“Finding light in the darkness”: exploring comedy as an intervention for eating disorder recovery

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Abstract

Purpose – *Eating disorders (EDs) remain a major health concern, and their incidence has further increased since the COVID-19 pandemic. Given the equally increasing demands on treatments and service provision and the high levels of relapse post-treatment, it is important that research explore novel and innovative interventions that can further support recovery for individuals with EDs. There is growing evidence that arts interventions are beneficial for recovery from EDs. This study aims to evaluate the feasibility of conducting a stand-up comedy course to support ED recovery.*

Design/methodology/approach – *The study used a qualitative interview study design to evaluate the recovery benefits of participating in stand-up comedy workshops for a pilot group of people in recovery from EDs (n = 10).*

Findings – *The comedy intervention was well-attended and had high acceptability and feasibility. For most individuals, participating in the course had a positive impact, including promoting personal recovery (PR) outcomes across all five elements of the CHIME framework. Unique assets of the course included providing participants with an opportunity to distance themselves from everyday worries of living with an ED; the opportunity to cognitively reframe situations by making them the object of humour; and providing a safe space to (re-)build a positive sense of self.*

Originality/value – *This is the first study, to the best of the authors' knowledge, that evaluates stand-up comedy workshops for ED recovery and further demonstrates the potential of arts interventions and the relevance of PR frameworks in this field.*

Keywords *Mental health, Recovery, Eating disorders, CHIME, Comedy*

Paper type *Research paper*

Introduction

Eating disorders (EDs) remain a major health concern. A recent meta-analysis established that the incidence of EDs has increased worldwide since the COVID-19 pandemic (Silén and Keski-Rahkonen, 2022). The UK has seen a record demand for ED treatment as referrals increased by almost two-thirds since before the pandemic (NHSE, 2022). At the same time, historically, only about a quarter of individuals affected by EDs access effective evidence-based treatments (Hudson *et al.*, 2007), which is very low in comparison to other psychiatric diagnoses such as psychosis (Layard, 2013). Additionally, healthcare professionals only detect around a third of ED cases (Keski-Rahkonen and Mustelin, 2016), and it is reported that post-treatment relapse rates are estimated at between 25% and 52% for anorexia nervosa (Khalsa *et al.*, 2017) and between 30% and 50% for bulimia nervosa and related EDs such as other specified feeding or eating disorder (OSFED) (e.g. MacDonald *et al.*, 2015; Yu *et al.*, 2013).

Clearly, research should explore novel and innovative adjuncts within interventions for ED prevention and treatment to help bridge this ever-growing gap between those needing and

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those receiving care (Nagata and Murray, 2021). To this purpose, this study tests whether running stand-up comedy workshops to support ED recovery is feasible and acceptable for a pilot group. We also evaluate which positive impacts occur and which dimensions of participating in a stand-up comedy workshop series have an impact on ED recovery (for specific people in specific circumstances).

Background

There have been calls for greater consideration towards alternative forms of therapeutic provision for people experiencing mental health difficulties (Ostermann *et al.*, 2019; Turgon *et al.*, 2019), including interventions to aid the adjustment from higher to lower levels of care (Davidson, 2016). In particular, there is growing evidence that arts approaches are beneficial for recovery from EDs, including creative and expressive art therapies, drama therapy, poetry therapy, as well as non-therapy creative interventions including visual art (e.g. painting, drawings, collage, modelling, clay work) and music (e.g. listening, improvising, recreating, songwriting) (Smriti *et al.*, 2022; Testa *et al.*, 2020; Ramsey-Wade and Ellen Devine, 2018; Wood and Schneider, 2015; Wood, 2015; Hershifelt, 2015). Specifically, performance-based approaches developed by drama therapists (i.e. "therapeutic theatre") have shown promising results to support the independent recovery of individuals in post-intensive treatment from EDs (Wood and Mowers, 2019).

The benefits of arts interventions for ED recovery are best understood within a personal recovery (PR) framework (Bucharová *et al.*, 2020). As opposed to clinically based recovery (e.g. the absence of symptoms), PR recognises recovery as a journey towards a greater quality of life, achieved through adaptation and thriving in spite of mental ill health or ongoing symptoms (Repper and Perkins, 2003; Davidson *et al.*, 2005; Leamy *et al.*, 2011). In spite of a lack of definitional cohesion and consensus in the field of ED recovery (Bardone-Cone *et al.*, 2018), there is evidence that patient perspectives on recovery align with this PR conceptualisation (Bohrer *et al.*, 2020; Pettersen and Rosenvinge, 2002) – even if only a few studies currently apply PR constructs to EDs (Dawson *et al.*, 2014; Noordenbos, 2011; Piot *et al.*, 2020). The CHIME framework of PR identifies five components of effective recovery-oriented services and interventions, i.e. connectedness, hope, identity, meaning and empowerment (Leamy *et al.*, 2011). These components are prevalent across the research literature (van Weeghel *et al.*, 2019), including with ED populations (Wetzler *et al.*, 2020).

A recent review established that the CHIME framework usefully frames the potential benefits of comedy interventions for mental health recovery – although, notably, no existing interventions contributed to meaning (Kafle *et al.*, 2023). However, although there has been much research activity around comedy and mental health, not many studies empirically evaluate interventions and even fewer elucidate which mechanics of comedy interventions stand to contribute to mental health outcomes (Kafle *et al.*, 2023; Fischer *et al.*, 2021). In line with the Medical Research Council's guidance on the evaluation and development of complex interventions, research should clarify which specific components of interventions have an impact on mental health (for specific people in specific circumstances) rather than focus solely on whether interventions are effective (Skivington *et al.*, 2021).

Unpacking the components of change is particularly important for comedy interventions. For one, there are different types of comedy intervention, ranging from performing (e.g. stand-up comedy workshops) to spectating (e.g. watching comedy films) (Kafle *et al.*, 2023). Moreover, although the folk belief that "laughter is the best medicine" endures, not all humour uses in everyday life are adaptative, e.g. self-defeating humour (Kuiper *et al.*, 2004). Laughter is also not a necessary response to humour or comedy (Kafle *et al.*, 2023). Much like everyday humour, comedy interventions are multifaceted and include social, emotional, cognitive and physical dimensions that could impact recovery (Martin, 2004).

This study therefore not only sets out to establish if stand-up comedy workshops impact ED recovery but also which core mechanisms support PR for participants.

Methodology

Intervention

This study evaluated a stand-up comedy course for ED recovery, i.e. Comedy for Coping (C4C). The course was created, developed and delivered by a stand-up comedian with lived experience of an ED (DC). The workshop took place online (over Zoom) to minimise access barriers (e.g. geographic location, reduced mobility, caring responsibilities, etc.) and accommodate COVID-19 restrictions. Workshop sessions ran for one hour, once a week, for six weeks (with a break of one week in the middle). The workshops train participants to deliver a stand-up comedy set to each other by the end of the series. Weekly sessions introduce key skills and understandings around attitude, stage presence, joke and set writing and performance. In a typical week, participants would learn about comedy theory and participate in practical exercises. After the course was completed, participants received a weekly newsletter for 12 weeks on how to incorporate comedy into their ongoing recovery.

The C4C workshops are a type of participatory arts-based (PAB) activity, i.e. an activity that is structured around participatory involvement in creative processes to support mental well-being (Williams *et al.*, 2023). As a PAB activity, C4C is developed and delivered by an artist/arts practitioner – i.e. a stand-up comedian – not a trained mental health professional – e.g. a therapist or counsellor (O'Donnell *et al.*, 2022). Hence, this intervention is distinct from creative arts therapies (CATs), such as drama therapy (Kalmanowitz *et al.*, 2019). While a drama therapist has received clinical training that enables them to adopt a dual role of group facilitator and primary therapist (Wood, 2015), the role of facilitator in C4C is to train participants to perform stand-up comedy while sharing perspectives of their own lived experience with anorexia. So, while a PAB activity such as C4C can have "therapeutic" outcomes for participants, it is not (framed as) "therapy" (Williams *et al.*, 2023; Pavarini *et al.*, 2021).

Participants

The inclusion criteria for participation were people who self-reported experience with an ED, were fluent in English and were over 18 years old. People who were currently attending inpatient or daypatient treatment were excluded because the workshops are designed to support people in recovery (not in crisis). Participants were recruited using purposive sampling via ED charity networks and media promotion, including social media posts and coverage in national and local radio, TV and print press.

A total of 48 individuals contacted the research team to participate in the study, after which recruitment was stopped, as this study was conceived as a pilot to test the feasibility of the intervention (and funding was only sought to run and evaluate one workshop). Ten participants ($n = 10$) were accepted and attended the course. Selection was based on availability and anonymised screening to ensure diversity in terms of gender, age, ethnicity, diagnosis and geographical location. All participants identified as being in recovery for a variety of EDs. Four people had anorexia (restrictive); one person had anorexia (binge-purge); one person had AFRID; two people had binge-ED; and two people had bulimia. Ages ranged from 25 to 46 (median age: 29), and the majority ($n = 9$) identified as white, with one participant identifying as British Asian. The majority identified as female ($n = 8$) and two identified as male; one participant identified as transgender.

Methods

We used a qualitative, multi-method and longitudinal research design to address three overarching research questions:

Q1. Is stand-up comedy feasible and acceptable as an intervention for a pilot group of people in recovery from an eating disorder?

Q2. Can participating in a stand-up comedy course positively impact eating disorder recovery (for a pilot group)?

Q3. Which dimensions of participating in a stand-up comedy workshop series have an impact on eating disorder recovery (for specific people in specific circumstances)?

Semi-structured interviews were conducted online in advance of the workshops, immediately after completion of the course, and three months later. Participants were also asked to submit weekly reflective written diaries to voice their subjective and lived "reality" of the recovery experience after each session. Through this approach, we could understand participants' expectations before the study, their experiences during the workshops and their impact after completing the course. Informed consent to share anonymised research findings was established in writing for each separate stage of this data collection process, and ethical approval was granted by the Central Research Ethics Advisory Group at The University of Kent.

We conducted a framework analysis (Ritchie and Lewis, 2003) informed by the CHIME framework of PR (Leamy *et al.*, 2011). Our coding framework used the five dimensions of CHIME to record expectations and experiences of the intervention, i.e. connectedness; hope; identity; meaning in life; and empowerment. The C4C course was designed by DC in advance of the study. An initial round of coding by DD established that many of C4C's core components organically pursued outcomes that mapped onto the CHIME framework. Some minor fine-tuning followed to incorporate feedback from JP, who had lived experience and had participated in an earlier delivery of the workshops. JP and UF led the semi-structured interviews, which included questions framed around CHIME components. EK, JP and SR conducted double-coding of interview transcripts under the supervision of DD and UF. JB advised on frameworks for PR.

Results

Participants reported a good level of acceptability for stand-up comedy workshops to support ED recovery (irrespective of a specific ED diagnosis), which demonstrates the feasibility of the intervention for this pilot group. The attendance rate showed promising results, while the themes that emerged from the interviews and reflective diaries evidenced recovery outcomes that map across the five elements of the CHIME framework.

Attendance

Overall attendance for the course was 83% (see Table 1). The first three weeks had 100% attendance. Six participants attended all six workshops. Two participants dropped out of

Table 1 Participant attendance by week

Participant no.	*Week 1*	*Week 2*	*Week 3*	*Week 4*	*Week 5*	*Week 6*	*Total attendance (%)*
6	1	1	1	1	0	0	60
7	1	1	1	1	1	1	100
4	1	1	1	1	1	1	100
9	1	1	1	0	0	0	50
2	1	1	1	1	1	1	100
10	1	1	1	1	1	1	100
8	1	1	1	1	1	1	100
5	1	1	1	1	1	1	100
1	1	1	1	1	0	0	60
3	1	1	1	0	0	0	60
Total weekly attendance	100%	100%	100%	80%	60%	60%	*Overall Total: 83*

Source: Table by the authors

the course overall, one because of health reasons and another because of work-related issues. Reasons for occasional non-attendance from other participants included internet connectivity issues, COVID-19 and scheduling challenges for childcare and work events. These results present a comparatively high rate of adherence to the intervention given the established challenges of engagement with ED programmes and research (Muir *et al.*, 2017; Leavey *et al.*, 2011; Williams and Reid, 2010), which demonstrates the feasibility and acceptability of this pilot.

Connectedness

Living with an ED makes it particularly challenging to connect with others. As one participant put it, "[e]ating disorders are very isolating illnesses, and I think it's very common to feel like you're the only person feeling a certain way [. . .]. [A] huge part of this sort of disconnect is declining invitations to things to listen to your eating disorder" (Participant 1, pre-course interview). One participant shared, "My instinct is always to be alone, but I'd like to be more sociable" (Participant 5, pre-course interview). For another participant, talking to the interviewer before the course was the first time they openly talked to someone else with lived experience: "I guess you're the first person I've spoken to who's got an eating disorder?" (Participant 4, pre-course interview).

Clearly, perceived stigma inhibited connectedness, especially for people living with "unseen" EDs. One participant stated that he had "not ever spoken to anyone else before about binge eating disorder" (Participant 6, pre-course interview). As a man, this participant felt that gendered stereotypes around EDs created an additional layer of inhibition: "I've got a friend, who had bulimia and he always talks about it, and so that was my first and only experience of another bloke talking about their eating disorder" (Participant 6, pre-course interview).

Several participants wanted to participate in the course to connect with other people living with an ED. Already from the first session onward, doing stand-up comedy tasks together created a sense of connectedness: "[a]lthough, really, we were just a group of strangers with eating disorders talking to one another on the internet, the task brought us together in a way I'd never expected [. . .] it really did feel as though we were all in it together" (Participant 1, reflective diary, week 1). As the course progressed, one participant who previously expressed a preference to be alone wrote that she "enjoyed being with people who had the same weird thought processes as me, and being together in a supportive way was helping" (Participant 5, reflective diary, week 3).

This sense of connectedness endured upon completion of the course and was an important learning outcome for some participants: "I think if I learned anything, it's that actually maybe I need to be in the company sometimes with other people who have eating disorders" (Participant 7, post-course interview). Other participants echoed this feeling, adding that "what I got out of it the most was the sense of community [. . .] By the end of the sessions, we were all really good friends" (Participant 8, post-course interview). Moreover, it became clear that this sense of enduring connectedness was key to an improved sense of recovery for this participant:

> It feels like it's related. [. . .] I think being in a space with other people with eating disorders [. . .] because I know like two or three friends off the top of my head [made during the course]. [. . .] I'm not sure how it helped but it clearly has because I'm a healthier weight and all round healthier in general. So it must have done (Participant 8, three-months interview).

One reason why participants felt able to connect to other people living with EDs during the course was, paradoxically, that ED recovery was not the focus of the activity. As one participant put it, "I loved being in a self-help group that wasn't talking about eating disorders" (Participant 6, post-course interview). Likewise, for another participant, "[i]t felt very much just doing a stand-up course, with a bunch of people who also had eating

disorders, as opposed to, like, focused on the eating disorder side of things and it was actually quite nice in a way" (Participant 2, post-course interview). She specifically valued

> [. . .] that movement [away] from the kind of rigidity [. . .] how recovery is approached from an NHS perspective, or, certainly within the trust I was in most recently, and it's very, almost feeds into eating disorders, because it's very tick box. And, you know, my eating disorder loves the tick box (Participant 2, post-course interview).

In this respect, some participants felt the course overcame the challenges of traditional group approaches to ED recovery. One participant had previously experienced group therapy for anorexia as "kind of toxic for me [. . .] I just kind of kept thinking I have to be the thinnest, the most unwell" (Participant 3, pre-course interview). Another participant similarly explained, "I've done group support stuff before, [but] I never really gelled with it [. . .] it felt almost like just comparing notes rather than in any way talking about, like, getting better" (Participant 7, post-course interview). By contrast, by taking part in the course, "what I really liked was knowing everybody was experiencing similar difficulties [. . .] it made me feel better about the shame I feel. It was such a relief, to be in an environment where, everyone knew I had an eating disorder, and no one was asking me if I got better that day" (Participant 7, post-course). This sense of "comradeship" and the fact that "no one had any expectations that somebody would turn up one week and say, by the way, I'm completely recovered" helped to foster connectedness (Participant 7, three-months interview).

Not focusing on overcoming illness also helped participants talk more readily to friends, family, and acquaintances about the taboo topic of EDs. One participant explained that "sometimes I can kind of feel a bit like I don't know what to start with talking about stuff that's actually going on with me but I think [the course] certainly gave me something to talk about with people, which is quite nice" (Participant 2, post-course interview). This participant framed comedy as a tool to make an otherwise difficult topic easier to broach, as "[i]t's easier to say to someone, I'm doing this stand-up thing, which is looking at recovery from eating disorders than it is to say, I'm doing CBT again, or I'm doing Mantra, or I'm seeing my dietician this morning" (Participant 2, post-course interview).

Similarly, another participant explained that "[s]ince doing [the course], everybody around me has learned that it's okay to laugh with me about that sort of thing [. . .]. I feel a bit better talking about that sort of serious stuff now" (Participant 8, post-course). Comedy served to foster such increased connectedness in the most intimate relationships as well. One participant shared that "I would never ever talk about my eating disorder ever with [my husband], he knows, but we never talked about it. And it just made it a bit more normal" (Participant 7, three-months interview). As the course progressed, "I think we learned stuff about each other, which was really nice – we've been married for 11 years!" (Participant 7, three-months interview).

Hope and optimism

Participating in the comedy course brought a sense of light-heartedness and fun to recovery. As one participant explained:

> [t]he course helped in how I could [. . .] make quite a dark subject matter lighter [. . .] [and] think about things differently and explore the subject matter [mental ill health] in a safe and sort of controlled way. [. . .] Actually just reframing things, it made the effect of them feel less negative (Participant 6, post-course interview).

Another participant agreed that you can "use comedy in a way that makes something quite difficult, distressing, or hard to understand, more manageable" and "you can just switch and find a positive in any situation even if it's a really silly thing" (Participant 1, post-course interview). Someone else added, "I've just learned to be a little less serious when speaking

about my mental health, which I guess is a coping mechanism" (Participant 8, post-course interview).

For one participant, continuing to perform stand-up comedy became essential to her recovery journey, as she explained that "[w]hen things do go to shit I have started saying to myself, no, there's gotta be some stand up material in this somewhere, which is a nicer way of thinking about the whole world exploding around me" (Participant 2, post-course interview). Another participant, who did not continue to perform stand-up, had nonetheless started using a similar coping strategy. When something went awry, she now imagined that "if I was doing stand-up, this would be hilarious!" (Participant 7, three-months interview). Although this participant acknowledged that "my eating disorder is an annoying part of my life that I wish I would not have", she countered that "I can recognise that the position I'm in now is brilliant" (Participant 7, three-months interview).

Apart from learning how to make light of otherwise distressing situations, participants also highlighted the influence of the course lead as a positive role model. The course lead's experience with recovery from anorexia was central to the development and delivery of the course – and resonated with participants. As one person said, "Having it delivered by somebody who openly will say that they've been there is and is no longer in that place is, yeah, that gave me a lot of hope" (Participant 2, post-course interview). Others similarly shared that "it's given me motivation, [the course lead] has done it, so I can do it too [. . .] he gave me the confidence to get stuck in and try stuff" (Participant 6, post-course interview). Someone else added that the course lead "was able to be vulnerable, and funny and instantly put everybody at ease" (Participant 7, three-months interview).

Identity

For several participants, the course offered a space where they could "be themselves" – and reclaim parts of their identity that otherwise felt "lost" to the ED. One participant shared:

> I felt comfortable enough to let go of everything that had been weighing me down, and really be myself [. . .] it's only when you do something that reignites that part of you that you realise it's been missing. [. . .] that's the part that gets squashed by my eating disorder (Participant 1, post-course interview).

To another participant, finding new topics for comedy became an invitation to look "at the multifaceted nature of yourself as an individual" (Participant 2, post-course interview). Similarly, another participant explained that "we never laboured on our eating disorders [in the course]. What we laboured on was our personalities" (Participant 7, post-course interview). Several months after the course ended, this participant still affirmed that "I have a more solid sense of my identity now. [. . .] [I]f you asked me to write a list of all the things that make me 'me", I don't think I'd even put my eating disorder on it. Because it wouldn't occur to me" (Participant 7, three-months course interview).

Another important identity process involved developing greater self-acceptance through light-heartedness. Living with an ED typically undermines self-worth: "the anxiety of it [ED] ties into the perfectionism. What if I'm not good enough, and that's always something I hear in the back of my head" (Participant 3, pre-course interview). One participant explained that participating in the course "definitely helped me be a little bit more playful. And to learn to let go of the idea that everything has to be perfect and planned" (Participant 1, post-course interview). She later expanded, "I am my own biggest bully [. . .] [And I feel better when I] get in touch with like a different part of myself, that can be a bit more spontaneous and can be like more light-hearted [. . .] and that's something that I've tried to hold on to [after the course ended]" (Participant 1, three-months interview).

Another participant related how she previously stopped engaging with creative activity because "it requires a lot of confidence that eating disorders kind of take from you. But then

also, I was like, well, I'm never going to be the best at it [. . .] the more the perfectionistic side came in" (Participant 2, three-months interview). By contrast, the course "was such a non-judgmental environment. It allowed me to kind of try something without the pressure to be good at it" (Participant 2, three-month interview). Somebody else similarly explained that "I'm slowly starting to accept that I'm ok. And this course has been part of that, that I'm ok" (Participant 7, post-course interview). She expanded that by feeling kindness towards others on the course, "there's definitely been a shift in my attitude towards myself, [I feel a] bit more relaxed with myself, a bit kinder" (Participant 7, post-course interview).

Meaning in life

Participating in the weekly sessions became a meaningful activity for participants. One participant explained that "it was time every Wednesday to think about what I liked doing, and doing something I can practice and be good at" (Participant 6, post-course interview). Engaging in an enjoyable and meaningful activity also created distance from the ED: "it's comedy, it's doing something that's good for me. I'm not thinking about food and eating" (Participant 6, post-course interview). Another participant similarly enjoyed "a bit of time in the week where [. . .] I knew that I was going to have a bit of a laugh, and everything was going to be quite light-hearted" (Participant 8, post-course interview). This person valued the course as "something to look forward to in the week and [. . .] that was a routine [that] really helped" (Participant 8, post-course interview).

For others, attending the course served as a mood booster, which positively impacted their engagement with recovery. One participant explained that the course "boosted my spirits, which, again, mood and eating disorders are so intertwined, so when I was having a down day, that makes it harder to kind of engage in my meal plan, etc. But like having my mood lifted, generally, like, makes everything a bit easier" (Participant 2, post-course interview). Crucially, the link between learning stand-up comedy skills and an improved sense of recovery was often indirect: "it was never even like, if you make your husband laugh today, you're less likely to eat three packets of biscuits. [. . .] We were trying to find humour in strange places and funny places. And I enjoyed that a lot" (Participant 7, three-months interview).

Allowing a sense of fun and lightheartedness into the recovery space also contributed to normalising and accepting living with an ED. As one participant put it, "[e]ating disorder recovery is not fun. In the same way as having any disorder is not fun and it made something that is really shitty and hard and horrible and feels really lonely, it made it a bit fun" (Participant 1, three-months interview). Another participant explained how they became able to accept the ED as part of their life by not seeing it as defining their identity: "the fact that I'm not allowing at the moment for my eating disorder to be like the primary thing in my life, I feel so much more accepting of it (Participant 7, three-months interview). This process of acceptance was closely linked to a sense of connectedness and rebuilding a positive identity as part of the course. This participant clarified that "the group context definitely helped with the normalisation of we're all here for similar reasons and no one is weird [. . .] I don't feel like some sort of alien anymore [. . .] I don't feel broken anymore" (Participant 7, 3-monhts interview).

Through participating in the course, some participants were also able to identify meaningful social goals and roles. Someone explained that "I'd really like to write a book [. . .] and I've learned so much from [the course lead], that sort of humour side of it, I can now actually employ and weave that into my work. And it's given me motivation" (Participant 6, post-course interview). Somebody else stayed in the habit of "doing it [stand-up comedy] quite regularly. In fact, I've just got my first paid booking" (Participant 2, post-course interview). This participant also explained that "[i]t has done me a lot of good to engage with a hobby [. . .] it really fits into the work I'm doing with my therapist, who has said, "you need to go and find something that, during this really hard time you're having, is just fun'" (Participant 2,

post-course interview). For this participant, the meaningfulness of performing stand-up comedy became a clear motivation for recovery: "I'm aware, if I go back into fully eating disorder mode, I won't be able to do it [stand-up comedy]" (Participant 2, three-months interview).

Empowerment

For many participants, taking part in – and successfully completing – the course was an empowering act of positive risk-taking. One person felt "so proud that I actually committed to something because normally, when it comes to anything relating to my issues, I've failed, I found fault or [. . .] couldn't be bothered. But I am very proud that I continued and that I completed [the course]" (Participant 5, post-course interview). Another participant felt that "we were pushed out of our comfort zones in certain situations. And I realised that I could do that. And it was okay. And after I'd done it, I felt good" (Participant 1, post-course).

The success of participating in the course also impacted other areas of life. One participant, who has a stutter, explained that "the main thing it helped me with was confidence, like speaking in front of people that I didn't know" (Participant 8, post-course interview). For somebody else, participating in the course was also among the activities that helped build greater confidence around public speaking, including speaking up in front of senior colleagues at work. This person had recently been promoted and felt that "a lot of that has to do with my confidence" (Participant 7, three-months interview). For somebody else, the reassuring experience on the course has "given me the confidence to go and do other activities [. . .] [Whereas otherwise] I might as well go into the sort of bubble because I'm not enjoying anything, I've got nothing to look forward to, life's crap" (Participant 2, three-months interview).

Committing to the course further enabled participants to secure a sense of personal responsibility for their own recovery. Some participants experienced a clear difference between voluntary participation in the course and prescribed therapy: "I wanted to do it [the course]. I was doing it for myself, like it wasn't like work. It wasn't like for money. It wasn't because someone else was telling me to. It wasn't like NHS therapy that they were forcing me into" (Participant 1, three-months interview). This level of agency stimulated a sense of responsibility to commit to recovery – even on difficult days. This participant explained that "I wasn't just showing up for other people, or out of a sense of obligation – I was doing it for myself. Which, I suppose, is what recovering from an eating disorder (or any mental illness) is all about" (Participant 1, three-months interview). Another participant similarly said, "I made a commitment and I wanted to stick to it" (Participant 7, three-months interview).

This sense of commitment carried over to activities beyond the course. One participant explained that continuing to perform stand-up comedy has "given me something to kind of keep myself motivated with in a way that previously I might have just, you know, kind of hidden myself away and gone back into a bit of a pit" (Participant 2, three-months interview). She expanded that "I've actually started using my calendar as my like main way to kind of pull through. [. . .] I write all my bookings on there for gigs and open mic nights I'm doing" (Participant 2, three-months interview). Another participant similarly expressed a renewed sense of personal responsibility, stating "[I'm] actually doing uni work for once" (Participant 8, three-months interview).

Discussion

This study demonstrates the feasibility of running a stand-up comedy workshop as an intervention to support ED recovery in a pilot group. Overall, participants reported that participating in a stand-up comedy course positively contributed towards recovery, irrespective of their ED diagnosis. The course was also highly acceptable among participants who felt they did not fit the "traditional eating disorders image", including

people who were not female or suffering from anorexia. The experiences of participants map across the entire CHIME framework of PR, as is evidenced through interviews taken before, just after and three months after the course, alongside reflective diaries written during the course.

Connectedness was perhaps the most significant recovery outcome among the cohort. Participants typically experienced EDs as a particularly isolating illness, which carried lots of stigma and made it difficult to connect to others. Participating in the course created an opportunity to connect with other people living with an ED. Crucially, the course facilitated such connectedness more readily because ED recovery was not the focus of the activities. Many participants highlighted the absence of specific expectations for recovery as a useful counterpoint to traditional forms of peer support. In this respect, compared to traditional clinical/therapeutic approaches, participatory arts-based (PAB) activities can serve as "alternative therapeutic social space[s]" (Williams *et al.*, 2023, 26). The arts-based approach to the course further served to diminish the stigma around EDs and recovery (see Pavarini *et al.*, 2021, p. 4), making it easier for participants to also connect to people outside the course.

Although some participants would have preferred face-to-face meetings to further foster social connectedness, the online delivery of the workshops was not a major concern in the cohort. Those participants who did express a desire for face-to-face interaction were typically also quick to acknowledge that online delivery made the course more accessible to people across the UK and easier to fit around busy schedules (including one participant who could still join the course when she had to travel abroad for work). The online setting was therefore acceptable to this pilot cohort. These results further support previous findings of positive outcomes from integrating online approaches in interventions for ED recovery (Bronwyn *et al.*, 2021; Samara *et al.*, 2023) and evidence of comparable results to in-person services, where outcomes are often mixed as well (Gorrell *et al.*, 2022; Mahon and Seekis, 2022; The British Psychological Society and The Royal College of Psychiatrists, 2014). Furthermore, research emerging from the move to remote interventions because of the COVID-19 pandemic has noted that service user choice remains the priority in such decisions to use remote technologies (Schlief *et al.*, 2022). Online delivery is typically also more economical – in this case, eliminating further costs such as renting a space or reimbursing travel for the facilitator – which further contributes to the feasibility of the intervention.

The nurturing social dimension of C4C is not unique to stand-up comedy workshops but is a characteristic of PAB activities or other group approaches more broadly. Nevertheless, some positive outcomes were more closely tied to the uniqueness of comedy. For one, comedy is lighthearted, fun and not serious – which is not to say that comedy cannot address serious topics (such as EDs or recovery), but it typically deflates some of the "heaviness" in the process (Lefcourt, 2001). During the workshops, participants learned to make light of situations and to reframe otherwise distressing situations as something funny (see Kuiper *et al.*, 1993) – which contributed to hope and optimism as a recovery outcome. In this process, recovery became associated with the joy of stand-up comedy, which also helped to normalise EDs and recovery. Equally, the course lead's own lived experiences using comedy to support recovery provided participants with a positive role model.

Comedy also proved to be a fertile vehicle for identity work, inviting participants to tap into aspects of themselves beyond their EDs. Many participants also explained how the trial-and-error process of writing comedy, alongside the lighthearted nature of the activity, helped them to overcome issues around unhealthy perfectionism (which they experienced as intertwined with their ED) (see Stackpole *et al.*, 2023). These results confirm findings from performance-based approaches in drama therapy, which show that playful activities with improvisational qualities can challenge psychological rigidity and increase mental flexibility for people living with EDs (Wood, 2015; Wood and Schneider, 2015).

Participating in the stand-up comedy course contributed to meaning in life for participants. Feeling amusement is a positive emotional state, that helps regulate mood (Robinson and Knobloch-Westerwick, 2016). Attending the workshops and seeking out amusement as moments of respite created some distance from living with an ED for participants, which supports long-term coping (Folkman, 2008). In this respect, the way participants used engagement with comedy as an aesthetic activity to introduce distance from worries is more akin to distancing as a coping strategy than therapeutic processes of aesthetic distance in interventions such as drama therapy, which involve a process of titrating feeling and cognition to deal with emotions or expand viewpoints (Frydman *et al.*, 2022, p. 8; Wood *et al.*, 2022).

The course also contributed to empowerment by pushing participants outside of their comfort zone and thus promoting positive risk-taking (similar to performance-based approaches in drama therapy (Wood, 2015)). Sticking to the course also required commitment, which cultivated a sense of achievement and personal responsibility that carried through to other areas of life, including recovery. Some participants identified new goals and roles through the course, which became reasons to stay committed to recovery. These results offer further support for the arts in general as fertile ground for "bolt-on" post-treatment interventions that are less coercive, clinical and demanding – and frame recovery as "giving something back" rather than "taking the eating disorder away" (see Bucharová *et al.*, 2020).

Currently, only a few studies apply the constructs of PR to EDs (Dawson *et al.*, 2014; Piot *et al.*, 2020). These results provide further evidence that PR frameworks such as CHIME are highly relevant to framing ED recovery. This study also goes beyond previous studies by demonstrating that comedy interventions can have positive outcomes across the entire CHIME framework of recovery, including meaning in life (Kafle *et al.*, 2023). As per user-led definitions of recovery, the social dimension of the workshops was an important catalyst for the recovery outcomes in this study (Bohrer *et al.*, 2020; Richmond *et al.*, 2020). The agency to engage in positive social activity is salient and central to PR definitions, as this journey requires positive subjective experiences of internal transformation (e.g. hope, meaning, healing, empowerment and connection to other people) alongside positive external conditions (e.g. recovery-oriented services, positive environments of healing and human rights agenda) (Wetzler *et al.*, 2020; Andresen *et al.*, 2003; Reisner, 2005). Furthermore, some participants also reported elements of clinical recovery, such as weight gain and improvements in quality of life. Thus, these findings replicate the growing evidence that PR and clinical recovery can be mutually facilitatory (Dubreucq *et al.*, 2023). In this respect, the stand-up comedy course was designed to complement, not replace, traditional therapies and clinical approaches.

It is also important to distinguish PAB activities such as C4C from psychotherapy, even though participants experience therapeutic benefits and there is overlap between some processes in stand-up comedy workshops and drama therapy interventions (see Wood, 2015; Wood and Schneider, 2015; Wood and Mowers, 2019). For example, C4C participants engaged in "dramatic play", a process of co-created, imaginative and spontaneous improvisation – which also established a "multi-dimensional" relationship of mutual and dynamic influence between the facilitator and participants (Frydman *et al.*, 2022, p. 8). Nevertheless, the primary aim of C4C is to teach people how to perform stand-up comedy, because these skills are indirectly beneficial to recovery. By contrast, drama therapy interventions are clinical modalities that are more directly focused on therapeutic goals (Johnson and Emunah, 2021). For example, while participants in a drama-therapy-based intervention such as the Co-Active Theater Model structure a performance around a theme in their recovery, many activities in the C4C workshops are not explicitly framed around recovery or EDs (Wood and Mowers, 2019).

Accordingly, expectations about what PAB activities such as the C4C workshops can achieve need to be appropriately managed. There was one participant who felt

disappointed because the course did not "cure" her ED – and for whom participating felt like a last-ditch attempt after decades of trying other avenues. These mistaken expectations also had a destabilising impact during the workshops, as this participant occasionally shared triggering comments around food or weight and sometimes also undermined the positive experience of other participants. The course group generally managed this disruption well, and participants acknowledged the important role of the course lead in handling this situation. Clearly, additional screening prior to the course is important to ensure participants start with the right expectations. Moreover, although facilitators of PAB activities are typically not mental health professionals, courses such as C4C need to be facilitated by people who have the necessary expertise, training and/or lived experience to practice ethically, e.g. to understand and successfully navigate the nuance of behaviours and cognitions that may be triggering and risky (see Pavarini *et al.*, 2021, p. 8).

Limitations

As a pilot, there are clear limitations to this study. Most obviously, our findings cannot be generalised beyond the studied sample, as the group of participants was small and our qualitative methodology does not aim for sample representativeness. The present study therefore limits itself to findings about this specific pilot group but nonetheless justifies further research into the potential benefits of stand-up comedy as an intervention to support ED recovery for larger groups of people. Although our study recruited about three times as many participants, there were no resources to run additional workshop series. Follow-up studies with larger cohorts and, ideally, control groups are required to investigate if the results of this study can be reiterated at scale – and to quantitatively analyse the impact of participating in stand-up comedy workshops as opposed to other forms of recovery activity. It would also be interesting to compare the experiences and outcomes of participants in online vs face-to-face settings – to examine if the extra cost of resourcing the latter would be outweighed by additional benefits.

This study introduced comparisons between PAB activities such as C4C and creative arts therapies – but this topic merits further investigation. Although it is important to distinguish performance-based approaches such as drama therapy, which occur in a clinical of formal therapeutic setting, from more informal interventions such as C4C, this study signals interesting areas of overlap. In this respect, PAB practitioners and creative arts therapists stand to learn from each other's practices. At the same time, we need to develop a greater understanding of how these approaches can complement each other. For example, arts-based approaches that are not therapy may be less stigmatising for some people and thus facilitate engagement of hardly reached groups. They may also serve as an entry point to drama therapy for people who engage well with performance-based approaches and want to pursue further recovery work in a more formal therapeutic setting. Yet, unpacking the potential complementarity of PAB and CAT approaches is a much larger topic, beyond the scope of the current investigation.

The study also did not engage in market research to test whether a wider audience of people with EDs would engage with stand-up comedy as part of their recovery journeys. Media coverage and the social media network of the workshop lead were significant contributors to recruitment. To test the C4C intervention at scale, future studies would need to develop strategies to reach a wider audience. In this respect, although participants had a variety of EDs, the cohort was predominately white and female. It is clear that a more developed recruitment strategy is required to reach a more diverse audience in terms of ethnicity and gender.

Although the study demonstrated the good acceptability of the intervention up to three months after the course finished, there were no resources for additional follow-ups or to facilitate ongoing opportunities for the group to continue performing comedy together. Participants did express that they wanted individual sessions or the overall course to be

longer, which strengthens acceptability, but introduces logistical challenges. Upon completion, the course lead did send a weekly newsletter around for 12 weeks, including during the Christmas holiday period, which some participants said they appreciated. However, this type of add-on does not in itself recreate the interactivity of the course. As more iterations of the course run, it could be possible to sustain a participant-led network of alumni. In any case, the challenge of "aftercare" is important for future studies to consider.

Conclusion

Overall, this study highlights that innovative approaches such as stand-up comedy workshops can positively support PR for people with EDs. Participants reported positive outcomes across the CHIME framework of PR, which was demonstrated to be applicable to the experience of people recovering from an ED. Comedy's lightheartedness enabled participants to find some light in the darkness of recovering from an ED. Clearly, innovative and PR-oriented interventions that approach ED recovery holistically have the potential to complement clinical recovery. Such innovative approaches can provide additional options for individuals finishing treatment, not meeting clinical thresholds, or for those who have limited options in traditional treatment models, e.g. people living with binge ED. No doubt, as this is only a pilot, further testing is required – but, at the very least, this study proves that further testing is worthwhile and important.

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