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Psychological kinship between fat therapists and fat patients: healing and solidarity around stigma, family relationships, and body image

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ABSTRACT

While therapist matching between patient and therapist based on race and gender has received much scholarly attention, and some work has examined fatness in therapy for either the patient or the therapist, little has been written about therapies that involve fat therapists *and* fat patients. This manuscript explores the psychological kinship of the patient and therapist relationship when both identify as fat, particularly as connected to therapeutic work on self, body, and family relationships. I draw from four case studies from the last two years of my therapeutic practice (shared within the context of an IRB-approved study) in order to make specific and broader speculations about the ways that being a fat therapist working with a fat patient informed the therapeutic work. Specifically, I discuss six areas of focus in working as a fat therapist with fat patients: food struggles, body image, attachment/loss, medical challenges, fat stigma, and family conflict. Solidarities around fat oppression, reimagining fatness in family and couples dynamics, and situating therapists as needing to do fat-affirmative work were all explored.

KEYWORDS

Psychotherapy; fat embodiment; psychological kinship; therapist matching; family therapy; romantic relationships; fat stigma

Introduction

Though kinship has most often referred to ties between immediate family members, the relationship between patient and therapist has often served both as its own relationship and as an intermediary between family members (Blow and Karam 2017). Therapy relationships have often been labeled as "psychological kinship," where emotional intimacy and relatedness become key dimensions of a positive psychotherapy experience (Antfolk et al. 2017; Bailey, Wood, and Nava 1992). Whether patients are working to better understand and gain insight about their families of origins, their romantic and sexual relationships, their friendships, or their coworkers/bosses, or whether patients include their family members in their therapy directly, the therapist's role is often one of understanding, evaluating, treating, and working with kinship relationships while also forming a kinship relationship with patients (Minuchin, Reiter, and

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Borda 2013). In this sense, the therapist's role often evokes psychological kinship with individuals who have sought help with their family conflicts or issues related to their early family-of-origin stories, or in couple and family therapies, where family dynamics play out in the therapy room itself. Given that many therapies involve content about bodies and embodiment, including body image, sexuality, and traumas located in the body, psychological kinship and shared social identities often inform how therapists help patients understand how their bodies interact with their emotional lives.

This therapeutic relationship has unique implications when addressing the role of fatness as an identity, particularly when patients want to address their own vulnerabilities about their fat bodies. Many patients, regardless of size, often try to avoid the self-concept of becoming fat (Fahs and Swank 2017), and many fat people have felt uncomfortable with terms like "overweight," "obese," "big," or "chubby" (Trainer et al. 2015), suggesting that sensitivity from therapists working with fat patients need a fat-affirmative framework when addressing issues of vulnerability and body size (Matacin and Simone 2019). While therapist matching between patient and therapist based on race and gender has received much scholarly attention, little has been written about therapist matching between fat therapists and fat patients. Fat embodiment in *either* patient or therapist has been studied (Kinavey and Cool 2019; McHugh and Kasardo 2012; Vocks, Legenbauer, and Peters 2007), though no previous research has looked at fat embodiment when *both* therapist and patient identify as fat. This manuscript explores the intimacies of the psychological kinship that develops between patients and therapists when both identify as fat, particularly as connected to work on self, body, and family relationships. In particular, I look at case studies from my psychotherapy practice to examine how being a fat therapist working with fat patients informed the therapeutic work, and I do so within the framework of psychological kinship at the core.

Embodiment in therapy

Though the body figures centrally in psychotherapy, as a repository of feelings and traumas, as a symbol, as a site of social comparison, as a source of joy and sexuality, and as a changing, aging, evolving entity, it rarely receives much attention in psychotherapy literatures. Therapists are rarely trained to think and talk about the body, with most graduate training programs either ignoring the body altogether or focusing on body language and stereotypes written onto the body (Burnes, Singh, and Witherspoon 2017; Chrisler 2018; Hall, Harrigan, and Rosenthal 1995) rather than meaningfully addressing more complex aspects of embodiment. Social identities come to stand in for discussions of actual embodiment. As such, psychology, counseling, and social work students learn very little about bodily diversity and the corporeal, fleshy, lived body in the therapy room, particularly when it comes to subjects as sensitive (and often

avoided) as fatness. The material qualities of the patient and therapist's mundane bodies are largely absent from the clinical literatures (for three notable exceptions, see Fahs 2019; Levinson and Parritt 2006; Orbach 2004).

Nevertheless, the body is crucial to mental health and constantly appears in therapy, whether through open talk about menstruation, assumptions about race and class projected onto both patients' and therapists' bodies, breastfeeding in the room (or leaking breastmilk while sitting on the therapy couch), and talk about similarities and differences in patients' and therapists' embodiment (Fahs 2019). Talk about fatness between fat therapists and fat patients can present a complex picture, as some patients assume their fat therapists want to diet, while others imagine a shared difficulty with selecting well-fitting clothing (Fahs 2019). Body size is a site of anxiety for many patients, particularly when patients struggle with body image and feelings of bodily inadequacy (Berman, Morton, and Hegel 2016). Notably, "Most mental and physical health care providers do not include attention to the larger social, cultural, or political contexts of sizeism, which leaves individual clients primarily responsible to 'get better'" (Matacin and Simone 2019, 201). The importance of fat-affirming therapy, particularly for patients who have been shamed and mistreated by medical doctors because of their size, is crucial for successful psychotherapies with fat patients (Davis-Coelho, Waltz, and Davis-Coelho 2000; McHugh and Chrisler 2019).

Therapist matching on gender, race, and therapeutic style

Therapist matching, or the similarities between therapists and patients based on social identities like gender, race, and religion, can influence the outcomes of therapy and patients' degree of comfort with certain therapists (Cabral and Smith 2011). A meta-analysis of over 200 studies suggests that patients overwhelmingly prefer a therapist of the same ethnicity or race (Bowman 2010). Further, patients with therapists of the same race perceived their therapists moderately better than those who were mismatched along race and ethnicity lines (Bowman 2010), particularly for African-American clients (Cabral and Smith 2011).

Gender matching had inconsistent results (Blow, Timm, and Cox 2008; Johnson and Caldwell 2011), perhaps because female therapists, in general, tended to show more empathy to patients than male therapists (Staczan et al. 2017), and female clients had better therapeutic alliances with female therapists than with male therapists (Bhati 2014). Further, gay, lesbian, and bisexual therapists of both genders and heterosexual female therapists were all rated as more helpful than heterosexual male therapists (Liddle 1996). At times, therapist matching along gender lines had no effect or even a negative effect on psychotherapy retention (Shiner et al. 2017).

Social identities were not the only way that therapists and patients matched with each other, as some studies focused on qualities of the therapist that patients desired. Patients rated the therapeutic relationship higher based on therapist empathy, expertness, attractiveness, warmth, cultural humility, and trustworthiness (Evans-Jones, Peters, and Barker 2009; Owen et al. 2016). A study of sexual minorities found that sexual minority patients wanted therapists who had LGB-specific knowledge and who did not espouse heterocentric viewpoints (Burckell and Goldfried 2006). Similar language styles between therapist and patients predicted better therapeutic relationships and alliances (Aafjes-van Doorn, Porcerelli, and Müller-Frommeyer 2020). To add complexity to this, one study found that mismatched attachment styles predicted better therapeutic outcomes, especially when the therapist and patient diverged on introject and attachment styles (Bruck et al. 2006).

Therapist matching and fatness

With regard to therapist matching and fatness, no research has looked at therapist matching and therapeutic outcomes or patient comfort when both patient and therapist were fat. That said, one study of both eating disorder patients and anxiety disorder patients found that eating disorder patients had stronger preferences for their therapist's body size to be similar to their own, though both groups preferred a therapist with an "average" figure (Vocks, Legenbauer, and Peters 2007). Further, some patients body-shamed fat therapists, as fat Latina therapists with thinner clients experienced shame about fatness, microaggressions from clients, and perceived their body size as impacting their clinical work and self-perception in a negative way (Carrizales 2015). These studies suggest that understanding therapist matching with regard to body size might allow for better understandings of the unique experiences of fat patients and fat therapists outside of the "mismatched" context.

Perceptions about fatness in therapy

In many professions, working women are perceived as less warm than homemakers (Cuddy, Fiske, and Glick 2004), and fat bodies are seen as antithetical to professionalism, personal responsibility, and health (Hutson 2013; Monaghan 2010a; Vocks, Legenbauer, and Peters 2007). Fat people were rated as significantly less active, assertive, athletic, attractive, happy, hardworking, masculine, popular, and successful than thinner people (Grant, Mizzi, and Anglim 2016), and were often deemed more suitable for "low contact," out-of-sight jobs compared to jobs with more social contact (Venturini, Castelli, and Tomelleri 2006). Further, employers at companies with workplace health promotion programs more often rated fat employees negatively and less often recommended them for promotions compared to employers at companies without

these programs (Powroznik 2017). In the medical world, fat bodies were often framed as "bad models" for patients, with the argument that clinicians and physicians should model individual responsibility for "correcting" their fatness and losing weight (Monaghan 2010a). Notably, this discourse often left out systemic politicized framings of fatness and assumed that fatness always becomes a liability for those in the medical world (Monaghan 2010b). That said, warmth and status may mitigate some of the negative professional perceptions of fatness (Vartanian and Silverstein 2013). This implicit link between fatness and lack of professionalism implies that fat therapists may grapple with a complex set of assumptions about their professional role, as patients often perceived fat therapists as psychologically unhealthy and professionally "unfit" (Moller and Tischner 2019).

The pervasive negativity about fatness can intrude on psychotherapeutic work; this has generated a need for more fat affirmative training for therapists and other mental health professionals (Calogero et al. 2019). Anti-fat bias among mental health practitioners has led to weight stigma in psychotherapy for fat clients seeking therapy (Kinavey and Cool 2019; McHugh and Kasardo 2012). For example, one empirical study found that fat psychotherapy patients were often subjected to therapist's biases about fatness and dieting along with assumptions that fat patients were unhealthy (Davis-Coelho, Waltz, and Davis-Coelho 2000). Further, one popular essay posited that therapists often constructed fat patients as lacking self-discipline or as inherently self-loathing (Caplan 2011), and a theoretical essay argued that therapists more often made generalized assumptions about fat patients compared to their thin patients (Pausé 2019). In a qualitative study, fat patients also reported that their therapists overly focused on weight, appeared less interested in them because of their weight, and subjected them to inappropriately small waiting room chairs, all of which harmed the therapy dynamic (Akoury, Schafer, and Warren 2019). It remains an open question whether such biases would remain in a fat therapist-fat patient therapy dynamic.

Research questions

In this set of brief case studies, I asked several broad questions to inform the analysis: How does being a fat therapist impact psychotherapy work with fat patients, and how does that dynamic underlie the therapeutic intimacy, psychological kinship, and connection between them? How does fat embodiment "show up" in the therapy room, both for patient and therapist, particularly in the context of couples and family therapies? How do patients talk about fatness with a fat therapist, and how does this inform their therapeutic work?

Method

In this study, I drew from four case studies from my clinical psychology practice based in a suburb of a large Southwestern U.S. city during the years 2018–2019. In my practice, I typically see a diverse group of patients in terms of race, class, education, employment history, sexual orientation, gender identity, and age. Many of my patients were referred through other clients, insurance companies, or relevant medical professionals, though many "find" me via my website, where I have a page devoted to the therapy practice and many pages devoted to my academic writing. In this sense, patients looking for fat-affirmative and politically progressive therapists can self-select once they see this work. Patients can also see a photo of me on my website and determine that I am a fat, white, middle-aged therapist who also works as an academic studying sexuality and embodiment.

These cases were selected because of the presenting problems related to issues related to body weight, fatness, and family disruptions and/or stigma connected to fatness. I excluded cases in this study where people sought out basic weight loss and included cases that more directly addressed complications around fat stigma and interpersonal, relational, and family dynamics. Case studies are often used when the selected cases offer insights into a unique situation or therapeutic dynamic and when researchers seek personal narratives outside of an interview context (Yin 2017). Further, case studies are especially helpful for understanding the "interwoven complexities of intrapsychic and interpersonal processes that emerge and unfold within a wider socio-historical context" (Rubaie 2002, 31).

Each of the cases outlined below drew from cognitive behavioral therapy as the primary theoretical orientation, with attention to the intertwined relationship between cognitions and affect (e.g., depression, anxiety). The couple and family components of the therapy (when applicable) drew from family systems work, which allowed an exploration of the individual within the family unit. At times, discussions of trauma also warranted a more psychodynamic orientation. This research was approved by the Institutional Review Board at my university. Patients consented to be included in the study after termination of therapy. All names have been changed to pseudonyms to protect their confidentiality, and some identifying information has been removed or altered.

Case studies

Case 1: Sharon (food struggles and body image)

Sharon, a 29-year-old cisgender white fat woman, presented for therapy after struggling with anxiety and depression related to her poor body image and severe dislike of her fatness. We met together for 22 sessions total over the

course of a year. She described her reasons for therapy as focused on wanting to feel comfortable enough to start dating, feeling unhappy and conflicted about her relationship with food, and having notably hostile feelings about her body, which she described as "always too big, never good enough" in our first session. She wanted to work in therapy on ways to feel better about her body and wanted to "sit inside my skin" without feeling that her skin was crawling, particularly in front of friends and coworkers. She also described wanting to be able to eventually wear a bathing suit and swim in a public swimming pool.

The first part of our work focused on her feelings about food and connections to her family related to food. She described her mother as having a particularly unhealthy relationship to food where she would forget to eat until late in the day and then become "monstrously" hungry and binge eat every night. The family did not eat meals together and Sharon had largely begun to eat take-out or fast-food every night because she did not want to be at home watching her mother eat tubs of frosting, entire pizzas, or full boxes of cereal. Sharon also noted that she had never learned how to have a healthy relationship to food, and often waited until she was "beyond hungry" to seek out food at a fast-food restaurant. She associated eating with feeling uncomfortably hungry, agitated, and unhappy, and she often felt that she should avoid food entirely at work during the day (like her mother), which resulted in huge surges of hunger in the evening. Like her mother, Sharon felt self-conscious about eating at work during her lunch break, or showing herself eating in front of friends. When she went to her friend's houses to socialize, she often refused food even when others ate, and waited until she left to go through the drive-through to get dinner.

We worked on how to manage hunger, food, and appetite in a more balanced way, and how to change some of her cognitions about the patterns of food and eating related to her mother. Sharon made great improvement on learning how to schedule meals in a more spaced-out manner, how to eat more regularly, and how to imagine the conditions of eating as not connected to feeling extreme hunger and jitteriness. She learned how to eat a small nutritious breakfast in the morning and take a lunch with her to work. She still felt quite self-conscious and often went out to her car to eat lunch rather than eat at her desk like her colleagues, but she at least began to eat more regularly. Building on a fat-affirmative model, we also worked on making space for her to eat in front of friends without feelings like her friends negatively judged her. Sharon, who tended to buy her friends excessive gifts to earn their approval and affection, started to reframe her value as a friend beyond money, and when this happened, her ability to eat in front of them also improved.

Sharon and I also worked on ways to advocate for herself rather than denying her bodily needs and realities. The therapist match between me as a fat therapist and her as a fat patient worked well in this regard, as we strategized about buying clothes that fit her rather than clothes that were

"aspirational." We talked about how to find clothes she liked; well-fitting clothing made a huge impact on improving her body image and allowing her to feel more comfortable in her own skin. As she had just begun flying for business trips, we also talked about how to advocate for herself while flying (e.g., Southwest Airlines' "person of size" policy, where fat people can check in at the counter and simply request the "person of size" extra seat next to them for no fee or hassle), how to cope with eating while on business trips, and how to feel like she *deserved* the work promotions she had earned.

Sharon commented frequently that she felt more comfortable having a fat therapist (though it was difficult to ascertain whether she held things back about internalized fat phobia due to my size, see discussion). Her emerging professional identity often felt incongruent with her fat body, and we worked on how to allow space for fatness *and* professionalism to coexist. We also talked about the concrete, material, physical realities of fatness, and how shame had often overtaken her views of herself and disallowed her to feel entitled to move around in the world, seek out a dating partner, or imagine herself as worthy of investing in from her employer. Sharon also made improvements on the concrete aspects of her body image. Eventually, Sharon wore a bathing suit to the pool at her apartment complex and reported feeling more confident and secure in herself. We terminated therapy when she applied for (and received) a job out of state.

Case 2: Eileen and Oscar (couple's work about attachment/loss)

Eileen, a 35-year-old cisgender white woman of average body size, presented for therapy with complaints of severe anxiety related to imagining her own, and others,' deaths. She worked for a funeral home as a receptionist and office manager, and noted that her job had triggered a nearly constant fear of death. She reported that she could not drive anywhere without imagining her car crashing, and could not spend time with friends or family without intrusive thoughts of their heads bleeding, bodies burning, or cancer taking over their bodies. She described these vivid cognitions as "destroying my life" and wanted to feel better about them. Eileen also reported that she had problems with her husband, Oscar, an African-American man who weighed 350 pounds and worked as a car salesman. Eileen felt convinced that he would "drop dead" if he did not lose weight and worried constantly about his death. She said that she wanted to eventually start couple's work with him so that he could "understand why he had to lose weight for my well-being."

Though much of our 18 sessions together focused on Eileen's anxieties, past traumas, difficult relationship with her parents, conflicts about having children, and ongoing fears of mortality, the couple's work vividly highlighted the tensions and dynamics around fatness as a repository of fear. When I met with Eileen and Oscar together, Oscar later admitted that he was immediately put

more at ease by my own body size, telling me that he "figured you wouldn't judge me like most people" and that I "got it" about fatness. Eileen explained to Oscar that she feared he would die because of his weight, that he did not do enough to exercise and eat well, and that he owed it to her to commit to this. We worked in these couple's sessions on how Oscar could better understanding Eileen's anxiety issues more broadly, and we tried to detach Eileen's fears about Oscar's weight from her accusations that he did not try hard enough, or that his weight was "her problem." In particular, we focused on Oscar's own feelings about his weight and how Eileen's anxieties impeded his ability to focus on what he needed to feel more comfortable, safe, and healthy in his own body. He admitted that he (ironically) ate more unhealthy food when Eileen told him he would die unless he ate better, and he talked with her about how the internal narrative he had about his body had gotten worse when she projected her anxiety onto him.

While Oscar successfully made a plan for caring for his body differently, avoiding some of the most destructive patterns of eating, and changing some of his diet to avoid large quantities of soda and salty snack foods, the biggest change occurred when Eileen better understood that Oscar could not "save" her from her feelings of anxiety and that her fears of him dying connected to attachment disruptions from early childhood. Eileen admitted that having a fat therapist helped in this regard, as she found it more difficult to attribute the causes of my fatness to "laziness" and "not caring" about myself compared to attributions about Oscar. Both Eileen and Oscar talked about their own racial histories and viewpoints about bodies, as Oscar found fatness and weight to be less problematic than did Eileen. With all of this in mind, we worked on different patterns of communicating about eating, weight, and bodies, emphasizing that both physical and psychological health were the responsibility of each person for themselves and not something they could impose on the other person or "rescue" the other person from. When each of them took more responsibility for their own choices – physical and psychological – including patterns of body acceptance *and* care for the body, their marital relationship improved. Eileen stopped associating fatness with imminent (violent) death, and Oscar stopped trying to lose weight only to please her (which then often resulted in him eating more unhealthy foods when he did not lose weight). The introduction of more exercise for both of them also worked to decrease Eileen's anxiety overall, improve Oscar's body image (even though he did not lose much weight), and it gave them something to do together that allowed them to talk and interact on a daily basis. We terminated therapy when both of them felt comfortable with working on these issues outside of therapy.

Case 3: Lupe (medical challenges and fat stigma)

Lupe, a 41-year-old cisgender Latina fat woman, presented for therapy after struggling with a variety of unexplainable medical problems that she could not get help for, which caused her to feel an increasing sense of "doom" and depressive feelings. Lupe had developed a variety of conditions that doctors could not explain, including severe itching all over her body, the emergence of rashes, and severe migraines that went unabated for days on end. When she had sought medical help for these conditions, doctors had repeatedly told her to lose weight and she had felt that her body size had nothing to do with these conditions. She wanted to work in therapy on how to advocate for herself medically, how to lessen her feelings of depression, and how to manage her anger about being dismissed and ignored by medical doctors.

During our initial sessions in the 15-session therapy, Lupe pointedly mentioned my body size and how she felt more comfortable talking to me about the medical issues she was having because she felt that I would not dismiss her as "just being fat and complaining about it." She talked about her struggle to be taken seriously for much of her life, and that she had been dismissed during the delivery of her first baby when she told doctors that she felt she was going to die and they had told her to calm down. She described how shortly thereafter she *did* nearly die, and how the doctors she had complained to had ignored all the signs of the problem. She had felt during this pregnancy that her fatness was always constructed as a liability and that doctors implied that she should not even have had a baby because of the higher risks. Her longstanding issues with medical stigma and the trivialization of her complaints had led her to become phobic of seeking treatment for anything. When these new problems emerged, however, she felt she had to try to find out what was happening.

We worked in this therapy on validating the problems of stigma and how stigma can alter people's relationship with their social world. Racial issues came up occasionally and seemed to inform our work as well, as Lupe felt that medical doctors treated her more poorly and told her that they "knew better than her." We thus worked to establish less of a hierarchy between us as patient/therapist. Connected to this, we also worked on what it would feel like to trust her body's signals and to keep seeking second opinions if necessary. We talked about how she did not need stay with a doctor who had routinely dismissed her complaints, and how this connected to early childhood experiences of being ignored when she reported sexual assault to her parents and they told her to keep quiet about it. The creation of a bridge between her earlier traumatic experiences and the reaction to those experiences from her parents also allowed for more exploration of what it meant to find her voice and assert herself, set boundaries, and seek quality medical care. Ultimately, after going to the Mayo Clinic and eventually finding their top autoimmune

specialists, Lupe discovered she had a serious auto-immune issue that could be resolved through a course of steroid injections. Her symptoms resolved and her depression lessened. She also started working with a new primary care physician who listened to her and did not stigmatize her about her body size. Once she felt listened to and validated by medical doctors, and once she understood the roots of some of her depressive thinking as connected to feelings of being dismissed, she reported a reduction in her stress and depression and an improved relationship with her body. We terminated therapy after she showed a significant improvement in her depressive symptoms.

Case 4: Deja (family relationships and dating)

Deja, a 21-year-old cisgender biracial white and African-American woman, presented for therapy with her parents to discuss family conflicts they were having related to boundaries, food, self-care, and difficulty with them accepting her as an autonomous adult. Deja said that her parents still treated her like a "baby" and that they were constantly meddling in her business rather than attending to their own problems with each other or within themselves. She said that she wanted to be treated like a "normal college student" who could make decisions for herself about her routines, schedule, eating, and sleeping choices, and friend/dating time. Her parents expressed a number of concerns about her starting to use Tinder, worries about her gaining weight because she ate too much and "snacked all day," and said that they often had conflicts in the household where they exploded at each other and did not talk to each other for days afterward. They had all agreed to seek out therapy to talk about their problems and work on their relationships.

While the initial presentation of problems did not coalesce around fatness, it soon became clear that most of this 12-session therapy would actually focus on fatness as a key centerpiece of their work. Deja's weight gain became a fixation for the parents, and Deja pointed out that both of her parents were fat and that they often behaved in cruel ways to each other about fatness. When they fought, for example, many times they would say hurtful or critical things to each other about their body weight. Both parents admitted that they found it difficult to share these anecdotes in front of a fat therapist, and they realized how destructive their words were to each other when recounting their fights. Deja said that she felt comfortable with her body and did not "hate myself" like her parents. She said that she was exercising regularly and that her job required her to constantly walk and move around. She pointedly suggested that she did not want to *become* her parents by using her body as a funnel for all of her other anxieties. She also said that no one had a healthy relationship to their bodies in their house, which caused her to question whether she had a body image problem or not. Surrounding this, the topic of race regularly came up, particularly given that

Deja did not want to identify with her African-American father and his poor eating. Deja also struggled with feeling like her black identity was a liability for her dating life; much of our work unpacked internalized racism and internalized fat phobia in tandem.

With regard to fatness, in this therapy, we worked on how to set boundaries with each other in the family, how to better communicate without veering into body shaming, and how to enact decision-making in the family. We talked about scapegoating and the problems of using body size as a weapon for anger or distress, and we focused on the challenges of having an adult daughter living in the household (and the challenges for Deja of living with her parents while working and going to school). Both parents explored how they carried shame about their body size and had experienced numerous episodes of being bullied or mistreated by their family members for gaining weight. Ultimately, the therapy focused on fatness and body size as a key site for how the family communicated and how they could improve their dynamics with each other, particularly as each person examined the damage that negative talk about fatness had on their sense of self. The family regularly sought feedback about reasonable, healthy, and productive ways of talking about fatness, weight gain, and body size, resulting in more positive modes of communication with each other. We terminated therapy when Deja felt comfortable with the new routines and boundaries they had set, and when her parents had learned how to communicate in a less destructive way with each other.

Discussion

Each of these case studies presented a portrait of why fat therapists working with fat patients can uniquely impact the therapy dynamic, and how psychological kinship and the emotional intimacy created through psychological kinship, significantly informs the work. While some of these patients appreciated or felt at ease by having a fat therapist, most often because it reduced the stigma of fatness, these cases also revealed how having a fat therapist seemed to open up dialogue about fatness as a subject of importance rather than keeping it hidden as a site of (excessive) vulnerability. Fatness became an explicit text in therapy rather than a subtextual element, as Deja's family explored the way that fatness became a funnel for anger and hostility toward each other, and Eileen and Oscar examined the way that fatness stood in for discussions about power, anxiety, and fear. This seemed notable given that fatness often goes unspoken about or "unseen" in psychotherapy, and such invisibility or lack of conversation about it can harm patients and their ability to understand how feelings about fatness links to their own vulnerability.

The way that fatness could not *hide* on the body, and was a visible and notable entity in the room, impacted both me as the therapist and them as patients. Being a fat therapist allowed me to facilitate conversations with

patients that affirmed their experiences and made room for talking about fatness openly and honestly, and while I cannot be 100% certain that my body size helped in these discussions, my fatness was clearly a "text" in the room in many ways, from making it okay to talk openly about size to sharing information about advocacy to talking about the material realities of fat stigma. Sharon and Lupe both experienced stigma related to fatness, and had a great deal of sadness and anxiety about how they had been treated because of their fatness. The challenges fat women face in the medical world, in particular, are sometimes difficult for thinner people to understand (Goldberg 2014), and the matching between fat therapist and fat patient seemed especially important in this regard. Lupe's frustration at not finding an appropriate answer to her medical problems, and her experiences with past medical *traumas* of nearly dying during childbirth, also spoke to the importance of seeing, validating, and affirming fat stigma. This affirmation may feel more real and authentic given that fat patients can assume at least some shared experiences with fat therapists based on body size and stigma. Sharon's feelings of unworthiness – to wear a bathing suit, to get a promotion, to date – also became subjects we could explore and talk openly about rather than burying them as shameful and unspoken. Sharon said that in her previous therapy experiences, she almost never mentioned fatness even though it was on her mind constantly. I worry that this is too often an experience that therapy patients have, where fatness sits at the center of their fears, anxieties, and thoughts, and yet they do not often feel comfortable discussing it openly. Facilitating more open discussions of embodiment – fatness, menstruation, medical concerns, fatigue, breastfeeding, and more – helps to ground the therapeutic work more fully while establishing psychological kinship as a key dimension of the therapeutic bond.

That said, there are of course many hazards to assuming a shared experience between therapist and patient, and this can sometimes wreak havoc on, or introduce complexities to, therapeutic alliances or dynamics, again pointing to some of the hazards of psychological kinship. Some patients assume that therapists also "hate themselves" and that all fat people feel as they do about their bodies. Patients may also feel conflicts about talking about their own shame about fatness in front of a fat therapist, as patients often care about and do not want to harm their therapists. This may lead to patients not being honest about feelings of self-loathing in order to protect a therapist from fat-negative talk. The *degree* of fatness also matters, as some patients are fatter or thinner than the therapist and this might inform the work in a potentially negative way. Other patients sometimes feel that fatness is *always bad* and have a hard time, especially at first, imagining that fatness can exist outside of negative stigma and negative emotions about it. Further, because fatness is not often openly discussed, some patients do not have experience talking about their fat bodies openly and honestly. Consequently, they may project onto the

fat therapist things that are, to varying degrees, harmful to therapy. For example, a fat patient who struggled with dating and feeling rejected kept looking at my wedding ring and making elaborate assumptions about my dating and relationship experiences. Fatness is something that, for many patients, exists but is not often openly discussed. In each of these cases presented in this study, patients seemed to feel appreciative and comfortable talking about fatness, but they also expressed that it felt difficult to talk about fatness and to imagine it outside of the context of *only* stigma and *only* negative feelings. As one poignant example, Sharon repeatedly asked me about whether I had ever worn a bathing suit, followed by astonishment when I told her that I swam at a local gym multiple times per week. She constructed publicly wearing a bathing suit as something to "survive" and "endure," while I felt joy and relaxation when I thought about swimming. Assumptions about a shared reality of fatness must be treated carefully and thoughtfully, particularly if the therapy is prioritizing psychological kinship, emotional intimacy, and a shared bond about an embodied identity.

When thinking more broadly about limitations of this study, understanding fat therapist and fat patient dynamics needs far more work. Case studies present only a small and limited view of what researchers should aim to understand about these relationships. These cases present illustrative examples of key features of therapies about fat stigma and family/relational dynamics without presenting the typicality and variance of such patterns. Perhaps a fatter or thinner therapist would have different outcomes, just as psychological kinship may differ between different therapists and their clinical modalities. Further, while case studies can point to some of the specific dynamics of importance in understanding the intimacies of therapies between fat therapists and fat patients, more systematic empirical research could prove useful, as would research that looks at a wider range of therapists and patients across social identity groups, social locations, and presenting problems. A study of psychotherapy outcomes could allow a more evidence-based approach to fat therapist-patient matching, as could an analysis of fat patient's perspectives about therapeutic bond, psychological kinship, and personal growth when working with fat therapists. This explorative study was meant only as a springboard for more exploration of fat therapies, particularly those that frame fatness as a strength or as a form of complex embodiment rather than an assumed limitation or personal weakness. Challenges to links between thinness and professionalism are also warranted, and this study imagined some new inroads into understanding fatness as an asset for therapists working with certain patients rather than a professional liability.

In general, these cases point to the need for solidarities around fat oppression and an opening up of discourse about and around fatness. As seen during the COVID-19 pandemic, people think about, imagine, and feel anxiety about fatness in a fairly constant way, often using it as a funnel for negative feelings

(e.g., instead of "I'm feeling trapped inside my house and powerless against a fascist government," worries about "getting fat" dominated informal discussions of distress during COVID-19). The fat body, and thoughts about food and eating, held the weight of many stories about individuals, couples, and families, and in each of these cases, open discussions of fatness allowed for deeper explorations of childhood patterns, relationships to food, previous traumas, and the necessity of better communication about embodiment. By situating therapists as doing fat-affirmative work, and by making space for talking explicitly about and exploring the meaning of fatness, body weight, fat stigma, body image, and the internalization of fat oppression, fat therapies can deepen in intensity, link up to justice perspectives, and, ideally, lead to transformative change.

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Notes on contributor

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