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The Therapeutic Use of Humor in the Treatment of Eating Disorders; or, There Is Life Even with Fat Thighs

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"What is *real*?" asked the Rabbit one day, when they were lying side by side near the nursery fender, before Nana came to tidy the room. "Does it mean having things that buzz inside you and a stick-out handle?"

"Real isn't how you are made," said the Skin Horse. "It's a thing that happens to you. When a child loves you for a long, long time, not just to play with, but *really* loves you, then you become Real."

"Does it hurt?" asked the Rabbit.

"Sometimes," said the Skin Horse, for he was always truthful. "When you are Real you don't mind being hurt."

"Does it happen all at once, like being wound up," he asked, "or bit by bit?"

"It doesn't happen all at once," said the Skin Horse. "You become. It takes a long time. That's why it doesn't often happen to people

who break easily or have sharp edges or who have to be carefully kept. Generally, by the time you are Real, most of your hair has been loved off, and your eyes drop out, and you get loose in the joints and very shabby. But these things don't matter at all, because once you are Real you can't be ugly, except to people who don't understand."

"I suppose *you* are Real?" said the Rabbit. And then he wished he had not said it, for he thought the Skin Horse might be sensitive. But the Skin Horse only smiled.

"The Boy's Uncle made me Real," he said. "That was a great many years ago; but once you are Real you can't become unreal again. It lasts for always."

Margery Williams's wonderful, poignant, and ever timely Velveteen Rabbit about the rabbit in search of himself and his role in life could be the perfect paradigm for sufferers of anorexia nervosa, as well as sufferers of bulimia. These are people with "sharp edges" who "break easily," who feel ugly and unwanted. But most of all they feel misunderstood and unloved. They are reluctant to become real, for they fear that the world around them will see them as unattractive and unworthy of love. They therefore bury their needs and longings under the obsessive/compulsive mantle of an eating disorder and retreat into an unreal world made up of calories, numbers on a scale, and portion sizes, shutting out a world they perceive as threatening and dangerous. This is a world that has made them feel worthwhile only if they look a certain way, act a certain way, or behave in a certain way, a world that generally finds them acceptable only if they are "unreal."

In my work with eating disordered clients, I have seen that some of the key issues for a successful therapeutic relationship are empathic listening, an understanding of the person behind the disorder, a sound theoretical base, an ability to make the client feel understood, and, just as important, a good sense of humor. Psychotherapy, by its very nature, is characterized by an intense joint effort by therapist and client to delve into and comprehend the needs, feelings, fantasies, realities, and fears of the client. This intense relationship requires many tools on the therapist's part: Humor is probably one of the most potent in the therapist's arsenal (Rosenheim and Gabriel 1986).

Amy, an extremely bright, accomplished seventeen-year-old student, had been in therapy with me for almost a year and a half. She was at the top of her class academically, was one of the best athletes in her high school, and had just been accepted to one of the best colleges in the country. She had been suffering from anorexia since the age of fourteen, and, although she had made progress in her weight gain and had developed insight into the genesis of the disorder, she was still struggling with self-esteem. Each newly acquired pound detracted from her self-image. She had enormously high expectations for herself and was rigid about her performance, berating herself mercilessly if she did not reach her self-imposed goals and punishing herself physically by starving, stating repeatedly, "If I can't be the best at whatever I set myself to do, I'll at least be perfect in my diet. I'll keep my thin thighs and be the best runner on my team." Cognitive and psychodynamic interventions addressing these distortions in her thinking had little or no effect.

At one particular appointment, she came in and happily showed me a watch she had acquired over the weekend. The queen of hearts made up the face of the watch, and she was particularly pleased to have found it because she already owned watches with the king and the jack. As she talked she complained that as excited as she was to have found it, she was troubled because it did not keep time accurately:

AMY: It bothers me that it runs slow. Of the three face cards, this was the one I wanted the most.

THERAPIST: Do you know why the queen runs slow?

By now Amy was used to my bantering and joking in our sessions. She was a very serious youngster, who nevertheless appreciated my humor and storytelling and had loosened up enough to tell humorous stories herself from time to time. She had stated at one point in the therapy that she felt I had helped her because I was "real," as opposed to other adults in her life who talked down to her, patronized her, acted "fake." Amy herself felt "fake." Most of her adolescent life had been spent creating a persona that pleased other people, and she was thoroughly and sincerely perplexed as to who the "real Amy" was. Therefore, when I asked her about the watch's timekeeping abilities, a slow smile of anticipation spread across her face.

AMY: Tell me, why does the queen run slow?

THERAPIST: It's probably because underneath all those heavy skirts, she has fat thighs. But isn't it amazing, Amy? She's *still the queen*!

Amy burst into laughter. My absurd comment showed her, with more clarity than any previous interpretation, that her obsessive striving for the "perfect/thin body" that would exemplify her "success" in life had stopped her from becoming a "real" person. She understood my message, that a person might not reach a particular goal and could still like herself (regardless of body shape) or that a person might find a way to reach the pinnacle without incurring the "sharp edges" of an emaciated body.

In the literature, many authors, belonging to different schools of therapy, have apparently recognized the potential for humor in psychotherapy. Among its major benefits are alleviating anxiety and tension; overcoming exaggerated seriousness; creating an atmosphere of closeness and equality; providing an acceptable outlet (by the client) for feelings of hostility and anger; fostering the capacity for self-observation; enabling emotional catharsis (Rosenheim 1977); promoting intimacy, humanness, and a more informal working alliance; and, of course, providing a wonderful and safe means of communication. In the case of eating disordered clients, we can add to the therapist's resources the use of levity, which shows we are not afraid to poke fun at ourselves, as well as at clients' own myths and distortions. We also offer a role model to aid in loosening some of their rigid control and perfectionism (Roncoli 1974). The joke, pun, anecdote, or appropriate story can be a teaching instrument of unique efficacy (Rosten 1968).

A prerequisite for the use of levity in therapy is the therapist's comfort with humor. My predilection is for puns and word play, and on numerous occasions I have used these with some success.

Lisa

Lisa had been referred to me with a diagnosis of bulimarexia. She was twenty-seven years old, the oldest of three children, and essentially the family's caretaker. Her mother was a severely depressed woman with a history of multiple psychiatric hospitalizations, and her father

was an emotionally distant man who had been an alcoholic for most of Lisa's life. Lisa cared for her siblings, tended to her mother, and enabled her father to continue functioning by assuming most of the family's responsibilities. She was the proverbial good girl—always there for everyone, feeling totally empty as far as any personal satisfaction was concerned but convinced that she did not deserve any more than what she had. She had begun a serious diet at age twenty-two in an effort to find something that would give her a sense of control and a measure of satisfaction. The diet had rapidly progressed to starvation alternating with episodes of bingeing and purging. She felt proud and "good" on the days she starved but never failed to berate herself for the binge/purge episodes, which she perceived as one more indication of her global worthlessness and failure.

Lisa was a secondary school teacher and an avid reader and lover of music but was extraordinarily serious and devoid of a sense of humor. She could talk about her life in intellectual terms but was unable to tap into any of her feelings. Any attempt to make an interpretation addressing her feelings elicited a stony look and a denial followed by silence. It was obvious that allowing herself to feel was a mine field she was not ready to cross.

She had been seeing me for almost six months when she started a particular session by telling me a dream she had had the night before. Lisa was quite concrete and had let me know in many ways that she preferred to talk about her starving, exercising, and binge/purge episodes rather than any possible reasons why she might be engaging in the behavior. I was therefore quite surprised when she began telling me about a dream that had so disturbed her that she remembered it clearly upon awakening: She had felt (in the dream) a terrible itching on her scalp that was "driving her crazy." When she went to scratch herself, she found to her horror and disgust that her head was full of crawling lice. "It was horrible," she continued, "no matter how much I scratched, the lice were still there."

"I guess your dream is telling you that you have been feeling pretty lousy," was my immediate retort.

Her mouth opened in surprise at my statement, and a smile spread slowly across her face. It was the first genuine response I had seen, and it was followed shortly by the first tears she had ever shed in the course of her treatment with me.

The pun, which targeted her repressed feelings and addressed with immediacy and poignancy how unhappy she was, had had more impact than any other interpretation up to this point. It had been a nonthreatening response to her distress, and with the smile and the tears she told me that she was ready to alter her narrow perceptions of her symptom. I felt, for the first time since she started seeing me, that she had really connected to me and was ready to trust me. No small feat for a person who had learned to distrust, and with good reason, most people in her life.

According to Driscoll (1978), the use of appropriate humor is one way to make material more acceptable. Humor can break the tension when things get too serious, and the amusement and enjoyment are a welcome alternative to the uneasiness or pain patients too often experience. In a lighter atmosphere, patients may come to see their concerns as more tolerable, and the toughest material can be better managed. Laughter can go a long way toward easing anguish. By accepting or even enjoying the material in the sessions, patients begin to accept themselves better and begin to improve their outlook on life. Patients who laugh in their sessions tend to reveal information more readily, making our job of assessment easier and speeding the therapeutic process. From the first session, be it individual or group, I attempt to put the patient at ease by acknowledging her difficulty in being there and having to share her difficulties and unhappiness with a stranger. If appropriate, I will use humorous banter to make patients feel more at ease and to make the experience less formal, less threatening. At times, of course, humor is totally inappropriate: If a person is severely depressed or has experienced a loss or tragedy in her life, forced humor would not only be absurd, it would certainly backfire.

Humor, like many other process-oriented interventions in treatment, should be used in an appropriate and balanced way. As mentioned above, humor is a wonderful tool that necessitates not only a therapist who is comfortable with its uses but also a person who is aware of its parameters and risks. Many authors have questioned the wisdom of using humor in the context of psychotherapy, warning about its possible pitfalls. In 1905 Freud wrote that humor "has in it a liberating element . . . it is something fine and elevating . . . what is fine about it is the triumph of narcissism, the ego's victorious

assertion of its own vulnerability" (Freud [1905] 1926). But he also spoke to the possibility that humor was a reflection of underlying anxiety, bitterness, or unspoken hostility (Freud [1905] 1960). Many other authors have questioned the use of humor in therapy. Greenson (1977) pointed out that patients can cover hostility and anger with humor and sarcasm. Paul (1978) agrees that a patient's humor or teasing is often disguised hostility, and Kubie (1971) is adamant in stating that a therapist's use of humor might stem from aggressive, hostile feelings toward the patient. He adds that, for a beginning therapist, using humor could divert the patient's stream of feeling and thought from spontaneous channels, act as a defense against the therapist's anxieties, lead to doubt about the therapist's seriousness, and distort transference phenomena.

If humor or jokes are excessively or inappropriately used, the patient may begin to doubt if he or she is being taken seriously. Both patient and therapist may, if not watched carefully, resort to the use of humor to avoid dealing with difficult, conflicted, or painful areas and thereby inhibit the therapeutic process (Haig 1986).

However, when the therapist is comfortable with his or her ability to use humor appropriately, when the same sensitivity that we expect a therapist to exhibit in other areas of the treatment process is applied to the use of humor, it can indeed be an invaluable tool, especially when working with an adolescent population.

My adolescent/young adult group has been meeting regularly and faithfully for about nine months. With the exception of one person who left because she had to be hospitalized, the membership has been steady. The girls seem to like one another; some have developed a support network outside the group; and most of them are able to relate to one another in the here and now. The group was cohesive and functioning well—but it was much too serious! My occasional attempts at puns and humor (i.e., "I guess you can't have your cake and eat it, too"; "That statement really gives us food for thought"; "Tell us again about swallowing your anger or being starved for attention") were met with smiles or a polite chuckle at best—until the time Karen, an outgoing, verbal sixteen year old who had been flirting with several forms of bulimia, told the group about the previous night's experience. She related that her mother, on the pretext of "helping her straighten out her closet," had found several

of the empty or near-empty boxes of laxatives Karen had been using on and off for several weeks.

"Wow! You should have seen her!" she said. "If you guys thought she used to get angry at me before, that was nothing! This time the shit really hit the fan!"

The laughter that ensued, spontaneous and honest, was a catalyst for the group and the group process. Karen's unplanned joke/pun helped her understand, probably better than a "formal/serious" interpretation, the tremendously hostile components of her bulimic behavior.

In conclusion, humor can be a powerful and important tool in psychotherapy if used appropriately and with sensitivity. Adolescents especially have trouble participating in the therapeutic process if they perceive the therapist as patronizing and "fake." Humorous interventions and banter are a way of lessening their discomfort and making them feel they are being treated as equals.

Humor is, of course, inexorably linked to the therapist's personality and to his or her degree of comfort with its usage; but when used by a skilled practitioner, it can help patients gain an objective view of their behavior, point out the self-damaging effects of black-and-white thinking, debunk some of their myths and distortions, and, most of all, cement the therapeutic alliance.

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