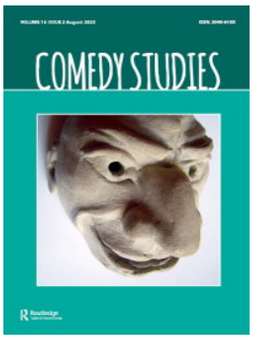

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'It's only going to work if people know what Fortisip is'. The inner workings of a stand-up comedy course for eating disorder recovery

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ABSTRACT

Comedy interventions for people experiencing mental ill health remain opaque (Kafle et al. 2023). Existing studies typically evaluate changes in mental health indicators for participants before and after, but rarely analyse what happens during a comedy intervention. These approaches fail to do justice to the complexity and diversity of different types of comedy as artistic practice and mental health intervention. In this study, we unpack the inner workings of a stand-up comedy course for eating disorder recovery. We use a multi-method qualitative design – including interviews, journals and workshop observations – to analyse how a group of participants engaged with specific comedy exercises and other workshop content. We also analyse transcripts of comedy produced in these sessions, which is required to improve understanding of the diverse mechanisms by which comedy interventions can impact mental health recovery. We conclude that the comedy course had a positive impact on participants, specifically by cultivating comic distancing and perspective shifting, sharing lived experience and re-framing comedy as a coping skill. We also demonstrate that what happens in these workshops is a culturally significant form of comedy worthy of analysis, which has previously received limited attention in humour and comedy studies.

KEYWORDS

Eating disorders; mental health; stand-up comedy; workshops; recovery

1. Introduction

Mental health has become an established part of the stand-up comedy industry. Since 2017, the Edinburgh Fringe Festival has run an award for the best stand-up comedy show about mental health in collaboration with The Mental Health Foundation (Scottish Mental Health Arts Festival Staff 2023). Susan Calman and Ruby Wax, among others, have carved out a space in the public sphere where stand-up comedians contribute to discussions around mental illness by drawing on their lived experience – in comedy performances, but also in books, podcasts, lectures, etc. (Kellaway 2023; BBC Staff 2018). Concurrently, several stand-up comedians and organisations have been offering

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workshops to promote good mental health, including The Comedy Trust (Liverpool), The Comedy School (London), Comedy on Referral (London/Bristol) and Stand Up For Mental Health (Vancouver).

This 'circuit' of stand-up comedians working with members of the public to improve wellbeing and mental health remains largely separate from academic research around comedy and mental health in university and clinical contexts. As a result, evaluations by comedians and third sector organisations remain largely outside the realm of peer-reviewed discussions, while academic studies tend to focus on evaluating mental health outcomes, rather than unpacking comedy's inner workings in relation to mental health (Kafle et al. 2023). This situation risks marginalizing comedians' contributions in this area and ignoring the specifics of different comedy interventions in debates about comedy and mental health. Moreover, to the best of our knowledge, the inner workings of a comedy workshop for mental health recovery has not previously received detailed analysis in the field of humour and comedy studies. There is previous work on comedy workshops for wellbeing in military training (Olah et al. 2022), for cultivating 'humour habits' (Ruch et al. 2018) or for supporting people in prison (Timler and Villaça 2021), but these studies have not closely analysed the comedy produced in these workshops (e.g. through analysis of workshop transcriptions).

To redress this situation, we develop a close analysis of comedy produced in a workshop course for people living with an Eating Disorder (ED), alongside an analysis of participants' engagement through reflexive interviews and journaling. The course ('Comedy for Coping') was developed and delivered by Dave Chawner, a stand-up comedian with lived experience of anorexia, who has personally experienced the benefits of comedy in recovery – which served as the impetus for our study. To overcome the mono-disciplinarity we have established in this field (Kafle et al. 2023), we have worked together as a team including a comedy scholar (DD) and mental health specialists (EK, JP and UF), alongside the industry expertise of DC. The team also includes lived experience of ED recovery.

Through this research design, we make two crucial interventions in the field. First, we improve understanding of the diverse mechanisms by which comedy interventions can impact mental health recovery, by demonstrating the importance of closely analysing comedy production in a specific workshop. In interdisciplinary and health studies contexts, such close analysis is currently lacking, but nonetheless crucial to bring more nuance and complexity to debates about whether comedy can improve mental health – and to precisely identify specific mechanisms of change (Skivington et al. 2021). We need to acknowledge that the experience of participating in one comedy workshop differs from participating in another workshop; and that these workshop experiences differ even more significantly from performing stand-up on stage or attending a gig, for example. Second, we demonstrate that the comedy produced in these workshops is culturally significant in its own right and merits greater analytical attention in humour and comedy studies. Although it is common to perform close analysis on transcripts of stand-up performances on stage (e.g. Double 2013), such analytical detail is far less commonly afforded to comedy produced in alternative 'circuits', including comedy workshops for mental health and wellbeing. We are therefore decentralising the importance of what are typically considered as

more paradigm forms of stand-up production, by focusing specifically on the context of comedy workshops for mental health and wellbeing.

2. Literature review

The idea that comedy and/or laughter can have (mental) health benefits has received considerable academic scrutiny (e.g. Gelkopf 2011; McCreaddie and Wiggins 2008). However, existing research is often less than fully conclusive (Fischer, Peifer, and Scheel 2021) and there are relatively few empirical studies which evaluate the impact of comedy interventions on mental health recovery (Kafle et al. 2023). These empirical studies often exclusively apply quantitative methods (such as rating scales before and after) that provide little detail about what happens during the interventions itself, which can range from performing stand-up (Barker and Winship, 2016) to humour therapy groups (Cai et al. 2014) and watching comedy films (Gelkopf et al. 2006). Some quantitative studies offer illustrative vignettes of participant interaction during interventions, but typically not in a sustained manner (Hirsch et al. 2010), while studies with a more robust qualitative component do not necessarily elucidate the comedy components of the intervention (Rudnick et al. 2014).

Foregoing such analysis does not only fail to identify the components of change which stand to improve mental health outcomes (Skivington et al. 2021), but also devalues the richness and complexity of comedy as an artform. There are many different forms of comedy and ways of engaging with them, ranging from watching sitcoms to sharing memes, going to a live stand-up comedy gig, seeing a stand-up special on TV or participating in a stand-up comedy workshop, etc. This complexity is not always acknowledged in health contexts. Here, the conflation between comedy and laughter interventions is particularly instructive. There is growing evidence that laughter yoga and related approaches, which aim to get people laughing without humour, can stimulate health benefits (van der Wal and Kok 2019). Although comedy and laughter approaches are clearly distinct, popular health advice often groups their benefits together (Sunshine Behavioural Health Staff n.d; Mayo Clinic Staff 2023). For example, Mayo Clinic promotes advice such as: 'Laugh at least once a day. You cannot overdose' – and invites us to 'read online joke websites', '[l]isten to your favorite comedian' or '[f]rame photos of you and your family or friends having fun', etc. (Graff-Radford 2019). These types of claims about the impact of comedy on (mental) health, which are not fully grounded in research that sufficiently acknowledges comedy's diversity and the diverse ways people engage with comedy, are common – including in the context of discussions (in the media and even UK Parliament) about comedy and social prescribing in the UK (Craic Health Staff 2025a; 2025b; Jackson 2025).

Such reduction of comedy to an impulse for laughter or smiling overlooks the richness in artistic variation across different media, genres, and traditions. Similarly, when studies do not unpack the inner workings of comedy interventions for mental health, they risk perpetuating a simplistic and reductionist understanding of comedy and do not provide a robust understanding of the mechanisms by which comedy interventions really impact mental health. Therefore, we need empirical studies which acknowledge the multifaceted nature of comedy (Kafle et al. 2023). Our focus here is on a specific stand-up comedy workshop course developed and delivered by DC,

rooted in his artistic practice as a stand-up comic and lived experience of ED recovery (details below). Stand-up comedy, more broadly, has certain qualities which are relevant to recovery, understood as a process of developing competences to mitigate and manage living with symptoms of illness (Leamy et al. 2011). We cannot strive for exhaustiveness here, so we limit ourselves to some key affordances of stand-up to recovery processes.

First, since Lenny Bruce, Mort Sahl and other comedians working post-World War II, stand-up has established itself as an artform which licenses autobiographical and authentic expression (Double 2013, 160-162). Stand-up can therefore serve as a vehicle for people who want to explore personal experiences and identity in relation to others. In particular, stand-up affords to navigate an appropriate distance from traumatic personal experiences to process and come to terms with what happened (Double 2017). Second, stand-up is a genre which affords the interaction between critical reflection and playfulness – as evident, for example, in traditions such as British Alternative Comedy (Double 2013). This type of interaction between the solace of entertainment and the agency of critique, evident especially in satirical stand-up, has mental health affordances in negotiating problems of living in an imperfect world (Declercq 2021). Third, stand-up, as a live and communal experience, depends on the interaction between a performer and audience in a 'room' (Quirk 2011). Material is shaped through the interaction in this room (and might land differently from one room to the other), meaning that stand-up creates a sense of visceral connection between those who are experiencing it.

3. Methodology

3.1. Aims

This study sets out to analyse how a group of 10 participants engaged with a six-week, online stand-up comedy course ('Comedy for Coping') for people in recovery from an eating disorder. Comedy for Coping (C4C) was created, developed, and delivered by a stand-up comedian with lived experience of anorexia (DC). In a previous analysis, we evaluated the feasibility of running this course to support Eating Disorders (ED) recovery and concluded that participant experiences map onto personal recovery processes (Declercq et al., 2024). The present analysis zooms in on specific workshop activities and focuses on participant performances to improve understanding of specific mechanisms by which this comedy intervention had an impact on the recovery journey of participants. This unpacking of the course's inner workings is necessary to move beyond generalist platitudes about how comedy can improve mental health. Moreover, we also consider the 'ephemeral' comedy produced in this type of workshop, which is not accessible beyond the experience of the people who were there, as a culturally significant form of comedy which merits close analysis in its own right.

3.2. Workshops

The C4C workshops were developed by DC, an award-winning stand-up comedian who has been part of the UK comedy circuit for over a decade. The workshops are rooted in techniques from DC's practice and lived experiences of recovery from

anorexia. During the one-hour weekly sessions, participants learned about stand-up comedy theory, watched comedy clips, and engaged in practical exercises to develop material for a short set. Sometimes, the facilitator made explicit connections to mental health, for example by showing participants clips of comedians who draw on lived experiences of mental ill health, like Felicity Ward, or by engaging with ideas from psychological theory. Nevertheless, although C4C is aimed at people in recovery of an ED, the workshops often did not focus on mental health. Instead, the activities were primarily structured around learning how to perform stand-up comedy as an end in itself. Therefore, the various weeks were orientated around distinct aspects of stand-up practice, including stage presence, attitude, joke writing, set writing and performing. Across the weeks, participants engaged in various exercises and activities to develop material that could fill a short set. They tested and refined this material by performing jokes and bits in front of each other as part of comedy exercises and games. In the last week, participants could perform a final short set in front of each other, although doing so was not mandatory. This approach differs from some other comedy courses around mental health (see SBS Staff 2012). While one workshop approach is not necessarily better than another, it is important for scholarship in this area to acknowledge the specificity of different workshops and mechanisms that might impact mental health. In this respect, C4C did not train participants to start careers in comedy and primarily aimed to teach transferable skills, rooted in stand-up practice, which participants could then implement in their recovery journeys. That said, at the time of the follow-up interviews three months after the course finished, one participant had just secured their first paid stand-up gig.

3.3. Participants

For this study, we recruited English-speaking participants living in the UK who self-reported experience of an ED, were over 18 years old and were currently not attending inpatient or day patient treatment (i.e. people in recovery rather than in crisis). Ethical approval was granted by the Central Research Ethics Advisory Group at the University of Kent (CREAG070-07-2021). Participants were recruited using purposive sampling *via* (social) media promotion. 48 individuals expressed interest in participating and filled in a brief survey, at which point recruitment was stopped (funding had only been sought to run and evaluate one workshop). Ten participants ($n = 10$) were anonymously selected for participation based on availability and diversity in terms of gender, age, ethnicity, ED diagnosis, and geographical location. Participants were between 25 and 46 years old. Nine participants identified as White and one participant as British Asian. There were 8 female and 2 male participants (one participant was a trans man, all other participants identified as cisgender). Ages ranged from 25 to 46 (median age: 29). Six participants attended all six workshops, while two people missed the final two sessions (for reasons of internet connectivity issues, COVID-19, childcare and work events) and two others dropped out after three sessions (for health and work-related reasons respectively). These results present a relatively high rate of engagement in light of established challenges in ED programmes and research (see Muir et al. 2017).

3.4. Data collection and analysis

With the written consent of participants, we recorded the workshops for focused ethnographic observation. DD, EK and JP observed the workshops and made field notes, which were discussed at team meetings, after which DD performed initial inductive coding on the workshop transcripts. Through subsequent coding, distinct workshop sequences were identified for fine-grained analysis of key themes (Knoblauch and Tuma 2011). This analysis followed an annotation practice for stand-up comedy developed by Oliver Double (2013) which signals salient information about the performance (such as gestures, laughs, pauses, etc.) between parentheses. Alongside analysis of the workshops, JP and UFconducted semi-structured interviews before the course to establish participants' expectations, followed by interviews directly after and three months after completion of the course, to evaluate ongoing impact. In-between sessions, participants also wrote down subjective experiences in weekly reflective journals.

There was a degree of attrition in engagement with the data collection components: 9 participants attended a pre-course interview, 6 attended a post-course interview, 4 attended an interview 3 months after the course was finished and 4 people submitted reflective journals. Attrition is an established issue in longitudinal research (Menard 2002, 34-49). In the context of this research, attrition in the interview study needs to be distinguished from the relatively high rate of engagement with the workshops themselves (see above). As a qualitative study, our findings also do not strive for generalisability across a larger population, but rather aim to capture the rich and detailed experiences of participants to elucidate how comedy may impact ED recovery for some people in certain contexts. Attrition in our interview study therefore meant a smaller group of participants shared their experiences after three months, as opposed to upon completion of the course and before starting the course. For the sake of transparency, participant pseudonyms and interview stage are clearly identified in the analysis below. EK and JP conducted inductive double coding of verbatim interview transcripts and journals for thematic analysis under supervision of DD and UF. Our Analysis presents how the most significant themes which arose in the interviews and journals link to specific workshop exercises and content.

4. Analysis

Five key themes arose across the interviews, journals, and observations, i.e. comic distancing; comic perspective shifting; (un)funny mental illness and EDs; shared experiences; and re-assessing comedy as coping skill.

4.1. Comic distancing

Several participants explained how participating in C4C offered a break from ED recovery and day-to-day stresses. In this respect, although the workshops were explicitly aimed at people in recovery from an ED, participants joined because they were interested in learning about the practice of stand-up comedy – and many components of the workshops did not explicitly focus on EDs, mental ill health or recovery. As

such, joining a stand-up comedy course functioned to create distance from living with an ED for several participants. One participant characterised the course as 'a space where you can have a laugh, and always feel better at the end' – and added that 'it was nice having that downtime, when I can let go of everything and not take life as seriously as I tend to do' (Participant 8, post-course interview). Somebody else explained, 'I've had really hard days in other aspects of recovery. And it has been almost a nice relief when I've had it in the evening' (Participant 2, post-course interview). Another participant valued that the course 'wasn't so heavily focused on the eating disorder element of it (…) [So] I'm dedicating this time to something else I enjoy' (Participant 6, post-course interview). Likewise, a final participant shared, 'I just had a really nice time. Like I just felt really happy for that hour' (Participant 1, post-course interview).

These comments tap into stand-up comedy's status as entertainment which distances itself from the serious business and toils of life, e.g. work, bills, illness, etc. (see Dyer 1992). Of course, although stand-up has a long history of addressing social issues, it is nonetheless an artistic practice that people primarily engage with for amusement and enjoyment. Such engagement with entertainment media is also an established resource for wellbeing and mood regulation, i.e. a way of distancing from everyday concerns and stresses (Robinson and Knobloch-Westerwick 2016). Distancing is therefore not a unique affordance to stand-up comedy (workshops) and could be achieved by other entertainment media and activity. Nevertheless, it was an affordance which clearly mattered to participants, who valued the distancing afforded by participating in the workshops. Moreover, participants engaged in a particular kind of comic distancing in the workshops which is linked to specific mechanisms that are unique to stand-up comedy (workshops) and not afforded by other entertainment media and activities.

A relevant example of a workshop activity which afforded comic distancing from ED recovery is a variation on the 'Find the Link' exercise, which Double lists among a group of common exercises for teaching stand-up comedy (2013, 462). As one participant recalls, '[o]ne of us (me) was asked to choose an animal, and someone else a job title, and then we all had 60 s[econds] to come up with as many crossovers between the two as we could think of' (Participant 1, reflective diary, week 4). This type of activity set the participants an engrossing challenge that creates the conditions for 'flow', a state of experience where people are absorbed in a task that matches their skill set and is therefore intrinsically rewarding (Csikszentmihályi 1990). The moment the facilitator introduced this activity in the workshop, several participants started writing down notes. The virtual room continued to fill with a collective sense of silent concentration for just over a minute, until the facilitator invited the first joke.

> Facilitator: Did anybody get any similarities between unicorns and police officers? (Responding fast to someone raising a hand) Oh! Participant 2. Love it.
>
> Participant 2: I might give away my politics slightly (some participants smile) – a moral one doesn't exist. (The facilitator laughs loudly and claps, other participants smile and laugh)

Facilitator: (Continues laughing) That's great!! (Laughs) Great! I love that. I love that. Anyone else? (Someone raises hand) Participant 1, yeah, great.

Participant 1: Um – they both have silly things on their heads. (Facilitator jubilantly throws hands in the air, participants smile)

Participant 5: (Fast) I had that!

Facilitator: That is *amazing*! I love – I love that! (Someone raises hand) Participant 10?

Participant 10: (Deadpan) I think unicorns and the police are exactly as good as preventing crime in dangerous areas.

Facilitator: (Laughs, participants smile) This is great. Anybody else? Anyone else got any?

Participant 6: I put – they – they're both well versed in self-defence. (Laughs and gestures in self-doubt, participants laugh and smile)

'Find the Link' exercises are designed as a mechanism to generate jokes which can then be integrated in a stand-up comedy set, by setting a task to draw unexpected and funny connections. Evidently, in this section of the workshop, participants' jokes do not address mental ill health. Some participants draw on broader parts of their identity to make jokes, such as political persuasion; others experiment with observational, deadpan or absurdist styles of comedy. In this respect, this exercise contributes to the cultivation of comic distancing that participants identified in post-course interviews as a fun and engrossing activity which orientates attention away from the everyday stresses of living with an ED.

The 'Find the Link' exercise is clearly generative for participants, which is not only an inherent affordance of its underlying mechanism, but also strengthened by the mediating role of the facilitator, whose contagious enthusiasm is crucial to sustaining the energy and connection between participants in the virtual room to keep the exercise going. A few more quick jokes follow, before the facilitator and a participant try to work through a variant for a longer joke, which gets some final big laughs. Intriguingly, participants rarely laughed out loud during the activity – apart from the facilitator, who offered steady positive reinforcement to the group. Hence, the mechanism which drives the comic distancing that participants identify in the post-course interviews cannot be reduced to indiscriminate stimuli for (belly) laughs. Rather, the 'Find the Link' exercise stimulates a kind of affective-cognitive engagement centred around playful concentration, which affords comic distancing. On a cognitive level, concentrating on an enjoyably challenging task stimulates engrossment and manages arousal levels, i.e. participants do not feel anxious, bored or overwhelmed (Csikszentmihályi 1990; Robinson and Knobloch-Westerwick 2016). Further, the positive emotions experienced by participants not only help to establish distance from stressors in the moment, but also serve as an emotionally restorative break, which recharges overall coping resources for dealing with future stressors (Folkman 2008).

Overall, participant feedback identifies stand-up comedy exercises like 'Find the Link' as a resource to create distance from daily struggles, including living with an ED. For many participants, there are no readymade solutions for ED recovery, which means using comedy exercises as a form of 'distancing' can be an adaptive coping mechanism (Folkman and Moskowitz 2000, 752). That said, not all forms of distancing

are adaptative, including escapism into substance abuse (Folkman and Moskowitz 2000, 752) or avoidance, especially avoidance of affect, which is a known risk among people living with an ED (Lampard et al. 2011). However, given that participants committed to pursuing a stand-up comedy course with other people living with an ED, which was framed around recovery and addressed mental ill health and EDs directly at some points (see below), the C4C workshops created a balanced environment where distancing was cultivated as an adaptive affordance of comedy.

Moreover, distancing is not the only affordance of the workshops or comedy exercises like 'Find the Link'. By working through such exercises, participants developed an understanding of the procedure of trial-and-error that underpins stand-up comedy. Sets (and parts of sets) tend to be crafted in an ongoing process of revision. New jokes do not always immediately land, and the facilitators' guidance in making sure participants are aware of this trail-and-error nature of stand-up comedy, creates an environment in the workshops where it is ok to try and fail. One participant explained that, when playing such games, 'it just felt okay to try something. And it felt like it didn't matter whether or not it was good enough because that wasn't really relevant' (Participant 1, post-course interview). These casual stand-up comedy games offered participants an opportunity to distance themselves from perfectionist rigidity, a personality trait which can be a risk factor for the development of EDs and contribute to their maintenance (Stackpole et al. 2023). In this respect, somebody else shared that C4C helped him 'get outside of that [rigid routine] (…) slowly but surely just changing behaviours, changing the way you do stuff' (Participant 6, post-course interview). Another participant valued the opportunity to 'let go of some of the perfectionism (…) you can do things and it doesn't have to be brilliant' – which, moving forward beyond the course, she took as an invitation 'to try and schedule that play' (Participant 2, post-course interview).

Indeed, the distancing offered by playful comedy games did not limit itself to just the workshops but became a transferable coping skill for some participants. One participant explained that 'I wasn't writing this stuff down (…) for any other reason than to at least, in the moment, to craft it into something that was funny. It didn't feel like I was doing something for its therapy' (Participant 6, post-course interview). He then added that 'one of my main coping strategies anyway, has been like distractions. (…). And I guess this is another thing I can do, sit down with a scrap of paper, and write [jokes]' (Participant 6, post-course interview). Crucially, although they were not explicitly framed as such, activities like 'Find the Link' had a clear psychoeducational dimension, as some participants identified these as a potential form of 'pleasant activity scheduling'. Identifying and applying such strategies is common in Behavioural Activation (BA), a set of techniques often (but not exclusively) used within a broader cognitive-behavioural therapy (CBT) framework – for example to treat depression/low mood (which commonly co-occurs with EDs).

Nevertheless, there is an important difference between these activities and traditional forms of BA, i.e. it was because these activities were pursued as an end in themselves – to craft funny jokes – that they became meaningful rather than laboured as psychoeducational and coping tools. In this respect, one participant contrasted their experience to traditional recovery activities, explaining that 'if you have therapy, and they say, oh, make a list of distracting things you could do. It wasn't like that'

(Participant 7, 3-months interview). Here, the experiential dimension of C4C workshops distinguish themselves from typical therapy sessions, which often involve identifying activities to boost and regulate mood, but do no put these into practice during the sessions (rather, the expectation is for people to pursue these outside the therapy room).

4.2. Comic perspective shifting

Another coping strategy which participants developed on the course, alongside restorative enjoyment, was the skill to comically shift perspectives on situations (see Kuiper, Martin, and Olinger 1993) – again, often through activities which did not address mental ill health directly. This skill of perspective shifting is closely linked to the mechanism of incongruity which many agree is crucial to the production and perception of humour, i.e. 'a deviation from some presupposed norm' or 'an anomaly (…) relative to some framework governing the ways in which we think the world is or should be' (Carroll 2014, 17). In other words, finding something funny depends on grasping something incongruous, where the incongruity is 'neither threatening nor anxiety producing nor annoying but [something] which can, on the contrary, be enjoyed' (2014, 34). This fundamental mechanism of humour production and perception can be harnessed as a skill to support recovery. One participant explained, 'I really learned how flexible you can be in your thinking' through 'the little games that we did (…) like the first day where we had to do the terrible inventions thing and explain why actually it was really, really good' (Participant 1, post-course interview). Similar to 'Find the Link', 'Terrible Inventions' gets participants to think on their feet and find unexpected connections, this time by explaining why a given terrible invention is the best idea in the world. It is an exercise grounded in the facilitators' own practice to generate new material for sets. In the context of the workshop, it was the first game played by the participants and served an important role in setting up a nurturing context.

At the start, the facilitator introduced the game as 'the opposite of Dragon's Den' and a means to 'create an accepting and nurturing kind of positive environment'. This framing serves to put participants at ease, so they do not worry about making perfect jokes or failing to be funny (see above) – which the facilitator makes explicit by stating '[n]o one is going to judge you on this call'. Moreover, this framing at the beginning of the course, which focuses on learning about stand-up comedy techniques in a nurturing environment, prompts participants to make connections between the stand-up comedy game and their recovery journeys, without belabouring the psychoeducational dimension of the activity. Participants are trusted to draw their own connections to recovery, as the activity focuses on a fast-paced succession of terrible inventions in need of redemption.

> Facilitator: So – pyjamas for squirrels. Why would that be an amazing invention? (some participants smile)
>
> Participant 9: Pyjamas for squirrels – well. (Collects thoughts) If anyone has a dog then they'll know how *desperate* they need to get those squirrels. (Speeds up, facilitator laughs, participant smile) Now if you've got pyjamas on your squirrel, they are going to confuse the dog and you won't have such a barking attitude – at your window. (Facilitator

continues laughing, participants smile and nod.) Secondly, they eat a lot of nuts and I don't know if anyone here has ever eaten too many nuts but your… shit comes out a different colour. So, you do need some different coloured pyjamas – probably shit-coloured ones (Laughs briefly, facilitator claps and laughs, participants smile and laugh)

The participant's absurdist and blue response to the prompt, greeted by the facilitator's warm encouragement, sets the tone that 'everything goes'. The fact that the joke is clearly not very polished also relieves the pressure for the other participants.

Participant 9: Anyway guys, that's not a hard act to follow. You can all do better than that. (laughs)

Facilitator: Exceptional. Participant 5, I'm gonna pick you next. So I'm going to say square wheels for bikes. Why is that good invention? (Someone chuckles)

Participant 5: Square wheels for bikes? Um – so that they can iron out all the bumps in the roads. I mean, it's simple. (Some participants smile and nod)

Facilitator: (Gestures for emphasis) I – I love your approach that kind of bish-bash-bosh there we go, potholes, done day. I think that's brilliant, I love that–

Participant 5: (Interrupts) because – they glide. (Facilitator nods) Whereas if you have – if you have circles (motions circle) they just (motions wave) – undulate.

Facilitator: I also love as well that that's a – that's a typical [Placename redacted] thing to say. Because the roads around here are – terrible. (laughs)

Participant 5: Yes.

Participants think on their feet to make new connections and associations, which they are often keen to follow up and add to the joke. The activity is self-generative, spurred on by the continuous positive reinforcement of the facilitator.

Facilitator: Great stuff. Participant 8, you're up next. Erm, transparent toilet doors? (Someone smiles)

Participant 8: (Speaks but no sound is heard)

Facilitator: Oh, I think you just – you need to take yourself off mute mate. Sorry about that. (Silence continues) Oh, I think we're still on mute. Sorry, mate. (Pause continues, facilitator laughs)

Participant 8: (Suddenly comes in) Oh for god's sake (Facilitator claps and laughs) Oow!

Someone: I was about to say, I could lip read that bit. (Everyone laughs and smiles)

Participant 8: I said that (stutters) – because they're see-through there won't be any queues. (Facilitator gestures in recognition) And so and so you'll be able to see if someone's in there. And – and people will be quicker because they won't have their privacy. It'll just speed up the public toilet system, you know?

While the focus is on finding some new-found sense in nonsense, participants also riff of unexpected contextual mishaps (which often get the biggest laughs). Again, dealing with unexpected circumstances has a clear psychoeducational dimension, but it is up to participants to draw that connection themselves, as the focus remains on generating comedy in response to prompts – with some very well-crafted results.

Facilitator: Brilliant, participant 4, you're next on. I'm gonna go for, erm, waterproof bath bombs – waterproof bath bombs.

Participant 4: Oh Jesus (pauses, facilitator and participants laugh) – waterproof bath bombs? Do they still – dissolve?

Facilitator: No – don't dissolve.

Participant 4: (Instantly) So it's a rock.

Facilitator: Yeah (suddenly gets the joke, laughs loud and claps, other participants laugh and smile) – yeah, yeah.

Participant 4: Basically, when you like go on a spa treatment – go on one of those hot rock treatments (Participants smile).

Facilitator: Yeah, I – that that is actually exceptional, because that's one of the techniques that we're gonna, erm – look at later on. But you just made that brilliantly funny by just reducing it instantly.

This great joke gives way to an educational moment which does not focus on mental health outcomes, but rather on signalling a particular comic technique (reduction). As such, the facilitator reinforces the focus of the activity on learning about comic mechanisms which can help develop a stand-up comedy set. The game quickly continues and draws to a conclusion after about eight minutes, as participants explore new connections and callbacks to previous jokes.

Facilitator: So that was great. Erm, Participant 7, Crocs.

Participant 7: (Surprised) Crocs? Crocs are – (participants smile)

Facilitator: They're just a terrible invention.

Participant 7: (Enthusiastic) They're the best thing ever. You can share them with your partner. They don't get like stuff on them. If your squirrel poos on them, then you can just stick them in the dishwasher. They're amazing. (Participants smile)

Participant 9: If you have squirrel pyjamas you wouldn't – you wouldn't need –

Participant 7: (Interrupts) You wouldn't need – you wouldn't need Crocs if you had squirrel pyjamas (Participants smile, facilitator laughs).

The callback to an earlier joke is indicative of the generative environment, as participants respond to each other's new and unexpected perspectives.

Although the facilitator did not belabour this point during stand-up exercises such as 'Terrible Inventions' or association webs (a type of spider diagram participants used to generate jokes during another exercise), several participants experienced these as an indirect form of psychoeducation, i.e. not just an amusing activity in the moment, but something which trains transferable coping skills. Similar to comic distancing (see above), there are parallels here with Behavioural Activation and CBT techniques, such as reframing unhelpful thoughts (see Beck 2020, 23). One participant explained that 'when things do go to shit, I have started saying to myself, that there's gotta be some stand up material in this somewhere' (Participant 2, three-months interview). Another person explained that the course has 'given me

some real skills in terms of kind of thinking about things in a different way. (…) I did all these like word association pages and I felt like in there, somewhere in there (…) like my life is funny and things happen that are funny' (Participant 7, post-course interview). Participants also applied this technique of comic reframing to their own mental health, as one participant stated that '[m]ental illness is such a difficult, complex, and highly individual subject, the nuances of which can often be misinterpreted, misunderstood, or lost altogether. And that, I am learning, is precisely what makes it such a great topic to write comedy on' (Participant 1, reflective journal, week 3). Another participant shared, '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 somebody else, exercises like association webs demonstrated 'how I could, you know, make quite a dark subject matter lighter (…) [and] made the effect of them feel less [negative]' (Participant 6, post-course interview).

One association web exercise invited participants to explore 'things a therapist would never say'. As opposed to 'Find the Link' or 'Terrible Inventions', this activity addressed mental health more directly, which is why the facilitator invited participants 'to avoid anything that's going to be triggering or offensive to other people' – continually reinforcing a safe environment. This framing created an environment to 'joke around' the topic of mental ill health (a distinction grounded in the facilitator's own practice), rather than making jokes at the expense of mental illness.

> Facilitator: So, has anyone got anything that they found funny, they found silly that they want to share that a therapist might never say? (Someone raises hand) Participant 10, is that you?
>
> Participant 10: Yeah (scoffs) – actually, I just decreased my hourly rates (Facilitator and participants laugh)
>
> Facilitator: Great. I absolutely love that. Anybody else got any, erm – anything?
>
> Participant 8: Erm yeah – erm mine might take a bit of explaining, which might mean it's not funny. (Participants smile) But therapists tend to – if you say you're trans, they blame everything on you being trans. So, if you're five minutes late, it's like – it's because you're trans. You were sad about your boobs, so you didn't want to get up. (Facilitator laughs and claps, participants laugh) Erm (stutters) – so I've got that: maybe that problem isn't related to you being trans in *any* way at all. (Facilitator and participants laugh)
>
> Facilitator: I – I love that! Genuinely, there is so much on that Participant 8. I think that is brilliant. Participant 5, what were you going to say?
>
> Participant 5: I was going to say – I *understand* (Facilitator laughs, participants smile). If I were you, I would (three short nods) – do this. I promise you that if you stick and commit to my sessions, you will get better. It is possible to overcome your issues. And then we'll be back on the [Participant 8] point of view. I'm Jewish – and everything is associated with your Jewish mother. It has to be! Because of course your mum and the Jewish guilt. '*Now, vat am I going to do?*' (Facilitator laughs) I mean my mum's now 72, and she still blames herself.

The facilitator then follows up with a joke himself, before handing it back to the floor.

> Facilitator: Participant 4, yeah?
>
> Participant 4: Listen to the voices. (Everyone laughs) Erm – wow, you're by far the craziest person I've ever met (laughter and smiles) Don't be silly. It's all in your head. (laugher and smiles continue) And it's *absolutely not* because you're a vegan. (overall laughs)

This exercise, which continued for around six minutes in total, features complex and layered performances. Participants took the prompt as an opportunity to reframe their lived experience of mental ill health, but also to express important parts of their identity, including gender, ethnicity and dietary philosophy. In this regard, post-war stand-up comedy in Anglo-American culture is an established vehicle for autobiographic self-expression (Double 2013, 160-162), which also gives performers permission to play around with truth (Double 2013, 148-149). As participants joked around things a therapist would never say, it was often not clear how much creative freedom they took in turning elements of lived experience into crafted jokes. This ambiguity created a space for participants to introduce otherwise stigmatized parts of their identity or lived experience, which creates connections between participants and is crucial to successful recovery (Leamy et al. 2011). The performances also had a clear satirical component as participants 'talked back' to therapists, who hold a position of power in their recovery processes, by critiquing reductive understandings of their mental health problems (see Hooks 1986). In this way, participants use satirical comedy to shift the understanding of agency and power dynamics in their own recovery process (see Demjén 2016). This satirical component is further proof of the variation and differentiation of comedy uses and the fact that the affordances of comedy for mental health cannot be reduced to physiobiological responses like the affective dimension of laughing.

4.3. (Un)funny mental illness and EDs

As discussed, and perhaps surprisingly for a course designed for people living with an ED, many of the activities in the C4C workshops did not directly address mental ill health. General mental health challenges would nonetheless sometimes come up, especially during check-in moments at the start of weekly sessions. To welcome participants into the session, the facilitator would typically ask people to frame their week in metaphorical terms like colour or weather, which created a space for people to share struggles with mood, stress or anxiety. Still, struggles with EDs were rarely discussed and jokes about the subject were also rare – even if the facilitator did not explicitly identify EDs as off-limits for comedy, apart from setting up an environment from the start in week 1 which avoided triggering behaviours ('I want to avoid anything, any numbers [e.g. weight or measurements], anything that you might consider triggering, and I think anything that might glorify, encourage or promote disordered behaviour'). When participants did make jokes about EDs, it was clear that some jokes were implicitly acceptable to the group, and some were not. These distinctions were clearly at play during an exercise where participants made jokes which implied they

were living with a mental illness, without explicitly saying so. The direct invitation to participants to draw on their lived experience did pose some challenges to engagement.

> Participant 8: I actually found that one really difficult – erm, and I'm not sure why but (stutters) – and the only half decent one, erm, I came up with is that my pharmacists know me (facilitator laughs) without me having to tell me their name (sic) (participants laugh and smile).
>
> Facilitator: (laughs) That's a great one, that's really weird because I actually had – I actually had down here: I know what sertraline[1] is (participants nod and smile).
>
> Participant 8: Yeah (nods) – related. Yeah, I couldn't, I found that really difficult and I don't know why.
>
> Facilitator: It is, I mean, it is really difficult. Does – has anyone else got any other examples? Any – (Someone raises hand) yes, Participant 4.
>
> Participant 4: I said: when I walk into a room all the sharp objects disappear. (Facilitator and participants expel laughs and cup their mouths)
>
> Facilitator: (Continues laughing loudly) Fucking hell that's great. (Laughs, participant 4 smiles) Brilliant.

As opposed to the activity where participants made fun of things a therapist would never say, this invitation to joke around their own mental ill health was more challenging – both technically (as in, harder to craft) and emotionally. Although Participant 8 is unable to articulate why he finds the exercise difficult, it reasonable to infer that the associated emotional struggles make it less straightforward to joke around living with a mental illness. Yet, this tension is undercut by the directness of Participant 4's transgressive joke, which helps to create a license for other participants to make light of this taboo topic and turn traumatic experiences into comedy (see Double 2017, 152-153).

> Participant 5: (Raises hand, sings) All the things she said, all the things she said (facilitator laughs, participants laugh and smile) running through her head, running through her head. Sorry about my voice.[2] (participants smile)
>
> Dave: (Laughs) That's great. Anybody else? (Waits, participant unmutes)
>
> Participant 7: I've got: Are you asking me? Or ask – or are you asking the other me? (Facilitator laughs, participants laugh and smile)
>
> Facilitator: *Love* that. Anybody else? I realise it's really difficult.
>
> Participant 1: I've got one, but it's only going to work if people know what Fortisip[3] is.
>
> Facilitator: Yes! (Participants nod and give thumbs up)
>
> Participant 5: Yes.
>
> Participant 1: Right. Okay, so (laughs) – for reasons that I am not going to go into, last night (laughs) – I accidentally got – quite a lot of Fortisip in my hair (laughs, facilitator laughs, participants laugh and smile). Instead of worrying about that, I thought, well – today is not hair wash day, but it's fine, because that stuff has got so many vitamins in (facilitator laughs and claps, participants laugh and smile), that if nothing else, I'll have really, really shiny hair (laughter and smiles continue).

Participant 5: Oh bless.

As the activity continues, participants show considerable vulnerability in sharing personal experiences related to mental ill health, including living with an ED. In the process, they bond over shared lived experiences like internal ED voices and dietary management drinks and this shared lived experience is a pre-requisite to 'get the joke'. Nevertheless, the sensitivity of the topic remains palpable.

Facilitator: (Continues laughing) love that, I genuinely love that. Participant 10, have you got any?

Participant 10: No (pauses, facilitator nods understandingly) – I couldn't really think of anything funny for this (facilitator nods vigorously). It was just kind of sad. (Facilitator smiles, gestures some awkwardness) So yeah.

The facilitator then continues to acknowledge the difficulty of the exercise before delving deeper into the genesis of the activity, which involves a funny back and forth around sweatiness as a side-effect to anti-depressants. When the activity draws to a close, Participant 10 is nonetheless eager to share a joke after all.

Facilitator: Right on that note, because I realize we've got to draw this close –

Participant 10: (Raises hand and interrupts) Wait, wait, wait, wait, wait –

Facilitator: Yes.

Participant 10: (Pauses) So this is, this is just very honest (nervous laugh). So (pauses) – I pre-emptively eat my feelings before they fully become feelings – like those birds that kick out the eggs from other birds' nests to lay their own monster eggs there that then eat the other eggs (Facilitator laughs loudly, participants laugh and smile).

Participant 10's interjection to share a joke before the end of the activity signals her emotional journey from dejected resistance to enthusiastic participation. It shows how joking around mental illness can help create a supportive environment where people feel comfortable to share despite initial resistance. In general, comedy can be a useful resource to address stigma around (mental) ill health, for example through stand-up comedians who authentically disclose lived experience of mental illness (Corrigan et al. 2014) – as the facilitator of C4C demonstrates himself in this course and in shows like *Normally Abnormal* and *Mental*. Nevertheless, as with comedy's coping affordances, nuance is important. While comedians with lived experience can help to confront stigmatizing stereotypes, stand-up comedy has historically sometimes perpetuated stigma by 'punching down' at the stereotypical Other, i.e. make fun of people who hold less power than the comedian or who are somehow 'subaltern' (Timler and Villaça 2021). Historically, this tension plays out, for example, in the development of Alternative Comedy in the UK during the 1980s, which reacted against mainstream comedy at the time, where racist and sexist jokes were rife (Double 2020).

In this respect, joking about mental illness and especially EDs was not always successful on the course. In the post-interviews, some people mentioned examples of other participants 'trying to make jokes around eating disorders that were just totally inappropriate. And I was like, okay, now that is how you don't do this' (Participant 2, post-course interview). Others similarly mentioned occasions they 'found a bit triggering, and difficult to listen to' (Participant 1, post-course interview),

including topics like 'somebody else's exercise routine' (Participant 7, three-months interview). Such triggering remarks could arise unexpectedly during otherwise innocuous stand-up games. For example, when participants were playing around with 'corny' jokes, one participant made a joke about EDs which the group clearly found unacceptable.

> Facilitator: (Laughing) I just love these bad jokes: What's blue and sticky?
>
> Participant 8: I don't know. What's blue and sticky?
>
> Facilitator: (Shakes head and smiles) A blue stick… (participants laugh loud and smile) That's the, that's the – and you keep can keep it going (laughs) – aah, it's brilliant, love it so much. Erm, so we're gonna go next to erm, Participant 5, tell us your rubbish joke.
>
> Participant 5: I'm not sure whether I'm going to get away with this because it's like, er, very, very close to home. Erm, how do you know if someone has an eating disorder? (One participant buries forehead in his hand) Toss it – toss them an onion ring and see if they eat it or use it as a hula hoop (the same participant mouths 'ooh', others grin and laugh incredulously)
>
> Facilitator: (laughs nervously) Righ-right. Again (participant 5 laughs nervously), that's like, yeah, that's, that is, that is – *that*. Erm great, Participant 6, great, participant 6.
>
> Participant 5: (Interjects) Sorry!
>
> Participant 6: Uhm – (laughs nervously) something a bit lighter. How do you make Christmas pasta? With an advent colander (participants laugh and moan about how corny the joke is).

The reactions of the facilitator and other participants, although restrained to avoid confrontation, clearly signalled disapproval of Participant 5's joke, which came at the expense of people living with an ED. For one, this joke transgressed the group contract established at the beginning of the workshop series, and reiterated throughout by the facilitator, that these sessions are not a space for sharing perspectives that promote maladaptive ED behaviours, such as mentioning weights, BMI or measurements, calories, tip sharing or exercise routines. Clearly, making jokes about EDs is not by definition beneficial to recovery. Here, the distinction between adaptive and maladaptive humour styles is useful (Martin et al., 2003). While self-deprecating humour can de-stigmatize a topic like mental ill health by giving others permission to laugh along, self-defeatist humour involves excessive self-disparagement (Kuiper and Martin 2016, 505). Joking about using an onion ring as a hoola hoop indeed transgresses from self-deprecation to self-defeatism, which further helps to explain the group's negative reaction. In a later session, the facilitator further mediated the parameters of acceptability by introducing the established stand-up distinction between 'punching up' and 'punching down' – i.e. only ridicule targets who have power (see Bhargava and Chilana 2022) and do not perpetuate the marginalization of social groups by 'mocking the weak', especially around intersections of gender, sexuality, ethnicity, religion, class and disability (see Davies and Ilott 2018).

These theoretical perspectives stimulated critical reflection for participants. In post-course interviews, one participant acknowledged that she 'really appreciated the punching up punching down thing' (Participant 7, post-course interview), while another

'realised, yeah, I do that to myself. And I don't have to' (Participant 1, three-month interview). In the post-course interview, Participant 5 similarly demonstrated awareness of her transgression, explaining that 'I poked fun at myself with my eating disorder and the sort of behaviours around it, [but] I don't really think anybody alluded to that really' (Participant 5, post-course interview). She also re-assessed some initial misconceptions about the course, explaining that 'I suppose I went in thinking: Oh, my God, I'm going to be able to use comedy to poke fun at myself, and therefore I feel instantly better and be able to sort this awful thing out once and for all, of course, that's not the case' (Participant 5, post-course interview). In this respect, it is important for facilitators of comedy interventions to appropriately manage the opportunity for participants to re-assess maladaptive humour uses without losing face, but also without disrupting the group dynamic. Here, preparation is crucial, and the facilitator planned strategies to deal with these types of situations, drawing on experience and in dialogue with the research team, which combined expertise at the intersection of ED scholarship, ED recovery practices in the NHS and lived experience.

4.4. Shared experiences

Taken together, the analyses in the previous section also highlight the social dimension of the C4C workshops, i.e. participants shared their comic performances with each other in a supportive and warm environment, which was held by the facilitator, who played a crucial role in providing ongoing feedback and encouragement. We have seen that participants did not necessarily always laugh out loud in response to each other's jokes and small performances. In part, this may well have been a result of the digital 'room' (see Quirk 2011), i.e. the workshops took place online, over Zoom, which does not have the same affordances for sharing laughter as a physical space (especially given that participants were often muted so that background noise would not interfere or interrupt someone else). Nonetheless, during games like 'Find the Link', there was a clear sense of mutual support and receptivity in the Zoom room though smiles and nods. Some participants picked up on this supportive social dimension in their final reflections. One person explained, 'I spent 6 w[ee]k[s] on a Wednesday for an hour being sociable and taking myself away from my thoughts' (Participant 5, reflective journal, week 6). Somebody else said, 'I actually also wanted to escape a little bit from the hideousness that was my week. I thought, I know if I join, someone will make me laugh, and that has to be better than this' (Participant 7, post-course interview).

Crucially, although many of the activities did not explicitly focus on ED recovery, the fact that everyone in the group (including the facilitator) had lived experience with EDs was very important to the social dimension of the shared experience. Several participants highlighted the importance of 'be[ing] in the company sometimes with other people who have eating disorders' (Participant 7, post-course interview), 'being in a space with other people with eating disorders' (Participant 8, three-months interview) and 'being with people who had the same weird thought processes as me' (participant 5, reflective diary, week 3). Participants also identified the facilitator as a role model, and highlighted the importance of '[h]aving it delivered by somebody who openly will say that they've been there is and is no longer in that place' (Participant 2, post-course interview) and the fact that '[the course lead] has done it

[the recovery journey], so I can do it too' (Participant 6, post-course interview). So while the exercises and activities in the C4C workshops are not inherently orientated around EDs and ED recovery – and could, in principle, easily be adapted for people living with other mental health conditions – the shared lived experience of the participants and facilitator was crucial. In this respect, C4C worked, only because everyone knew what Fortisip is.

It is also worthwhile to highlight that the shared experience of participants of the C4C workshops differs from the typical experience of stand-up comedians, i.e. C4C was a stand-up comedy *workshop,* not a gig. In other words, participants were primarily each other's audience and they were all in the same boat trying to make each other laugh, which differs from an audience-performer dynamic. Nevertheless, participants did still feel that the stakes were high to make each other laugh. As Participant 6 put it, 'I'm confident in talking to people and talking publicly (…), but as soon as you introduce having to say something funny into the mix, it gets a bit different' (post-course interview). Similarly, Participant 2 shared that 'I don't think I've ever really had the confidence to kind of stand up and be like, I'm going to try and make people laugh deliberately' (post-course interview). As a result, several participants reported that the workshops boosted their confidence. Participant 1 explained, '[the workshops] also did help me build confidence, because like I said, there were lots of little games that involved switching perspectives and switching viewpoints, like when you were put on the spot quite a lot' (Participant 1, post-course). Similarly, Participant 7 shared, I look back on how I operated at work in terms of my confidence, like it's worlds apart, I feel so much more comfortable with who I am' (Participant 7, 3-months interview). Interestingly, participants reported such boosts in confidence without having physically performed on stage in front of people outside of the workshop group. As a space, participating in a comedy workshop offers different affordances to performing on stage, including the opportunity to bond over shared taste in comedy and comedians (which was how the facilitator asked participants to introduce themselves at the start of the workshop, i.e. share your favourite comedian or comedy character) or learning about comedy theory (see below).

4.5. Reassessing comedy as coping resource

Finally, participating in C4C gave participants an opportunity to reassess their engagement with comedy as a coping resource. In the pre-course interviews, several participants signalled that they were already drawing on comedy as a coping device. One participant said, 'I deflect with humour. (…) and that's kind of how I got through my inpatient admissions actually, (…) I just used to try and make everyone laugh' (Participant 2, pre-course interview). Someone else similarly shared, 'when I was in hospital, a lot of the people around me were like you crack me up, you're really funny, and you make a joke of everything' (Participant 1, pre-course interview). Another person also reported that 'my best friend always said, the whole time through it [hospitalization] I continuously laughed' (Participant 4, pre-course interview). Nevertheless, before the course, participants also expressed uneasiness about using comedy as a coping mechanism. One participant admitted 'I've got quite a dark sense of humour. And I'm quite well known for it, like, within my friend circle (…) I can

take it a bit far sometimes' (Participant 3, pre-course interview). Someone else similarly shared, 'I have one of those weird dark senses of humour, where I would make jokes about things where people will be like, is she actually saying that?' (Participant 4, pre-course interview). Others said that 'a lot of it [how I use comedy] is sort of self-deprecating' (Participant 1, pre-course interview) or 'I laugh at everything. My therapist says I shouldn't but…' (Participant 7, pre-course interview).

After the course, several participants explained they had now reassessed the value of comedy as a coping resource. One participant shared, 'I was always quite good at finding funny in dark places in the past, but now I feel like that's kind of acceptable as well' (Participant 7, three-months interview). Somebody else similarly explained that 'it's probably always been presumed that using comedy to talk about some of these sorts of things [mental ill health] is probably an unhealthy strategy (…), whereas I've always felt the benefit of doing it (…) So, I guess the course has sort of helped me to affirm that, actually, there is a place for comedy' (Participant 6, post course interview). In other words, C4C helped to lend legitimacy to using comedy as coping resource. No doubt, the framing of the course as part of an academic study around ED recovery, with psychologists specialising in EDs on the team, contributed to this process of legitimization.

At the same time, the course also took comedy serious as an artform, including introducing theoretical perspectives on stand-up comedy which DC found relevant to his practice, e.g. punching up vs. punching down, joking around vs. joking about (see above). One of the affordances of these theoretical perspectives is that they help participants to make fine-grained distinctions between adaptative and maladaptive forms of coping. As one participant put it,

> my hope was that I would be able to use humour in a more positive way, in recovery, but also in my own life in general, and not just as a way to detract from everything and pretend I'm fine (…). And I think I did manage that […] [a]nd realise that you don't just have to use humour as another stick to beat yourself (Participant 1, post-course interview).

This comment is underpinned by a critical understanding of the multifaceted nature of comedy and the diverse ways people can use comic strategies in their own lives. It sums up how C4C's focus on learning to perform stand-up comedy in its own right has an important psychoeducational function by getting participants to reflect on engagement with humour in everyday life.

5. Conclusion

Through detailed analysis of comedy exercises alongside an interview study, we have identified specific mechanisms that supported ED recovery for participants in our cohort. Components that were particularly helpful for participants included distancing themselves from worries through an enjoyable activity, learning how to shift their perspective on situations, learning about comedy, sharing performances with others who have similar lived experience and taking comedy serious as an adaptive coping resource. In terms of evaluating comedy as a resource for ED recovery, it is important to acknowledge that this study has a small and relatively homogeneous group of participants in terms of ethnicity and gender. Follow-up studies with larger and more diverse cohorts are

necessary to test if the results of this study can be reiterated at scale – ideally alongside control groups, which would enable meaningful quantitative analysis and comparison to other types of intervention (Skivington et al. 2021). There are also clear grounds for follow-up studies around different areas of mental ill health, as beyond the shared experiences of the facilitator and participants (which were crucial), the comedy activities and mechanisms were on the whole not specifically tied to EDs. This study further demonstrates that unpacking the content and exercises that participants engaged with on the course is necessary to provide the level of detailed analysis required to meaningfully evaluate whether comedy can improve mental health. Clearly, the activities on C4C cannot be reduced to a stimulus for laughter, as participants often responded to the tasks with smiles or concentration, rather than belly laughs. This study also identified how specific activities such as 'Find the Link' or association webs support cognitive reframing. Finally, not all joking around mental ill health is equally helpful, and the group clearly distinguished between adaptive and maladaptive humour uses. To be truly meaningful, future investigations in interdisciplinary and health contexts about how comedy can improve mental health need to take the artform seriously and incorporate a similar level of analytical detail. We have also demonstrated that analysing the comedy produced in workshops like C4C is a culturally significant form of comedy worthy of analysis in its own right – and we invite other scholars in working humour and comedy studies to increase work in this area.

Notes

1. Type of antidepressant.
2. Many people with anorexia experience an internal 'voice' (Pugh and Waller 2017).
3. Brand of nutritional supplement.

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