showing solidarity and care through activist work. I asked Maria what the snake's form of advocacy might signify about what Maria was departing from in her relationship and where she hoped to go. This led us into the realm of what is precious, treasured and even sacred. Maria identified care, safety, integrity and solidarity as her preferred values, and we examined her knowledge of fostering community. This co-research led us to trace the social and relational history of her community-building skills, moving further into rich story development in relation to her hopes, commitments and life purposes.

I invited Maria to consider whether the snake that had advocated for relationships of care, safety and solidarity on her behalf against oppression might step back temporarily, allowing us to explore her current resistances alongside others or consider possible

collective or community steps. This approach avoided an assumption of opposition or animosity between the person and bulimia, opening space for nuanced exploration of their relationship(s).

Together, we drew on Maria's community-building skills to explore how they might support her in gathering a support network around her. We took considerable time to craft a safety plan for exiting the relationship, engaging a group of trusted people to avoid further harm. Throughout this preparation, Maria moved cautiously, operating under the radar of control and navigating through a fog of fear and uncertainty. Resistance is not solely about direct confrontation; it can also involve subtler, strategic actions and decisions (Wade, 2007). Together we explored how Maria's silence was not simply an effect of fear but an intentional act of self-protection that reflected her personal agency.

In our discussions, it became clear that Maria's experience was part of a broader narrative shared by many women facing violence (Pederson, 2024). Feminist narrative practices encouraged us to promote solidarity rather than individualise her struggle (Kitzinger & Perkins, 1993). I gently enquired about whether Maria might be interested in joining a group that I was facilitating, and she agreed. The group, made up of women who had escaped abusive relationships, offered invaluable collective solidarity. As bell hooks (1984) emphasised, collective care is essential for resisting oppression and fostering healing. Our group work included narrative documentation and sharing these stories with others, supporting the women to "speak through me" to others (Denborough, 2008). A detailed account of this approach is beyond the scope of this paper.

From practice to broader reflections

Contemporary understandings of bulimia often obscure the complexities and particularities of its tides, drawing a "natural" and linear link between bulimia and distress. This can lead therapeutic conversations to focus primarily on the most visible aspects of bulimia's operations. When therapy emphasises lengthy exploration of bulimia as the main character in the room, even when using externalising language, people can become immersed in its tides. Bulimia is often framed as "the main problem", and the distress accompanying its different tides is viewed as a natural outcome of bulimia's long history in the person's life.

This naturalistic account dismisses the particularities of the varied and shifting contexts in which these tides emerge and recede over time, leaving people with an unsettling sense that the edges of their being are constantly at risk of being crossed in ways that are unpredictable or out of control. It also tends to replicate dualistic thinking, which risks constructing a fragile or vulnerable sense of self. For example, naturalistic accounts of bulimia are frequently shaped by an enemy/victim dualism.

When people describe their experience of bulimia's tides, I invite them to identify the contexts in which these tides emerged. This unpacking allows for alternative understandings of bulimia that take in complexities and particularities. When sharing what bulimia's tides are in relation to, people may voice concerns, laments, complaints, frustration, disappointment, distress, confusion or despair about specific situations in their lives. These can be seen as actions that bulimia embodies through its tides. I listen for places where I can ask questions that help people to characterise the forces they are up against in an externalised form. For example, I might ask:

- What are you protesting or lamenting here that bulimia seems to know about?
- What is happening in your life that you are refusing to go along with, and in this refusal, what is bulimia speaking up for?
- As you question what has been going on in your life, what might bulimia be inviting you to reclaim?
- Is bulimia aware of the ways you are challenging what has been done to you or others?

People's expressions might be named as actions, such as an objection, refusal, protest or questioning, emphasising personal agency. Similarly, the expression of bulimia's tides can be understood as refusal to relinquish what was so powerfully disrespected, and explorations of people's skills in maintaining a relationship with these intentional states can be very significantly elevating of their sense of who they are and of what their lives are about. In my practice, people have shared how bulimia's tides can act as reminders or wake-up calls, pointing to areas in their lives that may need to be attended to or reviewed. They often count this as a position in relation to bulimia's rise. Questions about the absent but implicit can help to identify where the person stands in terms of their personal experience with bulimia. If we view bulimia's tides as a testament to what a person holds precious –

what might have been compromised or violated through hardship – then the experienced intensity of bulimia's operations can be considered to be a reflection of the degree to which these intentional states were held precious. These implicit accounts are a rich source of material for preferred stories.

This approach does not seek to romanticise bulimia, nor to minimise or obscure its intrusive and often long-lasting harmful effects. The impact of traumatic or oppressive environments produces the coexistence of creative means of responding or protesting that may be simultaneously harmful or helpful in the long term. Thus, experiences of safety, control, fear, power and identity are critical in this work. As feminist narrative therapists, we can double listen to stories, attuning to the absent but implicit in order to uncover more nuanced understandings of bulimia's roles and operations during difficult times, as well as the shifting, multifaceted relationship(s) a person develops with bulimia in response to life's challenges.

The questions we ask and those we choose not to ask

Reflecting on the medicalisation of my experiences, I've come to appreciate that we are accountable not only for the questions we ask but also for those we choose not to ask. In my work with people dealing with bulimia, I intentionally resist asking questions about weight, food management or body metrics that might replicate clinical descriptions and evoke experiences of failure. Narrative therapy, after all, centres deconstruction, power, context, intersectionality and safety (Anderson, 1997).

Storytelling and listening are often messy, nuanced and political. Considering the intentions behind questioning, I recognise that the questions we ask – or choose not to ask – have political implications. They signal which stories we, as active witnesses, are prepared and willing to receive and which conversations or discourses we deliberately resist participating in. At times, this awareness reveals a shift from what "should" be told to what it is possible to tell. This challenges the dominant idea that therapists should be "neutral". I find this understanding particularly helpful in turning my curiosities into questions that are response-based, deconstructive, invitational, political and relational – moving from problem-solving, management and saving to positioning myself as co-researcher.

Influence of lived experience on practice

Lived experiences can greatly influence how we come to our practices, creating a relational collaboration that extends beyond traditional mental health systems and ethics. People often seek me out after watching my videos, wandering my website, glimpsing me on TV or joining my workshops. By the time they reach me, they sometimes know parts of my story better than I do! I'm publicly open about my lived experience with bulimia. This kind of transparency often enables me to join in the conversation from a solid ground of shared experiences, where insider knowledges meet curiosity, and resonance encourages two-way transport. I deeply value this collective space of "mutual contributions" (M. White, 1997). Establishing a strong therapeutic alliance with an "ethic of care and collaboration" (M. White, 1997) is a vital component of trauma work, particularly with individuals labelled as "bulimic", who often, and understandably, grapple with fear of judgement and the imposition of external meanings and power over our lived experiences. The term "solidarity conversations" frequently pops up in feedback from those I engage with in therapeutic conversations, reflecting a kind of co-research that isn't typically found in clinical settings. I couldn't describe it better than Maria, who said that our time together often felt like I was swimming alongside her while she weathered the tide. As she traversed the currents beneath the surface, it felt as though we extended our hands to one another, finding balance in the waves together, rather than her struggling alone.

Engaging with people's stories often reconnects me with my own insider knowledge, yet this requires careful navigation of my power and privilege. It is crucial to reflect on how our lived experiences shape our assumptions and influence the questions we ask or don't ask. Making these assumptions visible for scrutiny is an essential part of accountability. I may offer a summary or editorial using the person's own words, articulating how their expressions resonate with my experiences. Then, I check to see if my insights align with theirs. If not, we explore together how recognising this difference might shape their understandings of their own experience. At times, my insider knowledge shapes my curiosity and highlights particular elements in people's descriptions. Rather than immediately offering a question, I remain transparent about this influence and seek permission before introducing the question. This practice underscores the complexity of staying decentred while drawing from my own lived experience.

I also like to ponder how my lived experience with bulimia shapes my practice in contrast to practitioners of different genders who might be missing that particular flavour. I wonder if different vantage points might keep certain power relations in play, like a sneaky puppeteer pulling strings behind the scenes. I'd love to hear from others about what unique considerations might be needed for practitioners of diverse genders and how their approaches might differ from mine.

Final words

The journey of writing this paper has been both challenging and therapeutic, as it weaves together not only my practice but also my lived experience. Throughout this process, bulimia has made its presence felt in complex ways, responding persistently to the act of writing. At times, it felt like an ongoing conversation – bulimia asserting itself while I wrote and me, in turn, writing back. The process was not just about documenting my experience but also about reclaiming space, carving out a place where I could speak about my ongoing, ever-shifting relationship with bulimia rather than it speaking for me. Writing became both an act of resistance and an offering – a testimony of solidarity shaped by the conversations, feedback and shared reflections of those who engaged with this work. This piece now stands as something I can touch, read and return to, a marker of the movements between myself and bulimia, where I no longer find myself pulled under by its currents but instead move with the tides, learning when to stand firm and when to flow.

In many ways, this act of writing connects to the solidarity I have experienced in therapeutic and community spaces where stories are held, voices are amplified and no-one is left to navigate alone. I hope this paper makes a meaningful contribution to the conversation on bulimia and resonates with practitioners, people dealing with bulimia, families, friends and others. The concept of solidarity conversations, as shared by the women I work with, aligns with the kind of therapeutic co-research I aspire to engage in. I find Poh Lee Lin's words deeply moving: "If I have access to power in a moment when you might have less access, I will meet you in those moments rather than watch you flounder – as others have done for me at different moments in this intentional engagement with power through communal practice" (P. L. Lee, personal communication, November, 2023). Reflecting on my own experiences, I've been profoundly supported by those who have stood by me through challenging times. This form of solidarity – leveraging community resources to support one another – is at the heart of my practice. This paper embodies my commitment to politically include my lived experience as an act of solidarity with the community of narrative practitioners and, most importantly, with those of us navigating complex relationships with bulimia. My intention is not to overshadow or dominate but to meet readers in the gaps, fostering a collaborative reflection on how we practice and move forward together.

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Notes

[1] Including my own experience of receiving narrative therapy is an intentional and political choice to make visible how lived experience directly shapes my practice. This challenges traditional hierarchies that privilege clinical or academic expertise over insider knowledge, and instead asserts lived experience as a legitimate and valuable source of insight, equally – if not more – vital in therapeutic work.

[2] In Greek, the word "bulimia" is gendered as she/her, carrying specific implications. From my extensive experience working with individuals affected by bulimia, I have noticed that when bulimia is personified using she/her, it often leads to assumptions about its "personality". Pronouns such as she/her and he/him are tied to broader cultural notions of gender. I recognise that these pronouns may not resonate with everyone across different contexts and languages. Therefore, in this paper, I use "it" to invite diversity and encourage readers to reflect on how they might support individuals in naming their experience of bulimia using their own preferred words and pronouns, if any.

[3] Performativity of gender is a stylised repetition of acts, an imitation or miming of the dominant conventions of gender.

[4] Although bulimia is experienced by people across genders, this paper focuses specifically on women's experiences, as these have shaped both my own lived experience and my therapeutic practice. I acknowledge that experiences of bulimia may be different for people situated in other gendered positions.

References

Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to therapy*. Basic Books.

Braidotti, R. (2006). *Transpositions: On nomadic ethics*. Polity.

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. Routledge.

Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services, 10*(3), 365–388. https://doi.org/10.2190/3h2h-3xjn-3kay-g9ny

Denborough, D. (2008). *Collective narrative practice: Responding to individuals, groups and communities who have experienced trauma*. Dulwich Centre Publications.

Epston, D. (1999). Co-research: The making of an alternative knowledge. *Dulwich Centre Journal*, (2), 21–28.

Epston, D., Morris, F., & Maisel, R. (1995). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. Norton.

Epston, D., & White, M. (1992). *Experience, contradiction, narrative and imagination*. Dulwich Centre Publications.

Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception*. Pantheon.

Hamann, T. H. (2009). Neoliberalism, governmentality, and ethics. *Foucault Studies, 6*, 37–59. https://doi.org/10.22439/fs.v0i0.2471

Hanisch, C. (1969). The personal is political. In S. Firestone & A. Koedt (Eds.), *Notes from the second year: Women's liberation, major writings of the radical feminists* (pp. 76–78). Radical Feminism.

Hegarty, K., Smith, K., & Hegarty, L. (2010). Applying narrative therapy to the care of women who have experienced domestic violence. *Australian Family Physician, 39*(6), 410–413.

hooks, b. (1984). *Feminist theory: From margin to center*. South End Press.

Kitzinger, C., & Perkins, R. (1993). *Changing our minds: Lesbian feminism and psychology*. New York University Press.

Lainson, K. (2016). From "disorder" to political action: Conversations that invite collective considerations to individual experiences of women who express concerns about eating and their bodies. *International Journal of Narrative Therapy and Community Work*, (2), 1–12.

Maisel, R., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. Norton.

Madigan, S., & Epston, D. (1995). From "spy-chiatric" gaze to communities of concern: From professional monologue to dialogue. In S. Friedman (Ed.), *The reflecting team in action: Collaborative practice in family therapy* (pp. 257–276). Guilford.

Pedersen, K. (2016). Uncovering bulimia's demanding voice: Challenges from a narrative therapist's perspective. *Dulwich Centre Journal*, (4), 1–12.

Pederson, L. (2024). *Honouring resistance and building solidarity: Feminism and narrative practice*. Dulwich Centre Publications.

Reynolds, V. (2013). *Justice-doing at the intersections of power*. Dulwich Centre Publications.

Turner, V. (1969). *The ritual process.* Cornell University Press.

van Gennep, A. (1960). *The rites of passage.* University of Chicago Press. (Original work published 1909)

Wade, A. (2007). Small acts of living: Everyday resistance to violence and other forms of oppression. *Journal of Family Violence, 22*(7), 489–492.

White, C., & Hales, J. (Eds.). (1997). *The personal is the professional: Therapists reflect on their families, lives and work*. Dulwich Centre Publications.

White, M. (1995). Therapeutic documents revisited. In M White (Ed.), *Re-authoring lives: Interviews and essays* (pp. 199–213). Dulwich Centre Publications.

White, M. (1997). *Narratives of therapists' lives*. Dulwich Centre Publications.

White, M. (2000). *Reflections on narrative practice: Essays and interviews*. Dulwich Centre Publications.

White, M. (2003). Narrative practice and community assignments. *International Journal of Narrative Therapy and Community Work*, (2), 17–55.

White, M. (2007). *Maps of narrative practice*. Norton.

White, M. (2011). *Narrative practice: Continuing the conversations*. Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. Norton.