Participating in mental health interventions on television: a multi perspective analysis

Hannah Jane Selby

A thesis submitted in partial fulfilment of the requirements of University of Brighton, for the award of Doctor of Philosophy

November 2022

Abstract

This study is a multi-perspective investigation of the challenges and rewards of making and appearing in UK factual television series featuring mental health interventions. These interventions could be onscreen therapy sessions or activities such as singing in a choir, exercise, or support decluttering. These kinds of programmes attract large audiences and generate ethical debate across multimedia platforms, however very little is known about their impact on the television contributors (central on-screen participants) involved, or the production practices behind them. This research integrates theoretical frameworks from psychology, media, and cultural studies to analyse 24 interviews with ex-television contributors, programme makers, therapeutic professionals, and on-screen intervention providers involved in making 'mental health intervention television'. This inter-disciplinary approach and specifically, the application of narrative psychology theory, has not been undertaken in previous research.

The thesis argues that the impact of taking part in mental health intervention television goes beyond whether television contributors believe the interventions to be successful and is intimately linked to their feelings towards, and feedback from, telling their stories on television. Television contributors presented the experience of telling their story as a quest narrative - a challenging but ultimately transformative journey. They depicted themselves as actively seeking to shape their television narratives and with it discourse about mental health. Their perceptions of successfully telling their stories and control were a central part of their evaluation of the experience and outcomes of taking part. The analysis identified the importance of having a receptive audience, feeling heard and having their stories validated.

In addition, the research found that producers and therapists presented a strong commitment to contributor welfare, revolving around collaborative storytelling, and informed consent. However, the analysis identified a fundamental tension between balancing an agenda to produce entertaining television series and meeting the needs of contributors. There were many factors that limited the agency of contributors over their personal stories, from production practices and televisual conventions to cultural discourses and unpredictable audience reception. This thesis makes a key contribution to debate around the ethical treatment of participants within British television shows

involving mental health, by reflecting the actual concerns and experiences of the contributors and professionals involved in their making. It provides new evidence of what makes participation successful, and the challenges in establishing principles of good practice when working with contributors experiencing mental distress.

Table of contents

Acknowledgements

This PhD would not have been possible without the consistent support of my three supervisors Dr Matthew Adams, Dr Aristea Fotopoulou and Dr Zoe Boden-Stuart. Their breadth of knowledge and constructive guidance has been invaluable. They have also been a pleasure to work with - calm, pragmatic and compassionate throughout. This PhD was funded by the ESRC South Coast Doctoral Training Partnership. I would like to thank both the lovely DTP team based at Southampton and the University of Brighton doctoral college team for their friendly assistance, practical guidance and fantastic training opportunities. I am forever grateful to all the participants in my study who gave up their time to be interviewed and make this research a reality. Finally, thank you to Mark Selby for encouraging me to take this project on and see it through to the end. I could not have done it without your support and excellent Word formatting skills.

Publications associated with this research

Selby, H. (2020). Continuity and Change in British Public Service Television's Engagement with Mental Health. *VIEW Journal of European Television History and Culture*, *9*(18). https://doi.org/10.18146/view.226

Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Hannah Selby

29th November 2022

A note on terminology

I am using the term *contributors* to refer to members of the public who have featured on television programmes. This is the term that is used within television production and I have chosen to use it instead of *participants* in order to differentiate between when I am talking about research or interview *participants* more generally and specifically television *contributors*. The exception is where I am referring to someone else's words or research where a different term is employed.

Chapter 1: Introduction

This PhD research project investigates the experiences of television contributors (central on-screen participants), programme makers, and therapeutic professionals, who are involved in the making of British factual television series featuring mental health interventions. This introduction presents the case for making this type of mental health programming the focus of specific investigation, providing a brief outline of the issues at stake. It briefly highlights the gaps in current academic understanding and the benefits of an interdisciplinary research approach. Finally, it clarifies the terminology used to discuss mental distress, before setting out the thesis structure.

1.1 Setting the scene

Programmes tackling the topic of mental health are relatively common on British television screens; from soap operas to documentaries, news reports and special seasons, the topic of mental health is not a taboo subject matter for television. UK channels, and in particular public service broadcasters, have had a long commitment to educating the public about mental health, however there have been considerable changes in the way mental health issues are featured in factual television production, reflecting, and arguably in some cases influencing, changes in mental health policy, broadcast culture and cultural understandings of mental distress.

The subject of this thesis is a relatively contemporary development within mental health programming which I am labelling as 'mental health intervention television'. Whilst these series under investigation vary considerably in format, style and therapeutic approach, their essential shared core, which is the central focus of this research, is that they involve members of the public (i.e. non celebrities[1]) taking part in 'made for television' interventions. The type of intervention could be explicitly therapeutic such as cognitive behaviour therapy, or it could be other activities like exercise, singing or specialist house clearance. There have been series of this kind addressing a range of mental health problems including obsessive compulsive disorder (*Extreme OCD Camp,*

[1] There has also been a spate of programmes where celebrities go on their own mental health journeys of discovery and sometimes therapy such as *Nadiya, Anxiety and Me* (BBC1, 2019) and *Freddie Flintoff, Living with Bulimia* (BBC 1, 2020).

BBC3, 2013), phobias (*Vertigo,* BBC 1*,* 2014), dementia (*The Restaurant That Makes Mistakes*, Channel 4, 2019) and hoarding (*Hoarders Homes*, Channel 5, 2020).

What makes these programmes distinct from earlier factual offerings is that they all go beyond documenting the subject of mental distress to actively intervening in the lives of members of the public (i.e. the central television contributors) with a presented aim of making a positive difference to their mental health and wellbeing. In this sense these programmes go further than the remit of documentaries and current affairs and share stylistic conventions with other genres - such as a constructed element that is synonymous with reality TV[2] and a narrative of expert intervention and transformation that is an essential ingredient of lifestyle and makeover shows (Lewis, 2009).

The following casting call out on twitter for a recent series on Channel 5 captures three important elements that make up the hybrid nature and appeal of these series:

> Could you help other people by sharing your hoarding story and get your home back at the same time? Crackit Productions is making a sensitive documentary for Channel 5 Call … in strictest confidence #hoarding #hoardernextdoor (Declutter Divas, 2019)

This request for contributors uses three different lines of approach to enhance its appeal. Firstly, it positions itself within the tradition of "sensitive documentary" film-making, thereby drawing on cultural constructions of documentary as a serious and truthful endeavour, in contrast to discourses around popular factual formats such as reality TV as low brow and sensationalist (Corner, 2002; Dovey, 2000; Kilborn, 2003). Secondly, it conveys a sense of civic duty, appealing to potential contributors that "sharing your hoarding story" is an altruistic act, which accords high moral status to this type of media participation (Ytreberg & Thorbjørnsrud, 2020, p. 6183). Thirdly, the implication is that taking part is an opportunity to deal with their difficulties and move forward. The important subtext is that there is some support on offer to help them achieve this. For me, this is the crux of why these series warrant in-depth academic research and should be the focus of greater critical scrutiny. Contributors within MHITV are offered the opportunity for support and guidance, but to access this help they must

[2] Reality TV is an ambiguous term used to refer to a wide range of popular factual programming from competitive staged realities such as Big Brother, to dating programmes and docu-soaps (Murray & Ouellette, 2009).

share their therapeutic 'intervention' with the viewing public. The possibility that vulnerable people may agree to take part in a television series because they see it as a way of accessing support is the first of several significant ethical questions raised by the premise of MHITV.

Another ethical issue revolves around the quality and validity of 'interventions' that can be provided within the context of a television programme. Often these series claim to make significant therapeutic breakthroughs, in rapid timeframes. However, they can cause controversy within the professional psychology and self-help communities in both their handling of vulnerable contributors and the simplification of how mental health difficulties and therapeutic treatments are presented to the audience (Wild, 2006). The restrictions of a one-hour broadcast and the production incentive to tell a clear, engaging narrative, necessitates the condensing and simplification of the contributors' full views and experience. There is also a lack of long term follow up that could establish whether any improvements in wellbeing are sustained once the cameras and attention have gone away, and contributors have gone back to their un-filmed lives. This leaves unanswered questions about the quality, meaning and longevity of any changes witnessed in these programmes.

If contributors do perceive positive outcomes from taking part in some of these series, another uncertainty is how these changes are being achieved. It is unclear how any therapeutic intervention provided for contributors is altered through the experience of having it filmed and documented for an audience. The idea that the documentary filmmaker (or television crew in this case) is merely an observer, documenting some truth of its subjects has long since been dismantled and re-examined (Nichols, 1991; Winston, 1995). When a production team turns up to film, they automatically change something for the people involved by the nature of their presence – whether it is due to the relationships formed, the experience of being filmed, the awareness of the imagined audience, or the outcomes of appearing on national television. This raises interesting questions about the interaction between these 'television factors' and the more formal therapeutic factors that make up any intervention.

Essentially, mental health intervention television attracts large audience figures and generates wide reaching debate across multimedia platforms. However, very little is

known about its impact on the contributors involved, or the unseen production processes, and the work of the therapeutic professionals involved in its making. Given recent controversy over the care and mental health of reality TV participants following several deaths of ex-television participants, there is even greater incentive to understand more about the production processes within MHITV and the long-term effects on the wellbeing of the people involved. In addition, although there are reasons to be concerned, if these series are achieving positive outcomes for the people involved, it is valuable to understand the factors underpinning successful interventions. Either way, there may be lessons to be learned that could be relevant to other contexts of therapeutic practice.

There is limited research looking specifically at this sub-genre of British television shows. Academic interest in television participation has primarily been led by theoretical debate from within media and cultural studies. A key focus has been the cultural, social and political implications of the increased representation of the 'ordinary person' on television (Bonner, 2003; Couldry, 2003; Turner, 2013). However, what is often crucially missing from debate are the first-hand accounts of contributors. In particular, the psychological impact for television contributors experiencing mental distress who take part in television has been mainly overlooked within academia.

On another axis, recent research on occupational distress within the production environment has highlighted the significant ethical and emotional pressures that crew members can experience when filming with vulnerable television contributors (Rees, 2019; Wilkes et al., 2020). In addition, psychological professional bodies have raised questions about the ways in which psychological support may be used or abused within the context of providing a duty of care for television contributors (BPS, 2019). However, research from the field of psychology has historically prioritized television audiences over contributors. One relevant area of audience research is televisions' role in reproducing attitudes towards mental health (Bates et al., 2020; Kimmerle & Cress, 2013; Miller et al., 2015; Whitley & Wang, 2017) and its possibilities as a tool for mental health education (King et al., 2018; McTernan et al., 2020; Turner et al., 2014).

This interdisciplinary research project responds to the gap in current knowledge and understanding of contributor experiences. It integrates theoretical frameworks from

psychology, media, and cultural studies, to analyse in-depth interviews with ex-television contributors, producers, on-screen intervention providers, and psychologists providing behind the scenes support. The goal is to better understand how contributors perceive the experience of taking part in mental health intervention television and explore the repercussions of their involvement for their lives and wellbeing. In addition, interviews with the producers and therapists involved in the making of these shows build a multi-perspective model of the processes and relationships within a production that can shape contributor experience.

A specific strength of this research is that it is interdisciplinary, drawing on narrative psychological theory to examine the experience and dynamics of the production of mental health intervention television, an approach that has not been undertaken in previous television production research. The thesis makes a key contribution to the debate around the ethical treatment of contributors within British television shows involving mental health, by reflecting the actual concerns and experiences of the contributors themselves, an area that is greatly under researched. It provides evidence of what makes participation successful, and what the challenges may be with a view to establishing good practice when working with participants with mental health problems. In addition, this research provides a unique lens to consider psychosocial factors that influence the success of the therapeutic outcomes for participants involved, with wider relevance to other mental health initiatives and contexts.

My own interest in this kind of programme making stems from personal experience. Before undertaking this research, I spent more than thirteen years working in factual television production on a range of psycho-social and health related subject matter. Many of the series that I have been a part of have involved television contributors taking part in different kinds of 'made for television' interventions aimed at helping them with some area of their life including parenting, bereavement, and health issues. I have substantial first-hand experience of the responsibilities and sensitivities of supporting contributors through a sometimes challenging production process, and then managing their expectations of the finished programme and the experience of being on television.

From my experience, I believe that when a production team works thoughtfully and collaboratively with contributors it can be a rewarding experience for them with positive

outcomes that to my mind seem to exceed the remit of the actual interventions. However there are also times when I have felt uncomfortable about what is being asked of a contributor, or conscious that they have not fully grasped the possible implications of being on television. Likewise, the amount of time I and other crew members have stayed in touch with contributors has varied significantly from project to project. As a consequence, I have often wondered about the longer term outcomes and impact of being on television. It was this niggling question about what happens to contributors once the cameras have gone away and the excitement has died down, combined with a long term interest in mental health that led me to seek funding for this project.

1.2 Defining mental health

Understandings and definitions of mental health are not static but intrinsically culturally, politically and historically situated (Porter, 2002). Likewise, the language used to discuss mental health (mad, lunatic, mental illness, distress) reflects different and often contested ideological frameworks across time, place and people (Cromby et al., 2013). The past three centuries have seen the consolidation of the dominance of a biomedical paradigm in Western societies which draws a parallel between physical disease and mental disease (Deacon, 2013). In this sense mental distress is understood as disease or illness of the brain or mind, with some biological basis, which can be diagnosed and treated appropriately by qualified medical professionals. The influence of this paradigm is reflected in the language used to describe mental distress which draws on medical terminology, for example: *mental illness, disorder, and diagnosis*.

Despite its continued dominance, the biomedical model has been heavily criticised as reductionist, deterministic and lacking in scientific evidence (Moncrieff, 2008; Rapley et al., 2011; Read & Dillon, 2013). The validity and utility of diagnostic categories of disorder has been questioned by service users (also a contested label) and mental health practitioners alike with many arguing that due to the stigma associated they do more harm than good (Ben-Zeev et al., 2010; Crisp et al., 2000; Schomerus et al., 2012). Research has led to greater understanding of how relational factors such as trauma and abuse, or social factors such as poverty and discrimination may be just as important to understand the basis of some forms of mental distress (Read & Dillon, 2013) .

A full discussion of the debate around conceptualisations of mental health is beyond the scope of this thesis, however it is important to recognise that language matters. Given the lack of consensus on terminology, I am avoiding using terms such as 'mental illness' or diagnostic categories, unless reflecting the words and positions of my research participants or specific academic or cultural references. Instead I am using the phrases 'mental health', 'mental health problems' or 'mental distress'. The latter term avoids restrictive medical associations, however it is less in common usage. The term 'mental health problem' is widely used and understood and has less contentious conceptual connotations than 'mental illness' (Cromby et al., 2013).

1.3 Thesis structure

Chapter Two: defining mental health intervention television

Given that there is not a clearly discernible genre of mental health intervention television, chapter two conceptualises the defining features of MHITV and where it fits within the televisual landscape. I provide a brief overview of where and how mental health has featured historically on British television. This sets the groundwork for the emergence of mental health intervention television. I then describe the narrative conventions of MHITV and discuss different ways of conceptualising these series in relation to other genres such as lifestyle and reality TV. I argue that these series share a set of common characteristics that justify researching them as a phenomenon.

Chapter Three: participating in television

Academic research focused specifically on the contributors of mental health interventions on UK television is virtually non-existent. Therefore, chapter three will draw on research on other related factual programme formats – in particular, lifestyle and reality TV genres, with which it shares many narrative features. Firstly, it will summarise critical perspectives on the representation of ordinary people on television. Secondly, this chapter will review research that directly involves television contributors and documentary participants. This literature will be broken down into key themes that I have identified from the research: motivations, power, and consequences of participation. It will explore how these issues are applicable to the contributors of mental health intervention television and where gaps in the research remain.

Chapter Four – making television with members of the public

This chapter will set out the regulatory framework which governs the way duty of care to contributors is provided within the UK television industry. This includes a reflection on changes to contributor care which were introduced in reaction to several suicides of television contributors who were involved in reality TV or talk shows. I will examine relevant empirical research into production practices which address working with contributors. Given the limited studies in this area, I also draw on research within documentary production where relevant. I also highlight the extremely limited research around the role of psychologists and therapists working with or on television. This body of work provides important contextualisation for the production practices and frameworks that play a part in contributors experiences.

Chapter Five – methodological framework

This chapter sets out the epistemological and ontological frameworks guiding my research design and methods. My project employs thematic analysis to examine the makers of mental health intervention television, and narrative analysis for the core contributor interviews. I shall set out why I have chosen narrative analysis and where my specific approach sits within the many branches of this methodology. I shall then elaborate on the theoretical and practical issues that have shaped my research sample and primary data collection. I will address personal reflexivity and the ethical questions raised by this work, before providing contextual information for my research data.

Chapter six - multi-perspective thematic analysis

This chapter presents a multi-perspective thematic analysis of interviews with those involved in the making of mental health intervention television. This includes production staff, on-screen intervention providers and the psychologists providing off-screen support. The accounts depict the making of MHITV as a delicate balance between the needs of producing a compelling and entertaining television series and meeting the needs and responsibility towards contributors. This chapter explores how interviewees present their roles in this balancing act – with different degrees of success, tension and individual pressures. I synthesise the themes raised across the accounts to offer a multi-perspective analysis of the experiences and challenges of making MHITV. This provides important contextualisation for the contributors' stories to follow.

Chapter seven – the transformative potential of telling my story on national television

This chapter presents a narrative analysis of form and content of the nine interviews I conducted with ex-television contributors (central participants who feature on screen taking part in interventions). My analysis presents the contributors' conceptualisation of telling their stories on national television as the 'meta story' or theme within their interview accounts. It sets out how telling their stories on television was presented in the form of a transformative quest narrative. I describe the different ways transformation was presented within their interview accounts and how this relates to their evaluation of their television experience.

Chapter eight – experience is more than a quest story

This chapter develops my narrative analysis further, exploring areas of tension within the overriding narrative quest genre. It examines how contributors manage audience engagement that challenges their preferred narratives of their television involvement. In addition it explores the relevance of agency over the telling of their stories within the context of mental health. I demonstrate how contributors exhibited lively engagement with what stories they wanted to tell and suggested they were actively seeking to shape their narratives and with it discourse about mental distress. Their success in this endeavour, as represented by audience feedback, was a crucial part of their evaluation of the experience and outcomes of taking part.

Chapter nine – discussion – the ups and downs of telling stories about mental distress

My discussion applies narrative theory to the contributors' stories of their television experience and discusses the central significance of contributor-audience engagement for how they evaluate their participation. I demonstrate that the impact of taking part in mental health intervention television goes beyond whether or not contributors believed the on-screen interventions to be successful and was intimately linked to their feelings towards and feedback from telling their stories. These points are supported by drawing on the findings from my analysis in chapter six of the makers of MHITV.

Chapter ten – conclusions

The conclusion chapter summarises my findings and contribution to existing knowledge. It considers the practical implications for television production, as well as how my thesis is relevant more broadly to research into the production of mental health narratives in various contexts. It also includes a consideration of the limits of my sample and scope of investigation, with suggestions of further research to build on this thesis.

Chapter 2: Defining mental health intervention television

2.1 Introduction

There is not a pre-existing category in the academic literature that fully captures the range of programmes that are the focus of my study, therefore this chapter is intended to explain what I am defining as 'mental health intervention television' and contextualise it in relation to other television genres. I will sketch historically where and how mental health has featured in British factual television and discuss parallel changes in UK broadcasting and mental health policy during the 1990s which set the background for the emergence of MHITV. With examples I will set out the key narrative conventions of MHITV and discuss different ways to conceptualise it in relation to popular factual television genres such as reality TV, lifestyle and talk shows. Situating these series within the wider framework of factual television and the cultural context is important. It helps to ascertain the relevance and limits of the surrounding literature which I will be drawing on relating to the representation and experience of television contributors across a range of formats, and the wider representation of mental health issues on television. I will argue that despite some differences, mental health intervention television series all share certain characteristics which justify their analysis as a distinct phenomenon, generating a particular set of questions around their impact on the television contributors who take part in them.

2.2 Situating mental health representations within a historic framework of British factual television broadcasting

2.2.1 The Hurt Mind – educating the public about mental illness

UK televisions' engagement with the topic of mental health is by no means new. There are examples on both early radio and television of programmes addressing mental health issues, even some giving airtime to first-hand accounts. The earliest factual television series to tackle mental health was the BBC series *The Hurt Mind* (1957), listed in the Radio Times (1956, p. 26) as: "A series of five weekly programmes, made with the cooperation of the medical profession, on the problems and treatment of mental illness". The objectives of the series were to reduce public fear and stigma, encourage those in need to seek help and increase public awareness and confidence in the latest

scientific treatments for mental illness (Long, 2014). The first episode is unusual as it is predominantly pre-filmed at a psychiatric hospital, at a time when most television was broadcast live due to technical restraints and the cost of pre-recording on film (Chapman, 2015). The ensuing episodes follow the more standard format of 1950s television - a live presenter-led studio set-up with some pre-recorded telecine inserts. These episodes included discussions and demonstrations involving mainly psychiatric professionals, with pre-filmed sequences depicting different physical treatments such as insulin coma therapy and the principles of lobotomy[3].

The series is an early example of British broadcasters working directly with charities and mental health professionals to develop programmes with a targeted public mental health education agenda, in fulfilment of the BBC's public service remit. An anti-stigma message centred around comparing mental ill health to physical ill health and reassuring the public that mental illness was now very treatable. Thus, in the first episode 'Put Away' the presenter, Christopher Mayhew, a member of parliament, comments over footage of a young woman who is filmed at an out-patients unit:

> Like most young and intelligent mental patients, this girl doesn't mind us filming her at all. She knows that she can't help her illness and it is nothing to be ashamed of, any more than any other illness (Long, 2014, p. 207)

In drawing a parallel between mental illness and physical illness, the series supported a bio-medical paradigm, emphasising medical interventions such as pharmaceutical drugs and electric compulsive therapy (ECT), with the psychiatric profession presented as providing the authoritative voice on mental distress (Johnstone, 2000). This reflected the continuation of mental health policy and practice that sought to align psychiatric treatment with general medicine, under the auspices of the recently formed National Health Service (NHS) (Crossley, 2006).

In choosing to focus on education and public reassurance, *The Hurt Mind* series allowed little space for questioning mental health policy or practices (Long, 2014). However Crossley's (2006) history of social movements in mental health documents that during

[3] Episode 5 of the Hurt Mind 'Physical Treatment' can be viewed on You Tube: https://www.youtube.com/watch?v=2KxU3dPeink&list=PLurd4kWgc8K30cOSZ_QftzQdpVHGEv8Cn&index=1

the 1950s politicians, mental health charities, campaign groups, and the psychiatric profession itself argued for reform of psychiatric care, drawing attention to overcrowded conditions, accusations of mistreatment and wrongful detention. Following on from a substantial parliamentary review (The Percy Commission), the 1959 Mental Health Act put into policy the principle of moving towards a predominantly community-based system of mental health provision. In practice, this would be a long time coming (Rogers & Pilgrim, 2001).

2.2.2 Current affairs – engaging with mental health policy

Whilst missing from *The Hurt Mind*, the debate in the public arena around the state of provision in psychiatric hospitals and the move towards community treatment were reflected in factual programming from the late 1950s onwards. Both the BBC and its new commercial rival, ITV, periodically examined mental health policies as part of a growing commitment to current affairs output as television attempted to be taken seriously as a medium (Holland, 2006). For example, the ITV programme *Insanity or Illness?* (1959) questioned the lack of funding for mental health care and compared the conditions in some hospitals to the asylums of old. ITV, whilst a commercial enterprise, was held to a similar remit to that of the BBC, requiring it to provide a suitable balance of information, education and entertainment programmes (Wheatley, 2003).

Programmes in both broadcasters' flagship current affair strands: *This Week: Mental illness in Great Britain* (ITV, 1964) and *Panorama: On mental illness* (BBC, 1966), directly addressed issues such as long term detention, conditions in psychiatric hospitals and the efficacy of a community-based treatment model by the mid-60s. There are notable differences in tone and format of these programmes from the earlier *Hurt Mind* series. Technological developments within television production practices in the 1960s, such as the wider adoption of 16mm film cameras and the availability of synchronised sound recording, had made it feasible to get out of the studio more readily and talk to people on the ground (Ellis, 2019; Sexton, 2003). These developments facilitated the programme makers' efforts to canvass a wider range of opinions including community mental health workers, families and ex-patients, moving the perspective further beyond the expert view, which dominated *The Hurt Mind*.

One standout example of critical engagement with mental health provision was the 1968 ITV current affairs strand *World in Action's* exposé of the conditions in Powick hospital. This episode, entitled *Ward F13*, painted a shocking picture of the unhygienic, overcrowded and inhumane conditions on a long-term female geriatric ward in the hospital. The programme revealed how 75 patients slept in one giant room without any privacy, showed how patients were dressed and toileted in front of each other, and distressed patients left soaked in their own urine. The programme relied on the footage to directly convey conditions, although the reporter does briefly speak to two patients, one of whom describes it as 'hell'. What is surprising about this report is that it included frank interviews with the chief medical attendant who was entirely upfront about the terrible conditions, blaming the public for their lack of interest and the unavailability of financial support. His willingness to be interviewed reflects the relative ease of access that the media had to mental health settings at this time, differing exponentially from the way access to vulnerable people has become codified in the professions both in front of and behind the camera[4].

2.2.3 Cultural challenges to mental illness

As well as current affairs programming questioning mental health policy, factual television output in the late 1960s, 1970s and 1980s, also began to give some airtime given over to alternative paradigms for understanding mental distress. For example, in 1972, the BBC ran a studio debate questioning the very concept of mental illness (*Controversy: the myth of mental illness*, BBC2 1972). Another BBC current affairs strand *Man Alive* covered mental health topics several times including *Out of Sight* (1974) which discussed alternatives to psychiatric hospitals; *Treatment for fear* (1978) about cognitive behaviour therapy; and *Put Away* (1979) which criticised compulsory detention. There was also airtime for a wider range of voices such as in the BBC's *Grapevine* series which featured communities solving problems and ran a self-authored report on a social club for people with mental health conditions (*Grapevine*, BBC2 1977). Another clear example of a Reithian commitment to public education can be seen in the 1987 BBC series *You in mind.* This 7 part series of 10 minute programmes was developed in collaboration with psychologists with the specific aim of investigating whether

[4] Most NHS services require strict protocols for filming. The filming of vulnerable contributors is regulated by OFCOM's broadcast code, which I shall discuss in more detail in chapter 4 on production.

television can be an effective vehicle for a preventative mental health campaign. It purposefully featured "ordinary people" discussing their coping mechanisms to deal with some "common emotional problems" rather than mental health professionals (Barker et al., 1993).

This eclectic programming may reflect that in the UK, mental health provision in the second half of the 20th century was being delivered by a multi-professional base offering a range of approaches, in parallel with psychiatry (Crossley, 2006). During this period, there were also some more radical challenges to the very idea of mental illness. A group of psychiatrists in the late 1960s including R.D. Laing and David Cooper were questioning the scientific basis of mental illness and the right of psychiatry to determine normal from abnormal behaviour. This movement, which came to be known as 'anti-psychiatry', yielded considerable cultural influence, attracting celebrity followers and commandeering mainstream media coverage of its ideas (Crossley, 2006). In the 1970s the growing 'survivors' movement', led by ex-patients who self-identified as having suffered abusive and inhumane treatment within the psychiatric system, added to these critiques. They began to mobilise around a desire to develop strategies to challenge the system and their lack of power (Adame & Knudson, 2007; Campbell, 2006; Johnstone, 2000; Morrison, 2005).

An ideal opportunity to present a survivor's alternative narrative account of the psychiatric system was provided by the extensive mental health season aired by Channel 4 in 1986. Channel 4 was launched in 1982, representing a new model of public service broadcasting, funded by advertising but operating as a not for profit public company with a specific remit to provide distinctive programming, reaching otherwise neglected minority audiences (Harvey, 1994). At its outset the Channel experimented with form and content, challenging established production practices and providing a platform for subversive or creative content that had been squeezed out of existing television schedules on other broadcasters under the prevailing political direction (Ellis, 2003). This ideology can be seen very much in play in Channel 4's *Mind's Eye* mental health season. This season was distinctive in that it allowed extensive opportunities for self-representation, championing the first-hand experiences of people living with mental health conditions and allowing them to determine the narrative collaboratively. It offered a direct challenge to the dominant bio-medical model of mental illness. It was

also innovative in format and style, blurring lines between genre. For example, it included *We're Not mad, We're Angry*, a documentary-drama authored in collaboration with a group of mental health service users offering a highly personalised and political account of their views on the failures and injustice of psychiatric system. Another of the programmes, *In the Mind's Eye* used the poetry and writings of a patient and staff writers group at Fairfields Psychiatric Hospital as the jumping off point to give the viewer a highly stylised and at times disorientating insight into their experiences.

2.2.4 Scare in the community - changes in television production and mental health policy

The arrival of Channel 4 brought opportunities for experimentation and innovation in programme-making and an emphasis on minority voices. However, its development and growth during the late 1980s and 1990s also coincided with a shift in government agenda in favour of consumer choice and competition within the broadcast industry. This ushered in a period of significant structural reform as political conceptualisation of the role of broadcast media moved away from a public service model towards a market-driven model (Chapman, 2015). These principles were put into practice by the 1990 Broadcasting Act which reinforced competition, deregulation and consumer choice. The same period saw the growth and consolidation of satellite and cable channels, signalling the end of an era of limited competition (O'Malley, 2003).

These developments engendered greater competition for revenues and audience share, and a corresponding growth of more populist content across broadcast channels (Brunsdon et al., 2001). In addition, tighter budgets combined with technological advances such as smaller cameras and digital production systems, influenced the growth of new hybrid genres involving 'ordinary people' such as docu-soap and reality TV formats (Dovey, 2000; Ellis, 2012; Kilborn, 2003). As an example of the move towards populist content, Brunsdon and colleagues (2001) chart the changes in the 8-9pm slot on the BBC across this period, comparing the television schedule in the same week in 1984 and 1999. They note the distinct increase in factual entertainment programmes in this slot, under which they group docu-soaps and lifestyle programming; at the expense of current affairs and documentaries. This period sees the increase in series about cookery, gardening, and what Moseley (2000) refers to as 'the makeover takeover on British television'.

In parallel to changes within the broadcasting industry, the government was also making significant changes to its mental health agenda with the introduction of the National Health Service and Community Care Act (1990). This bill ramped up the government's commitment to the de-hospitalisation of mental health patients, the process that had been initiated decades before but never fully realised. The implementation of this policy, widely referred to as 'care in the community' was subject to widespread criticism for the lack of government funding and support necessary for community health services to effectively manage the number of people discharged from institutions (Rogers & Pilgrim, 2001).

Cross (2010) argues that a renewed emphasis on the policy of community care, in conjunction with a shift towards populist programming, ushered in a change in how mental health issues were discussed and presented on television. On the one hand, television is implicated in stoking up public fear around the idea of dangerous patients being let loose in the community (Birch, 2012; Philo, 1996; Rose, 1998). On the other, de-institutionalisation also opened up the possibility of better direct access to people experiencing mental distress, without the control of gatekeepers (Henderson, 1996). In addition, the move away from the paternalistic didactic approach of PSB that was centred around expert opinion, created more opportunities for individuals to speak for themselves, albeit, not always presented on equal footing when it comes to claims of expertise (Cross, 2010).

Whilst much television coverage was inflammatory and sensationalist (see for example Cross's analysis of *Disguises: A Place of Safety*, ITV 1993), there were some noticeable attempts to include the perspectives of people with first-hand experience of the mental health system, both within debates and also through occasional authored accounts. For example in *Shabby Treatment* (C4, 1996), an ex-psychiatric patient went undercover to investigate community care. In addition, the BBC *Video Diaries* production featured a highly-personalised and authored account of a young black woman's experience of living with schizophrenia entitled *Mad, Bad or Sad* (BBC 1994). The video diary documentary format was developed by the BBC Community Action Unit. Enabled by the availability of lightweight handycams and digital production (Ellis, 2012; Kilborn, 2003), the principle was to hand control of the filming and editing over to members of the public. They covered diverse topics personal from religion to adoption. In *Mad, Sad or Bad*, the

central subject, Sharon, delivered a complex portrayal of living with a diagnosis of schizophrenia that covers issues such as medication, stereotypes and the experience of hearing voices (see Birch, 2012 and Cross, 2010 for a detailed analysis of this episode).

2.2.5 The Rise of Therapy TV

The appropriateness of community care for the treatment of severe mental health conditions was not the sole focus of television coverage of mental health during the 1990s. Mental health was no longer a topic solely for journalistic or scientific investigation, but was also becoming the domain of more populist formats such as talk shows and chat shows, with a growing trend in programming across different genres featuring therapy or therapists offering advice or support on a range of psychological problems. In this vein, eating disorders became a topic for daytime talk television, with shows like *Trisha* (ITV 1998-2004), whilst on *States of Mind: The Enemy Within* (BBC2,1995), famous actors and media personalities took to the couch to discuss their personal mental health struggles with psychiatrist and broadcaster Dr Anthony Clare. Therapy was also the focus of documentaries, with a six-part series that took viewers inside the therapy room of the psychotherapist in *The Talking Cure* (BBC2, 1999).

The growth of mental health talk across wider television formats may in part reflect the influence of concerted public mental health campaigns by mental health professionals and organisations to normalisation mental illness and decrease stigma (Crossley, 2006). Examples include the mental health charity Mind's RESPECT campaign and the 5 year anti-stigma strategy 'Changing Minds: every family in the land' launched by the Royal College of Psychiatrists, which included a Media Working Group (Crisp, 2000). However the increased cultural profile of psychological subject matter and language has also been characterised more critically as indicative of a harmful rise of 'therapy culture' within Anglo-American societies (Füredi, 2004). Wright (2008) examines how this therapeutic turn has been framed as a negative cultural shift, with a move towards a focus on our inner selves and individual emotional states, held up as a marker of a cultural malaise, and criticised for enabling new forms of social controls. However Wright offers a more nuanced evaluation, arguing that discourses from psychology and the therapy room have also provided a common language to articulate private suffering and legitimise the emotion pain experienced by marginalised people. It is possible to see how both these readings can be applied to the proliferation of therapeutic talk and ideology within

popular television formats. Talk shows in particular have been critiqued for the individualising of social problems and perpetuating principles of self-governance (Abt & Seesholtz, 1998; Henson & Parameswaran, 2008; Ouellette & Hay, 2008; White, 1992). However it has also been argued that they have provided space and discussion for marginalised voices and issues (Gamson, 1998; Livingstone & Lunt, 1994; Shattuc, 1997).

These new genres and media representations package mental health issues differently, prioritising individual experiential accounts and emphasising personal accountability for wellbeing over critical engagement with the social and political context of mental health issues (Harper, 2009). There is a greater emphasis on entertainment and revelation, exemplified in the sensational and confrontational way that talk shows claimed to tackle people's problems, in the illusion of privileged access to celebratory secrets, and in the voyeuristic intimacy of the therapist setting. This programming marked a division in how television represented different types of mental health conditions. Severe mental illness was still being presented as problematic, threatening and in need of medical solutions. However, there was growing coverage of a broader range of other kinds or contexts of mental distress, which were presented as more acceptable and treated more sympathetically. These included anxiety and phobias, or mental health conditions that came with celebrity endorsement (Harper, 2009), and problems that can be helped by on-screen television experts (Ouellette & Hay, 2008).

2.2.6 Continuity and change – paving the way for mental health intervention television

Since the broadcast of *The Hurt Mind* in 1957, it is possible to see the continued influence of a public service remit in UK factual television's consistent efforts to inform and educate the public about mental health. Broadcasters have continued to regularly work with mental health charities and professionals to engage in mental health promotion, with continuity from early programmes onwards of anti-stigma messaging that has generally reinforced the culturally dominant bio-medical model of mental illness (Henderson, 2018; Walsh & Hallam Foster, 2021). However, they have periodically provided screen time for alternative paradigms for understanding mental distress as well as critically examining mental health policies at key points of change and debate. The format and content of mental health programming has changed significantly across time. In comparison to earlier broadcasting, there are now greater

opportunities for individuals to share their first-hand experiences of mental health conditions. In addition, mental health issues can now be found across a broader spectrum of programming from lifestyle and talk shows to celebrity-led documentaries. In part this reflects (and has arguably contributed to) greater public acceptance of mental health conditions and the lessening of taboo for the discussion of mental health in public and personal life (Robinson & Henderson, 2019). An increasingly competitive marketplace and changing production practices have engendered new factual formats emphasising immersive personal journeys and 'expert' intervention over critical scrutiny into the social or political frameworks that perpetuate mental health conditions. It is within this context that mental health intervention television has emerged.

2.3 Mental health intervention television as formatted documentary

Within the broadcast industry, series such as *Extreme OCD Camp* (BBC3, 2013), *Call the Cleaners* (ITV, 2019) and *Anxiety and Me* (BBC1, 2019) are referred to as 'formats' or 'constructs', however in academic work this kind of programming would likely be placed under the broad umbrella of 'reality TV'. The key distinction from other factual series such as observational documentaries, is that these shows purposefully intervene in the action, creating events and situations that would not happen if the cameras were not present. Hill (2007, p. 49) refers to programmes with this constructed element as "made-for-TV factual". In the case of mental health formats, the construct is some form of therapeutic intervention or activity designed to improve the central contributors' mental wellbeing. This could take the form of conventional therapy such as Cognitive Behavioural Therapy or evidenced-based wellbeing practices such as exercise, but there is normally a television added extra twist – for example in *The Vertigo Road Show* (BBC1, 2014) five participants with fear of heights underwent exposure therapy, a recommended treatment for phobias involving gradual exposure to the subject of the phobia in a controlled and safe way (NHS, 2022). However, to add challenge and dramatic affect for the television audience, the television participants were sent off to face their fears visiting some of the highest places and buildings in beautiful settings around the world.

The first notable formatted series tackling mental health was *The House of Obsessive Compulsives* (Channel 4, 2005). This two-part series brought three people with OCD

together in a house for intensive cognitive behaviour therapy (with exposure response prevention) led by a therapy team from the Maudsley Hospital centre for anxiety disorders and trauma. A review in the *British Medical Journal* by a psychiatrist illustrates how this show was seen as taking elements of Big Brother and applying them to a serious subject matter, engendering a different set of audience expectations than if it had been an observational documentary filmed in a clinic setting. The reviewer writes:

> The title of this show suggests the coming together of *Big Brother* and *Hammer House of Horror*. This is a pity as the subject, obsessive compulsive disorder, and the three hapless sufferers, their partners, and the therapists involved deserved better. Reality television has brought live sex and a real time autopsy into our front rooms. I work at the Bethlem Hospital, where, in 1808, people paid a penny to see lunatics chained to the walls. Were television viewers getting the same voyeuristic thrill in the *House of Obsessive Compulsives*? (Dosani, 2005, p. 409)

The review concluded that in spite of first impressions the series "was a fine stab at enlightened educational entertainment" (Dosani, 2005, p. 409). This illustrates a key feature of this contemporary approach to making programmes about mental health. Whilst there is almost always an expressed educational element in keeping with the public service values associated with documentary, the packaging of the message has changed considerably and is evidence of the blurring of genre conventions, in this case combining a serious issue with the "will they, won't they succeed?" premise of reality gameshows and the high drama of soap-opera (Hill, 2007).

This hybridity of genre values is even more apparent in some of the series that have followed such as *The Panic Room* (BBC3, 2007) addressing phobias and *Freaky Eaters* (BBC3, 2007-2009) which featured people with extreme restrictive diets. Both these series featured elements of CBT and exposure therapy and included some footage of the on-screen psychologists attempting to draw out the affective and cognitive underpinnings of the television contributors' issues. However the central lynch pins of the programmes were the attention-grabbing constructed stage pieces which take the intervention into very different territory from conventional therapeutic practices. In *The Panic Room* this consisted of an enclosed room with wall high television screens playing video images of their worst fears. In *Freaky Eaters*, participants were presented with visual shock gags representing their dietary intake such as trails of sausages and a

paddling pool of cooking fat. These scenes bring to mind the staged sets of reality TV series or even the theatrics of live entertainment shows (Brunsdon et al., 2001).

The House of Obsessive Compulsives, which was followed the year after by *The House of Agoraphobics,* opened the way for addressing mental health issues in a new way, going beyond documenting the experience of the television contributors involved, to actually placing them in an immersive experience, akin to other reality formats. For some this might represent a dumbing down of serious documentary values (Corner, 2002). These series failed to critically engage at a social or political level with mental health issues, and instead focussed solely on individual experience and interventions (Harper, 2009). However I would suggest that a potential counterargument is that these attention-grabbing formats opened up discussion around mental health to a wider audience; and by providing a platform for first-hand stories, have the potential to promote empathy and dispel stigma (Janoušková et al., 2017).

2.4 Mental health intervention television as mental makeover

Another indispensable aspect of the series discussed so far is that they all contain a central narrative of transformation, whereby, with the aid of experts and advisors the main protagonists are helped to move from their old self 'before' the intervention to their new improved self 'after'. This is firmly in the traditional territory of lifestyle television, or more specifically makeover programming where individuals or sometimes groups are guided by television experts to transform an aspect of their lifestyle such as personal appearance or interior design (Lewis, 2009).

Lifestyle and makeover television has its roots in daytime magazine shows however Lewis (2009) describes the increase in this style of programme making within primetime broadcasting and the growing proliferation of expert advice applied to a wider range of life issues from employment to marriage. Ouellette and Hay (2008) label these series as "life intervention" which they describe as programmes which: "mobilize professional motivators and lifestyle experts from financial advisors to life coaches, to help people overcome the hurdles of their personal, professional, and domestic lives". (Ouellette & Hay, 2008, p. 63).

The authors reference examples of parenting series such as *Supernanny* (Channel 4 in the UK) and health and fitness series such as *Honey, we're killing the kids* (BBC1 in the UK). They also link these formats to therapeutically orientated talk shows. This connection has been made by other scholars as well who have documented how the use of experts with backgrounds related to the "psychological" and the language of psychotherapy has become an expected convention within life intervention programmes (Lunt, 2009; Palmer, 2008). It is possible to see therefore how mental health intervention television series could be categorised as an extension of this style of programming, whereby a variety of psychological experts provide the trappings of a mental makeover for the willing participants.

This parallel with makeover and life intervention television is most apparent in hoarding programmes where the focus is on transforming both the self and home of the participants through the intervention of therapists and/or 'house clearance experts' who in effect provide a home makeover. Hoarding series have been a regular feature on British screens in the past two decades and are arguably a whole genre in their own right. The level and content of intervention provided has varied between series. A minority have included psychologists or psychotherapists undertaking extensive therapy sessions with the central protagonists (e.g. *The Hoarder Next Door*, 2012-2014, Channel 4; *Britain's Biggest Hoarders,* 2017*,* Channel 4). Other series toy with the idea of therapy with a psychologist or related 'specialist' occasionally turning up to offer one off sessions or advice (*Hoarder Homes*, 2019-2021, Channel 5; *Britain's Biggest Hoarders*, 2013, BBC1). However in some series the intervention is led by specialist cleaners or declutters with no apparent reference to therapeutic support (*Call the Cleaners*, 2017-2018, ITV).

These series tend to follow a standard narrative arc in three main sections as described by Kaplan (2014), writing about American hoarding programmes: first the main protagonist and the scale of the problem is introduced and a crisis point is established that demands change. Secondly the remediation efforts begin led by firm but empathetic 'experts', who, often in the face of considerable resistance gradually get hoarders to relinquish some of their hoard. The floors are rediscovered and the skip is filled. During this process, the experts offer their analysis of why people hoard and how they can be helped. In the final stage before and after shots reveal the scale of the visual transformation. This is accompanied by personal testament to what has changed for

the individual and what the future now holds. Kaplan argues that hoarding series reflect a sometimes conflicting meeting of reality TV's voyeuristic visual and narrative conventions, and the therapeutic movements goals of promoting public empathy and understanding of hoarding. Therefore whilst they provide space for first-hand accounts of experience and offer psychological explanations for the central contributors' behaviour, these messages may be undermined by shots of 'hoarder porn' and over-dramatic commentary.

One way to think about MHITV therefore, is not as a new approach to documentary, borrowing from factual entertainment conventions, but as an extension of the realm of makeover programming into more and more areas of life (Hill, 2015). Lifestyle programmes have been criticised for presenting a myth of transformation where any individual has equal access to a good life through hard work and the right choices (Palmer, 2008). In a similar vein, it could be argued that by focussing on personal journeys of transformation aided by expert intervention, MHITV ignores the social foundations of mental distress. In addition, whilst these series are built around first-hand accounts of the experience of mental distress, there is a degree of continuity with the expert/patient power differential of earlier mental health programmes, with similar framing of the dependence of the central contributors on expert intervention to help them get better.

2.5 Mental health intervention television as public health campaign

Another way to think about MHITV is as a targeted form of public mental health education, arising from the greater cooperation between television production, mental health practitioners and campaigning groups. As previously discussed, mental health organisations have long been aware of the potential of the media to deliver a public mental health intervention and have sought to influence cultural discourses about mental health (Morris, 2006). This is epitomised in the UK by the Time to Change campaign, set up by mental health charities with the aim of directly changing negative perceptions about mental health (Robinson & Henderson, 2019). One aspect of their work has been to produce guidelines of media best practice in how mental health topics are discussed. It is also now common for mental health charities and organisations to have a media and communications contact and to sometimes work directly with

television producers on content encouraging positive portrayals of individuals experiencing mental distress (Henderson, 2018; McGowan, 1993; McTernan et al., 2020).

There are several examples of mental health intervention television series that demonstrate collaborative attempts at public mental health education. *The Invictus Choir* (BBC1, 2016) charted the bringing together of a choir of wounded ex-armed services personnel, led by Gareth Malone, choirmaster and presenter. The series collaborated with Prince Harry's charity 'The Invictus Games' and the choir has since continued with support from the charity 'Help for Heroes'. The series followed Gareth recruiting, training and co-writing a song with the singers, and culminated in an emotional performance at the International Invictus Games in Florida. Key themes were the therapeutic potential of music for recovery and the psychological battles that the participants continued to deal with. *Mind Over Marathon* (BBC1, 2017) was a two-part series following participants with mental health issues training for the London marathon in support of 'Heads Together', a charity set up by Prince William, Prince Harry and Kate Middleton to promote conversations about mental health. The contributors were led through their training by the presenter Nick Knowles, fitness coaches, and a nutritionist. Its central message was the importance of talking about mental health and the benefits of exercise for mental wellbeing. Meanwhile, *The Restaurant That Makes Mistakes* (Channel 4, 2019) revolved around the 'made for television' construct of a restaurant staffed by people with dementia to raise awareness of the condition and challenge discrimination in the workplace. The Alzheimer Society was a partner in the development of the series.

These series all had strong anti-stigma messages at the heart of their remit. However they were a far cry from the didactic style of previous television mental health campaigns. They borrowed elements from different genres, combining central themes of personal transformation with elements of docu-soap, gameshow-esque challenges and the earnestness of a public service health promotion agenda. These series then come closest to the public service tradition of educating and informing the public on prominent issues. However these themes were lightly touched upon and packaged within individual storylines which home in on the personal challenges, emotional journey and eventual triumph of the participants in all their raw detail. The didactic

elements were sweetened using dramatic techniques associated with docu-soap (such as following the group dynamics) and entertainment (e.g. the triumphant finale performances of the choir/marathon finish).

Whilst these series overtly addressed mental health, they differed to the series described so far in that the interventions were based around recovery and general improvement of mental health rather than targeted therapies to tackle specific difficulties the participants may be experiencing. This may reflect the wider growth of the recovery paradigm within mental health practice, which had put forward a more holistic approach to managing mental distress (Frost et al., 2017). However, it was also likely driven by the televisual and dramatic potential of choirs and challenges over talking therapies. These series did not involve on-screen accredited therapists but presenters and experts chosen for other skills. However, they often took on a quasi-therapeutic role, supporting the participants through to the finale, whilst also acting as a guide for the audience – asking empathetic questions to reveal the experience of living with mental health problems.

The portrayal of the central contributors in these series was significantly different from the people who feature in the hoarding series discussed earlier, or other series such as BBC3 *Extreme OCD Camp* which revolves around intensive therapy. Whilst these people were presented as still needing the guidance and support of experts, here the emphasis is on them as brave role models, demonstrating how through self-will and commitment it is possible to overcome difficulties. Unlike the shock visuals that reinforce otherness in hoarding series (Kaplan, 2014), the homelife sequences included in the narratives reinforced the campaign message that they are people 'just like you and me'. This shift in representation from victim/other to hero/one of us potentially engenders a different set of audience responses from, for example, hoarding representations. This may have implications for what the contributors take away from their television experience. This is one area that my research aims to investigate further by finding out how television contributors in different styles of mental health format evaluate their representations and audience reception. In summary, some MHITV series have clear public mental health education messages at their heart. However their anti-stigma aims are packaged around personal stories of trial and transformation, differing significantly from other

factual formats such as science and current affairs, which are more traditionally associated with a public service broadcasting remit.

2.6 Conclusion – so what is mental health intervention television?

In this chapter I have situated the development of MHITV within some of the historical broadcasting and mental health policy contexts that have influenced the ways that mental distress is represented on British public service broadcast television. I have demonstrated that there has been a consistent commitment on the part of broadcasters to engage with mental health education and challenge stigma, however the content and style of mental health programming has changed significantly over time. Cultural shifts in how mental distress and treatment are conceptualised, combined with changing production practices have led to a greater emphasis on first-hand accounts, and the consideration of mental health issues across a wide range of programming genres and formats. Documentaries taking a scientific, current affairs or observational approach to mental distress still feature periodically on UK public service broadcast channels (e.g. BBC1 *The truth about improving your mental health*, 2021; *Losing it: Our mental health emergency*, Channel 4, 2020). In parallel I have demonstrated that an approach to mental health programming has developed with brings together elements from public health campaigns, documentary, reality television and makeover. The balance of these elements varies across formats, therefore the style and content of different shows may have specific implications for both the contributors involved and audiences. However, based on the examples I have identified, I propose six key common denominators:

- They directly address the issue of mental health
- They involve some form of therapeutic or mental wellbeing intervention constructed for the purpose of the television production
- The intervention involves some on-screen expert guidance
- At their centre is a narrative of before and after – transformation
- They use naturalistic filming techniques from a documentary tradition and include some filming in people's actual lives (as opposed to studio based interventions – e.g. talk shows)
- They predominantly focus on personal stories and experiences over social, political or cultural analysis

I would argue that despite differences between formats, the common features outlined above create a distinct set of questions for television contributors that are worthy of investigation and have not been addressed by existing research. At the crux of the issue is the implications of these formats providing, filming, and broadcasting an on-screen intervention for television contributors experiencing mental distress.

MHITV follows a distinct narrative structure, constructing a before and after narrative arc of transformation for the central protagonists. From doubtful beginnings, with help from television's 'handpicked experts' and a 'bespoke intervention', they overcome obstacles and set- backs to emerge triumphant. Their reward is improved mental health or returning home to a clean house and a fresh start, but the key transformation is the life changing personal realisations they have made along the way and can pass on to the audience. This narrative structure where the central protagonist must respond to a problem, face difficult challenges aided by enablers, and is rewarded by the transformation of their fortunes has been characterised as a quest story. It is a model that is recognisable in a wide range of story texts from myths (Campbell, 2008) to film (Lacey, 2000) and television makeovers (Thomas, 2016). It is sometimes referred to by different names such as an enlightenment, growth or conversion story (Thornhill et al 2004)[5].

The work of Arthur Frank (2013) on quest stories is particularly relevant to the narratives on display in mental health intervention television. Frank takes the genre of the quest story and applies it to one possible narrative response to serious illness. He writes:

> Quest stories meet suffering head on; they accept illness and seek to *use* it. Illness is the occasion of a journey that becomes a quest. What is quested for may never be wholly clear, but the quest is defined by the ill person's belief that something is to be gained through the experience (p115)

[5] It is so ubiquitous as a story format that whilst I was working on this analysis, my ten year old son was being taught how to write a quest story in school receiving guidance on key elements to include such as the initial problem, the call to the quest, the journey and helpers, the final challenge, the "we did!" it ending.

Frank draws on Campbell's (1949) work on myths to describe three plot phases in quest illness stories. Firstly there is the departure, the events which set in motion the quest such as the discovery of an illness. This is followed by the initiation or road of trials which is marked by a period of suffering and challenges before the final apotheosis, and the return – where the central protagonist returns to share what they have learnt from the experience. Frank is theorising about physical illness stories but there are strong parallels with mental health stories and the way MHITV packages the struggles of the central contributors. The return, where the central heroes must reveal their learning as described by Frank, neatly mirrors the narrative climax of the programme format where the contributors must summarise all they have gained from the experience. In my methodology chapter and narrative analysis I will examine the potential implications of the quest narrative structure for the contributors of MHITV.

My conceptualisation above of these series in relation to formatted documentary, mental makeover and public health campaigns leaves out one important point of cross comparison which is crucial for my research - c*an mental health intervention television be considered as a therapeutic intervention?* The understanding of what constitutes an appropriate therapeutic intervention for mental distress varies between context, treatment paradigm and mental health condition (van Agteren et al., 2021). Within a clinical treatment context the National Institute for Health and Care Excellence (NICE) sets guidelines for suitable therapeutic interventions, such as cognitive behavioural therapy for anxiety (NICE, 2019). However there are many other models for therapeutic intervention – one example being the recovery college model which focusses on providing holistic activities and skills from self-care to gardening (Whitley et al., 2019). It is beyond the scope of this research to evaluate whether the interventions provided within mental health intervention television meet the evidence threshold for efficacy required within formal scientific trials or other means of service evaluation. However, given the central narrative claims of these series to have a positive impact on the lives of the contributors who take part – it becomes all the more relevant to understand whether those involved perceive this to be the case. This is a central motivation for this research.

In reviewing existing literature, it seems there has been no academic work examining this style of mental health programming as a specific group. The closest research is that

by Blaker (2013, 2017) whose thesis charts the rise and characterisation of what she terms "non-institutional factual therapeutic programming". Her focus is specifically factual programming which features psychotherapy delivered by qualified and accredited therapists conducted away from institutional settings. Whilst there is crossover between some of the programmes in her sample and the series I am categorising as MHITV (e.g. *The Hoarder Next Door*, C4 *Freaky Eaters*, BBC3), her definition does not include series which do not include conventional talking therapy such as some hoarding series and other more holistic mental health interventions.

Given that there is no pre-existing category that covers all the series, I decided to use the label 'mental health intervention television' (MHITV). I take as my inspiration Ouellette and Hay's use of the term "life intervention" (2008, p. 63), however whilst there is some cross over, I am not implying that these series are just an extension of their definition or that I endorse all they have to say about these types of programmes. Whilst they offer a valuable critique, by their own omission, they are not interested in whether the interventions depicted are effective, or their impact on the contributors, which is of primary interest for my research. It is important to recognise that my conceptualisation of these programmes together under the term 'mental health intervention television' may not necessarily concur with how audiences or other academics would categorisation these programmes. As such, I am applying the term lightly, mainly as a convenient term to group and explore programmes with the characteristics set out above. In the following chapter I shall elaborate on what the implications of this type of series for contributors may be by looking at the existing literature around participation on television and ascertaining where there are gaps in the current research.

Chapter 3: Participating in Television

3.1 Introduction

This chapter addresses research and theory that is relevant to understanding the experience of contributors who take part in mental health intervention television. Academic research focused specifically on the contributors featured within mental health interventions on television is virtually non-existent. Therefore, the chapter will draw on research from other related factual programme formats – in particular, lifestyle and reality TV genres, with which it shares many narrative features. In addition, it will include some relevant studies from the field of documentary ethics. Firstly, it will summarise critical perspectives on the representation of ordinary people on television. This work raises some important points about the social, political and cultural contexts that influence the way contributors are used within the practices of television production. It also highlights the ways in which contributors' lives, choices and problems are framed in relation to dominant cultural discourses.

Secondly, this chapter will review the handful of mainly qualitative research studies that directly involves research with television contributors and documentary participants. This research is important to my thesis as it provides a richer insight into the first-hand perspectives and concerns of actual television contributors in their own words. This literature will be broken down into key themes that I have identified from the research: contributor motivations, contributor power, and consequences of participation. It is vital to understand these issues, as they are all potentially applicable to the ways in which contributors of MHITV make sense of their experience. This chapter will also reflect on the debate within the United Kingdom on the ethical treatment of television contributors, which followed several suicides of television contributors who were involved in reality TV or talk shows. It will highlight some of the contributor accounts that were submitted to the government inquiry that into reality TV, as illustrations of the unpredictable consequences of appearing on television.

3.2 The rise of the 'ordinary person' on television

Academic interest in the contributors featured in popular factual, reality TV and lifestyle shows has primarily been led by theoretical debate from within media and cultural

studies. A key focus has been the cultural, social and political-economic implications of the increased representation of the 'ordinary person' on television across both daytime and primetime schedules, from talk shows and docu-soaps to makeovers and talent shows (Bonner, 2003; Couldry, 2003; Livingstone & Lunt, 1994; Turner, 2010).

The growth of reality TV and lifestyle formats featuring 'ordinary people' has often been polarised as representing either a dumbing down of cultural values or a democratisation of an important cultural platform (Biressi & Nunn, 2005; Kilborn, 2003). Therefore on the one hand it has been argued that popular factual formats offer increased opportunities for members of the public to engage in and be represented in the public sphere (Klein & Coleman, 2021), and a cultural shift whereby areas and issues once seen as domestic or 'feminine', now take centre stage in primetime (Brunsdon et al., 2001). On the other hand however other commentators have critiqued what is perceived as a move to softer narrative values emphasising subjectivity and 'the inner story' rather than a focus on the contextual, 'the outer world' as a diversion from the serious business of documentary (Corner, 2002; Dovey, 2000). A prevailing critique has framed the growing participation of ordinary people in relation to neoliberalist values, whereby contributors are exploited for cheap labour (Collins, 2008) and used to perpetuate principles of individualism, competition, consumerism and self-governance (Grazian, 2010; McMurria, 2008; Ouellette & Hay, 2008; Redden, 2017).

Within this context Ouellette and Hay (2008) have critiqued the array of reality TV and lifestyle shows offering expert intervention into seemingly every sphere of our domestic and personal lives from parenting and relationships to health and career management. They characterise the goal of these shows as: "transforming needy and at risk individuals into successful managers of their lives and futures" (p. 63). Whilst on the surface this may seem an innocuous or even laudable aim, Ouellette and Hay argue that this style of 'life intervention' television enacts a form of governance from a distance, whereby wayward individuals can be re-educated to become better citizens. A key critique is that these shows make little reference to the wider social and economic context that might explain the difficulties of the main protagonists. Instead: "excessive consumer behaviours and desires with many interpretations and social determinants are construed as horrible individual tics that – if caught in time – can be brought under control by professionals" (p. 71).

Building on this emphasis on self-governance, another critique of the increased prevalence of the ordinary person on television is the over-representation of working class contributors as subjects in need of re-education and policing (Hill, 2015; Skeggs & Wood, 2011) and the replication of middle class norms through the lifestyle choices depicted as desirable and tasteful (Biressi & Nunn, 2008). Palmer (2008) argues that lifestyle series focussed on the body and home attempt to disguise the reality of structural inequalities in society by presenting a world view whereby anyone can choose to live differently and make themselves "respectable merely by looking respectable" (p. 4). Scholars have also offered strong critiques of the representation of female contributors and ideals about gender appropriate behaviours (N. Patterson, 2015; Sukhan, 2013; Tsaousi, 2017). Makeover programming in particular has been challenged for reinforcing normative values about femininity as white, middle class and heterosexual (Weber, 2009). Critiques have highlighted the insidious way these messages are packaged into a contradictory dichotomy which equate bodily transformation and beauty conformity with self-empowerment and individuality (Sukhan, 2013).

Another key concern raised by commentators of lifestyle and makeover formats is the way certain formats utilise shaming and humiliation to reinforce discourses on socially appropriate behaviours (Inthorn & Boyce, 2010; Palmer, 2008; Rich, 2011). This is particularly true of weight loss programming as illustrated by Inthorn and Boyce's study of discourses of obesity presented on UK television. They found contributors across a range of factual formats were consistently rebuked and made to feel guilty for their lack of self-control and publicly ridiculed for their eating habits. This was especially true of lifestyle intervention shows (Inthorn & Boyce, 2010).

As well as being framed as unwitting victims in the reality TV production line, television contributors are held up by some commentators as signifiers of our obsession with celebrity culture and the desire to be famous for fame's sake (Andrejevic, 2004; Turner, 2013). Scholars have examined how the requirement of reality television for cheap labour (Collins, 2008) has enabled a new brand of dispensable celebrity, the reality TV star or 'ordinary celebrity' (Grindstaff, 2009) whose fame is tied to their ability to successfully perform themselves within specific formats. This has been theorised in relation to a political-economic environment in which we are all encouraged to develop

and commodify our self brand (Hearn, 2014) and as an indicator of the centrality of visibility and self-promotion as a means of performing and validating selfhood in the digital era (Andrejevic, 2004; Turner, 2013; Wilson, 2014).

Offering a more positive reading, Klein and Coleman (2021) have theorised participation in reality TV as an opportunity for marginalised groups to be seen, not just for fame's sake, but as a way of participating in the public sphere. Klein and Coleman highlight how some successful contributors have used the celebrity status enabled by reality TV participation to create a platform to "speak as, about or for groups, issues or values with a view to bringing them to public attention" (p. 13). They provide examples such as Nadiya Hussain, the 2015 winner of *The Great British Bake Off* (BBC1[6]) who has found herself representing Muslim women along with ideas of a more "inclusive Britishness" (Klein & Coleman, 2021, p. 9). Grindstaff (2012, 2002) makes a similar point about talk show contributors being motivated by a desire to be recognised and part of public dialogue, even if talk show participation is perceived as low status.

The rise of the ordinary person on television has also been theorised in relation to the perceived rise of 'therapy culture', characterised by Furedi (2004) as a debilitating cultural turn towards a focus on the inner self, emotions, and therapeutic ideology to make sense of society's problems. Scholars have pointed to the confessional and therapeutic character of many reality TV formats; which encode the expectation of touching performances, poignant revelations, and access to hidden inner lives of the central contributors (Biressi & Nunn, 2005; Grindstaff, 2012; Lunt, 2009; White, 1992). The emphasis on the display of strong emotions has become ubiquitous across genres from the DIY home makeover which requires the justification of distressing back stories, parenting programmes where parents must tearfully recognise their shortcomings, to Big Brother and other personality led reality TV contests, where an affective performance is heralded as a mark of authenticity (Kavka, 2014). These quasi-therapeutic exchanges are often overseen by what Palmer (2008, p. 9) refers to as "psy-experts", a group of psychologists, life coaches and self-help gurus who he characterises as having their credentials validated by the marketplace and who "all offer a model of the psychological that floats free of any social, political or economic determinants". In

[6] The Great British Bake Off has since moved to Channel 4

this framing, the psychological discourse within these television formats operates as another form of social control, teaching the contributors (and the audience with them) to police their own behaviour rather than look for wider societal answers to any difficulties (Ouellette & Hay, 2008; Palmer, 2008).

It is possible to see how many of the issues raised above can be related to aspects of mental health intervention television. Like reality TV and lifestyle formats, MHITV also relies on ordinary people putting themselves forward, willing to share their intimate struggles in the name of transformation. There is an expectation of authentic affective performances, access to private spaces and personal revelations that are characteristic of the reality genre. Lepselter (2011), in her analysis of the discourses presented in America hoarding series, contends that these series represent hoarders as aberrant individuals, whose over consumption of goods must be brought back into line with the normative values of rational choice offered up by neo-liberal societies. This is the only way they can be accepted back by friends and family and re-join the social realm. In other words, the television contributors (and the audience) are taught they must take personal responsibility for their lives and living well becomes a moral obligation, their duty as good citizens (Ouellette & Hay, 2008).

Likewise, whilst some mental health intervention television programming offer more empathetic explorations of the roots of contributors' difficulties (when addressed at all), these tend to retain very localised frames of reference. The focus is on individualistic explanations such as past trauma, or medicalised understandings of mental distress, rather than socio-economic, political, or societal contexts. In another parallel, the shaming tactics employed in some lifestyle formats are also a feature of some MHITV series. In hoarding series, empathetic portrayals are often undercut by 'hoarder porn' shots of their chaotic, unhygienic clutter and contributors are challenged about their behaviours in ways which present their choices as illogical (Kaplan, 2014; Lepselter, 2011). Humiliation is also a feature of other formats, such as phobia series like *The Panic Room* (BBC3) which feature challenges, calculated to cause powerful negative emotive reactions from their central contributors.

The body of work above illustrates the importance of situating television participation within the wider contexts within which television programmes are produced. However,

much of this critique often tends to happen at the genre level, masking significant differences between programme formats, and underplaying the agency and motivations of individual contributors. It could be argued for example, that celebrity culture has a different influence on someone deciding to go on a competitive format like Big Brother than on an individuals' decision to take part in a mental health programme. Analysis of participation has also predominantly focussed on television series as text, or at the macro level of the wider political and economic background guiding production practices. This work raises many interesting points at the level of theory, what is interesting to me is to understand their direct relevance from the perspective of the people at the centre of MHITV. For example, what are the potential implications for contributors experiencing mental distress of being expected and encouraged to deliver emotive performances? What ability do contributors have to hold some parts of themselves back, or how they make sense of the expertise, psychological or otherwise on offer to them. What is often crucially missing from debate are the first-hand accounts of the contributors in these shows (Sanders, 2016), and as Turner (2014, p. 315) notes, the concerns raised by academics are often far removed from the concerns of actual contributors.

3.3 Key themes from direct television contributor research

Whilst there is no qualitative research that seeks to understand the lived experience of contributors who have taken part in mental health intervention television in the UK specifically, there is a series of studies conducted in Norway by a group of academics which are particularly relevant to my thesis as they involved interviews with television participants who took part in factual programmes about mental distress (Lånkan & Thorbjørnsrud, 2022; Thorbjørnsrud & Lånkan, 2022; Ytreberg & Thorbjørnsrud, 2020). One of these is a case study of a series which was premised around providing the contributors with group therapy and would meet my criteria for MHITV (Thorbjørnsrud & Lånkan, 2022). In addition, there is a small body of international work that has looked at the first hand experiences of contributors of other television factual formats or documentaries (Andrejevic, 2004; Grindstaff, 2002; Hibberd et al., 2000; Mast, 2016; Moore et al., 2017; Nash, 2012; N. Patterson, 2015; Sanders, 2012; Shufeldt & Gale, 2007; Syvertsen, 2001). This research is relevant in that it can give an indication of the broader issues that might influence how contributors of MHITV experience taking part

in a television or documentary project. It is important to note that there are differences between television and documentary production cultures; and local production cultures and regulation between countries which need to be recognised when drawing conclusions about their relevance to mental health intervention television in the UK. However, the consistency of themes across genres and countries illustrates a degree of universality. I have also included some first hand accounts that were submitted as evidence to the government Digital, Culture, Media and Sport (DCMS) select committee inquiry into reality TV (UK Parliament, 2019a) or appeared in the media at the time. These accounts raise important concerns about the specific sensitivities of filming with potentially vulnerable contributors. I have identified three key themes within the research and accounts which shall be discussed in turn: contributor motivations, contributor power, and consequences of participation. The related theme of *informed consent* will be discussed in the following chapter when I present the regulatory framework guiding duty of care to UK television contributors.

3.3.1 Contributor motivations

Several studies have questioned contributors about their motivations for taking part in a television show and unsurprisingly the answers given vary and are influenced by the type of format and the subject matter. Whilst some contributors of reality TV shows were candid about seeking fame (Andrejevic, 2004; Grindstaff, 2012), this was not the most common emphasis. This in part is a likely a reflection of awareness of the negative connotations applied to reality TV contributors who are seen to be chasing fame for fames sake, the television 'wannabes' (Hill, 2007, p. 193). Instead of self-promotion, contributors sited the opportunity for self discovery, personal challenge and adventure (Andrejevic, 2004). In constructed reality shows where the focus is on performing yourself, contributors framed themselves as fans of pre-existing formats looking to be part of the experience (Curnutt, 2009). With dating shows or DIY programmes, contributors presented themselves as doing it for the fun or it (Shufeldt & Gale, 2007; Syvertsen, 2001).

Fun and personal growth are not the only reasons given for choosing to go on television, especially if the subject matter under discussion is more personal or serious. In 2000 a

detailed report funded by the Broadcasting Standards Commission[7] (BSC) was published looking specifically at the issue of the participation of 'ordinary members of the public' in UK factual television (Hibberd et al., 2000). Whilst this research is dated, it is included here in some detail because there has been so little research focussing on the first-hand experiences of contributors from British television series. The researchers interviewed 40 television contributors from a range of factual programming including talk shows, documentaries and docusoaps. They also interviewed 40 production staff about their experiences of working with members of the public. The researchers found that the most common reason given for agreeing to be part of a television programme was the desire to raise awareness about an issue or share with the wider public some experience they had been through. This was particularly true for documentary contributors who were going through or had been through a life changing experience like serious illness. These contributors often recounted that they were seeking to find some way of achieving some good out of a difficult experience.

The aim of helping others through sharing personal difficult experiences was also a key motivation presented by contributors with mental health issues interviewed within three Norwegian studies. Lånkan & Thorbjørnsrud (2022) interviewed patients who were filmed in psychiatric hospitals for a documentary series (*Five days Inside*, NRK 2015-2020). They also interviewed patients who chose not to be filmed, hospital medical staff and the television producers. In a second study, they interviewed eleven young people with mental health challenges who had taken part in a therapy series (*True Selfie*, NRK, 2016, 2018). The format involved being filmed during group therapy, led by a psychologist, and recording extensive video diaries (Thorbjørnsrud & Lånkan, 2022). In separate research Ytreberg & Thorbjørnsrud (2020) interviewed participants who had repeatedly shared their illness stories related to either cancer or mental health in the media, including on television. Central to the motivations for participating in the media presented in all three studies was a discourse around the benefits of openness. As one documentary participant explained "I thought it might remove some of the shame, that OK, now it is not such a big deal, now that everybody knows, it is okay." (Lånkan & Thorbjørnsrud, 2022, p. 136). Sharing their stories publicly was framed as a welcome

[7] The BSC was the statutory body for broadcasting standards and fairness. It was replaced by OFCOM in 2003

opportunity to help others, reduce stigma and with the hopes of self-healing. In addition their participation was presented as providing recognition for their difficulties or as one participant explained, at the time they were asked to be involved "What I needed was attention, basically" (Ytreberg & Thorbjørnsrud, 2020, p. 6118). This research covers a broader range of media involvement than MHITV, however it is certainly possible that the contributors of UK mental health intervention television may be similarly motivated by both discourses which stress the importance of speaking openly about mental health and a desire for recognition, particularly given the marginalisation of the voices of those experiencing mental distress (Baldwin, 2005).

In a different televisual context, Laura Grindstaff reached similar conclusions about the importance of recognition as a key motivator for television guests in her ethnographic study of American daytime talk shows (Grindstaff, 2002, 2012). Whilst talk show guests are widely condemned as 'trashy' for revealing their dirty laundry in public in order to secure their moment in the limelight, Grindstaff concludes from her interviews that: "America's poor and working classes want much the same thing as everybody else: to be noticed, to feel like they matter in the world, and to participate in public discourse in a locally and meaningful way" (2012, p 31). She argues that by appearing on television, talk show guests are seeking access to what is perceived as a central social space (Couldry, 2003) which is often denied to them. Therefore, despite the potential for their participation being represented and received negatively, the attention gained by taking part offered validation in itself (Grindstaff, 2012). Whilst studio talk shows are formatted differently to how I am conceptualising MHITV, there is some cross over in subject matter and framing. This is particularly true of hoarding series, which like talk shows can veer towards the sensational and judgemental in their characterisation of the central contributors and their lifestyles. Rather than assuming that contributors choose to participate out of naivety, lack of self awareness, or desperation, Grindstaff's research suggests that contributors may be seeking a form of validation through being seen. If this is the case with some MHITV contributors, it has implications for what they may take away from their television experience.

The critical point from the above examples is that television contributors come with a range of agendas and expectations shaped by personal experience, cultural and social norms and their knowledge of the medium. For contributors with mental health

problems appearing in a television series may be perceived as an opportunity for recognition and validation when historically, these perspectives have been underrepresented in mainstream media. In addition there are potential status benefits from appearing on screen - Ytreberg & Thorbjørnsrud (2020) argue that patients who share their illness stories in the media are generally regarded as "good participants" (p. 6182) and afforded high moral status. They make the important caveat however that certain mental health problems may still attract prejudice or blame. Importantly, contributors do not necessarily enter into television shows naïvely, ripe for exploitation by the production company. Particularly where the subject matter is serious or personal, they present themselves as generally not entering lightly in a decision to participate, weighing up the benefits versus risks, and seeking reassurances where possible (Grindstaff, 2002; Hibberd et al., 2000; Lånkan & Thorbjørnsrud, 2022; Nash, 2012). However, as will be discussed in the next section, obtaining their desired outcomes of participation is not always straightforward.

3.3.2 Contributor power and control

The balance of power between the subject and the film-maker has long been of interest to theorists and researchers alike, particularly within the field of documentary ethics (e.g. Nichols, 2017; Winston, 2000). However, the focus of analysis has often been the documentary text itself or the film-maker perspective (Nash, 2012). In direct research with participants of both documentary and popular factual genres, a common theme is the challenge for participants to maintain control of their identities and agenda, within production structures and practices which work to disempower them (Grindstaff, 2002; Mast, 2016; Moore et al., 2017; Nash, 2012; Shufeldt & Gale, 2007). For example, an ethnographic study of two families' experiences of taking part in a U.S home improvement show (Shufeldt & Gale, 2007) depicts how the tightly controlled format (and filming structure), the editing process, and the contractual obligations that contributors must agree to, all serve to strip away any power they have and retain control firmly within the production.

Another issue highlighted, particularly in popular factual television, is the conflict of interest between broadcaster and production goals and contributors' expectations. Grindstaff's (2002) interviews with talk show contributors highlight the tension between the needs and agenda of contributors and the requirement of the talk show to produce

drama, entertainment and ultimately ratings. Contributors' complaints ranged from last minute changes to the schedule which changed the tone of the debate and a lack of time to discuss policy points, to victimisation and the manipulation of arguments between family members. As Grindstaff explains "when producers and guests come together, each with their own set of goals and expectations, and with unequal amounts of power and influence, points of friction and moments of tension are inevitable" (p. 178). Likewise, U.S contributors of the competitive weight loss series *The Biggest Loser* (NBC) reported feeling manipulated at times during the filming of the series and their believes that producers were more interested in drama and ratings than their health and wellbeing (Moore et al., 2017).

Within documentary production, in particular when dealing with serious subject matter, there is evidence of more considerate attempts to respect contributor opinions and concerns. Many of the producers interviewed for the BSC report, especially within documentary productions, expressed the importance of working in collaboration with television contributors and developing trust. The contributors generally reported feeling consulted and in some cases were allowed to review the edited programme (Hibberd et al., 2000). In the Norwegian documentary series filmed within a psychiatric hospital, patients were given the option of asking for footage to be removed or even to withdraw their participation altogether from the final films (Lånkan & Thorbjørnsrud, 2022). Some patients did decide to withdraw and were edited out, however one contributor felt unable to withdraw their consent despite their misgivings, whilst others were deeply ambivalent about whether they had done the right thing. In these cases, it seems that the freedom to withdraw was counteracted by an overriding narrative presented to them of the benefits of openness. They expressed that they did not want to let those involved, or the audience down. This demonstrates how contributors may find it hard to assert control and go against the flow, even within a supportive production dynamic. This may be compounded by their mental health situation, and in this example, the limits of autonomy afforded within an institutional setting (Beauchamp & Childress, 2019).

Similarly, in the series where young people were filmed undergoing therapy, participants reported being told informally they were in control of what and how filmed material would be used. However in practice, some participants felt let down by the

true extent of their agency once it came to the edited pieces, leading to them feeling exposed or disconnected from their representations (Thorbjørnsrud & Lånkan, 2022). Significantly in relation to the format of MHITV, one participant also reported perceiving the on-screen psychologist as not separate enough from the production company and therefore unable to represent their needs.

Other research suggests that it should also not be assumed that contributors are entirely powerless. Patterson (2015) interviewed female ex-contestants of Canadian talent based reality shows (e.g. *PopStars*, *Canada's Next Top Model*). She drew attention to themes of resistance and how contributors were able to subvert filming processes by refusing to perform or breaking the rules, thereby taking back some control. Grindstaff (2002) describes how contributors can operate some degree of power within talk shows by threatening to pull out, or by conducting a silent rebellion once in front of the cameras, refusing to deliver up the performance expected of them. Nash's case studies of Australian documentaries also demonstrate how power and control can be a two way process between subject and film-maker (Nash, 2009, 2012). Nash describes how Lyn Rule, a participant in the film *Molly and Mobarak* (Zubrycki, 2003) presented herself as an active contributor who is confident in her ability to assert control over the documentary project. Lyn explained ways that she would disrupt filming if she deemed it necessary such as putting on loud music or swearing. Likewise, in Nash's second case study the documentary participant described a push and pull between herself and the director as both tried to assert their agendas over the content of the film. Nash argues that central to the relationships in both documentary productions was the trust established between film-maker and participant, however control is often a contested site that must be negotiated (Nash, 2012). These examples disrupt the idea of documentary and television production being a case of 'power over' illustrating how the contributors can also hold power.

In summary the necessity of keeping people on board in order to have a viable commercial product might afford contributors a degree of control during the production process. There is also evidence that particularly within documentary production, some directors (and participants themselves) theorise contributors as co-collaborators (Sanders, 2012) and are willing to give up some of their creative freedom to meet their sense of ethical obligations (Aufderheide, 2012). However generally speaking, the

structure of the production process lends itself to a power differential between producers and contributors (Mast, 2016), where the producers, who are in familiar territory and a position of greater authority have the upper hand (Grindstaff, 2002). In the case of MHITV, contributors are seeking help and are consequently potentially vulnerable, exacerbating this power imbalance. Finally it is worth noting that apart from the report for the BSC (Hibberd et al., 2000), which was conducted over twenty years ago, none of the above examples are of British television shows, where different economic, cultural and regulatory contexts of production exist to the model of production for UK broadcast channels, and in particular, public broadcast television. I shall discuss the regulatory framework guiding UK broadcast and production responsibilities towards contributors in the next chapter.

3.3.3 Consequences of participation

A crucial issue for my thesis is how contributors perceive the consequences of taking part and whether they present their participation as beneficial. There is no qualitative research specifically focussing on the outcomes for contributors of mental health intervention television shows in the UK, however there is one quantitative study that is highly relevant as it has directly examined the outcomes for contributors taking part in televised therapeutic activities in an Australian series. This study examined the impact of positive psychology interventions for the eight contributors of *Making Australia Happy* (ABC, 2010) and was undertaken by the consulting psychologist and presenter of the series, Anthony Grant (2011). In the three part television series, the contributors underwent an eight-week programme of activities, designed by Grant and colleagues including coaching, mindfulness, acts of altruism and reflective journal keeping. The contributors recorded subjective survey measures of mental wellbeing, life satisfaction and positive affect during and after the project. Grant reports that the contributors scores improved across all the measurements and significantly, improvements were maintained at a twenty-four week follow up, extending well beyond the broadcast. These are interesting findings that would suggest that certain series really do have the potential to improve wellbeing for contributors. These contributors were suffering from stress and life challenges rather than diagnosed mental health issues however, and this series might be better described as a wellbeing intervention.

Grant, while professing delight at the results concedes that the study was not a controlled scientific experiment (Grant, 2011). It is also important to acknowledge the conflict of interest between his multiple roles as study author, project advisor and on-screen expert. A limitation that is more significant from the perspective of this PhD project is that Grant takes the results to represent a validation of the positive psychology interventions and input of the experts, without acknowledging the potential effects of the production process and the experience of being part of a television show. Grant suggests the maintained improvements at 24 weeks are evidence that the results achieved in the series were not simply due to all the attention received by the contributors during the project, however without in-depth research it is impossible to discount other explanations that might explain the survey results, such as personal investment in the programme or the influence of audience feedback.

Research from other television genres provides some insight into the importance of aspects of the television experience itself. One notable conclusion is that despite the criticisms covered in the previous sections, across genres from dating to talk shows, the majority of contributors conveyed satisfaction about their involvement, or at the least, that they did not regret taking part (Grindstaff, 2002; Hibberd et al., 2000; Lånkan & Thorbjørnsrud, 2022; Moore et al., 2017; Syvertsen, 2001; Thorbjørnsrud & Lånkan, 2022). A key factor that influenced contributors' attitudes towards being on television was their reception by the public and wider media in the aftermath of their involvement. For some the public notice was welcome and rewarding. Contestants who appeared in a Norwegian dating series described the extra attention received from friends and family, out and about, and on occasions in the media as one of the highlights of taking part and being an "intense positive force"(Syvertsen, 2001, p. 332). However the motivations for, and consequences of, appearing on a dating show may be very different to those of contributors who are seeking help with their mental health and being asked to place their intimate personal struggles centre stage.

Research with contestants of *The Biggest Loser* (Moore et al., 2017) may offer a closer parallel to MHITV. In this American series the obese contributors were also seeking help (albeit for a prize) and were also open to potential stigmatisation and negative judgement because of public attitudes towards obesity (Tian & Yoo, 2015). In the series, clinically obese contributors were brought together to compete to lose the most weight

with the help of dieticians and personal coaches. Fifteen contributors were interviewed for the study, who all successfully lost a significant amount of weight on the series. The contestants reported positive experiences of having their fifteen minutes of fame such as being asked to appear on local television or endorse health and fitness products. However, they described this positive attention as for the most part short lived. Contestants were also subjected to negative attention such as comments on social media or in person – one contestant had people scrutinising their food shopping basket. They reported feeling unprepared for life after the show and unsupported as they struggled to come to terms with mixed public reactions, fluctuating attention and the challenges of maintaining weight loss by themselves. One contestant referred to the challenges as "post traumatic reality tv syndrome" (Moore et al., 2017, p. 699). It is worth pointing out that despite these difficulties, the majority of the interviewees said they would go on the show again, given the opportunity, which suggests that negative feedback was not enough to overshadow the perceived gains from taking part.

The two Norwegian case studies of mental health television series provide insight into both the benefits and disadvantages of discussing mental health issues in a public forum (Lånkan & Thorbjørnsrud, 2022; Thorbjørnsrud & Lånkan, 2022). Many interviewees in both studies discussed their pride about being part of an important anti-stigma message about mental health and connected the opportunity to speak out with their own self-healing. For example one patient said, "I don't have to keep my mask on and say that everything is going well, and that has been such a relief" (Lånkan & Thorbjørnsrud, 2022, p. 142). The study authors propose that their involvement in the television series may have helped to reduce their self-stigma. Likewise, mental health participants interviewed by Ytreberg & Thorbjørnsrud (2020) also supported the rewards of self-disclosure and subsequent affirmation from positive audience feedback, both within their immediate social circles and through continued engagement with the media. This is interesting because the implication is that there could be beneficial outcomes of taking part in television which are separate from, or interact with, any on-screen intervention provided in the series I am focussing on. I shall develop this point about the benefits of having the opportunity to talk openly about mental health in the following chapter when I discuss narrative psychology.

Equally relevant to my research however are the potential pitfalls and difficulties that the above studies identified about speaking about mental health (and cancer) in the mass media. A principal issue highlighted was how the participants' relationships with their mediated selves changed over time. In some cases participants experienced regrets about how much they had revealed publicly, especially as they moved further away from the point of time of their original revelations. For some the mediated versions of their stories provided an unwanted reminder of darker times that they would like to move past, made harder by re-runs or other uses of their original appearances (Ytreberg & Thorbjørnsrud, 2020). In their analysis of the therapy television case study, the study authors propose that for some participants a mismatch between the informal reassurances of control given to them and their subsequent disillusionment with how they were represented led to negative feelings towards their participation. As one participant said, "I felt better right after the group therapy, but the relapses later on due to that feeling of lack of control were far worse than this intermediate improvement"(Thorbjørnsrud & Lånkan, 2022, p. 947)

Another key point raised was how talking publicly encouraged mutual disclosure from audiences who would share their own stories or request help. One cancer patient described the impact of this emotional burden: "when I hear about people who are in the place I used to be, all those emotions come back, and it takes some time to get back out of that again." (Ytreberg & Thorbjørnsrud, 2020, p. 6189). Most seriously, a small minority of contributors reported that their involvement had a negative effect on their mental health. One patient felt that their anxiety around being recognised in public had led to them being re-hospitalised, saying "I simply felt mentally ill from it" (Lånkan & Thorbjørnsrud, 2022, p. 143). In addition, a minority of participants in the therapy series reported consequences including "relapses of self-harm and eating disorders, anxiety, social isolation, suicidal thoughts and reduced trust in others." (Thorbjørnsrud & Lånkan, 2022, p. 948). This is a significant finding which demonstrates the high stakes involved when contributors who are in the midst of mental distress are encouraged to discuss their experiences in such a public forum. These studies are a reminder that individual people can react differently to the same situation of being filmed and appearing on television, therefore it is crucial to attempt to unpick how best to identify risks and

protection needed in individual cases. This is an area where more research is needed, and directly addressed in this thesis.

In summary, the consequences of participation reported in the above research varied depending on factors such as the television format and type of participation. An important aspect for how contributors made sense of the outcomes of their television participation seemed to be their experiences of audience engagement. Where the audience response was positive, contributors generally reported positive outcomes and that they would be happy to appear on screen again. However where audience responses were more challenging, the consequences of participation were presented more ambiguously. Control over their representation was another important factor.

3.3.4 Unintended consequences of appearing on television – the UK reality TV scandal

Other studies have also shown how there can be unintended consequences of appearing on television. Grindstaff's interviews with American talk show contributors illustrate how the unwanted repercussions of discussing personal information on television can go beyond "embarrassment, humiliation, strained personal relations" (Grindstaff, 2002, p. 197) and include legal sanctions or damage to career prospects. Nash's research with documentary participants also attests to unforeseen outcomes. One participant she interviewed attributed their involvement in a documentary about cuts to a university music department, with vindictive treatment by their employer post filming, and a subsequent breakdown. The participant however framed these negative personal outcomes as counterbalanced by the wider positive impact of the documentary (Nash, 2012).

Another example of unintended consequences which is highly relevant to contributors of mental health intervention television is documented by Blaker (2013). Her analysis of a BBC documentary series about psychotherapy, *The Talking Cure* (1999) illustrates the unpredictable ramifications of conducting and presenting psychotherapy on screen, as demonstrated most notably in the third episode of the series. This episode featured a school, where the headteacher had responded to an advertisement for the show offering schools help for staff with stress management. A psychotherapist worked with the staff for several weeks, however this process raised issues about the head's

management and staff relationships that resulted in the head taking long term sick leave. This was clearly neither the intention or expected outcome of the production team, the school or the psychotherapists involved and illustrates the inherent risks attached to such a venture: "Just as the consequences of engaging in psychotherapy cannot be predicted, nor can the consequences of participating in a television programme. In programmes which feature on-screen psychotherapy, these two activities combine to form a high-risk pursuit which is overseen by the individual media practitioner" (Blaker, 2013, p. 206). As alluded to here, when therapy, television practices and audiences meet the consequences are unpredictable and ethically fraught. This raises issues of accountability and who is best placed to safeguard the needs of television contributors.

The issue of protecting contributors from negative outcomes from their participation was brought sharply into public focus in the UK in 2019 by controversy over the death by suicide of Steve Dymond, a contributor on the ITV daytime talk show *The Jeremy Kyle Show* (Boyle, 2019). The show had long been the subject of criticism for its confrontational format which relied on tropes such as lie detector and DNA tests to create drama and conflict onscreen (Cadwalladr, 2008). Steve Dymond was reported to be devastated after failing a lie detector test on the show, which he had hoped would prove to his partner that he had not been unfaithful. A week later he died of an overdose, and it emerged that he was being treated for depression (Morris, 2020). The episode never aired, and the long running series was subsequently cancelled by ITV, however the media outcry surrounding the death, and connections made with the suicides of two ex-television contestants from the reality TV dating show *Love Island* (ITV) put duty of care towards television contributors into the spotlight (Marsh, 2019; Rajan, 2019). In response, the government Digital, Culture, Media and Sport (DCMS) select committee launched an investigation into the treatment of reality TV participants[8] (UK Parliament, 2019b). It collected evidence from broadcasters, production, academics and professional bodies such as the British Psychological Society. I will discuss the inquiry's evidence on production practices and the implications for television production of this renewed focus on contributor care in the following chapter.

[8] The inquiry was closed before making recommendations due to the announcement of a general election

With regards to consequences of participation, amongst the evidence presented to the committee were first-hand accounts from contributors from a range of series (UK Parliament, 2019a). Newspapers and news programmes also ran interviews with past reality TV contributors (BBC, 2019; Reynolds, n.d). Many of these reports referred to the negative impact on contributors' mental health from taking part and appearing in television series. Some ex-contributors had specific grievances with the way they were represented such as Dwayne, a guest of Jeremy Kyle, quoted by *The Guardian* newspaper as saying, "that show ruined my life" (Waterson, 2019, headline) and that he tried to take his own life following the sustained abuse he received after his appearance. Another contributor who was filmed for the audition stage of *Britain's Got Talent* (ITV) sent a detailed complaint to the inquiry documenting "the emotional and reputational damage" (Pye, 2019, p. 1) experienced after her group of performers were unfairly edited as "The Joke Act" (p. 5). Other ex-contributors documented more generally the challenges of finding themselves subject to public scrutiny and the pressures of social media and other media coverage on their wellbeing (UK Parliament, 2019a).

The series referred to in the reality TV inquiry and media reports of the time may be different in content and protocols to mental health intervention television however there are some important points that are relevant. The issues raised above surrounding the pressures of television exposure and the consequences of potentially damaging representation are broadly applicable. The *Jeremy Kyle Show* was notoriously confrontational and has been exposed for appallingly unethical practices towards guests, including active deception, manipulation and shoddy aftercare[9]. There is no evidence that any mental health intervention series operate similarly, however the systemic problems with the show's format and practices, are a clarion call to better understand points of similarity and difference within television programming that feature vulnerable adults.

One key shared format convention, between MHITV and *The Jeremy Kyle Show* is that they both provided contributors with access to services such as counselling and addiction support. This has been put forward in defence of *The Jeremy Kyle Show*, however it is also a point of criticism, as incentivisation for potentially vulnerable adults

[9] A two part documentary on Channel 4 'Jeremy Kyle Show: Death on Daytime' was broadcast in March 2022. It included interviews with past guests and staff who were highly critical of the treatment of guests.

to appear on the series in lieu of services which may be hard to access in the public domain (Woods, 2021). This is a criticism that could also be levied at mental health intervention television. The research and examples above demonstrate that the outcomes of appearing on television can be unpredictable. Given the potential for unforeseen negative consequences, it is vital to establish the motivations and outcomes for contributors who appear in MHITV programmes.

3.4 Conclusions – participating in mental health intervention television

Theoretical analysis of participation in popular television foreground some of the political, economic, structural and cultural factors and influences that inform the ways in which ordinary people are produced and received in television programmes. However, this work can only go so far to explain the context specific and embodied experience of contributors who take part in MHITV. Empirical research from other genres demonstrates how television and documentary contributors come with a range of motivations. However whether their expectations can be realised may be limited by their ability and opportunities to control their television journeys both in terms of the production process and the reception of their mediated stories. Whilst it should not be assumed that television contributors are powerless within the production dynamic, the structures of programme making inevitably favour the needs and agendas of programme makers and broadcasters.

There is limited research that address the consequences of appearing on television, however the studies that have been undertaken, and other related accounts from contributors, highlight that outcomes can be unpredictable, especially for those involving sensitive subject matter and potentially vulnerable contributors. Whilst the experience of being seen and heard can be rewarding for some, the exposure can also have a negative impact on people's lives and wellbeing. The tragedy of the deaths of reality television contestants and talk show guests demonstrate the need for formal research into television contributor care and mental health outcomes more broadly. A production crew arriving, filming and putting a contributor on television is making an intervention in their life, with a set of consequences. What is unknown in the case of mental health intervention television series, where therapeutic support is being

provided for participation, is how these television specific factors may interplay with the formally offered interventions provided on the programmes. There is an ethical imperative to understand how the motivations, production experiences and outcomes of being on such a high profile public forum come together with the intervention and pre-existing vulnerabilities to shape contributors' experiences.

The body of work covered in this chapter has helped clarify the direction of my research. It has demonstrated the importance of paying attention in my study to the power dynamics at work where contributors, production teams and audiences come together. It also highlights the relevance of examining motivations for participation and whether the outcomes of participation meet these expectations. These issues are particularly pertinent given that the narrative conventions identified within some MHITV formats may limit the ways that contributors and their experiences are represented on screen. The research above illustrates how what is shown on screen is only one part of the story. Importantly, identifying the significant gaps in current research into the experiences of UK television contributors has reinforced my commitment to placing their voices at the heart of my project.

Chapter 4: Making television with members of the public

4.1 Introduction

In the following sections, I shall explore the limited research with UK television production staff which addresses their working practices with contributors, and put this in the context of the recent changes to the UK regulatory framework that sets out the legal responsibilities of broadcasters to television contributors. Contemporary research that considers the ideologies and practices of producers specifically in relation to television contributors is rare. One exception is the study by Hill, Askanius and Kondo (2019) into production practices and audience involvement in the making of a live dance competition series. This study did consider the care structures in place to protect the child performers involved, however it represents a very different production context and programme content to mental health intervention television. Additionally, two recent industry reports investigating occupational stress and mental health within the creative industries provide some useful insight into producer-contributor dynamics, although this was not their primary focus (Rees, 2019; Wilkes et al., 2020). The lack of UK television production research into contributor welfare points to a gap that this PhD project helps to address, specifically by including as research participants those involved in producing MHITV.

Given the paucity of empirical research into UK television production practices towards contributors, I also draw on contemporary international studies within documentary production. The director-participant relationship has been a consistent area of interest within documentary ethics (Nichols, 2017). As discussed in earlier chapters, contemporary factual television production is characterised by genre hybridity and fluidity (Creeber, 2015). Whilst there may be significant differences in practice between the making of an independent documentary film produced for cinematic release and the production of a heavily formatted television series, the processes and considerations involved in the making of a television documentary sit somewhere more in the middle. Therefore work such as Aufderheide's (2012) interviews with television documentary makers can add important context to the accounts provided by my production interviewees. Research from within documentary ethics is also interesting in how it can highlight differences with a mainstream television context, such as Thomas's description

of how going outside of mainstream television industry production allowed a more collaborative approach to working with contributors (Thomas, 2012).

Finally, I will highlight the limited research into the involvement of therapists within factual television production, both on screen and behind the scenes. As discussed in chapter two, media and cultural studies scholars have critiqued the role of therapy experts in both talk shows and reality television (Henson & Parameswaran, 2008; Ouellette & Hay, 2008; Palmer, 2008; Shattuc, 1997; White, 1992) however much of this work has focused on texts and audiences, rather than directly examining the implications for therapists and contributors of participating in on-screen therapy. Within the field of psychology, empirical research into the implications of screening therapy have concentrated around the pros and cons for audience understandings of mental health, treatment and stigma (Bates et al., 2020; Rasmussen & Ewoldsen, 2016; Stuart, 2006). There has been surprisingly little consideration given to professional and ethical implications for psychologists involved in television work. The recent focus on the treatment of reality television participants has led to a greater discussion within both the television industry and the psychology profession of the role of therapeutic professionals within television production. The British Psychological Society for example was one of several professional bodies to submit evidence to the inquiry into reality television and the Office of Communications (OFCOM) consultation on changes to the broadcasting code.

4.2 UK Regulatory framework – working with television contributors

Under the regulatory authority of OFCOM, television broadcasters in the UK are legally obliged to meet certain standards regarding content. These are set out in the Broadcasting Code (OFCOM, 2020). The procedure for complaining to OFCOM is explained in Appendix A. Broadcasters such as the BBC, ITV and Channel 4 publish editorial guidelines for independent production companies for how to enact the code. Whilst much of the code is focused on the prevention of harm to audiences, there are several sections that apply to the treatment of television contributors. 'Section seven: fairness' sets out the parameters of what constitutes informed consent and fairness of representation. This includes guidelines about accuracy and giving the right to reply. Crucially it states the expectations of the information that should be provided to

contributors about their involvement. 'Section eight: privacy' sets out the practices to be followed so that the privacy of individuals and organisations is not infringed without justification. This would include ensuring broadcasters have obtained permission to film in private locations or in sensitive public settings such as hospitals, or if recording personal conversations or people in distressing circumstances such as car accidents. Finally, 'section one: protecting the under eighteens' sets out specific responsibilities when working with young people and children.

The only direct reference to contributors with mental health issues is under section seven: privacy, whereby people who are experiencing a mental health problem are classified as "vulnerable people". The code gives the following definition:

> Meaning of "vulnerable people". This varies, but may include those with learning difficulties, those with mental health problems, the bereaved, people with brain damage or forms of dementia, people who have been traumatised or who are sick or terminally ill (OFCOM, 2021, Privacy 8.20-8.22).

The code requires broadcasters to pay particular attention to ensure that the right to privacy for vulnerable people is not infringed. In practice this entails broadcasters should apply enhanced measures around the issue of informed consent, and in changes to the code which came into effect in 2021, taking a more pro-active stance towards contributor duty of care (OFCOM, 2021, Fairness).

Broadcasters have a legislative responsibility to obtain informed consent. Under section 7.3 fairness, the code states that unless there is a justifiable reason to withhold information, television contributors should normally be informed of (in summary):

- The nature of the programme and why they have been asked to contribute
- Where it is likely to first be broadcast
- what their contribution will involve such as an interview, debate
- The likely areas of questioning and if possible the nature of other likely contributions
- Any significant changes during production that could alter their original consent
- Their contractual rights and obligations and those of the producers and broadcaster
- The limits of their editorial control if offered a pre-view of their finished contribution
- Any potential welfare risks related to their participation and steps to mitigates these

The last point was added following the controversy over participant care in the wake of several suicides and the subsequent inquiry discussed in the previous chapter.

For individuals defined under the OFCOM code as vulnerable, the code also requires that unless their participation is trivial, as well as the consent of the individual, additional consent must be obtained from "a parent, guardian or other person of eighteen or over in loco parentis" (OFCOM, 2021, Privacy 8.21). This would mean in theory that anyone with a mental health problem would require consent from an additional appropriate adult to take part in a television programme. In practice however, it appears that broadcasters have interpreted this rule as necessitating a consideration of whether vulnerable contributors have the capacity to consent. This may include discussing their situation with central care providers and/or getting an independent assessment. For example the BBC editorial guidance on working with contributors states: "Consent for broadcast can only be confirmed when it is clear that the vulnerable person has the capacity to give informed consent on the issue of broadcast. A professional will sometimes be required to assess whether this is the case" (BBC, 2021, Vulnerable contributors with the capacity to give informed consent). The BBC guidelines go on to specify that when a vulnerable contributors cannot give informed consent, *then* another adult with primary responsibility for their care should normally be required to give consent. The guidelines also state that it may be necessary in extreme cases to re-establish consent if filming with individuals whose mental state is changeable (BBC, 2021). ITV and Channel 4 both take a similar line in their guidelines for producers (ITV, 2021; Channel 4, n.d.).

In summary, the OFCOM guidelines require broadcasters and production companies to ensure that contributors have enough information to make an informed decision about participating in a television programme. Contributors with mental health problems are classed as "vulnerable", requiring extra measures to confirm that they have the capacity to consent and fully understand the potential consequences of their involvement. However as the next section details, there are questions about how consent is obtained and conceptualised within the context of television productions.

4.3 Informed consent in practice

Practices around informed consent are central to understanding the experiences of contributors who take part in a television programme. Their motivations for participating, views on the production process, and reactions to the outcomes of being on television will all be influenced by their understanding of what they are agreeing to be involved in. From an industry standpoint, the principle of informed consent is the first line of defence in justifying the treatment and representations of television contributors, especially in controversial formats when this might appear questionable (Brenton & Cohen, 2003). Academics and practitioners however have questioned how informed consent is conceptualised, particularly within the field of documentary ethics.

An important issue raised by this work is the power disparity between contributors and producers built into the practices by which consent is formalised through the signing of release/consent forms (Nash, 2012; Nichols, 2017; Thomas, 2012; Winston, 1995). It is standard procedure for productions to obtain signed consent from contributors in the form of a brief written agreement which sets out basic information about the programme, nature of contribution (e.g. interview) and contractual rights and obligations of both parties. From an ethical standpoint, consent forms are problematic because they favour the rights of the filmmakers over those of contributors. These forms employ formal legal terms and are predominantly focussed on defining the production or broadcasters' rights – such as assigning them worldwide copyright, setting out the limits of their liability and giving permission to edit and adapt 'the contribution'.

Unlike the principles of informed consent within health care and research, the production release form has the effect of limiting the rights and control of contributors (Lånkan & Thorbjørnsrud, 2022). Nash (2012) found that both documentary participant and film-maker in one of her documentary case studies perceived the signing of consent forms as running counter to the process of building trust and mutual understanding within the film making process. Its effect was to disempower the documentary participant rather than enhance consent. What does emerge from interviews with practitioners however, is that documentary filmmakers sometimes informally offer more control to their contributors over their participation than what is specified in their signed agreements (Aufderheide, 2012; Lånkan & Thorbjørnsrud, 2022; Nash, 2012).

This was the case in Aufderheide's interviews with television documentary directors and producers. The interviewees reported an acute awareness of their position of power over their subjects, which led them in some cases to offer contributors more leeway, such as letting them see footage or request that something is not included. However, the informal unwritten nature of these arrangements allowed directors to maintain their creative control if necessary. For example one film-maker explained how he will tell contributors "We will show you the film before it is finished. I want you to sign the release, but we will really listen to you. But ultimately it has to be our decision" (Aufderheide, 2012, p. 373).

In another example, in the Norwegian documentary series filmed in a mental health institution, patients were offered a preview, as well as given the right to withdraw their consent. Interestingly this was written into the consent forms for patients at one particular institution due to the involvement of a legal specialist at that institution. This was not offered in writing to patients filmed at other clinical settings however (Lånkan & Thorbjørnsrud, 2022). The failure to enshrine the right of withdrawal to all participants suggests that regardless of an outward commitment to the principles of collaboration and autonomy, it suited the production to limit their written obligations. The Norwegian production's approach may be a recognition of the sensitivities of dealing with contributors who are experiencing serious mental health problems and whose conditions are potentially unstable. As the production was filming within a mental health institution it is also highly possible that making certain concessions to patients and staff filmed was a necessary part of obtaining access. In the case of MHITV, where it is individuals who are being targeted to take part, they may lack some of the bargaining power that an institution or collective group of people can action.

The examples above demonstrate that the standard processes by which productions evidence consent through release forms potentially disadvantage and disempower contributors. Within documentary production however there can be a difference between the formal versus informal rights assigned to contributors. This would seem to be very much dependent on the particular ethical stance of individual producer/directors. It may also be dependent on the culture and expectations set from other interested parties such as channel commissioners. For example, Thomas (2012) advocates for a more collaborative approach to filmmaking where consent is

reconceptualised as a continual process. To achieve this outcome, he describes how he raised his own funds for his documentary project which allowed him to avoid "the increasingly controlling interference of television commissioning editors and executive producers" (p. 332) which restrict documentary makers' ability to operate ethically and creatively.

There is a shortage of work that looks specifically at the practices of obtaining informed consent within television production, particularly in the UK context. Nash (2012) points out that the voices of documentary participants have largely been absent from debates about consent. The same could be said of television contributors. One of the few studies that addressed the issue of informed consent with television contributors was The BSC report (Hibberd et al., 2000). It found that in general, television participants felt that they had been given enough information to make an informed decision about taking part in a programme and were happy with the procedures in place to obtain their consent. However, this research was conducted before the OFCOM guidelines on consent were updated. In addition, the way in which audiences watch and engage with television across multiple media platforms has changed dramatically since this research, and with it, the implications of appearing on television.

Other research from different countries has demonstrated that despite being briefed, ordinary people with little understanding of the production process can still end up being surprised (Hibberd et al., 2000; Mast, 2016; Shufeldt & Gale, 2007). It is hard from them to comprehend the amount of filming and subsequence editing that goes in to make a programme, or the extent of the disruption that filming can entail (Aitken et al., 2012; Lånkan & Thorbjørnsrud, 2022). Mast (2016) raises another problem with the concept of informed concept, based on interviews with both producers and participants of Belgium versions of international reality TV formats. Mast found that when participants give their consent to take part in reality TV shows; they may not fully understand the consequences of public exposure and the impact of other media platforms such as social media, or the longevity of the programme life, which could remain on online mediums far beyond the initial broadcast. In a similar vein, Thomas argues that an intrinsic flaw in the concept of informed consent is that: "A particular problem lies in the impossibility of predicting the full effects of participating in a film until after it has been released" (Thomas, 2012, p. 333).

The crux of the matter therefore is the extent of the responsibility of productions to inform and prepare contributors for negative outcomes. One candid response from an editor in the Belgium study highlights how production teams can be conscious of not wanting to tell participants so much about what to expect after broadcast: "You can only warn them they will be recognized everywhere they come, and that if things go wrong, they may be laughed at. But, well, you don't want to cry this out loud either, do you, because it's just that unknowing attitude you want" (Mast, 2016, p. 2187).

The research above illustrates the problems with how consent is managed in practice. It demonstrates how contributors can be at a disadvantage due to a lack of understanding of the production process and the way consent is documented through releases forms which favour the rights of productions. In the UK several suicides of ex-reality television contestants put the responsibility of broadcasters (and productions) towards re-evaluating consent and welfare for contributors firmly on the agenda. This led to the added clause in the Broadcasting Code on informed consent whereby contributors should be informed of potential risks and importantly, steps to mitigate them (OFCOM, 2021, Fairness). In theory this means that contributors should be more informed and prepared for what is ahead of them. However as will be discussed next, there remains questions over how the new guidelines translates into practice, with a particular debate being over role of 'psych' professionals within television consent and welfare procedures.

4.4 Duty of care – the problems of using 'psych experts' behind the scenes

The changes that OFCOM introduced in 2021 were designed to increase the responsibility taken by television broadcasters and productions to protect the welfare of ordinary people who appear on screen. As well as adding an understanding of the risks to the threshold for the definition of informed consent, OFCOM introduced a new clause specifically related to duty of care, section 7:15, which states:

> Broadcasters should take due care over the welfare of a contributor who might be at risk of significant harm as a result of taking part in a programme, except where the subject matter is trivial or their participation minor. (OFCOM, 2021, Fairness 7:15)

Contributors defined by the code as at risk of harm are (in summary):

- "vulnerable contributors" (as detailed above)
- people not used to being in the public eye
- formats with artificial and constructed environments
- formats that involve conflict or emotional challenging situations
- programmes that will involve discussion about sensitive, life changing or private aspects or people's lives.

In separate guidance for broadcasters on interpreting the code, OFCOM provides examples of best practice. These include conducting a thorough risk assessment and the use of independent expert advice to screen the suitability of contributors, assess the welfare risks and necessary measures of support (OFCOM, 2021, Guidance Notes).

During the OFCOM consultation period in 2019, the need for change was largely acknowledged by the television industry (OFCOM, 2020, Statement). Broadcasters have since updated their guidelines for productions to reflect the changes, most significantly incorporating the risk matrix provided by OFCOM as a point of reference for productions to assess what measures should be in place. It is too early to know what difference this will make to the experience of contributors however there have been some signs of positive changes. For example ITV announced an enhanced package of welfare measures in advance of series seven of *Love Island* including pro-active contact and therapy for all ex-contestants rather than as needed; and advice on finance, social media and securing management (ITV, 2021, *Love Island*). The BBC (2021) has updated its editorial guidance emphasising that productions must pay attention to the needs and understanding of vulnerable contributors. It gives examples such as taking some responsibility for deciding whether participation is in the best interests of a vulnerable contributor, having one main point of contact within the production, and considering letting vulnerable contributors see their edited contribution before broadcast. In particular, it emphasises using expert advice to assess the risks and support needed.

Formalising the need to pay attention to the welfare of contributors is an important step, which was entirely missing from broadcast regulation before the update to the code. It is important to note however that many of the safeguarding steps implied by the OFCOM changes were already common practice within factual productions, therefore it cannot be assumed that the new code automatically fixes things. Most notably, the use of psychologists or other 'psych' professionals such as psychotherapists

to provide screening and welfare services for contributors has been a long standard practice for series which involve substantial filming with members of the public. However, the involvement of psychological experts in this way has been subject to substantial criticism. As far back as 2003, Brenton and Cohen gave a damning critique of the role of psychological experts in earlier competitive reality television series such as *Big Brother* and *Survivor*. They argued that their expertise was used to provide such series with a defence against exploitation, but this was undermined by their lack of independence. Furthermore, they claimed that the information provided by psych experts in screening contributors for vulnerabilities was used to aid the picking of personalities for the show likely to generate the most drama and interpersonal conflict. According to Brenton and Cohen (2003, p. 97) "This is the root of the problem with media consultancy on television shows – in whose interests is the psychologist-consultant working?"

This question over the independence of psych consultants working with productions remains relevant nearly two decades later. *The Jeremy Kyle Show* for example, which was instrumental in triggering the review of contributor welfare in reality television had a dedicated aftercare team tasked with the assessment and support of guests both pre and post broadcast. This team was led by a psychotherapist registered with the UK Council for Psychotherapy (McCall, 2019). This did not stop the specialist advisers to the reality television inquiry from finding significant failings in the protection of the welfare of guests (Dare & Wood, 2019). One of the major criticisms was the lack of independence of the Director of Aftercare. They concluded that there was a clear conflict of interest and blurring of boundaries between the Director of Aftercare's role in guest welfare and their onscreen appearances providing expert opinion. Therefore, despite on paper having the kinds of support available that would potentially fulfil the new requirements of the broadcasting code that have since followed, in practice, the care and assessment provided was compromised by the conflict between the obligations of the psych experts towards the series and the welfare of guests.

Television practitioners have also raised concerns about the potential limitations of psychological screening to provide protection for contributors within production. Directors UK, a professional association of UK screen directors submitted the concerns of members about the veracity of screening to OFCOM during the consultation on

changes to the broadcast code. It argued that limited budgets sometimes meant a lack of the level of rigor applied to psychological screening of contributors: "The resulting 'psych reports' are taken seriously, but feel like a box-ticking exercise that exists to clear production and broadcasters of blame rather than a truly rigorous exploration grounded in care" (Directors UK, 2019, p. 3). Directors UK argued that without the introduction of a formal requirement for a dedicated budget for contributor care, funded by broadcasters, then the welfare of contributors will not get the due attention that is necessary. The perception of screening as a tick box exercise was reiterated by production staff interviewed for the Dart Centre investigation into occupational distress within UK factual television (Rees, 2019). The report raised concerns about the lack of standards over who performs screening and how testing is conducted. Echoing Brenton and Cohen's criticisms, some interviewees intimated that the information provided by screening may also be mis-used to choose contributors who will provide maximum drama. In addition, two psychologists involved in screening were interviewed for the study and reported incidents when they had been pressured to change their reports or where the producers had gone against their suggestions.

A related problem is the opaque process by which productions navigate and choose appropriate professionals to provide contributor support from the myriad of psych professionals, therapeutic qualifications and associations connected to mental health and the provision of therapy. Both the British Psychological society (BPS) and the Association of clinical psychologists (ACP-UK) have raised concerns about productions employing *psych experts* who may not be suitably qualified to be responsible for contributor screening or welfare judgements (BPS, 2021; ACP-UK, 2019). The ACP-UK point to the problem that *psychologist* is not a protected title and therefore anyone with minimal training can call themselves a *consultant psychologist* or similar and offer their services to productions[10]. They argue that *clinical* or *counselling* psychologists more specifically, who will have undergone accredited post graduate training and are regulated by the Health and Care Professions Council (HCPC) are most qualified to provide appropriate support to contributors within television productions (ACP-UK,

[10] There is also a difference between regulated and registered – Psychologists may be registered with the British Psychological society for example and agree to certain minimum standards but it has no regulatory power. See for example the website of Jo Hemmings – who describes herself as a 'duty of care psychologist' who is registered with the BPS - but does not specify in what capacity or what specific qualifications she has https://www.johemmings.co.uk/duty-of-care-psychologist/

2019). Similarly, the BPS guidance for television commissioners and producers advises productions to verify the credentials of psychological experts working on productions (BPS, 2021).

In summary, new OFCOM guidelines require production companies to inform contributors of any potential risks of their participation and measures to mitigate them. Many series employ psych professionals in this capacity to screen and support contributors where necessary. However even the validity and veracity of psych screening and support in some circumstances has been challenged by academics and professionals and producers. Therefore the ability of these measures to protect contributors has not been established and requires further investigation.

4.5 The ethical challenges of providing therapy as an on-screen psych expert

As well as the challenges and limitations of using psychological expertise behind the scenes, there are important ethical questions around the ramifications of *psych experts* appearing and conducting therapy on screen. Blaker (2013) is one of the few researchers to examine the practical ethical considerations for media practitioners and psychotherapists involved in programmes which show therapy "who must negotiate the challenges which emerge when the rights of vulnerable programme contributors are pitched again the demands for 'good television''' (p.193). Blaker's analysis of therapy on screen in *The Talking Cure* (BBC2, 1999) demonstrates how the introduction of filming and the removal of the confidentiality inevitably impacts on and changes the experience of therapy. This presents questions over who is responsible for managing the potential risks for contributors when the normally private process of therapy is made public. Blaker argues that the psychotherapists involved in filming the Talking Cure provide an additional ethical safeguard for contributors, however because the production retains control of the editorial direction of the series, they have a greater responsibility for contributor welfare.

Another way to think about this, is that the therapists are unlikely to have final control over how the contributors and the therapy are represented on screen, which limits their ability to protect them. This lack of control over what ends up on screen is one reason why psychologists and other therapeutic professionals may be wary of allowing their

therapeutic work to be filmed for television. In an article in the BPS publication, *The Psychologist*, about working with the media, common themes were distrust and frustration over how media contributions can be edited, oversimplified, or misrepresented, as typified by one psychologist's concerns: "I also regularly worry about how my contribution will be perceived by my colleagues or whether it will end up resulting in more harm than good. This worry is not entirely unfounded, as typically there is little or no control over what gets written or aired" (Viding, 2018, p.38). This quote demonstrates that as well as the ethical challenges of protecting any contributors they may be working with, a lack of control over the representation of their own professional image is perceived as a risk. Whilst there can be many professional benefits from the opportunity of high profile media exposure, there is also the danger of reputational damage and censure from peers if it goes wrong. The lively commentary and debate generated within the psychotherapy community and wider media in response to *The Talking Cure* is evidence of this, with some commentators highly critical of the psychotherapists involved and their decision to take part (Blaker, 2013).

Blaker's analysis of *The Talking Cure* was based around textual analysis and secondary data from the series. There is little research that has examined first-hand the experiences of psychologists and other therapists who are filmed for television. One article that does provide some insight is an account given by a family therapy team from Greenwich Children's and Adolescent Health Mental Health Services (CAMHS) about their involvement in a BBC documentary film (Aitken et al., 2012). Their report documents how they had underestimated how filming would affect their normal therapy procedures and their consternation when they realised that the production crew were also filming the families in therapy in their home, something the clinical team had not been prepared for. Their account also demonstrates that they grappled with the limits of their control over the editorial direction of the film, encapsulated by their disappointment over the final title *I Hate Mum*. This was changed from a working title of *Family Rescue*, and the team had no say in the name change. Whilst the therapy team concluded that the experience and final documentary were ultimately a success, their account demonstrates the considerable challenges of maintaining control over the content of the final film or what was being filmed with contributors (and therefore their ability to protect them and their own professional identities).

The issues of filming therapy are particularly relevant to mental health intervention television where the use of psychological and other experts to deliver on-screen interventions is a central feature of the series formats. One important difference with the examples discussed above is that they involved the filming of therapeutic teams in their normal working environments (although in the case-study presented by Blaker, the production company found the contributors who underwent therapy.) In formatted television series where the production company has designed the construct of the series and cast both the experts and central contributors, the issues of who has control of the therapeutic project and responsibility for the contributor welfare becomes even more complex. As demonstrated by the example of *The Jeremy Kyle Show* (ITV), when the experts themselves have been in effect auditioned and contracted by the production company to offer up an onscreen performance, their independence to make the right ethical decision for the contributors' welfare and treatment could be compromised. As Brenton and Cohen phrase it "they are hardly going to bite the hand that feeds them" (2003, p. 120).

There are also questions over the legitimacy of what kind of therapeutic interventions are offered on-screen and by whom from the wide range of *psych experts* offering interventions for mental health and general wellbeing (Palmer, 2008). When productions are working with therapeutic professionals who are not part of accredited bodies or established public services, this potentially removes a layer of accountability and/or quality control for the services being provided. For example, the unverified qualifications and therapeutic approach of Nik and Eva Speakman who regularly appear as therapists on *This Morning* (ITV) was challenged during the Government inquiry into reality TV (Dare, 2019). The examples presented in this subsection demonstrate that televising therapy creates significant ethical dilemmas around the impact of cameras, the efficacy of what is being provided, accountability, and independence. Crucially, there is limited academic work that has explored these issues in practice.

4.6 Making programmes with vulnerable contributors

Whilst it would seem the television industry is finally being forced to pay attention to its responsibilities towards contributors who appear on screen, another area that has been generally overlooked and under researched is the impact on production staff of working

with vulnerable contributors and producing content around sensitive subject matter. Within qualitative social science research, there has been a growing focus on the personal challenges researchers may face when engaging with vulnerable communities, and interviewing participants about traumatic experiences (Dickson-Swift et al., 2009). Melzer (2019) draws on this literature to examine the parallels between conducting research and her own experience of filming a documentary project in which she interviewed caregivers of veterans with Post-Traumatic Stress Disorder (PTSD). Melzer applies Hochschild's (2012) concept of 'emotion work', referring to the work involved in dealing with other people's emotions, to explore the personal toll of directing a film about such a difficult and traumatic subject. She argues that emotional work is an integral part of the film making process:

> the emotion work I undertook was crucial to the project's success facilitating access to participants, securing their ongoing involvement, encouraging them to share their stories with openness and candour, and motivating them to distribute and promote the films. Whilst demanding, draining and difficult, emotional work is a necessary element of quality documentary filmmaking. (Melzer, 2018, p. 47)

Melzer powerfully explores the impact of this emotion work on her own mental wellbeing and the potential for vicarious trauma when making a film about other people's traumatic experiences (Eriksen, 2017). She describes her initial reluctance to discuss this openly, or seek help, for fear of seeming weak or indulgent, given that within documentary ethics, the impact and ethical responsibilities of filmmaking have focussed on the filmed participants.

Many of the points that Melzer raises have been replicated in two recent UK studies which demonstrate similar issues for production staff working within television production (Rees, 2019; Wilkes et al., 2020). The Dart Centre for Journalism and Trauma investigated causes and management of occupational distress within factual television production through interviews with twenty-two producers and other industry stakeholders (Rees, 2019). A second study commissioned by the Film and TV Charity investigated the mental health of workers within UK film, television and cinema (Wilkes et al., 2020). It comprised an analysis of nearly 5000 responses to an online survey and 30 in-depth interviewees. Both of these studies specifically highlight the challenges of working with vulnerable contributors. Notably the Dart report identified that when

interviewees were asked the broad opening question: “what do you see as being the main drivers of occupational distress?” that whilst there were multiple suggestions, “everyone, however, mentioned at some stage the strains that result from close involvement with vulnerable contributors.” (Rees, 2019, p. 10).

Like Melzer, both UK reports stressed the danger of vicarious trauma for producers who are working closely with vulnerable contributors and exposed to distressing stories and emotional responses. Melzer however was working independently and in control of her own ethical conduct and moral decisions around working practices. In contrast, the UK reports highlight that a significant source of occupational distress for producers working within a television production environment was their lack of control at times over how vulnerable contributors were dealt with. Interviewees in the Dart report described either witnessing treatment of contributors that they felt was unethical or feeling pressured to act in ways they were uncomfortable with:

> Dilemmas involving highly vulnerable contributors extend across genres, including moral doubt about informed consent, manipulation of contributors and concerns about the abuse of psychological testing of contributors. Nearly one-third of interviewees volunteered, without prompting, that they had been forced at one time of another to act against their conscience in this regard. (Rees, 2019, p. 7)

Similarly, respondents to the Film and TV Charity Survey also reported feeling pressured to take decisions that compromised their ethical standing such as misleading contributors about the nature of a programme or depicting contributors in negative ways. The report found that pressure to ignore ethical concerns was compounded by a working culture that made it hard to challenge the decisions of superiors for fear of being labelled as difficult, particularly given the precarity of freelance work.

Another issue identified was the weight of responsibility for vulnerable contributors, and the fear of doing them harm: “What if I knock them over the edge?” (Rees, 2019, p. 11). This was particularly felt by more junior producers who are often responsible for maintaining regular contact with contributors and keeping them on board. Respondents reported blurred boundaries between where their responsibilities towards contributors begin and end, an example being that producers are normally expected to give out their mobile numbers to contributors. As Melzer (2018) has identified, part of getting the good material entails building trust and being a willing ear for contributors, however this

leaves producers navigating the line between what is exploitation, what is right for the programme and what is right for themselves. The boundaries between interviewer, friend and therapist can be hard to navigate as one respondent in the Dart report explained: "You have such intense relationships with your contributors and your job is to kind of get to know them and get them to reveal themselves. And you are kind of like a therapist almost" (Rees, 2019, p. 13). Despite at times taking on pseudo-therapeutic roles, respondents suggested that they did not feel they had the proper training to manage the complex needs of contributors.

The Dart report makes some interesting distinctions between different genres of factual television production which are relevant to mental health intervention television. It suggests that in certain specialisms such as medical or social issue documentaries there is a subset of highly skilled, experienced producers who place significant emphasis on the need to support and train junior members to sensitively deal with contributors and manage traumatic subject matter. However, the report also suggests that certain formatted factual programmes by nature of their compressed schedule and the need to hit specific format points may limit the ability to carefully consider the needs of contributors, with the potential of problems for contributors and producers being higher. As one producer explained:

> There's very little freedom to just go out there and meet someone, let them be themselves and tell a truthful story, instead what we're doing now is we're going out there and we're telling someone what their story is and we're pushing it into that narrative which is also super harmful. (Rees, 2019 p. 13)

The Dart report author concludes that the combination of exposure to distressing material, the weight of personal responsibility towards vulnerable contributors and pressure at times to go against ethical instincts are liable to cause moral injury to production staff with serious implications for wellbeing. Likewise, The Film and TV Charity report that found that 87% of respondents reported experiencing a mental health problem, a significantly higher rate than in the general population. It cites working with vulnerable contributors as one of the risk factors for mental health issues amongst workers within the film and television industry (Wilkes et al., 2020).

This research raises crucial issues for both production staff and contributors that are extremely relevant to MHITV. It highlights the serious impact on the mental wellbeing of producers of working with vulnerable contributors. This is an issue that has been greatly overlooked and is not addressed by the OFCOM changes, despite submissions from industry bodies who have highlighted this gap. The reports by respondents of the manipulation of contributors and decisions taken which were not felt to be in their best interests is a serious concern. Equally worrying is the implication that producers may find themselves taking on pseudo-therapeutic relationships with contributors but without the appropriate training or support to protect both sides. Combined with the pressures mentioned above, there is the danger that this could do more harm than good. These are important concerns, where further research such as this PhD project undertakes is clearly warranted.

4.7 Summary – can you make ethical mental health intervention television?

This chapter has demonstrated that despite welcome changes to the OFCOM Broadcasting Code which provide a stronger regulatory framework to direct how broadcasters and productions protect the welfare of contributors, there are still questions about how these changes are put into practice. Notably, the conceptualisation of informed consent which is a central principle of protecting contributors has been criticised by academics and television practitioners alike. There are questions over whether informed consent is achievable within a commercial television production framework, given the need to ensure broadcaster rights over footage, and the unknowable impact of appearing on television. There is little current UK research that has explored these issues from a contributor perspective to ascertain how they make sense of their preparedness for being involved in a television project. With series that feature vulnerable contributors who are forfeiting their rights to privacy to take part in on-screen interventions the ethical dilemmas are particularly complex. The research reviewed above has highlighted that working with vulnerable contributors throws up a distinct set of challenges for crew, therapists and other intervention providers. Unclear boundaries between roles and responsibilities are a potential danger both for the production team attempting to provide unqualified support and the contributors whose needs may be missed between competing agendas. For on-screen therapists there is a

tension over how they can maintain their independence from a production and whether it is possible to deliver ethical treatment given the impact of cameras. There is limited empirical work which has examined the decision-making processes and working practices behind series which provide on screen interventions such as therapy. It is crucial to understand how the welfare of contributors is managed between media practitioners, intervention providers and behind the scenes advisors.

4.8 Literature review conclusions and research goals

The research presented in these three chapters demonstrates how with any television series that uses real people, there are important ethical questions to be asked about the potential implications (both negative and positive) of putting people on television and opening them up to public scrutiny. This is even more significant where contributors are being encouraged to publicly discuss highly sensitive, personal topics that could expose them to potential stigma and negative feedback. The consequences, reach and longevity of any such exposure are unpredictable and complex, the more so, given the transnational and multi-media contexts for television consumption, whereby content may be aired, viewed and discussed across international borders and different online media platforms.

Any act of filming is a form of intervention and has a set of consequences. However, introducing additional therapeutic activities for contributors, which will be part of their filming experience raises an added set of ethical challenges and I would argue necessitates greater responsibility. Taking contributors who are experiencing mental distress and putting them through a conceivably difficult therapeutic process, with the added pressure that this process will be publicly documented for an audience raises many problems. There are unknown questions about the interplay between any intervention and the experience of taking part in a television series. There is the added complication of whether a desire to receive help is influencing contributors' reasons for being involved in a television project.

Television series involving mental health interventions proclaim substantial changes for contributors but there are significant questions over the unseen process involved, the support contributors receive, the sustainability of any changes to wellbeing and the ethics of putting vulnerable individuals through a public regime of therapy. There is no

research looking specifically at the sub-genre level of British television shows involving mental health interventions from the perspective of contributors therefore there is clear incentive for research examining in detail the outcomes for the people involved. The aim of this research project then, is to take tentative steps to understand how contributors perceive the experience of taking part in mental health intervention television and explore the repercussions of their involvement for their lives and wellbeing. In addition, interviews with production crew, on-screen intervention providers and off-screen support providers involved in the making of these shows will help build a multi-perspective model of the processes and relationships within a production that can shape contributor experience. Given that my interviewees were involved in programmes that were produced before the OFCOM rule changes to enhance duty of care, it is also highly relevant to learn about what support was provided, whether this would meet the current guidelines and whether this was perceived as satisfactory. The two central aims of the research project are as follows:

Research Aim One: Explore how television contributors understand and evaluate their experience of participating in television shows involving mental health interventions.

Research Aim Two: Identify common themes and factors that make participation successful (or unsuccessful).

These two aims will be explored via the following research questions:

1. How do contributors narrate the experience and outcomes of taking part in a show?
2. What narrative constructions are evident in the contributors' interviews?
3. How do contributors perceive the representation of themselves and the intervention within the broadcast shows?
4. What, if any aspects, of being in a televised show do contributors identify as influencing wellbeing?
5. How do the perspectives of other key protagonists (production teams, therapists and other intervention providers) contextualise the narrated experiences of contributors?
6. What challenges are identified about making MHITV

The next chapter will set out my methodological approach to achieving these aims and to beginning the process of lifting the lid on mental health intervention television.

Chapter 5: Methodology

5.1 Introduction

This chapter sets out how my study was developed and conducted. It clarifies the epistemological and ontological frameworks guiding my research design and methods, before describing my analytical model and processes. I then elaborate on the issues that have shaped my research sample and data collection. I will address the issues of personal reflexivity and ethics, explaining how these have shaped my project and any implications for the analysis of my data. Finally, I will set out the context of the programmes and interviewees included in this research.

My methodology has been strongly directed by the discovery, as illustrated in the previous chapters, that there has been very little empirical research looking specifically at this sub-genre on U.K. television (the exception is Blaker, 2013; 2017) and almost no research considering the perspective of those involved (e.g. contributors, producers, therapists) in their own words. The lack of a substantial body of empirical work to draw on led to the decision to take an inductive qualitative approach which is particularly appropriate for exploratory research, where the emphasis is on understanding the texture and quality of experience (Willig, 2013). Concentrating on an in-depth investigation with a relatively small number of research participants enables the development of a 'thick' description of the experience of being involved in mental health intervention television, with the space to consider the specificity of each case. Whilst acknowledging my values and experience that are guiding my research, my aim has been to take a 'bottom up' approach, envisioning this research as the process of predominantly building an understanding of the experience of being a television contributor within MHITV and tentatively identifying the factors that shape this.

My specific approach has primarily been guided by research and theory within the field of narrative psychology (Bruner, 1990; McAdams, 1997; Polkinghorne, 1988; Smith & Sparkes, 2006). The narrative approach is an established method for researching questions around identity, mental distress and recovery (Spector-Mersel & Knaifel, 2018) and as I am pursuing similar themes, it is well suited to looking at ex-television contributors' stories of taking part in MHITV. Within this broad and diverse framework, I am taking an experience-centred narrative approach (Squire, 2013) which emphasises

what participants' narrative accounts can inform us about how they make sense of their experiences. This will be used to analyse contributors' interview accounts. In addition, a thematic analysis (Braun & Clarke, 2006) of interviews with producers, therapists and other intervention providers involved in the making of these shows provides context for contributors' stories by exploring the cultures of production behind the making of MHITV. My research aims and methods are summarised below:

Research Aim One: Explore how television contributors understand and evaluate their experience of participating in television shows involving mental health interventions.
Method and research questions: **Narrative analysis** of interviews with ex-television contributors 1. How do contributors narrate the experience and outcomes of taking part in a show? 2. What narrative constructions are evident in the contributors' interviews? 3. How do contributors perceive the representation of themselves and the intervention within the broadcast shows?
Research Aim Two: Identify common themes and factors that make participation successful (or unsuccessful).
Method and research questions: **Narrative analysis** of interviews with ex-television contributors 4. What, if any aspects, of being in a televised show do contributors identify as influencing wellbeing? **Thematic analysis of** interviews with production teams, on-screen intervention providers and off-screen support providers 5. How do the perspectives of other key protagonists (production teams, therapists and other intervention providers) contextualise the narrated experiences of contributors? 6. What challenges are identified about making MHITV?

5.2 Narrative Inquiry – a theory of knowing and a methodology

Narrative inquiry is an interdisciplinary practice that centres on the idea that humans are "story telling animals" (Smith & Sparkes, 2006, p. 170) and that we instinctively construct narratives to organise the complex intersections of events, interactions and ideas that make up our experience, with the aim of creating order from disorder (Murray, 2015) Therefore, by paying attention to the stories people tell, narrative inquiry advocates propose we can learn about their lived experience and gain an insight into their meaning making process (Squire, 2013). Within psychology, *the narrative turn* was pioneered during the 1980s in response to growing disillusionment with the dominant positivist paradigm within psychological research, which critics argued was overly focused on laboratory testing and controlled stimulus and response experimentation (Bruner, 2004; Polkinghorne, 1988, 2007). Seminal works by Sarbin (1986), Polkinghorne (1988) and Bruner (1990) drew attention to narrative methods being employed in social sciences and the humanities and how they could be relevant to psychological research (Chrz et al., 2017). These influential texts recognised the virtue of narrative as a method of inquiry, but also went further, proposing a theory of narrative as a primary form of human understanding (Polkinghorne, 1988), a specific cognitive process distinct from reasoning which is central to how humans make experience meaningful (Bruner, 1990). In the words of Sarbin:

> I propose the narratory principle: that human beings think, perceive, imagine, and make moral choices according to narrative structures. Present two or three pictures, or descriptive phrases, to a person and he or she will connect them to form a story, an account that relates the pictures or the meanings of the phrases in some patterned way. On reflection we discover that the pictures or meaning are held together by the implicit or explicit use of a plot. (Sarbin, 1986, p. 8)

Crucially, storytelling implies an audience, and a key focus of narrative inquiry is to draw attention to narrative construction as social action, emphasising the contexts within which different narrative accounts are produced and the purposes they may serve (Riessman, 1993). This could be the localised context such as how narratives are co-produced in an academic interview setting or with reference to the wider social and cultural influences that may encourage certain stories to be told and not others. Bruner (2004) contends that in forming our stories of self, the individual is restricted by the narratives available to them within their cultural setting, therefore the stories we create

will reflect canonical plot types and roles (e.g. trickster, hero) and current ideas about appropriate ways to be. As Riessman (2008, p. 105) explains:

> Stories don't just fall from the sky (or emerge from the innermost "self"); they are composed and received in contexts – interactional, historical, institutional, and discursive – to name a few. Stories are social artifacts, telling us as much about society and culture as they do about a person or group. How do these contexts enter into storytelling? How is a story co-produced in a complex choreography – in spaces between teller and listener, speaker and setting, text and reader, and history and culture?

In practice then, narrative researchers' interest in stories is typically two-fold; firstly, what can a story reveal about the experience of the narrator and secondly, what does it reveal about wider contexts and practices. However, whilst there is a broad shared interest in the telling and reception of stories, it is by no means a unified research approach (Andrews et al., 2013). Underlying these variations of approach are ontological and epistemological questions about what constitutes a narrative, what a narrative represents, and what should be the analytical focus of narrative research. As these issues have implications for how I choose to conceptualise and analyse my interview data, I will summarise these differences briefly before discussing specific research on narrative and mental health. I will then set out the approach I am taking to collecting and interpreting data.

5.2.1 What is a narrative?

Riessman (2008) cautions that there is no unified definition of narrative and notes the many forms narrative can take from myths and drama to biographies, health records, scientific theories and art works. Narrative is often used interchangeably with 'story' and a typical starting point is to draw on ideas originating from literary theory such as plot, characters, action and scene. Many definitions emphasise how narrative is a way of presenting these elements to create meaning and order from experience (Murray, 2015; Riessman, 1993). Within psychology and sociology, narrative inquiry has been used to tackle a broad range of issues but it has been particularly employed to examine participants' responses to significant moments of disruption or change, for example how people respond to receiving an HIV diagnosis (Crossley, 2000), job loss (Riessman, 2008) or in identity research, examining how people plot key twists and turns that have occurred across their life course (McAdams et al., 2006). In much of this research, there

has been a strong emphasis on narratives produced in interview settings. Within an interview, a narrative might be defined as a specific response to one question, or the story constructed across the interview. In some cases the focus may be the overarching narrative produced across multiple interviews (e.g. Papathomas et al., 2015).

Other researchers have stressed the value of focussing on *small stories* (Bamberg, 2004, 2006; De Fina & Georgakopoulou, 2008); typically occurring in natural settings such as student's classroom conversations (Georgakopoulou, 2008) or on social media (De Fina, 2016). According to Georgakopoulou (2014) these small stories can be non-linear, multi-linear or involve on-going events. In this approach the emphasis is on everyday *world making*, the mundane occurrences and interactions that shape our lives on a daily basis. Narrative methods have also been applied to materials other than talk, such as visual images and historical texts (Riessman, 2008).

5.2.2 Ontology and nature of narrative

The approach that researchers choose to pursue can reflect differences in how the ontology of narrative is theorised. Broadly speaking, narrative psychology is held up as a social constructionist approach (Willig, 2013) however Smith and Sparkes (2006) have highlighted theoretical tensions between researchers that take a (neo)realist position in their interpretation of what stories represent and those that advocate relativism. The crux of this debate is whether a narrative account should be understood as something that gives external expression to the narrator's embodied experience and/or internal reality or whether it is only in the act of telling (and audience listening) that reality is constructed, or at the very least can be known.

This division can be illustrated using the example of research into narrative and identity as discussed by Smith and Sparkes (2006). Narrative theorists recognise how the life stories people tell are shaped by the social and cultural contexts of which they are a part. However there is a continuum between theorists who appear to give the self (as manifest through narrative) the status of a real entity that exists out there in the world (i.e. an inner self) that can be known or discovered (Crossley, 2000; Lieblich et al., 1998; McAdams, 1997) and those that argue the self is purely a construct, constantly re-created through language (specifically the stories we tell) from moment to moment (Gergen, 2015; Holstein & Gubrium, 2000). In the former position: "life stories, when

properly used, may provide researchers with a key to discovering identity and understanding it-both in its "real" or "historical" core, and as a narrative construction." (Lieblich et al, 1997, p. 8). Researchers in this group tend to emphasise the importance of forming a coherent life story that weaves together multiple events and relationships, providing a sense of a unified self (Baerger & McAdams, 1999). In the latter understanding, identities can be thought of as multiple, fragmented and there is not necessarily any internal imperative for coherency (Gergen, 1991). Instead, "identities are treated as something people create, do and perform in relation to a particular audience and in different contexts." (Smith & Sparkes, 2006, p. 180).

The ontological view of narrative taken by researchers has direct implications for the methodological approach to undertaking a narrative analysis – for example researchers may choose to take an analytical approach that treats narrative as a social accomplishment or as a way of accessing subjective experience. However in practice, often studies fail to set out clearly what theoretical position they are starting from. Other theorists at times attempt to synthesise positions, combining for example a commitment to the humanistic leaning towards the promotion of a coherent subject with a recognition of a multiple, socially constructed concept of narrative (Andrews et al., 2013). Whether researchers overtly subscribe to a particular ontological position, the interpretive framework of the method of narrative analysis they choose to employ will have theoretical assumptions about what narrative can tell about the world. I shall now look at how these assumptions translate into practical analytical procedures.

5.2.3 Analytical approaches

There are many versions of narrative analysis too numerous to do justice to here, as illustrated by the range of different guides to narrative methods published in the last few decades which all delineate the options for analysis in slightly different ways (e.g. Andrews et al., 2013; Bold, 2012; Kim, 2016; Lieblich et al., 1998; Riessman, 2008). Despite differences, I have identified four key interlinked dimensions along which analytical approaches can be plotted – *i: individual/society ii: whats/hows iii: agentic/non-agentic and iv: empathetic/suspicious.* These dimensions map on to the ontological positions discussed in the previous section and represent a series of analytical choices that I feel it is important for researchers to address clearly in their work. Therefore, I shall summarise them here.

Individual versus social. Analytical approaches may position the data as revealing the subjective experience and sense making of the participant such as McAdam's (1997) life story interview model, or may seek to examine the social production and contexts of narratives. This could be at a cultural and political level such as how the stories people construct incorporate dominant discourses, e.g. Foucauldian narrative analysis (Andrews et al., 2013) or at a more micro-level such as how stories are performed with specific audiences in mind, e.g. dialogical analysis (Riessman, 2008).

Whats or hows of storytelling. This is closely linked to the above and concerns whether the analysis prioritises the content, e.g. thematic narrative analysis (Riessman, 2008) or the form, e.g. Gee's poetic model (Gee, 1991). In addition, as well as *what* and *how*, narrative is generally concerned with the whys of storytelling - what is the narrator aiming to achieve in telling this story that way? (Riessman 1993, 2008).

The dimension of agency relates to how the analytical lens applied characterises the agency of the narrator and/or audience (Andrews et al., 2013). This could vary between analysis that does not address this issue at all or assume a lack of agency, analysis that implicitly imply agency - e.g. as an active agent creating a sense of self – or those that are interested in the agency of stories at a societal level such as a political tool for change, for example Adame and Knudson's (2007) exploration counternarratives from the survivor movement.

Empathetic or suspicious. As with all qualitative investigations, researchers must decide what interpretative stance they intend to take when seeking to establish the meanings inherent in the data being studied. This process of interpretation is referred to as hermeneutics (Willig, 2013, p.40). They may decide to interpret the narratives presented to them at face value or examine them through a more critical lens (Josselson, 2004). Whilst research which is interested in narrative as a reflection of participants' subjective experience may take a more empathetic stance, aimed at understanding, other approaches apply a suspicious hermeneutic, which involves a more critical search for hidden layers of meaning (Ricoeur, 1970). For example, psychoanalytical narrative approaches seek to reveal hidden unconscious motivations behind narrative accounts (e.g. Hollway & Jefferson, 2013).

Whilst researchers most likely position themselves more towards one end or the other of these various dimensions, it should be noted that different analytical approaches can be used in tandem. Frost (2009) advocates that a pluralistic narrative analysis can add different layers to deliver a more complex understanding of a narrative. I shall return to my own position in relation to the dimensions above after specifically examining the ways in which narrative has been used to explore mental distress and how this has influenced my research approach.

5.2.4 Narrative and mental distress

Narrative approaches have grown in popularity as a framework for studying mental health issues (Sools et al., 2015). For example, narrative studies have been used to investigate schizophrenia (Lysaker et al., 2003; Ogden, 2014; Roe & Davidson, 2005) eating disorders (Papathomas et al., 2015), trauma (Crossley, 2000), and conceptualisations of recovery (Brown, 2008; Rhodes & De Jager, 2014). By advocating for the importance of paying attention to first person stories, narrative inquiry has arguably contributed to a shift in paradigm within mental health research and care practices (Spector-Mersel & Knaifel, 2018) whereby there is now greater recognition of the importance of valuing and understanding the lived experience of people with mental health issues (Borg & Davidson, 2008; Kirkpatrick, 2008). In parallel, the increased prominence of personal testimonies of mental health experiences, in particular stories originating from the psychiatric survivor movement, have presented a direct socio-political challenge to the dominant medical model of mental health. These stories question a master narrative focussed on biologically based explanations and treatments and a dichotomy of 'well' versus 'ill' (Adame & Knudson, 2007; Slade & Longden, 2015).

Narrative methods are credited with playing a central role in the growth of alternative understandings of mental health based around the concept of recovery (Llewellyn-Beardsley et al., 2019; Spector-Mersel & Knaifel, 2018). The recovery paradigm emphasises a holistic view of the person, and the ability to live a meaningful life and form a positive identity, instead of focussing (solely) on clinical outcome measures such as remission from symptoms (Ellison et al., 2018). Spector-Mersel and Knaifel (2018) in a systematic review of narrative studies into recovery goes as far as to argue that the narrative and recovery paradigms are sister paradigms, with shared ontological and epistemological values that make them ideal bed fellows. They outline joint areas of

focus such as an interest in identity, change, agency and cultural contexts; and common values such as taking a holistic view of people's experiences and giving voice. Narrative has been proposed as an integral tool of recovery (Roe & Davidson, 2005). Sharing stories of lived experience has become an established part of peer support programmes and other recovery-based health care practices. Research has highlighted benefits for both narrators and recipients such as increased self-esteem, learning about self and others and feeling less alone (Moran et al., 2012; Nurser et al., 2018; Rennick-Egglestone et al., 2019). Similarly, research into informal networks for sharing stories with peers such as social media and You Tube have also suggested the potential of these sites as a helpful way of forming connections and accessing support (Fergie et al., 2016; Naslund et al., 2014; Singleton et al., 2016).

The assumption that sharing personal stories of mental distress is automatically beneficial however is subject to challenge. Research demonstrates that whilst hearing recovery narratives can have positive benefits such as providing hope and validation, there can also have harmful outcomes for story recipients such as a sense of inadequacy, increased pessimism or burden (Rennick-Egglestone et al., 2019). Woods, Hart and Spandler (2019) argue that the potential downsides of sharing personal stories such as the emotional burden have also been underplayed. They point to the restrictions on the type of stories that can be told, and how an emphasis on the need for coherence and hope, can limit the control the teller has to shape their story how they see fit. Some activists and scholars go further, arguing that the emancipatory and political goals of sharing stories of lived experience have been commandeered by the very systems and cultural practices they sought to challenge (Costa et al., 2012; Fisher & Lees, 2016; Yeo et al., 2022). For example, the protest collective 'Recovery in the Bin' reject the assumption that telling their stories provides a form of empowerment, stating in their key principles "We refuse to feel compelled to tell our 'stories', in order to be validated" (Recovery in the Bin, n.d.). These points feel very relevant to mental health intervention television. It is a reminder that not every opportunity to tell a story is necessarily a good one, and it is important to ask "what purpose does personal story telling serve? (Costa et al., 2012, p. 93), and question what the after-effects might be.

Narrative theory has also been used to theorise mental health problems as presenting a potential threat to forming a coherent and well adapted narrative, with resulting

negative consequences for self-identity and wellbeing (Dimaggio, 2006). This centres on the idea, discussed earlier, that maintaining a coherent self-narrative is essential for wellbeing (Baerger & McAdams, 1999; Crossley, 2000; McLeod, 1997). Importantly, narrative research with its focus on the experiential and the social function of stories has moved debate beyond the idea of narrative difficulties as resulting from individual cognitive deficits, to highlighting ways in which people with serious mental health issues may have restricted opportunities for their narratives to be heard or recognised as such (Adame & Knudson, 2007; Baldwin, 2005). Developing this argument, Baldwin (2005) outlines three potential challenges to narrative endeavour posed by severe mental illness. The first is impaired ability to construct a coherent narrative either through lack of capacity or reduced social opportunities to share and develop narratives. Secondly, he argues that the narratives produced may not be recognised or understood as stories as they may not conform in structure to the accepted narrative conventions of storytelling. Thirdly, these narratives may not fit comfortably within the boundaries of culturally accepted meta-narratives, a point that resonates with both the benefits, but also criticisms, made of recovery stories discussed above. As McLeod (1997) argues: "The task of being a person in a culture involves creating a satisfactory enough alignment between individual experience and 'the story of which I find myself a part'" (p. 27). In other words, it is important for mental wellbeing to be able to create stories that are not incongruent with culturally available narratives.

Narrative research has also drawn attention to how trauma or serious illness can disrupt our temporally ordered life stories and challenge our self-concept (Crossley, 2000; Frank, 2013; Neimeyer et al., 2006). In his seminal book on the impact of serious illness Frank refers to this as "narrative wreckage". He describes the process of having to create new stories in the face of this challenge to selfhood:

> Serious illness is a loss of the "destination and map" that had previously guided the ill person's life: ill people have to learn to "think differently." They learn by hearing themselves tell their stories, absorbing other's reactions, and experiencing their stories being shared." (Frank, 2013, p.1)

Frank sketches three potential narrative responses to this – the restitutive story - where the focus is on getting better, the chaos story – where narrative descends into confusion and lack of hope, and the quest story - where people plot the illness experience as an opportunity to learn something. Mental health intervention television, as noted in

chapter two replicates the structure and features of a quest narrative. Frank argues that one of the strengths of quest stories is that they return agency to the narrator, allowing them to be the hero of their stories, however in the context of MHITV where narration is mediated, agency over the narration of one's own story may not be straightforward (Thorbjørnsrud & Lånkan, 2022). In addition, Frank (2013) cautions that quest stories can run the danger of romanticising illness and presenting "transformation as too complete" (p. 135) rather than an ongoing process, thereby implying everyone should be expected to rise above their difficulties and move on, reborn. Whilst Frank points out that people may move across different story types, the implication is that the story they favour will have direct consequences for how they make sense of and adapt to the experience of serious illness. Carless and Douglas (2008) relate Frank's story typology to mental health arguing that the culturally dominant restitutive story which many people favour may be counter-productive in severe mental health where full clinical recovery may not be possible. Similarly, Papathomas, Smith and Lavallee (2015) apply Frank's typology to the experience of having or living with someone with an eating disorder, concluding that an overreliance by family members on a restitutive narrative may have negative consequences as it may create unrealistic expectations. This work illustrates how dominant cultural narratives can intersect with personal narratives and shape how people create and interpret their own stories.

Within this framework of narrative identity as both an individual endeavour and a socially-constituted act, there has been interest in how people experiencing mental distress can be helped to re-story their experiences in ways that are conducive to creating a more coherent narrative of their experiences, and to reaffirm positive self-identities (Roe & Davidson, 2005). This is the premise of narrative therapy (McLeod, 1997; Singer & Rexhaj, 2006; White & Epston, 1990) "where the goal is to open space for persons to re-author or constitute themselves, each other and their relationships according to alternative stories or knowledge" (White & Epson, 1990 p. 75). What perhaps makes narrative therapy different from other therapeutic approaches is an emphasis on the social role of stories and the recognition that a coherent story is not just for the individual to make sense of their lives, but to enable clients to "make meaningful connection with the audiences in their lives." (Singer & Rexhaj, 2006, p. 212). The ability to incorporate problematic experiences into a coherent life story and reframe

them in a way that can retain or rebuild a more positive sense of selfhood are also important concepts within the recovery paradigm (Carless & Douglas, 2008; Llewellyn-Beardsley et al., 2019). An important theme in this research is agency over narrative, and that it is not enough just to replace people's ideas with 'better stories' but important to enable them to take back control of their own stories (Singer & Rexhaj, 2006).

In this vein, Carless and Douglas (2008) present a case study of men with serious mental illness who are engaged in a sports programme. They carried out a holistic analysis of form (Lieblich et al., 1998) to identify general types of stories underlying how these men talk about their involvement in sport and exercise, describing three narrative types – action, achievement and relationship narratives. They conclude that the men's involvement offers the opportunity to re-story their lives and create a counter story to the dominant medical narrative of mental health.

The research on narrative and mental distress feels extremely relevant to the contributors of MHITV. Drawing on the idea of opportunities to 're-story' experience, I am interested as to whether, and how, taking part in a television series may provide television contributors with an alternative narrative to their current understanding of their mental health problems - a way of re-storying their experiences. Equally, the criticisms of the co-opting of how recovery stories are produced and used are pertinent to the production of MHITV and I am interested to explore the implications for contributors of the mediation of their stories. With this in mind, I believe a narrative approach provides a novel and interesting way to address my research aims. Below I outline where I position myself within the diverse range of narrative approaches addressed in the previous sections.

5.3 My philosophical framework – an experience-centred narrative approach

There are two particular strengths of using narrative to explore contributors' recollections of their involvement in mental health intervention television: firstly the narrative approach retains the integrity of individual accounts rather than subsuming them within wider themes. This feels important because the individual circumstances of the contributors and the set-up of each production vary considerably. Secondly, being involved in a television-mediated narrative is at the heart of the contributors' experiences, therefore it seems appropriate to consider their interviews as an alternative storied account of their experience. I am interested in unpicking the layers of narrative and exploring the relationship between their television-mediated narrative, their self-story, and their interviews, as co-constructed narratives. However, to clarify, I am considering the television series' narratives through the perspective of the participants rather than directly analysing them.

My primary aim in using a narrative framework is to understand how participants make sense of their experience. Whilst I am interested in the layers of contexts that may shape the narratives told to me, I concur with Crossley (2000) who offers a critique of an extreme relativist position as reducing self-experience to a series of moment-to-moment constructions, which she argues are not in keeping with the phenomenological reality of people's lives. Therefore I find Squire's (2013) description of experience-centred narrative research fits well with my philosophy and aims. Squire (2013, p. 48) sets out four key assumptions of this approach.

> The experience-centred approach assumes that narratives:
>
> - are sequential and meaningful
> - are definitely human
> - 're-present' experience, reconstituting it, as well as expressing it
> - display transformation and change

At the heart of this approach is a focus on personal narratives that are meaningful to the narrator, and an understanding that stories are a way of making meaning. However there is a recognition that stories are not just a direct window on the narrator's world but a process of construction (Bruner, 1991). Therefore, it is important to take into account not only what people say but how and to whom it is said (e.g. language,

structure and context). The emphasis Squire places on transformation and change seems relevant as this is often how television intervention narratives are packaged and I am interested to see whether and how these themes relate to the contributors' accounts of their television participation. Squire however also cautions that experience-centred approaches can: be too prescriptive about 'good and bad stories', over emphasise coherence and subjectivity, ignore language, and be relativistic in how they frame interpretation. She advocates overcoming these limitations by undertaking experience-centred research whilst also paying attention to "the social and cultural character of personal narratives" (2013, p. 62). This could include local contexts and wider cultural narratives (for example media discourses about mental distress).

In undertaking a narrative analysis, I summarise my position in relation to the four dimensions I highlighted earlier as follows:

Individual vs social. I am predominantly interested in what these accounts can tell me about the individual's psychological experience rather than attempting to apply a broader societal level critique (e.g. how neoliberal policies shape television production practices). However, I will explore how their personal narratives reflect or depart from canonical narratives and the programme narratives. I also believe it is important to recognise my role in the co-production of stories through the interview process (Mishler, 1986) the practicalities of which I will discuss later in this chapter.

Whats vs hows. My analysis primarily focusses on content rather than how narratives are told, however I will examine elements of tone, genre and story construction that can be compared across accounts. Whilst my analysis will include a reflexive component that takes into account the interview context, a focus on *what* is being said feels more fitting for my research focus than an approach such as dialogical analysis, which might have been more relevant if I was analysing data in naturally occurring settings.

Agentic vs passive. I am conceptualising the interview participants as agentic individuals who are actively constructing their stories and doing the work of making sense of their experiences. This reflects my ethical standpoint as a researcher. Whilst I recognise there may be political, social or simply self-reflective limits on what interpretations are available to participants (or myself as the researcher), I want to recognise participants'

role and capabilities in shaping their accounts and lives, rather than treat them as passive subjects at the mercy of unseen forces.

Empathetic/suspicious. In line with the above, I am starting from an empathetic stance, which acknowledges that my participants are the experts in their own lives. I agree with the scholars above that storytelling is a social performance and there are many factors that shape the story that a participant produces (cultural, social expectation, self-awareness, unconscious). However, I am keen to avoid what I see as a false dichotomy of the researched and the expert researcher, and thereby risk over-asserting my interpretative authority (Willig, 2013). Therefore, whilst I intend to draw on psychological and social-cultural theories that may account for some of the features in the accounts I am given, I intend to prioritise the meanings ascribed by my participants.

5.3.1 Narrative Analysis Stages

As discussed, there are many ways to approach narrative inquiry, however very few guides set out a detailed template for undertaking analysis and many studies fail to elucidate the steps they have taken. Therefore I used many different texts to develop a process by which to examine the contributor interview accounts. In particular I have drawn on the holistic-content approach outlined by Lieblich and colleagues (Lieblich et al., 1998) and a study by Thornhill and colleagues into narratives of recovery from psychosis (Thornhill et al., 2004). I broke down the analysis into four stages:

Stage One	Holistic summary (genre/core narrative/tone)
Stage Two	Thematic Narrative Analysis
Stage Three	Synthesis of narratives across interviews
Stage Four	Applying narrative theory

Stage one: Holistic summary (genre, core narrative, and tone)

During this stage my aim was to think holistically about the essence of the narrative produced across each interview individually. This involved a consideration of the core content, elements of the structure, language and genre. I was strongly influenced by a

study by Thornhill, Clare and May (2004) who carried out a holistic analysis of form (Lieblich et al., 1998) to illuminate the differences between types of stories that are told about recovery from psychosis. In their study, they focus on the core narrative (Mishler, 1986) and tone (McAdams, 1997) for each interview and then group these into three genres which they classify as narratives of enlightenment, escape and endurance. There are methodological similarities in their study with the approach taken by Murray (2015) in his example of analysing cancer stories. I decided to also consider genre, core narrative and tone as stage one of my analysis. In essence, I reviewed the audio recordings and transcripts several times with three questions in mind: What type of story is it?; What is this story about?; and What is the tone of this story?

What type of story is it?

Analysis of genre is a common approach within narrative studies of illness, trauma and mental health (Thornhill et al., 2004) and therefore allows me a point of comparison with other types of mental health experience stories. By thinking about genre, it is also possible to attune to ways in which cultural and personal narratives interact (Squire, 2013). Classifications of genre often draw on work from literary theory (e.g. Gergen & Gergen, 1986). Langridge cautions about too rigidly attempting to apply a genre or plot structure from theory and instead argues for "letting the subject speak" (Langridge, 2007 p.132). I approached genre loosely, looking for similarities with existing narrative typologies, but attempting to stay close to the data. My assessment of genre was conducted by examining the overall structure of the narrative, plot development and language (Thornhill et al., 2004).

What is this story about?

Mishler argues that reducing an interview to its core story and asking: "What is this story about?" (Mishler, 1986 p.236) is a power analytical tool that can be applied at the level of both individual and social meaning and enable cross comparison of collections of stories. I followed the steps suggested by Lieblich and colleagues as the first stages of a holistic content analysis. They propose that initially the interview data should be listened to/read several times: "until a pattern emerges, usually in the form of foci of the entire story". (Lieblich et al., 1998, p. 62). They emphasise paying special attention to evaluations, openings and ends of story parts and elements that contradict or seem to produce disharmony in the story.

What is the tone of this story?

McAdams' (1997) concept of narrative tone developed for his life story work has been taken up by other narrative researchers (Crossley, 2000; Murray, 2015; Thornhill et al., 2004). McAdams suggests the way in which key life events are interpreted and storied has a tendency towards either optimistic or pessimistic tone and is an indicator of the narrator's worldview. From a phenomenological perspective, Langridge (2007) suggests looking for the best descriptor to fit the data. For example, Thornhill, Clare and May (2004) identify two dominant tones for each interviewee's account such as 'thoughtful', 'angry' or 'educating'. Similarly, I considered whether each interview was generally optimistic or pessimistic, or what other descriptors best captured the narrative tone of the accounts.

Stage two: thematic *narrative* analysis

Riessman (2008) says that a thematic narrative approach is probably the most commonly used form of narrative analysis. This approach prioritises the content of narrative accounts over structure or performative aspects and is similar to the thematic analysis that is a central tenant of much qualitative research (Braun & Clarke, 2006; Willig, 2013). However Riessman makes the distinction that *narrative* thematic analysis aims to retain the integrity of the overarching individual stories, instead of reducing the data to a series of themes across cases. This stage is an essential part of addressing my core research questions allowing me to begin to unpick what are the key thematic elements *within* accounts which may explain the similarities or differences in core narratives produced *across* accounts.

In practice this stage begins in the processes identified in earlier stages above however, having considerer the overarching narrative, I sought here to conduct a more structured identification of themes, initially considering themes within each interview separately. I approached this by continuing the stages for a holistic analysis of content (Lieblich et al., 1998). This involved identifying and colour coding themes that stood out because of their repeated occurrences, or the level of detail and salience given to them by the narrator. It is also suggested to note transitions between themes, where and how they occur in the over-arching text and looking out for anomalies in content, or what is left unsaid. I went through each transcript line-by-line using Nvivo software to code themes

in an iterative process, starting with descriptive categories which were gradually refined and combined to form broader conceptual themes. Whilst my main attention was on content, in the process of analysis, I took into account the context (such as questions) which introduced particular themes. I also considered how individual themes contributed to the core plot and genre of the narratives.

Stage three: synthesis of interviews

Having considered the interview accounts individually, I then compared narrative features across accounts. In practice this stage is not separate from the ones above, and in fact the process of comparison began with the interview process. However this stage represents a formalisation of the process of cross-comparison. Again the difference with thematic analysis and what I see as a key strength of a narrative approach, is that the point is not to break up narratives into decontextualized themes across accounts. Instead I asked: how do similarities and differences between accounts feed into the over-arching types of narrative across accounts? This allows for a much more contextualised understanding of experiences. For example – the question might be how the theme of agency materialises in different accounts and does this relate to the overall narrative genre and tone produced.

Stage four: applying narrative theory

Squire (2013) suggests that experience-centred approaches to narrative can be strengthened by an orientation towards the intersection between personal narrative and socio-cultural influences. She uses the example of her research into narratives about living with HIV in South Africa where she related personal stories to the broader currency of religious conversion narratives in the social context. Similarly, Langridge (2007) details as a later stage in his critical narrative analysis, applying lenses from critical theory to destabilise the narrative. At this stage my aim was to draw on narrative theory to interrogate the narratives produced further, whilst also remaining open to other theory and research which may be relevant, led by the data.

5.4 Contextualising contributors' narratives – a thematic analytical approach to production practices

The central focus of my thesis is to explore contributors' experiences of taking part in MHITV. This focus is captured by my first aim, facilitated by a narrative approach. However, with my second aim: *identify common themes and factors that make participation successful (or unsuccessful)*, my goal is to also move beyond the individual narration of experience to more closely considering the processes and interactions that might be crucial to shaping these individual stories. To address this, my thesis includes interviews with other key people involved in making MHITV: the producers, intervention providers and off-screen duty of care psychologists. In analysing these interviews the intention is to explore aspects of the production process (for example crew-contributor relationships) that provide context for the stories told by contributors, and might help to make sense of why their stories are constructed the way they are.

As the purpose of these additional interviews is to provide background information to 'set the scene' for contributor's narratives, I chose to employ thematic analysis (Braun & Clarke, 2006) as a pragmatic approach to extract value from this data. Broadly speaking, thematic analysis is the process of identifying and organising patterns of content and meaning within data. As such, it underpins many analytical approaches to qualitative data (Willig, 2013). Braun and Clarke (2006) however have been influential in arguing for thematic analysis to be recognised as an important methodological approach in its own right. Unlike other analytic methods that are attached to particular theoretical frameworks, they have pointed to its flexibility to use with a range of epistemological stances, data sets and subject matter. This is not to imply that using thematic analysis is 'theory free', on the contrary they argue that it is therefore essential that researchers make their background assumptions and theoretical stances clear within their research.

In undertaking a thematic analysis, I am not assuming that this set of interviews are a different kind of data to my contributor interviews. I am still viewing them with the same theoretical assumptions, for example, as co-constructed partial accounts rather than providing direct access to events or information. It is simply that my interest in them is primarily as context for understanding the contributor narratives, rather than to

undertake a detailed exploration of this sub-set of interviewees sense-making through the stories they tell. My main goal is to establish common themes across the production and intervention providers' accounts, rather than retain the overarching story produced in each interview as a unit of data as in 'narrative thematic analysis' (Riessman, 2008). I am also not applying the same range of narrative analytical techniques as with my contributor interviews (i.e. analysing genre, tone, core narrative).

The epistemological dimensions however that I have outlined above in the context of narrative inquiry are equally relevant here. In undertaking a thematic analysis my interest in these interviews is both in *individual* actions and values, and the *social*, however at the localised level of specific production practices in action. This places my work within a growing field of media production research from a cultural studies tradition where the focus is mid- and micro-level analysis of media industry practices (Paterson et al., 2016). Banks, Conor and Mayer label this approach as *production studies* and describe it thus: "Production studies examines specific sites and fabrics of media production as distinct interpretative communities, each with its own organisation structures, professional practices, and power dynamics" (Banks et al., 2016, p. x). This emphasis on the cultures of production fits well with my own research goals of understanding the day-to-day practices, inter-relations and shared value systems within mental health intervention television, as formative factors in the experience of contributors seeking help for mental health problems.

More so than with my narrative analysis, my thematic analysis prioritises *whats* over *hows*. However, this does not imply that my analysis assumes that these accounts represent an uncomplicated reflection of my interviewees' views and experience. I am construing my interviewees as *agentic*, both in choices they make within their production roles and what they choose to share in interview. With this in mind, my stance is predominantly *empathetic*, whilst retaining an awareness of influences, such as the interview context and social discourses, which may factor in how they present their version of events.

5.4.1 Undertaking thematic analysis of the making of MHITV

My thematic analysis of interviews with production crew, on-screen intervention providers and off-screen support providers, broadly drew on the steps identified by Braun and Clarke (2006, p. 87). They identify six recursive stages:

1. Familiarising yourself with the data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Familiarising myself with the data started with making notes directly after interviews of ideas and points that stood out. I added to these during transcription and whilst re-reading through each interview. I then used the qualitative software package Nvivo to systematically work through each transcript, generating a list of predominantly descriptive codes. Once I had generated codes for each interview, I began to collate codes into broader categories, looking for overlaps, gaps and tentatively exploring deeper meaning beneath surface codes.

It was at this stage that I decided there were important differences between production team accounts and those of the on-screen intervention providers and behind the scenes support. I began to analyse these as separate groups, but also keeping in mind connections and contradictions. This process continued until I felt I had one major theme and several key subthemes for each which captured the majority of the data. The final stage that Braun and Clarke identify is writing up the report. The process of writing up my data helped me to refine my themes and led to additional insights about the making MHITV by attuning me to the points of tension and agreement between two sub-set of interviewees.

Given the limited existing research, I took an inductive, bottom-up approach to analysing the data, however it is likely other research which has investigated themes such as control and power attuned me to these issues. I prioritised information that related specifically to contributors, rather than general comment on production processes. My primary aim was to provide context for the contributors' narratives, so I kept their interviews in mind, however I was also paid attention to themes that stood out in their

own right, as providing interesting insight into the role and perspective of making mental health intervention television. The pressure crew experienced in supporting contributors experiencing mental health problems was one such theme.

5.5 Sample and selection of case studies

Despite industry contacts, establishing access to participants has been a challenge throughout my research. This has undoubtedly shaped my research and has implications for my findings, which are discussed in my conclusions. My initial research plan was to conduct ethnographic research within a current series however I was unable to establish an appropriate series happening in my time frame. I therefore took the decision to focus on historical programmes. My initial series research was carried out using online television databases and search tools such as Box of Broadcasting, the BFI website, BBC Genome project, IBMB website and Google to identify relevant UK series. Search terms relating to mental health such as "mental health/illness" and "mad/crazy" were employed as well as terms relating to specific diagnostic categories (e.g. "hoarding" "OCD" and "anxiety"). I then manually sorted through results to collate factual programmes or series that involved an intervention with the premise of offering some improvement to their mental wellbeing – for example: therapy, decluttering, or an activity/challenge such as singing or exercise.

The pool of relevant series was small (see Appendix B). This presented both practical and ethical challenges. I had initially hoped to work with production companies to approach past participants however they proved unresponsive to requests to assist me. Some individual producers and therapists were happy to talk to me about their work, however most were either not authorised to put me in touch with past contributors or were not still in touch with them. I recruited additional television contributors via mental health organisations and conferences. These contributors then put me in touch with others. Through snowballing sampling I established a pool of participants from a range of series which included programmes involving physical challenges, decluttering and house clearance, and therapy.

5.6 Data Collection – interviews

The data for this project consists of 24 semi-structured interviews with ex-television contributors, production team members, therapists (on and off screen) and other on-screen intervention providers involved in the making of MHITV. Most interviews were face-to-face, however six were conducted via Skype and two by telephone. This was either due to participant preferences or Covid restrictions. Both phone and Skype interviews have become recognised as a viable alternative to face-to-face interviews (Hanna, 2012; Holt, 2010; Iacono et al., 2016; Ward et al., 2015). Interviews took place in people's homes, offices or cafes and lasted between one to two hours.

The interview process was influenced by the principles of narrative interviewing as first set out by Mishler (1986). Mishler's contribution to the narrative turn in social science was proposing a reconceptualization of interviewing as the site of a joint production of discourse between the researcher and the researched. Mishler argued that understanding the interview as a dialogue necessitates paying attention to interview context within analysis, asking questions such as what may be told or left untold in different settings, with particular people or with certain questioning. Rather than presenting this as a limitation of interviewing, Mishler highlighted how by treating interviewing as socially meaningful acts between people, we can produce different kinds of insight such as ways in which people make personal-social identity claims.

My interview procedure was designed to encourage storytelling and interviews were envisaged as an informal conversation rather than a one-way neutral extraction of information (Riessman, 2008). The interview schedules (Appendices C & D) started with a general question where they could choose to interpret what seemed the most relevant, i.e. *"tell me about the experience of being involved in X?"* Following this starting point prompting questions (as needed) were designed to take contributors and crew through their involvement with the television series chronologically – from how they got involved, the filming process, the intervention, to the broadcast of the series and beyond. Participants were encouraged to give examples to illustrate their points.

5.7 Reflexivity

Qualitative methodologies emphasise epistemological and personal reflexivity (Willig, 2013). Etherington (2017) argues that reflexive practices which acknowledge the role of the researchers' own experiences and contexts within their work are an ethical responsibility, as well as a way of adding rigour and validity to research. My personal experience has shaped my aims and research questions and whilst this is valuable in grounding my project in actual practice, it also possibly means that I have overlooked other explanations or ways to approach this subject matter. For example, I have been naturally drawn towards interviews (as something I am experienced with and believe in the value of) and an interest in the day-to-day practices of producers and contributors, rather than thinking about my participants in terms of what they represent within our current political and economic climate. My background in television has also been central to my ability to get access to production teams however due to the specific reach of my network of contacts, this has potentially led me down certain avenues but not others where I have less pre-existing knowledge and access. It will have also had an impact on the co-construction of interviews, shaping the way I engaged with participants. Finally it will have had an important influence on the way I have analysed and interpreted my data, potentially leading me to different readings and conclusions than those another researcher may have formed.

To address how my personal experiences have informed my thesis I have built reflexive practices into my research processes throughout my project. Langdridge (2007) in his framework for conducting critical narrative analysis suggests the first stage should be to consider the researcher's own position and bias. Similarly, Josselyn (2011) suggests as a first step considering both the relational context of the data collection and the interpretive context (who is analysing the data and what they bring to it). Firstly, I have kept a research diary to capture the development of my ideas, interview reflections and methodological dilemmas. Secondly, I have included a consideration of the contextual factors of interview in my discussion. Thirdly, wherever possible, I have made my role as the researcher explicit by using an active voice to detail my decisions rather than obscuring my research role behind a façade of third person neutrality.

5.8 Ethics

This project received ethical approval by the Tier 2 social science cross school research ethics committee (CREC) at the University of Brighton (Appendix E). There are a number of key ethical issues that needed careful consideration and preparation.

5.8.1 Informed consent

As some of the participants have self-identified as experiencing mental health problems (such as depression, anxiety and post-traumatic stress) they could be considered vulnerable (Keogh & Daly, 2009). There could therefore be concerns about their comprehension of what they are consenting to or that they might feel under pressure to take part. However Keogh and Daly (2009) state that there is often misunderstanding about the ability of people experiencing mental health problems to consent. They argue that it should not be assumed that because they have experienced difficulties they are unable to make autonomous decisions and denying opportunities to share their experiences could also be viewed as unethical. It is relevant to note that this group of participants had all chosen to openly discuss their mental health in public. Several of the participants have their own personal blogs and/or are active on Twitter. As the participants have experience of being interviewed on the subject matter, they have some understanding for what the interview process is like and how it might affect them. This in turn arguably helped them to make an informed decision of whether they would like to take part in the research. With these caveats in mind, clear guidelines were put in place to ensure participants understood the nature and implications of the research and felt under no pressure to take part and all participants were given participant information sheets (Appendices F & G). In addition, my ethical protocol stated people who indicated that they were currently experiencing distress, or where there were any doubts about their ability to consent were excluded from the research, although no one was excluded on this basis. Consent was given verbally before interviews and confirmed in writing (Appendix H).

5.8.2 Upsetting material

As the research is considering peoples' wellbeing, there was the possibility that it would bring up upsetting memories or sensitive issues. However, as referred to above, the ex-television contributors, who this is most relevant to, already had extensive experience

of being interviewed and had previously talked openly about their mental health in public forums. This experience is likely to have helped prepare them for the experience of being interviewed and how it could affect them. The interviews were approached to minimise the possibility of the research process causing undue distress. Participants were briefed in advance about goals and general subject matter and given time to consider what they were happy to talk about. It was made clear at the beginning of interviews that participants can choose not to answer any questions they are uncomfortable with and/or stop the interview. The focus of interviews was on the television process and outcomes rather than specifically asking questions about current or previous problems – however it left it up to participants to choose what they would like to share. All ex-television contributors were provided with additional details of helplines and support.

5.8.3 Anonymity

Another issue was anonymity and confidentiality. Whilst it would have aided my research to be able to openly identify the case study series involved, anonymity was an important condition of enabling participants to have the freedom to discuss their experiences openly. This was relevant to both ex-television contributors who may wish not to re-publicise their involvement, or their attitudes to others involved in the production; and television production members or therapists and other professionals, who are still working within the industry and need to be sure that there are no negative repercussions of speaking about their work. To protect anonymity in publications based upon the research, the case study series have been disguised, research participants were assigned pseudonyms and every effort taken to remove any identifying information. This has meant at times in my analysis I have had to sacrifice a deeper exploration of the specific contexts highlighted by the interviewees, such as the details of interventions.

5.9 Context – the programmes and interviewees

The narrative analysis was applied to nine interviews with television contributors from three different series. Whilst the case study series are all very different, they share the features of MHITV outlined in Chapter two: a mental health focus, a made for television intervention, expert guidance, narrative arc of transformation, documentary filming techniques and an emphasis on personal stories. All the contributors self-identify as experiencing a range of mental health conditions such as depression, OCD or anxiety.

- Three contributors were involved in a physical intervention series which brought together contributors with mental health problems to train with coaches before competing in a final live challenge in front of an audience.
- Three contributors were involved in a group therapy series which brought people together for intensive therapy away from home with trained mental health professionals.
- Three contributors were involved in a hoarding series. Two of these were filmed having their house cleared out and cleaned by professional cleaners, the other received some advice on what they might do with their hoard. They did not meet other contributors and the series did not involve therapy.

The original date of broadcast varied between series, ranging from 2013 to 2020, therefore whilst for some contributors there is a gap of six years between first appearing on television and my interview, for some their involvement was much more recent. One interviewee had only appeared on television weeks before their interview. This is an important variation between interviewees. Each individual's relationship with their television series is not a finished story but one that is evolving with time, subsequent events and retellings; therefore how they evaluate and make sense of that experience is not static but constantly changing. An advantage of narrative inquiry is that by considering each interview individually, as well as a group, it is possible to honour and explore these differences. I am conscious however to emphasise that the analyse presented here should not be read as the closed or definitive account of these contributors' experiences, rather I am presenting some possible ways to interpret the stories told about the experience at one point in time.

The thematic analysis which follows next in Chapter six is based on fifteen interviews with professionals employed in the making of mental health intervention television. The interviews break down as follows:

- six production team members. Their roles on production were as producers/directors, assistant producers or DV directors[11]
- two on-screen declutterers in hoarding programme
- two on-screen cleaners in hoarding programmes
- three on-screen therapists
- two psychologists involved in behind-the-scenes screening and support.

It is important to clarify that some of these interviewees were involved in the same series as the contributors I interviewed, however some were involved in different MHITV series including another hoarding series featuring therapy, and a series about phobias. Therefore, the thematic analysis should not be considered as directly contextualising or corroborating the specific themes and details which follow within the contributors' accounts, but as providing a broader background for the practices and perspectives of individuals involved in the making of these types of series.

[11] This role involves self-shooting and producing/directing content on location but not necessarily being involved in casting/research or editing the material. It sits between assistant producer and producer/director in terms of seniority.

Chapter 6: Making mental health intervention television - balancing entertaining television with happy contributors

6.1 Introduction

This chapter presents a thematic analysis combined with discussion of fifteen interviews with individuals involved in the making of mental health intervention television. I have presented the results of this analysis below as two distinct groups. These groups are i) the six production team members, and ii) the seven on-screen intervention providers and two off-screen support providers (psychologists providing contributor support and screening). I have identified where possible in my analysis the different programme types and roles of the interviewees, however at times I have been purposefully non-specific to preserve the anonymity of those involved.

Whilst I did not apply the same degree of narrative techniques as in the following chapters, there is overlap between general thematic analysis and thematic *narrative* analysis (Riessman, 2008). I found myself noticing the overall narrative thrust of their accounts and questioning what their accounts were achieving. I also found myself thinking of these interviewees as sub-characters in the contributors' stories. This is one of the reasons I have presented the results in two separate analyses. Each one presents the perspective of these sub-characters – their aims, actions, impact on contributors and specific challenges involved in their roles within the production of MHITV. Therefore, the analysis of this chapter provides a necessary context for the themes that I have identified within the contributor narrative analysis in Chapters 7 and 8. Additionally, this chapter presents some other themes that reflected the emphasis of the interviewees, which ensue from analysis of my data, such as 'it's hard making programmes about mental health' and 'authenticity of mental health intervention outcomes'. At the end of the chapter I highlight the parallels between the two sets of accounts, where their accounts diverge and the significance of this divergence, while I discuss the implications for contributors involved in MHITV.

6.2 The producers' role: mental health comes first – unlike other TV

My analysis identified the central theme running through these production accounts of making mental health intervention television as 'mental health comes first'. All production interviewees emphasised their commitment to make programmes responsibly, placing contributor wellbeing at the centre of their working practices. Key sub themes which underpinned this presented commitment to giving their contributors a positive experience were control (over filming and narratives) and the challenges faced by crew of working with vulnerable people. These themes are described below in the context of relevant production research into working with contributors.

6.2.1 Mental health comes first

> Other programmes you make, you're observing, purely observing, and this one, you're not observing. You're bringing in change, even though you're not the psychologist...They've been brought in by you, you're filming the whole thing. There's a lot of responsibility in there. (Rachel)

> Right from the start, we were aware that we were dealing with people with mental health. We didn't want the film to have adverse effects on them. We didn't want what we were doing to be too stressful. (Sam)

> we were all just so conscious of making sure it was the right thing. (Ellie)

The quotes above epitomise the overall tone and emphasis of the production interview narratives which was that 'mental health comes first'. The use of words like "responsibility" and doing "the right thing" were common in these narratives, with the interviewees at pains to convey a recognition that their actions could have serious consequences for the contributors under their care. The responsibility they felt was heightened by the unique properties of MHITV which introduces "change". All the interviewees stressed that they took the obligation to protect the mental health needs of the contributors very seriously. Whilst they acknowledged the potential pressures on contributors of filming and appearing on television, all bar one interviewee emphasised clearly that within their specific production contexts, mental health needs took precedent over the needs of the programmes. Leila, who worked on a hoarding series as a DV Director, offered the only counternarrative in this respect. She raised doubts about whether the contributors' mental health needs were always put before editorial requirements, a point I shall return to shortly.

This construction of a conscientious commitment towards protecting contributors is in startling contrast to other investigations into occupational distress within the British creative industries and factual television (Rees, 2019; Wilkes et al., 2020). These two reports paint a negative picture of overarching production pressures leading to short cuts in duty of care, manipulation of contributors and a "programme first" focus. The contrast of findings may partly be explained by methodological differences between these studies and my research. My sample size was much smaller and my research was framed to my interviewees as exploring their individual roles in supporting contributors with mental health difficulties on specific projects. It is probable therefore that my interviewees may have felt under more presentational pressure to justify their involvement and their individual conduct in a more positive light, than if they were responding to an anonymous survey of interview questions (Wilkes et al., 2020), or to questions more focussed on their own broader experiences of occupational distress (Rees, 2019). A wish to project an acceptable professional image both outwardly and to self is likely to be an influential factor on how they chose to respond to my questions. This may be increased by my perceived position as a television insider, who they may want to think well of them.

However, there is more common ground between my research and these previous studies than it might first seem. Whilst my interviewees told a very different story, it is notable that in setting out their 'ethical' approach towards filmmaking they simultaneously reinforced an image of normal television practice as often 'unethical'. As Rachel said: "I have to say, I've worked in a lot of TV where things haven't been done properly, but this was done really, super carefully." How these productions were different to previous productions the interviewees had worked on and the norms of television production in general was a recurrent point of reference. Ellie explained:

> This is one of the only programmes where I have met people so many times not to film, like we'd just go and meet them, not bring the camera, like if someone was in a bit of a down stage, having a low period, we'd just go and check that they're O.K, go out for lunch, go for a walk, just like chat. Which, you know, normally TV you're like, you've got to film, you've got to get the content, you should be bringing that camera and you should be filming those moments.

Ellie conveyed the idea that adhering to an ethos of a strong duty of care towards contributors, translated into a set of filming practices and editorial decisions which set

the production apart from a typical production framework. Conversely, she created a counter narrative of the expectations on crew working within “normal TV” to deliver content at all costs. Ellie’s emphasis on how the crew were enabled to be “flexible and fluid with how we make TV” suggested that in order to create a more considerate and positive experience for contributors it was necessary to remove the pressure of delivery that crews can experience from further up the chain of command (Rees, 2019).

When prompted, all the production interviewees described a range of measures and checks within the production processes to protect contributors including psychological support, keeping care logs and providing advice on social media. However, the majority of the illustrations they gave of their approaches to making MHITV related to more understated working practices and unwritten rules. For example their narratives highlighted the importance of developing good relationships with the contributors, and building trust, before they sit them down to do sensitive interviews. Notably, interviewees presented the decision to make television with a ‘mental health comes first’ principle as stemming from personal value systems rather than adherence to guidance or protocols for working with mental health. Sam explained: “Ethically, we would absolutely always put a contributor first, which is just the kinds of film makers we are. I always said, "I need to be able to sleep at night." Sam presented the decision to put contributors needs first as an individual moral choice and reflection of her integrity. The implication is that there are other kinds of film makers where this might not be the case.

This shadow of the unethical producer and more dubious television practices was present in all of the interviewees’ narratives and was used as a point of contrast to strengthen their own moral stance towards filming making. Chris for example opened his interview before I had even asked any questions by stridently setting out his personal ethos to filming making:

> I haven’t had any reticence about talking to you about it but I think that it comes down basically to like the morality of the individual,[...] whether they can deal with the kind of pressure that’s asserted in different ways […] I think that if you want to make decent programmes in the right way for the right people you will find other people who want to do that and they will make kind of good programmes with a decent heart but I think that’s individualistic, I’m not quite sure it’s industry wide.

By referencing that he did not have doubts about being interviewed, there was the acknowledgement of what could be at stake about speaking openly about television practices, but in mentioning it, he also reinforced the point that he did things the 'right way' and hence did not have anything to hide. By contrast, his emphasis on "morality" and doing things with a "decent heart" clearly implied that there is a 'wrong way' to make television, that he is setting himself apart from. What's more he suggested it takes moral fortitude to resist these forces of bad television practice. He placed himself within a small band of producers who want to make programmes with high integrity. This construction of the 'right' and 'wrong way' to make programmes and the need for moral strength to stand up to the negative forces was reiterated by Ben who compared the series he worked on to the controversial Channel 4 series *Obsessive Compulsive Cleaners*[12]:

> And a show like 'OCD Cleaners' I think is unacceptable really. That is exploitative. We were absolutely adamant that we were never going to go do anything like that, because I would not have put my name on it if it had turned out like that.

Chris and Ben constructed a mirror image of the dark side of television, where contributors' needs may not be respected. They conveyed the message that taking the mental wellbeing of contributors seriously involves having the strength to take a personal ethical stand as a producer. As such it positioned the producer's role and the programmes they produce as beholden to a series of exterior pressures which must be actively fought against. Like Ellie, they constructed themselves as working in a way which is outside of the norms of general practice and standards within television production. Given the context of my research and the recent wider focus on contributor welfare, it is not surprising that my interviewees might desire to distance themselves from negative perceptions of television practice. Aufderheide (2012) argues that one way documentary makers manage the cognitive dissonance experienced where they had not lived up to their own self subscribed ethical standards is to shift blame to the broader production environment that restricts their ability to do the right thing. In a

[12] This series paired participants who were either formally diagnosed with OCD or self identify as being obsessed with cleaning and sent them to clean the homes of people who for various reasons (including hoarding and mental health issues) have let their homes get into a state of disrepair and uncleanliness. It was the subject of multiple complaints to Channel 4 by OCD representative organisations and psychologists.

related way, arguably there is an element of cognitive dissonance in how my interviewees positioned themselves as separate from a system they described as generally unethical.

Another possibility is that when television production overtly takes on the topic of mental health, there is more considered attention paid towards the duty of care towards contributors due to the sensitivity of the subject matter and the danger of repercussions. The television series that my research covers were made before the new OFCOM (2020) guidelines into contributor care discussed in chapter 4. However prior to these changes contributors with mental health issues were still classed as vulnerable. Channels such as the BBC already had in place editorial guidelines which emphasised the need to work sensitively with vulnerable contributors (see Blaker, 2013). A more considered approach to contributor care may also reflect the ethos of the producers who choose to work with mental health subject matter. The Dart Report highlighted a small subgroup of highly skilled producers working on what they describe as 'contributor-centred sensitive-issues driven filmmaking' (Rees, 2019 p. 40) who, like my interviewees, emphasised high standards of duty of care to contributors.

The Dart Report also found that producers felt that there were good and bad production companies with regard to both crew and contributor care, with some more ethical than others. This idea is supported by my interviewees who emphasised the importance of working with production companies and professionals with a shared ethos. My interviewees were mainly working on niche projects in small teams, where it is easier to retain and promote a shared culture of production. Notably, the one exception to the generally positive take on contributor welfare was Leila who was involved on a bigger formatted series, which involved a larger crew in which she had less direct input into the overall approach and shape of the series. As a DV director on a hoarding series, she filmed with several contributors, but she was not involved in the casting or editing. Leila was the only person who waivered from a script of 'mental health comes first'. She presented a much more ambivalent account of how contributors' needs were balanced against editorial decisions about the series.

One issue that Leila raised was the disparity of care that different contributors received, depending on how central they were to the main narrative of the programmes:

> Then there were people who were maybe B characters as, unfortunately, we call them, who weren't going to take up as much time in the programme itself and would have some but not all of the psychotherapy sessions. That was a bit challenging in that some people, I felt, were going to benefit more than others. It wasn't always perhaps the person that might need it the most. It was often the person who had some appeal in terms of either their story was strong or they were younger and there weren't that many young people.

This extract provided by Leila demonstrates how the productions team's evaluation of editorial factors played a key part in influencing the scope of the 'filmed' intervention that was provided to contributors. This example highlights how there are two important connected but distinct areas of ethical consideration with regards to the format of MHITV and the mental wellbeing of contributors. Firstly, there is a general duty of care to contributors which is applicable to vulnerable television contributors as set out by OFCOM (2020). This includes whether the production has obtained clear consent, treated contributors fairly, and supported them appropriately through the filming process. Secondly, there is the pretension of MHITV to provide contributors access to specific filmed therapeutic support. Leila's account highlights how, whilst productions may work with clinically trained professionals to provide an intervention, there are likely to be other dynamics at play (e.g. financial, editorial, delivery timeframes) which may be in tension with providing contributors with the best possible intervention. In short, the primary aim of television companies is to deliver a television programme, not provide therapy.

In summary, the production interviewees projected a strong commitment to prioritising their contributors' mental wellbeing, however they presented this as going against the norms of television production, and in this way, their interviews indirectly support other studies that portray television's treatment of contributors as ethically debatable. In addition, Leila's account provided a note of caution in what were otherwise generally positive accounts of how the production crew considered contributors mental health needs. It is a reminder that there may be significant differences in practices between productions, and there is not one homogenous approach to making MHITV. The accounts support the idea that contributor welfare is influenced by several structural

factors; there are the attitudes of the individual production team members, the team ethos, the tone set by the production company (and television channel commissioners), and whether the scale and organisation of a production is likely to enable a supportive approach (Rees, 2019; Thomas, 2012). Another factor, as the second half of the chapter demonstrates, may be whether productions are working with established clinical service providers, or gatekeepers such as charities. These individuals or organisations may bring their own protocols and conditions around consent and duty of care (Blaker, 2013; Lånkan & Thorbjørnsrud, 2022) as part of an agreement to provide access or services.

6.2.2 Whose story is it? – it's a collaboration, but we retain control

Underlying the principle of 'mental health comes first', an important sub-theme revolved around how the production interviewees approached the issues of control, power and trust within the making of MHITV. Specifically, the production accounts suggested that involving contributors in decisions about filming was an important part of looking after their mental wellbeing. Nash's (2009, 2012) research has illustrated how within documentaries both participant and director have ways of negotiating and asserting power and control over the filming process. My research within the specific format of MHITV also supports the idea that power and control were negotiated during the production process. For example, when I asked Chris whether there were any times when people did not want to be filmed he exclaimed jollily "yeah I mean like so people just didn't turn up for things!". Chris's comment points to a practical way contributors can assert influence within a production. Whilst the consent forms signed by contributors give the productions rights over materials already shot, contributors maintain some control over the filming process because they may choose to pull out during filming, which can cause major difficulties for finishing a programme.

All my production interviewees gave examples of conceding some control to contributors over what was being filmed, and of engaging with them over how material will be used. One commonly mentioned practice was allowing contributors to place boundaries around certain topics which they did not want to discuss on camera, as Ellie explained: "just having those conversations with people about what they feel comfortable talking about". Another was telling contributors that they could ask to stop filming or that they could request for something they had said to be left out of the final edit. As other research has demonstrated these agreements were informally made

rather than documented in written contracts (Aufderheide, 2012; Lånkan & Thorbjørnsrud, 2022; Thorbjørnsrud & Lånkan, 2022). Rather than presenting these agreements as negotiations or concessions, the production accounts framed this as part of a collaborative approach:

> So we were asking quite a lot of them, but this probably felt more like a collaboration than anything I've worked on before. I think that's probably what the difference is…It was like a team telling a story, I think (Sam).

Sam implied that working collaboratively with contributors to tell their stories counteracted the potential pressures of the production process. As with the mental health comes first examples discussed above, the suggestion was that a collaborative approach is atypical in most television productions. Chris connected taking the unusual step of a collaborative approach to a specific commitment to the mental wellbeing of contributors:

> We're doing something with vulnerable people and they have to come first which isn't the way that these things are kind of usually done, you want to tell the story so you, you'd cast it, or people cast it looking for people who are going to say what would be good for them to say but we wanted them to say what they wanted to say. (Chris)

Chris positioned allowing people to "say what they wanted to say" as a crucial element of working with people with mental health problems. The inference was that the duty of care towards vulnerable contributors went beyond protocols and psychological support to a commitment to allowing them to tell their own story. In contrast he constructed "the way that these things are kind of usually done" as pre-determining what kinds of stories and performances can be included. His concerns echo those raised by other UK factual television producers who have been critical of how format points and tight schedules can limit the ability to do justice to contributors' stories (Rees, 2019).

Whilst the production interviewees emphasised collaboration, their accounts also contained some tensions and ambiguity which undermine the suggestion that contributors could retain control or were even, *at least,* equal partners in determining how their stories were mediated. Sam acknowledged an essential power differential

that she attributed to the contributors' vulnerability:

> The stakes were so high, and they were so vulnerable, and you're aware of power of the camera and of what people will tell you when you're in that position. Even now, I'm like, "Yes, I'll tell you, you think it's fun to share, isn't it?" And you know that you have that power as a Director. 'Power' is the wrong word for it, really, but you know that with especially someone who's vulnerable, and you're giving them this attention and this love and this feeling part of something. You have to be careful with them.

Sam highlights here several ways that producers held power over contributors, which were also developed by other respondents. There is the acknowledgement that contributors were most likely unfamiliar with television production processes and norms, and were therefore reliant on the crew to guide them through the process of 'sharing their story'. In addition, the production team were potentially providing a valued and receptive audience that may not be on hand in their day to day experiences. Other research has demonstrated that a dynamic of dependence and gratitude between contributors and crew gives the production team a substantial amount of power over contributors (Rees, 2019). However, the best interests of contributors and the programme may not always be aligned (Thorbjørnsrud & Lånkan, 2022). The power disparity is compounded by the unique format of mental health intervention television whereby contributors are provided with help in return for their participation. This potentially provides additional pressure to cooperate.

The power imbalance and sticky issue of control is even more relevant when it comes to the editorial direction of the final programmes, where as a rule, producers are much less likely to concede significant control (Aufderheide, 2012). There were moments in the production interview narratives which revealed friction between editorial decisions and contributor sensitivities that raised the question of how much ownership contributors can really maintain over their stories. Leila's interview stood out in this respect. She gave an example about a storyline that the producers wanted to explore with a contributor that caused some objections:

> There was one point when she didn't really want to talk about her age. She didn't feel that was relevant to discuss[…]They wanted that part of her story[...] I think there are probably editorial choices made. That she's the younger person facing a future of hoarding and so that's how she will be described. Yet she probably didn't really want to be described in quite those terms.

This example demonstrates how there can be a disconnect between the expectations and agenda of contributors around how their story will be told and the editorial criteria that the production crew are applying to decisions about what to film and include. As Leila added:

> I suppose whenever we interview people in a documentary, we want them to be themselves and want to have genuine answers but we're also thinking about the bigger story of how we are setting up who they are, what the issue is and then how we might resolve that later on down the line.

As with her earlier comments explaining 'A' and 'B' stories, Leila highlights the behind the scenes machinations at work that influence and direct the construction of a television programme narrative. In a process that starts with developing a television proposal, securing funding and casting contributors through to decisions about what to film and the editing down of copious amounts of footage – there are multiple agents and dynamics involved in shaping how contributors' stories will be presented on screen.

These issues were not exclusive to Leila's account, other interviewees more subtly pointed to the challenge of balancing editorial decisions with contributor needs, however their accounts were more likely to focus on how these issues were mitigated such as allowing contributors to see the rough cuts before transmission and keeping contributors informed of what aspects of their story were to be included. However, managing the expectations of contributors, especially where multiple storylines were involved, was presented as challenging even with the best intentions. Chris gave the example of how some contributors were disappointed that they were not featured more prominently in the final programme. He explained the editorial choices behind this:

> Their story didn't always make sense which I think is part of their mental health so we kind of had to let some of it go. Umm and also […] they never struggled with any aspect of it, so it became really difficult to tell their story.

The 'struggle' that Chris referred to in this instance related to the filmed intervention. The suggestion was that the contributor found the tasks set for them too straight forward and therefore did not deliver a suitably interesting narrative. Therefore, whilst earlier Chris emphasised allowing contributors to tell the stories they want, his admission here seemed to acknowledge that some stories did not fit as neatly into the

constraints of specific genre conventions. In this case it was the expectation that their stories should take the shape of a quest narrative, following a trajectory of struggle, overcoming and ultimately triumph which forms the core plot structure of MHITV. The underlying implication was that despite a professed commitment to collaborative storytelling, cultural assumptions about what make a good story, combined with genre conventions potentially limited the kind of stories that could be told and lead to the prioritisation of the stories of contributors who had the most dramatic trajectories. As Ellie said to justify the need to make choices that may not be popular: "You have to make the best programme as I said to get the best impact."

In summary, my interviewees presented a collaborative approach which framed contributors as partners in telling important stories. The interviewees emphasised attempting to create a safe, unpressured environment where contributors could set some of the parameters around what was filmed and were given time to tell their story. In describing their ethical ethos, the interviewees also created a mirror image of production practices where contributors are less centrally considered in the story telling process. Their accounts support Thomas's (2012) lament that the normal restrictions of television documentary production allow little opportunity to work with contributors on more equal terms. My analysis suggests that whilst producers presented a commitment to working with contributors to tell their stories, they acknowledged that they entered into any collaboration from a position of greater power, where more was at stake in the relationship for the contributors. Their accounts indicated that the control of the series narratives remained firmly in the hands of the production team (and channel commissioning editors) and any decision to make editorial concessions to contributors was at their discretion. As such any real agency contributors had over their story was down to the extent that the production team was willing to involve them in decisions. In addition, contributor agency was limited by where and how their story fits within the wider programme narrative and genre conventions. More broadly cultural assumptions about what kinds of stories should be prioritised played a role in influencing whose stories got told. This may offer some explanation for how in some instances contributors can end up feeling let down, disempowered or unprepared for the consequences of sharing their stories, as has been found in other research (Thorbjørnsrud & Lånkan, 2022).

6.2.3 It's hard making programmes about mental health

The burden of responsibility of making a programme about mental health was a consistent sub-theme within the production interviews. Their narratives as a whole presented a deeply felt sense of personal obligation for the welfare of their contributors, translating into considerable stress over providing an appropriate duty of care. Chris described the pressure the crew experienced thus:

> it was a very hard project to do because I think we felt the weight of responsibility far heavier than any of them will ever know but I think it was kind of glorious thing, it was lovely and I'm really proud of it, but it was really, really hard to do. (Chris)

The interviewees described numerous pressures during the production process such as acting as a confidante and support network on a day to day basis, concerns about making things worse for contributors, and the impact of personal exposure to upsetting subject matter.

My analysis identifies that many of the issues that the production interviewees described related to the challenges of navigating ambiguous boundaries between the roles of programme maker, friend and therapist. For example, Ellie described a blurred "weird line of friends and professional" and Sam depicted the series she worked on as trickier than previous projects, specifically relating this to: "treading the line between counsellor and being very aware that I am not trained as a counsellor." Whilst all of the productions had some level of professional psychological support available for contributors either behind or on screen, in practice the assistant producers and producer/directors had much more extensive contact with contributors on a day to day basis. Ellie, who was the primary contact for several contributors over a six month period described the implications of this:

> I think with my contributors I found that they would just call me rather than the psychotherapist, in a way I felt like I was becoming their therapist because again, to have somebody like when they're having a panic attack, call you, that's like the first thing they think is like 'ooh I'm panicking I'll call Ellie', it's not even about the programme, like a lot of what we spoke about was not even related to the programme it was just about their lives and how they were feeling…

Ellie depicted how the relationship she had carefully built with contributors encouraged them to see her as more than just someone who was there to produce a programme;

they were encouraged to view her as a potential source of friendship and support. My findings correspond with previous studies that have found that production crew members can find themselves taking on quasi-therapeutic roles, however without the protocols or training established within professional therapeutic practice to protect both practitioners and clients (Rees, 2019; Wilkes, et al., 2020). In contrast to the boundaries in place within therapeutic services, the examples provided by my interviewees demonstrate how typical production practices such as giving out personal mobile numbers and a lack of structure between working time and being off duty creates a grey area for both contributors and producers as to where their responsibilities towards contributors begin and end. Ellie for example explained that she would receive and respond to calls from contributors at all hours. Many of the interviewees also discussed personally staying in contact with contributors' long after filming, aside from any formal aftercare. As Sam explained: "I'm still friends with them, I still see them on Facebook, keep in touch with everybody and then checking in". Producers framed this multi-faceted role of producer, friend, therapist as part of the job, however navigating the overlap of these boundaries seemed to underpin some of the pressure they described in making a programme with contributors experiencing mental distress. The asymmetry of these relationships added to the challenges for production staff.

The pressure of successfully filming and producing highly emotional stories was a related issue raised by crew members. This was framed in terms of the fear of unwittingly causing contributors harm, as well as the personal impact of listening to and taking on the weight of people's difficult stories. Sam gave this example:

> Some of them had really tough, emotional stories […] so it's quite hard not to take that home with you. I remember, we were sat […] going, "Our job is amazing, isn't it?" We were having a lovely coffee, and the Assistant Producer went, "Yes, but we are just about to go and make someone cry," because we were about to do her interview. I know it sounds like I'm being facetious, but that's the truth of it. It was like, actually, we had to go to that place with her and sort of guide her through it, if you like. So it was a hard day. (Sam)

This example demonstrates how even when working consensually with contributors who were prepared to tell their stories, the emotional labour of producing this content had an impact on both contributors and crew (Melzer, 2019). A common refrain from my interviewees was how contributors would sometimes share things they claimed to

have never discussed openly before, an issue which is reported in previous research (Rees, 2019). The production interviewees presented these intimate disclosures from contributors as a double-edged sword. Several interviewees pointed to the therapeutic value for contributors of having an opportunity to talk openly about their situation, however they also discussed their own fears of the danger that they could say something wrong or open up trauma:

> Are we probing in the right way and questioning as we should do in the hope that the psychotherapist will also pick up on those things or are we taking things off in a direction that perhaps they hadn't wanted to go? (Leila)

As Leila highlights here, the members of the production team were often entering into sensitive, potentially distressing subject matter, without being fully able to predict the potential consequences of unearthing traumatic recollections. Melzer (2019) argues emotion work is an integral aspect of producing a successful documentary, whereby forming close relationships with contributors is necessary to maintain access and get the best material. However, the impact of this emotion work has been largely overlooked. The interviewees reported that good team support was crucial in order to manage these difficulties. They also reported being able to refer to the duty of care psychologist for guidance. None of them however, had received any formal training in mental health or trauma.

As well as the danger of harm to contributors, in some cases, the pressure of supporting contributors' mental wellbeing was presented as effecting their own wellbeing. Chris referenced feeling lost at the end of the series he worked on because of the dedication and focus on making it a success for all involved. He added: "We used to joke that as their mental health was getting better ours was faltering slightly because we would take on all of their weight" This knock-on effect on the mental health and wellbeing of production crew of working with vulnerable contributors is documented by other production research (Rees, 2019; Wilkes, et al., 2020). These studies report crew feeling inadequately trained and prepared to support vulnerable contributors or manage exposure to distressing topics, with significant impact on their own mental health in some cases. My research supports the call of these studies for the need for systematic training in these areas for production staff.

To summarise this sub-theme, my production interviewees framed their involvement in series about mental distress as a positive and worthwhile personal choice. However, my analysis also points to the challenges that can be experienced in navigating and maintaining the lines between their commitment towards the programme, the individuals being filmed and their own wellbeing. My analysis suggests the complexity of the relationships that producers developed with contributors, where forming intimate relationships is an expectation of their role (Melzer, 2019), combined with limited mental health training created difficulties in managing the boundaries of their responsibilities. This has implications for the wellbeing of both the production team and the contributors.

6.3 The intervention/support providers' role - I'm here to help, not entertain

A central part of the narratives of the *on-screen* intervention providers (therapists, cleaners and declutterers) and *off-screen* support providers (psychologists providing contributor support and screening) revolved around the ethical challenges of delivering a fit for purpose intervention and ensuring contributors' needs were protected within the constraints of a television format. Their accounts depicted an inherent tension within the making of mental health intervention television between an explicit agenda of helping contributors and an implicit agenda of producing entertaining television. I have named this headline theme 'I'm here to help, not entertain'. 'Authenticity' and 'control' are identified as central sub-themes reflecting the perceived centrality of this conflict regarding the programme objectives. The challenges of 'being watched', i.e. filming interventions for a public audience is established as a related sub-theme, providing further context to the stories related by contributors about their experience.

6.3.1 I'm here to help, not entertain

As with the accounts of the production interviewees, the *on-screen* intervention providers (IPs) and *off-screen* support providers (SPs) were keen to emphasise that they placed contributors' mental health first, whilst also presenting themselves as motivated by a broader mission of public mental health education. However, the IPs/SPs framed these motivations as at times placing them at odds with the goals of the production, whereas the producers more readily offered accounts of their goals working in tandem.

Whilst almost all of the IP/SPs were positive about their experiences working with productions, they constructed a sense of compromise, and occasionally conflict, between their own focus on providing a therapeutically useful intervention and appropriate care, and the competing agenda of the production teams to generate entertaining television. Caroline, a specialist declutterer on a series about hoarding behaviours commented: "I have to say, the cameraman was really happy when we got into arguments". Chrissy, a cleaner on a different hoarding series put it more bluntly: "It's all sensationalised. […] Even how the producers gear it. They steer you a certain way so that it can be entertaining". Paul, a psychologist providing behind the scenes contributor screening and support remarked about television in general:

> I think it's inherently quite exploitative, I make a point of pointing that out to people which is you know 'these people are not interested in your wellbeing, they're paying me to be interested in your wellbeing so they don't have to give a shit!'

Paul here constructs a television production system which views contributors as commodities that must be protected and supported only in so far as it is necessary to the successful outcomes of the series, and to meet any regulatory obligations. His stance may seem paradoxical, given his choice to be involved, however he presented his involvement as offering some necessary protection for contributors. His comments and the ones above undermine the general premise of MHITV as aspiring to improve the mental wellbeing of contributors. In this sense they echo critiques that have been made by cultural theorists that the systemic structures of popular television favour producers over participants (Thorbjørnsrud & Lånkan, 2022). These comments were also in clear contrast to the narratives presented within the production accounts.

Other interviewees presented the production teams' motivations less sceptically. Zoe, an on-screen psychologist on a hoarding series, felt the series producer/director: "was so compassionate, so caring. She genuinely wanted to make sure they were followed-up and that things were still moving forward." Most of the IP/SPs emphasised that despite tensions, the crew were thoughtful and keen to help contributors, often highlighting individual crew members. However, the general sense across accounts, bar Zoe's was that the production teams, whilst perceived as pleasant and well meaning, had a different set of priorities to themselves. This difference of agendas has important implications for the intervention and care offered to contributors. Tim and Cathy (on-

screen therapists but in different series) both presented a tension between what might be appropriate clinically for contributors and production agendas which privileged entertainment:

> You know, [the channel] were paying them for this documentary, so it needed to have some kind of, I suppose, entertainment value to it. So, their purpose wasn't the same as mine and wasn't the same as the participant's either. So, to some extent, there were times when we were at odds with each other. (Cathy)

> There was a genuine will to collaborate, but ultimately, I don't think there was anybody who was under any illusions that, you know, there needed to be a programme produced and it needed to hit certain points[….] That need to entertain is to some extent, you know, offset against the other demands of the clinical situation. So that, I think, was sometimes a bit of a tension. (Tim)

The emphasis here on multiple actors and agendas in conflict illustrates the challenges perceived by IPs involved in producing a documentary; in creating a collaboration between very different professional domains with distinct working practices, ethics and importantly, measures of success. Crew members were positioned as operating within a commercial production system which has its own imperatives and principles which were not necessarily aligned with the principles of therapeutic treatment avowed by the IPs. As Cathy added about the need to satisfy multiple agendas: "Actually, that does cause slight disruptions to the therapeutic experience."

The systemic commercial pressures to produce entertaining television were constructed as a limiting factor on the scale and quality of the interventions that could be delivered, and as therefore constraining the ability to create meaningful change for the filmed contributors. Caroline, a specialist decluttering on a hoarding series, pointed to the incompatibility between the focus on featuring extreme cases and the short filming schedule:

> My gut feeling is it just wasn't long enough. If you want to work with extreme people, then you've got to do a longer-term job. If they'd have worked with people who were less extreme, the shorter time intervention might have helped them more.

This example highlights a paradox created by the commercial structures and principles underpinning television production. Competition for audiences fuels a demand from broadcast channels for attention grabbing storylines, and extreme characters (Kilborn,

2003). However, increasingly smaller production budgets and narrow profit margins may limit the resources available to achieve the dramatic narrative transformations aimed for within formats such as hoarding programmes and other kinds of MHITV. On some series the tight production schedule doubled up as a format point, as Chrissy (on-screen cleaner) explained about one house clearance: "It had to be squashed into three days, which is absolutely ridiculous!"

From a critical perspective, introducing a time limit is a win-win for production companies. It creates drama by adding pressure on the delivery of the intervention whilst also acting as a budget control, limiting their exposure for what could otherwise spiral into an expensive and more long-term intervention. Whilst this might suit the interests of productions, it has potential repercussions for the support and care being provided to contributors. A criticism that can be levied at some hoarding programmes for example, is that they focus on rapid turnaround clear-outs. These can be extremely stressful for individuals with hoarding behaviours and without the addition of therapy, do not actively address the underlying causes (Holmes, et al., 2015). The implication is that the commercial principles underpinning television production which privilege entertainment led formats and a fast turnaround, shaped the therapeutic intervention provided to contributors, rather than the focus being predominantly on providing them with the best possible care.

It is worth noting that there was one counter example to the general trend described above. Zoe (an on-screen psychologist) described how in the hoarding series she was involved in, they ended up extending both the filming schedule and the number of therapy sessions that she was providing (both on screen-and off) when it became apparent that this was needed. It seems that the production was willing to adapt to the needs of contributors, although arguably it was also conducive to the requirement of the programme narrative for a positive resolution. This responsiveness on the part of the production may account in part for Zoe's highly positive appraisal of being involved in this television project.

Given financial and narrative restrictions on the making of MHITV identified above, their accounts raise doubts about the potential of these series to achieve long term change for the contributors, despite the apparent success stories depicted on screen. When I

asked the interviewees whether the contributors had been helped by their involvement in the programmes, all of them suggested that the contributors had gained something from the interventions they received. However, some interviewees expressed qualms about the way either the interventions or the contributors' progress were packaged. Caroline (declutterer) conveyed discomfort that the outcomes for contributors were presented as a fait accompli:

> **INTERVIEWER:** How representative do you think the programmes are of the process and what people achieved?
>
> **CAROLINE:** I don't think they are because they always want a happy ending. There are happy endings, but they don't happen that fast, so they're not true. That's a bit upsetting. If you're part of that non-truth. You can do anything with a television camera, can't you? You can make things look amazing or terrible.

Caroline positioned the narrative conventions of the genre as limiting the story that could be told. She depicted that the programme narratives were built around a positive resolution which necessitated glossing over the 'messier' reality. The suggestion is that there is no room for failure in how contributors' stories are packaged within mental health intervention television. In a related way, Tim, a therapist, who was filmed for a series which he described as 'factual entertainment' also expressed unease about authenticity, in this case over how therapeutic content was packaged. He complained at finding himself delivering an intervention process that was at times "more pantomime than it was therapy". He cited discomfort over the limits of the format to tell an authentic story as one of the reasons why he chose not to work on further series:

> Those programmes tell a particular story. I was a little bit frustrated after a while. It didn't occur to me, I think, when I first started I was very naive and I didn't quite appreciate, sort of, the narrative trajectory that was required and the points, the format points, the idea that there are format points in these things[…]Entertainment isn't normally, you know, too challenging, but I wish sometimes that things had been a little more naturalistic in that life isn't tidy.

The implication here is that the expectations for factual entertainment have limited the ability to provide and document a more realistic therapeutic experience and outcomes. This is a criticism that has been made by other psychologists working in the media, who have highlighted the media's tendency to simplify and ignore parts of the story that don't fit into their preconceived idea for a programme or article (Wild, 2006). It is also

possible to identify a connection between the questions about authenticity raised by Caroline and Tim, and broader criticisms that have been made about popular lifestyle formats and talk shows drawing on 'psy' experts and terminology over the promotion of unrealistic ideals of self-improvement (Abt & Seesholtz, 1998; Ouellette & Hay, 2008; Palmer, 2008). In a similar vein, the IP/SP interviews highlighted that the way transformation is packaged within MHITV is potentially problematic. Their accounts suggested that the narratives contained within MHITV that better mental health is something obtainable through a few quick expert pointers or home clearance and renewed self-belief are a misleading oversimplification. Tim and Caroline demonstrated how on-screen providers may find themselves in an ethically challenging position of endorsing, by their involvement, a 'narrative version' of events where the appearance of a successful resolution was more important than either the actual benefits of what was being offered or the actual outcomes.

In summary, IPs/SPs were generally satisfied with their experiences of being involved in mental health intervention television. However their accounts indicated a tension created by the multiple agendas behind the making of the series. They presented themselves as seeking to uphold the therapeutic standards of the programmes and ensure a duty of care to contributors, in the face of pressures arising from a production focus on producing entertaining television. Their accounts also pointed to production constraints that limited the scope of the interventions provided within the context of a television project. A few interviewees raised doubts therefore about the authenticity of the transformative outcomes presented on screen, signifying that there can be a difference between a television narrative fix and a real-life fix. This has implications for contributors involved in MHITV and whether they experience a discrepancy between their experiences and the outcomes presented on screen.

6.3.2 Control and accountability over contributor wellbeing

Given the issues identified above, mental health intervention television generates ethical issues around who is responsible for the intervention offered to contributors, and for their wellbeing both on and off screen. This was a significant sub-theme. The IP/SPs narratives constructed a process of navigating, negotiating and justifying where their control and accountability for the therapeutic invention, and duty of care to the contributors more broadly, began and ended. Cathy referred to the negotiation of

control at various stages of the production process. She appeared in a series which (re)constructed a more conventional clinical set up of talking therapy sessions. She described discussions with the production team over contracts for both herself and the contributors, in which she wanted to establish clear expectations and division of responsibilities, such as ensuring a set number of therapy sessions and her right to review the final edit. Within filming she described negotiating with crew over control of the content of therapy sessions following unwelcome interjections from the director:

> I kind of said, "Obviously, we are filming a documentary, but in terms of this [person's] therapeutic journey, there are things that-" we had got a set number of sessions, "there are a few things that we need to achieve every session." […] But if there was anything maybe specific that they would like us to do, we can talk about it beforehand, or afterwards in preparation for the next session, and it would be up to me, essentially, whether we include that, or not, whether that is appropriate." (Cathy)

Cathy here presents herself as open to discussion with crew about what they wanted to achieve but having to pro-actively assert her authority as the clinician to ensure that the intervention did not become subject to other non-clinical pressures. She positioned herself as retaining primary responsibility for the intervention and presented this control as important to protecting the integrity of the therapeutic aims of the project.

In more heavily formatted series, which moved further away from established practices, there was the suggestion that the lines of accountability were more ambiguous. Blaker (2017) has argued that in taking therapy out of therapeutic settings the onus of authority and responsibility moves further away from clinicians and more into the hands of production companies. One way the IPs in heavily formatted series appeared to manage this ambiguity over responsibility within their narratives was to assert the limitations of their power. Caroline stated her lack of control bluntly: "I have absolutely no power. I can say what I'd like and occasionally it happened, but not very often." Tim also downplayed his ability to influence decisions within the production. He described the constraints on his control over the design of the on-screen intervention:

> I felt, that the clinicians were certainly involved genuinely in designing interventions […] But there were only certain kinds of answers that they wanted […] very quickly, you know, one became aware that if one was going to make a useful suggestion, it was going to need to be something visual, dramatic.

Tim again presented a picture in which entertainment took precedence over clinical validity. He appeared to manage any inconsistency between his critical stance of this approach and his own involvement by reasoning that in order to have any say over the intervention content ("if one was going to make a useful suggestion…"), he must also adhere to an agenda prioritising visual and narrative drama. In addition, he presented the process of designing the intervention as collaborative, but with asymmetrical relations of power, in part because television is unfamiliar territory:

> you are a stranger in a strange land, so to some extent, you too, it's not just contributors, but you too are trying to work out what is required of you and how do you operate within this terrain?

According to my analysis, there is an important subtext underlying his intimation that he was trying to work out "what is required of you"; which is the ambiguity within his role which comprised responsibilities as a clinician but also as a presenter. For all the on-screen intervention providers, there is the potential for these dual roles to be at times conflicting. A conflict of roles was one of the criticisms raised about the production structure within the Jeremy Kyle show, whereby the psychotherapist leading guest duty of care also had an on-screen role (Dare & Wood, 2019). In re-narrating their experiences to me therefore, emphasising their lack of control, whilst a realistic reflection of the production set up, may also be one way of managing discomfort or potential criticism over their involvement, given the flaws they have identified above.

The issue of control and accountability was also raised in the accounts of the two psychologists, Charlie and Paul, involved in behind-the-scenes contributor screening and duty of care (SPs). Both used the idea of informed consent to explain the boundaries of their responsibility towards contributors. They emphasised making contributors fully aware of the potential downsides of appearing on screen, describing a key part of their role as making sure "they've really understood the implications of what it means to be part of a TV programme"(Charlie). The SPs constructed the necessity in their role of navigating the ethical boundaries between protecting contributors and allowing them autonomy. For example, when I asked Paul whether there were any contributors in the series that he advised against, he used informed consent and contributor autonomy to validate their involvement, despite his concerns:

> not everybody who was approached I thought it would be in their best interest to take part, but it's that difficulty because ultimately it's down to them, so you run through the options and say 'I'm not going to deny you the opportunity of being on TV, my advice is I don't think this is suited to you and I'll make that advice known to the producers but ultimately it's up to them.
>
> **INTERVIEWER:** O.K
>
> **PAUL:** I don't think there was anybody who was incapable of giving informed consent. See, the threshold is quite low.

Paul appeared to make sense of any discrepancy between his advice and the decisions taken by the production team by positioning his role as not that of gate keeper, but as ensuring contributors have been fully briefed and understood the potential downside to their involvement. With informed consent established, he presented the responsibility for whether contributors should proceed as the choice of the individual and the production team. This position was also taken by Charlie when we discussed hoarding programmes where the representation or treatment of contributors may seem questionable:

> So it's still, you know whilst there might seem, some of these programmes are seen as exploitative, the characters that end up on the TV programmes essentially are able to offer informed consent, when you put aside and you've taken account of any mental health difficulties, they are still able to consent. (Charlie)

Here, Charlie seems to be using informed consent to counter potential criticism of his involvement in programmes that in his own words might be "seen as exploitative". In this way the consent process was offered as a rational justification for the limits of his professional accountability for the programme contents, or outcomes for contributors.

Another aspect of the theme of control and accountability revolved around editorial control. Within most factual television and documentary production, it is standard practice for producers and broadcasters to retain editorial control[13]. However several of the IP/SPs were able to preview and offer advice on the rough cuts of the programmes they were involved in, with a view to protecting contributors or correcting any inaccuracies. A small number of accounts highlighted areas of tension however over

[13] For example the BBCs editorial guidelines (section 6.3.32) sets out the principle of editorial independence

editorial decisions beyond their control. One on-screen intervention provider gave the example of how the name of the series was changed at the last minute to one they felt was inappropriate. As with the experience of the family therapists filmed for a BBC documentary (Aitken et al., 2012) they discovered too late that they had no contractual say over the title. Another issue for two of the IPs were concerns over the inclusion of material of contributors that they felt was potentially exposing or inappropriately private. Chrissy (cleaner in hoarding series) described how the producers included footage of a central contributor in a distressed state: "They still used the footage without considering her feelings and I thought that was wrong." Cathy (on-screen psychologist) was unhappy about a scene with a contributor which she said "was probably good from a dramatic point of view" but that she "didn't think it was appropriate [to include]".

What is relevant in both these examples is that the intervention providers were not present at filming and that in the second case, the contributor had agreed for the footage to be used. These cases again illustrate the potential difficulties of a blurred line of where the on-screen intervention providers accountability and authority begins and ends. Whilst the IPs were able to maintain some control over the filming they were directly involved in, they were not necessarily able to influence how contributors were filmed at other times, or how they were represented on screen. Given the difficulty in separating the intervention from the television experience, a lack of oversight beyond the filming they were directly involved in, not only constrained their ability to protect contributors but had the potential to impact the therapeutic process.

In summary, the accounts of the IP/SPs suggested that in MHITV, where the production has sourced the contributors and arranged the therapeutic intervention, the influence and responsibility of the IPs/SPs over the therapeutic project or the welfare of contributors is not always clearly defined. Within certain formats the control they have over the intervention, the duty of care and the story told was constrained by both narrative conventions and production practices. They presented the production as holding the reins over the project and control as something they must negotiate. Like the main contributors, once the filming was done, they had to trust the production to tell the right story. Given these issues, some of the interviewees appeared to deflect possible criticism over their involvement, by emphasising their lack of control.

6.3.3 Being watched – the challenges of taking part in televised mental health interventions

Another subtheme identified by my analysis was how being filmed and specifically, an awareness of 'being watched', might change the intervention experience. This was a theme that was discussed mostly by the three psychologists who were tasked with providing on-screen therapy. Their accounts established the influence of perceived audiences on the intervention delivery and outcomes for contributors. This ranged from the effects of the crew's presence and the awareness of imagined future audiences during therapy, to the potential impact of real audience responses on the contributors' wellbeing.

A key element of this theme revolved around the ethics of providing therapy on screen and the impact of filming what is normally a private process. The therapists presented having other people present and the awareness of being filmed for public viewing as a significant difference. As Tim said:

> One of the fundamental differences between therapy and onscreen stuff is that it's private. And so people are able to open up and disclose things that certainly they wouldn't, or perhaps shouldn't be advised to do so within the context of an open public forum and that's ultimately what the programme is.

As Tim highlights here, the importance of confidentiality is a central tenet of talking therapy (British Association for Counselling and Psychotherapy, 2018) which conflicts with the aims of MHITV to document the therapeutic process of contributors. Tim constructed this as potentially limiting their ability to open up, and also putting them at risk of exposure. This supposition is supported by the findings of Thorbjørnsrud & Lånkan's (2022) study in which some of the Swedish television participants filmed for a therapy show reported feeling unable to be engage in therapy or regretful of sharing too much. The study authors point out that the legitimacy conferred by involving a professional therapist within the production framework, leaves participants extra vulnerable to permeable privacy boundaries which may suit the needs of the producers but is not necessarily in the participants' best interests. My interviewees described measures in place to try and limit any negative impact of filming on the therapeutic process in certain productions. For example, agreements to stop filming on request, sessions that weren't filmed, and the understanding that contributors could ask for

anything said in therapy to be left out of the films. Despite these measures, the therapists acknowledged the ethical dilemmas of filming therapy and the inherent pressure that cameras added. Zoe described how it was only when she did some therapy sessions with the contributor which were not filmed that she appreciated the difference:

> Both of us just went, "Oh my God, this is really different when it's not being filmed." We couldn't quite put our finger on what it was. Obviously, we were a wee bit more relaxed and, I don't know, maybe I swore more, probably, but both of us, sort of, said, "Oh, it does feel different,"

Zoe conveyed a sense that without the cameras, both herself and the contributor were more comfortable to be themselves and less guarded about what they might say and do. The pressure to guard against revealing something frontstage, that they would like to remain backstage was removed (Goffman, 1959). Cathy also presented the cameras as having an effect which "really impacted on, I suppose, our ability to engage in the session". She gave an illustrative example of how a contributor got up and walked out of the therapy room during one emotional exchange. She explained how this interruption allowed her to have a few words off camera in private with the contributor:

> I think that was a really powerful moment where [they were] then able, privately, without anybody else watching or listening, just to talk a little bit about [their] background. And in that few minutes, I think I remember saying, "They might ask us to talk about this upstairs. What bits do you want to talk about?"

This example clearly illustrates that the presence of the filming crew changed the therapeutic experience. What made a dramatic scene in the documentary of the contributor walking out arguably would not have happened at all if the camera was not there, creating the necessity to move out of the eye of both the production team and the imagined audience. It also points to an understanding between the contributor and therapist that they were required to offer up some part of the therapy process for public viewing, however may want to hold back other information until they were in private. They were distinguishing between two processes – the public performance of therapy and the actual therapy. Cathy's account indicated that the challenge of managing appropriate boundaries for private versus public disclosures may be problematic for the ability of MHITV to deliver on its therapeutic goals for contributors.

Another element of the theme of 'being watched' was a consciousness that the intervention providers themselves would also be subject to public scrutiny. Their accounts showed a keen awareness that they too were offering up a performance, where their professional conduct could be open to criticism:

> I think I'd got in the back of my head, "Ah, what are my colleagues going to say?" and I was certainly, sort of, picturing people taking the P, as you're doing it. So, although, obviously, you're trying to give 100% to the session… and, obviously, you can't always. (Zoe)

> Your attention is very divided, in a way, you know, you've got half an eye on thinking, you know, "Okay, what's this going to look like? Is it going to be satisfactory? Is it going to be engaging?" (Tim)

The implication in the quotes above is that a hyper awareness of whether they were delivering a suitable performance acted as a barrier to focussing on the needs of the contributor. This reticence of how they will be perceived is unsurprising given criticism of the role of therapeutic professionals both on screen and off in reality TV series (Brenton & Cohen, 2003; Rees, 2019). Whilst the potential for criticism may have operated as a suitable check on the appropriateness of their conduct, they constructed this additional pressure as distracting from their primary goal of supporting the contributors.

In summary, "being watched was generally presented as having a negative impact on the delivery of on-screen therapeutic interventions. The on-screen therapists accounts constructed both the immediacy of the crew as witness to difficult conversations, and the awareness on both sides of the future audiences as potentially problematic to the therapeutic dynamic. Like other research has found, the introduction of cameras changed the therapeutic experience (Blaker, 2013; Thorbjørnsrud & Lånkan, 2022). Therapists were conscious that there may be a discrepancy between what information was helpful to share for the purposes of therapy and what information was appropriate to share publicly (or more importantly to protect contributors from sharing). This complicated the process of aiming for the best outcomes for contributors' wellbeing.

6.4 Comparing accounts – is it possible to help and entertain?

This analysis offers insight into the production processes, decision making and the challenges of making mental health intervention television from the perspective of those involved in the making of these kinds of series. The main aim was to provide valuable context for the narratives that contributors tell of their experience. In addition, my second aim was to begin to identify common themes and factors that make participation successful (or unsuccessful). My analysis establishes that there were parallels but also significant differences in how the two groups presented their different roles and the challenges of making MHITV. A key impression that was conveyed across both the production and IP/SP interviews was the idea that there was something unique, particularly challenging, but also rewarding about making MHITV. As the chapter title suggests, at the centre of the interviewees' accounts was the depiction that making these kinds of series is a delicate balance between the needs of producing a compelling and entertaining television series and meeting the needs and responsibility towards contributors. Both groups emphasised how they took the contributors' mental health very seriously and presented themselves as competent and ethical professionals who are seeking to make a difference. However, what is interesting is where their accounts diverged significantly, with the IP/SPs offering a strong counterpoint to the production interviewees who placed such focus on their own moral standards and distinction from wider television practice. Whilst there is no suggestion by the IP/SPs that the production teams acted inappropriately towards contributors and they generally present crew members as caring and supportive, they positioned themselves as upholding the therapeutic project in the face of an overwhelming emphasis on entertainment.

However, whilst at first glance they appeared to cast doubt on the production interviewee representation of events it is interesting to consider the similarities in how their accounts are presented and what they are achieving. Just as the production interviewees shaped an 'other' as the problem – the unethical producer, the intervention providers also appeared to be passing over responsibilities for any shortcomings of the television projects, in this instance back to the production team. In the 2019 reality television inquiry by the Department of Digital, Culture, Media and Sport the involvement of psychologists and other counselling professionals within television

production was placed under scrutiny, alongside production practices[14]. Given this focus on the mistreatment of television participants, and ongoing concerns about the role of television in perpetuating negative representations of mental illness (Henderson, 2018) it is arguable that it is in the interests of both the IP/SPs and the production interviewees to deflect potential criticism by shifting the focus of any blame away from themselves (Aufderheide, 2012). It is a reminder that both sets of accounts should be treated critically.

This analysis highlights critical issues related to the experience of contributors who take part in MHITV, providing an instructive reference point when it comes to understanding and interpreting how contributor interviewees present their involvement. Three areas stand out: control and accountability, validity of the interventions, and the suitability of television as a vehicle to deliver mental health support. Control and accountability featured strongly in both sets of accounts. The IP/SP interviews demonstrated that without the formalities and safeguards of the clinical setting or other work protocols, there can be a lack of clarity over who is in charge of the therapeutic project and what constitutes the boundaries of the intervention providers' responsibility for contributors, both on and off-screen. The unspoken issue within the IP/SP narratives, however, is the potential benefits, both financially and in public status, to be gained from a successful collaboration on a television project. Brenton and Cohen (2003) have argued that it is not in the interests of psychologist-consultants to challenge productions companies that are providing them with work, and the opportunity to build a media profile. A fundamental lack of independence could make it difficult to challenge production decisions. Conversely, the production accounts point to the central involvement of crew members in supporting contributors, and in effect acting as pseudo-therapists. They highlight the difficulties this blurring of roles may bring to both parties. Ambiguity over the accountability and design of the intervention and support provided in some series is potentially problematic for contributors who could be led by the involvement of "experts" to expect an unrealistic level of care and assistance, when the production retains primary control of the intervention provided to them and for their off-screen welfare.

[14] The inquiry was closed prematurely due to election being called. Evidence submitted can be found at their website

Another aspect of control and accountability raised by the accounts related to how the contributors and their experiences were represented on screen. The production interviews presented a collaborative approach to storytelling as key to a positive experience for contributors and an integral part of addressing their mental health needs. However my analysis also identifies the limits of control that contributors may have over their stories and how the constraints of specific format conventions and predetermined ideas about narrative, influenced what or whose stories were prioritised. In addition, the IP/SP accounts cast doubt on the authenticity of on-screen narratives which focus on personal transformation and triumph, problematising the oversimplification of mental health issues and therapeutic treatment. In some cases there is the intimation that the validity and success of the interventions may have been misrepresented. For contributors who have committed to a process in part with expectations of receiving expert help and support, this raises the question of whether rather than receiving the best possible care, they are just getting the appearance of it. Inadequate care could potentially set them up for failure, if not on screen, then further down the line and risk them loosing trust in therapy. This uncertainty over the outcomes of the interventions provided suggests there may be a need for longitudinal support for contributors, as well as research into the long-term consequences for contributors, something this PhD contributes to.

A crucial question raised by this analysis is whether MHITV is the right vehicle to offer therapeutic interventions, or whether it involves too much compromise. By taking familiar professional therapeutic practices out of the clinical setting the IPs experienced their intervention as subject to other objectives and pressures beyond delivering an effective treatment. An important implication is that the cyclical relationships between commercial pressures, genre conventions and production practices, may be by default in tension with the needs of contributors. This has repercussions for contributor care more generally and echoes concerns raised by recent production research over pressures on crew members to prioritise dramatic content over ethical conduct towards vulnerable contributors (Rees, 2019; Wilkes, Carey & Florisson, 2020). It also has direct implications for the design and premise of MHITV specifically, raising questions about whether a commercial television format can deliver valid treatment for mental health difficulties whilst simultaneously meeting the established narrative conventions of

reality TV. My interviewees indicated that the effectiveness of any support offered may be constrained by the format conventions, as well as the limitations of the production process. Whilst this may vary by production, even in programmes which attempted to mimic a conventional therapeutic process, the accounts suggested that the very act of filming inevitably changed (and potentially interfered with) the therapeutic process. In addition, the interviewees highlighted the ethical concerns of disclosing highly intimate information to a public audience (Blaker, 2017; Thorbjørnsrud & Lånkan, 2022).

This analysis of 12 interviewees provides a unique insight into the processes and inter-relationships behind the making of mental health intervention television. Whilst the practices and perspectives documented are highly diverse, collectively their accounts raise significant questions about the televised therapeutic experience on offer for contributors. This provides valuable context for the next chapters which will explore the perspectives of the contributors themselves, and how they make sense of their MHITV experience and the outcomes for their wellbeing.

Chapter 7: Narrative analysis - The transformative potential of telling my story on national television

7.1 Introduction

This chapter is a narrative exploration of the nine interviews conducted with ex-television contributors (central on-screen participants). I examined the genre, tone and central themes for each contributor and interpreted and summarised individual core stories for each of them (Appendix I). The individuality of each person's account was fascinating, however what emerged from this process of analysing each interview account separately and holistically was that it was also possible to chart repeated patterns in the types of stories I was hearing and in certain key themes. These patterns have guided my analysis as, to my mind, the most constructive way of extracting meaning and value from unique accounts. Whilst I have attempted to hold on to the specifics and 'whole' of individual stories, what I present here is a holistic analysis of form and content (Lieblich et al., 1998) of the *meta story* of the experience of taking part in mental health intervention television. I aim to capture the dominant narrative genre, plot and themes whilst also providing some explanations for where individual stories may diverge.

I have labelled this meta story 'the transformative potential of telling my story on national television'. This was the central thread running through the contributors' research interview narratives. My analysis establishes the crucial significance of how contributors conceptualise telling their stories to how they evaluate their television experience. It ascertains that the principle and expectations of telling their story were presented as key motivators and objectives of becoming involved in a television series. Contributors exhibited lively engagement with what stories they wanted to tell and suggested they were actively seeking to shape their television narratives and with it discourse about mental health. Their perceived success in this endeavour, as represented by audience feedback, was a crucial part of their evaluation of the experience and outcomes of taking part. In the following chapters I will argue that the impact of taking part in MHITV goes beyond whether or not contributors believed the interventions to be successful and was intimately linked to their feelings towards, and feedback from, telling their stories.

This chapter breaks down 'the transformative potential of telling my story on national television' into four themes. I will briefly summarise the overriding **genre and plot structure** of the research interviews. This will explore how the interview narratives mirror the quest convention within MHITV but with crucial differences. I will then examine two sub-themes relating to how contributors narrate their motivations for becoming involved in a television series – **finding purpose by helping others** and **showing the reality of mental distress.** These starting points within the contributors' interview narratives set the trajectory of the central narrative of **transformation through telling my story** which I will describe and argue is the heart, plot resolve and 'so what' of their stories as told to me. In the chapter Nine, I apply narrative theory to examine what this can reveal about contributors' experiences.

7.2 The interview narratives - a quest story of making a quest story

As set out in Chapter Two, mental health intervention television fits within a quest genre, taking the shape of a transformational journey of discovery, emphasising personal realisations and new beginnings (Frank, 2013). Whilst the stories told within the research interview setting were more complex, subtle and non-linear than the mediated versions of experience, presented on screen; the characteristics of the quest genre that structure the television programme narratives were clearly replicated. The contributors' accounts emphasised that their involvement was not the stuff of day-to-day but a significant and meaningful moment in their lives with transformational impact. This is captured in the tonal qualities of their effusive language used to summarise the experience – Laura referred to it as "a huge life event" which "does still have a lasting impact" years after taking part. Sarah described it as "an amazing thing to be part of" and George introduced it as "the best thing I ever did, the best decision I ever made."

The process of taking part is for the most part depicted as exciting, at times challenging but ultimately rewarding. I asked everyone whether they felt taking part had impacted on their current life and wellbeing. The responses were varied and specific to each person's circumstances, but they typically employed the kind of phrases that both the series and more broadly the conventions of a quest genre encourage, emphasising challenge, change and enlightenment. Laura, for example, replied to my question that her involvement "has properly like shaped a lot of what I do now or how I see things

now". Sarah explained how after completing the final challenge, "generally I now feel like I can do anything I put my mind to, and I believe in myself". Contributors framed taking part as a turning point for practical changes in their lives such as moving to a new city, getting a job or opportunities that came as a result such as being asked to speak at events. For some, taking part was presented as shaping old and new relationships.

An important way their interview accounts of their involvement differed from the narratives portrayed within the television series however, was that their descriptions of the catalysts for change invariably went beyond the intervention itself and sometimes followed from the aftermath of taking part and from being on television. When analysing how personal transformations are presented across the contributors' accounts of the experience, what stands out is how often their evaluation of the changes they have gone through are intimately linked with the experience of telling their stories. As Chloe phrased it: "It was a big turning point in my life, not just getting the flat sorted to live in, but actually just doing the filming and telling my story". The contributors repeatedly linked positive gains for their self-esteem and understanding with the process of sharing their story, such as pride: "I'm proud of myself that I told my story" (Ali), healing: "It helped me with my healing process of actually the opportunity to speak about how I felt" (Sarah) and self-discovery: "It made me realise that I'm brave" (Kate).

Frank (2013) writes that a commitment to sharing what has been learnt with a wider audience is a necessary end point for quest stories. This is also an explicit goal of any factual television series – by becoming involved and being filmed, contributors are making a commitment to sharing their highs, lows and self-realisations with the viewing public. This goal was similarly reflected in the contributors' accounts. However, what is interesting is how the 'telling of their stories' was not just the end point for their quests but was presented *as* the quest. This particular quest narrative plot is: the contributors have been through dark and difficult times with their mental health. They have faced stigma, misunderstanding and their own shame. Despite the risks of exposure, they have made the brave decision to share their journeys to improve their mental health with the television audience in the hope of inspiring others and educating the public. The process of speaking out has its challenges but is ultimately healing. The reward for telling their stories is validation from the audience. They have newfound pride, self-esteem and have learnt what they are capable of, which has taken them in new directions.

The experience of telling their stories on national television was the central thread that ran through all the contributors' narratives during my research and exemplified a quest narrative in structure. Not all the contributors' stories followed this exact plot, it is an idealised narrative arc designed to capture the overall thrust of the interview narratives. It also leaves out many other ways of storying and making sense of the rich and varied data provided in the interviews, a point I shall return to in my discussion. The next sections will explore in more detail how the key plot elements that I have identified above manifested across accounts.

7.3 Finding purpose by helping others

> I don't want other people to go through it without noticing it. So what can I do to help them? (Susie)

Whilst the narrative trajectories of MHITV generally plot a journey from a place of despair to new beginnings, contributors' interview accounts of their experiences were much more nuanced. The predominate starting point for their involvement was not presented as initiating out of a desperate need for personal help, but as a motivation to help others. As with other research with participants who have shared personal illness stories with the media (Ytreberg & Thorbjørnsrud, 2020), their accounts emphasised the belief that openly sharing their difficult experiences can help someone else in a similar situation. As Chloe said: "I like to put my information about how I got there, out there to help someone else". This goal provided the 'call to the quest' (Frank, 2013), which in this case provided the impetus for them to embark on the journey into the unknown of being filmed and publicly sharing their stories.

Frank argues that the framing of difficult experiences as a quest or learning journey offers tellers a way of finding some meaning and purpose in the face of the randomness or lack of control people face when dealing with serious illness, trauma, or in this case, mental distress. Constructing these stories are a way of holding "chaos at bay" (Frank, 2013 p.115). This description seems fitting for many of my interviewees' accounts. The way in which some contributors described their decision to share their stories suggests that taking part in a television programme is perceived as an opportunity to direct difficult personal narratives towards a more constructive end point, by using them to help others. Sarah's narrative is a powerful example of this. Some years before her

involvement in the television series, she experienced the tragic loss of a family member, which led her to set up a charity and talk publicly about her loss. She explained that she saw the series as a further extension of this work, another vehicle to convert her negative experiences into something positive:

> I also love the fact that [their] death was leaving a legacy and that's when you know, I set up the charity for that, but I also feel by sharing my story and if someone can come up to me and say 'thank you for sharing your story, you know, I've been to the doctor since', that means that [their] legacy is making a difference.

Sarah conveyed a strong impression that by sharing her story to help others she was trying to make sure that the death of her loved one is not meaningless. In presenting her experiences in the form of a quest story that can help others, she was possibly attempting to take back some control over her story and share a more hopeful narrative, whereby some good could come out of the otherwise senseless loss she has experienced.

In a distinct but related way, Dom talked of being motivated during filming by thinking of what would have helped his younger self:

> I kind of kept in my head the whole time what would have helped you back in the day when you started to really struggle with life and what if there was someone on TV that you could relate to, what could they have said that made you feel like you're less alone in that feeling.

Framed within a quest narrative, Dom, like Sarah above, is the 'returning hero' who has persevered through suffering and come to share what he has learned (Frank, 2013). His imagined audience is his younger self. Susie also explicitly presented herself as having something worthwhile to share: "I've got all of this experience…So what can I do to help?" Positioning themselves as the helping heroes, who are selflessly and bravely sharing their stories, arguably provides contributors with an alternative, agentic way of evaluating their mental health history and ongoing difficulties. Sharing personal accounts of illness in the media is often perceived as an "an act of goodness" which conveys upon the sharer a "high moral status" (Ytreberg & Thorbjørnsrud, 2020, p. 6183). Assuming the role of narrator of a quest narrative to help others may have allowed contributors to conceptualise themselves not just as people who are having difficulties and in need of help but as people who have something of value to offer.

Whilst most of the contributors' narratives constructed the opportunity to help others as providing a sense of purpose and self-value, an important caveat is that that this was not true of all contributors. Kate was much more ambivalent about the aim of helping others and her account pointed to some tension in the pressure to live up to such a worthy ideal:

> I thought I was insane, I was like, I can't, I can't do this, this is like, people like me don't do stuff like this, like, and I wanted to be the kind of… talk about mental health and be like really inspirational and stuff but then I was like don't be a martyr, like there's like hundreds of other people out there who will do it instead.

Kate's use of the words "insane" and "martyr" captures the contradictions in current cultural discourses about speaking out about mental health. Whilst public mental health campaigns have heavily promoted the importance of open discussions about mental health there is still stigma attached to being labelled with a mental illness (Henderson & Gronholm, 2018; Schomerus et al., 2012). Not all stories are received equally. Kate's self-doubt about whether she is the right person to be "really inspirational" may reflect the domination of a certain kind of slickly packaged, ideally celebrity-endorsed, overly positive mental health story in the media (Harper, 2008; Lakeman et al., 2007). This is an ideal Kate perhaps felt unable to live up to.

In fact, Kate's reluctance to put herself forward is the starting point of a narrative arc which culminated in her discovering "that I'm a very brave person". However, she expressed doubts throughout her account about whether she did the right thing by exposing herself on television. The conflict she constructed between openness and privacy echoes that of some of the mental health patients interviewed by Lånkan & Thorbjørnsrud (2022). It demonstrates how moral pressure to speak out about mental health can be experienced as a burden. Repeated cultural discourses of the benefits of openness which are reiterated on many levels from the production crew to public mental health campaigns and therapeutic discourses in the media, can create an expectation and pressure that it is good and the right thing to share your mental health story. Kate's account is a reminder that this may be counter-productive in some situations and for some individuals (Woods, et al., 2019).

7.4 Showing the reality of mental distress - challenging dominant media narratives

> I just wanted to break the stereotypes really and show that you can live a full life with OCD (Ali)

A mission to educate the wider public and challenging negative discourses about mental distress was often presented in contributors' research interviews alongside 'helping others' as a starting point for their involvement in MHITV. In narrative terms, it was a related part of the 'call to the quest' of telling their stories. Like 'helping others', this goal appeared to provide contributors with a sense of purpose. It is returned to in their narratives as justifying and getting them through difficulties along the way; and achieving this outcome, as represented through audience feedback, is part of the payoff that concluded their narratives, a point I shall return to in the next section. Whilst connected, this theme has some distinct qualities from 'helping others'. The tone was more campaigning, and even angry at times, as captured by George who exclaimed "I was desperate to tell a story, I'd had enough of seeing shit stories!". Contributors appeared to be led by a desire to construct media narratives that more directly reflect their own mental health experiences. For some contributors their involvement also seemed to be an opportunity to receive recognition for the difficulties they have been through.

When recounting their motivation to share their own stories, the interviewees demonstrated a significant interest and engagement with existing televisual narratives of mental health and whether they were good or bad. They expressed strong ideas about what narratives they wanted to portray and see more of on television. Contributors talked about "showing what it's actually like to have a mental illness" (Dom) as an alternative to media messages that promoted over simplistic, sensationalised caricatures for "entertainment" (Ali), or overly positive public health messages which "felt a bit clinical and sanitised" (Dom). This engagement with problematic televisual stereotypes was particularly noticeable for contributors who identified as having a hoarding disorder or obsessive compulsive disorder (OCD). Television's portrayal of these conditions has been controversial within the OCD and

hoarding communities and charities working in this space[15]. Counteracting unhelpful media stereotypes was depicted by contributors as a key motivation for their involvement, through the offering of their own alternative stories. Susie for example described wanting to influence the portrayal of hoarding to show that "it's a mental health issue" and challenge "this preconception that people are maybe a bit dirty". She emphasised that "we're not all the same" before going on to develop this point:

> So I really wanted to prove that, you know, I can be a hoarder, but you don't have to be a dirty hoarder. You know, they call it wet and dry hoards. So everyone was like, "Oh my god, it doesn't even smell when you walk in; it's just so much stuff to see and look around, and oh my goodness."

Susie presented the programme as an opportunity to construct an alternative to the more typical narrative about hoarders as living in unhygienic and extreme circumstances, with herself as the central character. The repetition of "dirty" suggested Susie's acute awareness of the negative stereotypes associated with hoarding and by reproducing the comments of outside observers to her situation, she strengthened her case to the audience (in this case, myself as interviewer) that she does not fit that stereotype. The impression this gave is that the series (and the interview) is an opportunity to explain the kind of hoarder she is and is not. This made sense within her overall narrative where she explained that she has only quite recently come to recognise that she has a problem with hoarding behaviours and has not told many people, however she is now taking the step of "admitting to the world that I'm a hoarder". In doing so, it seemed that she was attempting to influence the public image of hoarding to be more consistent with her personal experience and how she wanted to be represented.

George's interview account also indicated the relevance of a perceived mismatch between popular narratives of mental distress and his lived experience as a key driver in his quest to share his story. This theme is developed across several examples he gave in his interview from his motivation to go on television, his attitude towards filming and his engagement with social media after the broadcast. The tone of his account was more

[15] As an example the predominant view during the open panel discussion about media representations at the 2019 National Hoarding Conference I attended was that television coverage of hoarding is exploitative, sensational and humiliating.

forceful than Susie's. He started by animatedly describing how the 'call to the quest' of sharing his story was his reaction to the Channel 4 series *Obsessive Compulsive Cleaners*[16] which led him to apply to take part in an alternative television documentary series:

> it was just like a shock and anger factor that I was like 'right, something needs to change, I need to do something, I need to say something… I think really I sort of put my name in for that with a little bit of a 'fuck you' I suppose.

George's strong language conveyed that his decision to tell his story came from a place of anger and is reminiscent of the rhetoric of social movements for change. This fits with Frank's description of 'manifesto' quest stories, the idea being that for some people telling their illness story takes on a socio-politico dimension, demanding action (Frank, 2013). George went on to build his case for change:

> Obsessive compulsive cleaners was bringing in two/three million a week from people and then I was getting people that had known I'd had the condition for years messaging me asking if I'd come round and clean their house!

In this extract George connected the shortcomings of popular media narratives of OCD with a direct impact on his day-to-day interactions, and how he is understood by others. This supports the arguments of narrative theorists who theorise that individuals can encounter difficulties when their experience does not fit easily within canonical narratives (Baldwin, 2005; McLeod, 1997). George's account pointed to the frustration and anger that can be felt when individuals do not see their own experiences reflected in their equivalent cultural representations. As George developed his interview narrative, what stood out is that his participation appeared to be about more than an attempt to feel represented in the abstract sense, but also connected to a specific desire for personal recognition and understanding. A good example of this was his description of his attitude to filming:

[16] This series paired participants who are either formally diagnosed with OCD or self identify as being obsessed with cleaning and sents them to clean the homes of people who for various reasons (including hoarding and mental health issues) have let their homes get into a state of disrepair and uncleanliness. It was the subject of multiple complaints to Channel 4 by OCD representative organisations and psychologists.

> I remember I went into it being like 'I'll do it but like everything, film fucking everything!' Errm, so that was hugely important to me because I wanted it to be, if I was going to kick off at something or if I was going to cry or shout or scream I wanted for them to show that I was crying and shouting and screaming, I didn't want it to be just sort of, you know, they're out there in the wilderness, look at this, they're making campfires' I wanted it to be, if this is fucking horrible, show it!

George's presentation of his stance towards filming can be read as part of the quest narrative he built where from a difficult beginning of living with debilitating OCD symptoms and daily stigma, he persevered through hardships and challenges to turn around his mental health and go on to triumphantly share with others the true nature of OCD and what he has overcome. The emphasis he placed on having the most challenging points of this journey witnessed is interesting in itself however. Building on his earlier comments about misunderstandings about his OCD, the implication is that the series represented a forum to have the full extent of his difficulties recognised. In other words, the quest was not just about telling his story to help others or challenge media discourses about mental distress – but potentially a plea for recognition, a need to have difficult experiences acknowledged and witnessed.

In a similar vein to George, Chloe's interview also supported the relevance of having an opportunity to gain recognition for distressing personal experiences. She had experienced long term difficulties with hoarding behaviours and she emphasised having the opportunity to explain herself:

> I can tell my story of why I ended up the way I am, even though I don't care if people judge me but you know I still like to have my story out there to say well it's not what you think, it's completely different. I wasn't a slob, I wasn't lazy, I was going through hell and I was going through hell to be honest.

Chloe presented her involvement as an opportunity to justify her situation in the face of criticism she had received. Like George, her narrative appeared to indicate that her involvement was not just about challenging negative stereotypes from some higher duty of public service, but a response to highly personal experiences of direct stigma and judgment. She referred at another point in her interview to "people calling me a slob, calling me a tramp" and whilst she claimed above not to care what people think, there is some ambivalence indicated by her repeated referrals to wanting to "tell my story and you know sort of like explain why I got into that situation". She distinguished that the

audience she had in mind is local to her. For Chloe therefore the programme represented an opportunity to explain herself directly to her critics and have *her* version of her story told and heard for the record. Amongst other things, it appeared to be an appeal for understanding.

In summary, these two sub-themes demonstrate how the quest stories that contributors told of the experience of participating in a television project began with a call to help others and challenge stigma. Organising their experiences as quest stories afforded contributors a more agentic, purposeful way of conceptualising their participation. Whilst many of them were keen to receive the help on offer through taking part, framing their involvement predominantly as a 'good thing' to do potentially provided a positive way to use their past experiences. My analysis has identified that some of the contributors' motivation for sharing their stories was also driven by the specifics of their personal experiences, whereby they have perhaps not always felt understood or supported – both in terms of cultural discourses of mental distress that they and others have access to, and in their day-to-day experiences. For these contributors, participation represented an opportunity to challenge popular media narratives, and construct more authentic, personal, positive ones, grounded in their own experience.

7.5 Transformation through telling my story

This part of my analysis charts the ways in which "telling my story" was framed as transformational and what this reveals about the experience of taking part in MHITV. Whilst each contributor's individual quest story varied, there were recurring elements within how this transformation is presented. I will describe three different narrative arcs of transformation that stood out in the interview accounts, each of which relates predominantly (although not exclusively) to a different core audience. Not all of these storylines featured in every interview, but they capture different ways telling their stories was presented as a quest narrative. The first plotted a shift *from shame and self-doubt via helping others to pride and openness*, with the viewing public as the important audience. The second a *transformation from being ignored to being heard leading to new shared understanding and recognition*, with the local audience of family and friends as the key audience. The third was a narrative arc *from suffering through sharing stories to healing*, with the audience constructed in the making of the project - the crew and

other contributors at its centre. An important caveat is that aspects of their interview accounts contradicted and complicated the transformative thrust of their narratives. I will delve deeper into these contradictions in the following chapter when I consider the audience responses which did not fit so easily with the stories contributors wanted to tell, and when I discuss how contributors presented their control over the construction of their story.

7.5.1 From shame and self-doubt - through helping others - to self-discovery and pride

> It's definitely made me realise how brave I am and there's sometimes when I'm trying to psych myself up to do something and I'm like "you know what you went on national tv and did this" (Kate)

A consistent narrative theme in all the contributors' interview accounts linked taking the "brave" step of speaking publicly about their mental health to positive changes to their own attitudes towards their mental health situation and self-identity. This speaking out about mental health was constructed as one of the transformative processes of the quest of sharing their stories. Specifically, speaking out about their experiences and being part of a public dialogue about mental distress was portrayed as a significant source of pride and achievement. Susie gave an example of her improved self-belief:

> It's made me grow in stature to realise, I can talk about hoarding, I can talk about a subject that people want to listen to, and I've got knowledge, to impart and to help make changes (Susie)

In narrative terms, where the call to the quest was to help others and challenge stigma, this was the self-discovery learned in the process of achieving these goals. In building this narrative, contributors framed talking openly about mental health as a risky business, where the responses from imagined audiences are potentially negative and the risks of exposure are many. However, by taking this risk contributors discovered hidden bravery and ultimately, acceptance. Dom described what he had gained

> I've got no problem just saying you know, speaking up about my experience…I feel like that's a direct result of being involved in that process and knowing that I can say things that are deeply personal and to not be judged by them. (Dom)

Dom captures here how the risk of speaking openly has been rewarded. Crucially his story has been accepted by the audience, providing validation.

This narrative arc of transformation from self-doubt to pride stood out particularly strongly in Kate's research interview. As I have already discussed, at the start of her account, she positioned herself as a reluctant spokesperson for mental health who had concerns about being on television and had been actively discouraged from disclosing her mental health problems: "my parents were always very much like "don't tell people about our problems, don't tell your employer that you're having a day off through mental health because they'll think you're weak and pathetic". Her narrative portrayed the filming process as a challenging series of highs and lows and she explained how she wanted to back out of filming at various points. Importantly, it is not just the intervention or the practicalities of filming that she constructed as difficult but the expectation of sharing her story itself and her fears about speaking openly about her mental health. She described how she struggled with "the pressure of like having to tell everyone everything about you and not like being able to keep anything to yourself". However, in her overarching interview narrative, despite reservations, she constructed the process of taking part and appearing on television as having a significant effect on her attitudes towards herself and her mental health issues. Here she explained the shift:

> Through the whole process they kept being like, "you should be so proud of yourself, you should be so proud of yourself,"….but I was like, "no, I'm not proud of myself, I'm not proud of myself, I'm ashamed of myself because I've got problems ….and now I'm like, "no! I am proud of myself, I've done a really cool thing and I don't care what other people think about it."

This is powerful imagery of transformation from shame to pride and defiance. The implication in her narrative is that her participation in something "cool" that others have told her she should be "proud of" has allowed her to re-evaluate how she views her mental health difficulties and help her move towards a more defiant attitude. Like some of the participants in Lånkan & Thorbjørnsrud study (2022), Kate's account supports a connection between speaking openly about mental health with the removal of some of the burden of shame and self-stigma (Corrigan et al., 2006).

The crucial mediator in Kate's narrative, which linked speaking out to more constructive self-perception, was the positive audience reception to her public disclosure:

> It wasn't just the [intervention] and it wasn't just us all sitting in a room and talking about our problems that made me kind of change, it was, it was a lot of it was, the biggest thing I've taken away for myself is that I'm a lot braver than I thought I was and because so many people came up to me afterwards and were like, "you're so brave, you're so brave"

Specifically, Kate's narrative implied that the positive affirmation she received in telling her story allowed her to view her own story (and with it herself) differently. It suggested that seeing her actions reframed by the audience as a "brave" thing to do, rather than having her fears around exposure realised, challenged her previous assumptions about speaking about mental health and opened up new ways to understand her own situation.

Whilst this narrative progression is particularly strong in Kate's interview, the importance of the positive audience response in validating the contributors' decisions to speak openly about mental health was a key theme in most of the accounts. Many of the interviewees made references to expectations of receiving negative audience feedback or "being judged" (Sarah). Several interviewees did receive some derogatory audience responses, a point I will return to later, however for the most part their uncertainties about speaking out are juxtaposed in their narratives with how they received overwhelmingly positive audience responses. Sarah for example described her awe at the positive feedback, placing it in the context of her expectation that there would be at least some negative response as "people still do make fun of people with mental health":

> You know people really took us on board. It was it was amazing how people just loved us all and wanted to know more and that's what people messaged you mostly about is how you doing, you know, and I get messages all the time saying "Oh I've [done this] because you inspired me, umm how you doing?"

In the context of Sarah's core narrative which revolved around 'helping others', the positive feedback was the confirmation that her quest has been a success. In narrative terms, her story as told on screen had been accepted and endorsed by the audience, which she articulated as providing a huge source of validation and acceptance.

In a related example, Dom explicitly discussed the validation of having a public audience, in a way which demonstrated how the television audience might offer a unique source of validation from other audiences the contributors had available to them:

> There's a part of me that's always wanted to be sort of a public figure and so you know being, having that bit of recognition and being validated in that kind of way I feel like that was good, I feel like I had to satisfy my own ego a little bit which I don't think's always a bad thing

Dom's response illustrates how appearing on television provided access to a platform to reach a wide audience which is not available in most people's everyday lives and the potential of obtaining microcelebrity status. Whilst only a few contributors openly expressed a goal of being a media figure, many of the interviewees' accounts constructed the attention from appearing on television as exciting, enjoyable or novel. As Robin put it: "I must admit it gave me a big head for a little while! [laughs] I felt like I was a star". Being on television holds valuable social capital (Turner, 2013). The perception that their stories had been designated as worthy of being told on such a culturally significant platform also appeared to be a source of affirmation. As Dom admitted "I was kind of proud to be on TV". In other words, the validation was not just about a specific audience response but the more abstract notion of being seen by a large imagined audience, and the prestige of appearing on television itself.

In summary, many of the contributors' narratives plotted a progression from a place of self-doubt, or at the least, apprehension of speaking up about their mental health, to a celebratory conclusion where they have not only helped others, but in doing so, have personally benefited from being open. Highlighting the potential risks and how that they are stepping up to the challenge of facing stigma strengthens their narratives of self-achievement from taking part. Central to the transitions that their accounts chart was the positive audience reception to the telling of their stories, as well as their satisfaction at being part of a dialogue about mental distress on television; an important cultural forum. As with other studies (Lånkan & Thorbjørnsrud, 2022; Thorbjørnsrud & Lånkan, 2022; Ytreberg & Thorbjørnsrud, 2020) this is framed in their interviews as a significant source of validation and affirmation. In narrative terms, this was the reward in their quests of telling their stories.

7.5.2 From suffering - through sharing stories – to healing

> But if anything, it helped me with my healing process of actually that opportunity to speak about how I felt, not feeling like I was being judged. (Sarah)

'The healing power of telling my story' as captured by Sarah above was another variation on the quest presented by some contributors, in which the sharing of their stories was presented as having a transformative impact on their mental wellbeing. This narrative plot crosses over with the one described previously, linking to discourse about openness and acceptance. However there are some notable differences which justify separate consideration. Firstly, whilst the underlying catalyst for change was once again the audience, in this case, it was a more immediate audience than the wider viewing public, composed of friends and family members on the one hand, and the crew and other contributors on the other. Secondly, the 'therapeutic' benefits of telling their stories constructed in this theme drew on conventional therapeutic discourses about talking as good for individual mental health, as Chloe explained: "People say well talking is the best thing, talking is the best therapy to be honest"

The "healing" process of talking through their experiences was a central plotline in Sarah and Chloe's interview accounts. This theme was present in other accounts but less overt. For example, George pointed out when I asked him what it was like being interviewed "We were spending all day being asked questions by therapists, so I suppose it just, they did blend a little bit." Ali when asked if there were any positives of being filmed replied "It made me verbalise what I was thinking more which is therapy in itself." These quotes hint at the soft borders between the formal therapeutic intervention and the less structured process of talking and reflecting about their feelings and situation on camera as part of the filming process, but this was not something these contributors developed further. Sarah and Chloe however repeatedly returned to the theme of 'healing' and 'therapy' in relation to telling their stories, as something that happened in parallel to the on-screen interventions.

Sarah, as I have discussed earlier, presented herself as highly motivated to talk about her experiences with a view to helping others. In parallel, she constructed the opportunity to share her story as deeply beneficial to her own wellbeing - "I hadn't realised how much it was going to help me but also help other people". Her account

described a narrative trajectory from a place where she was just surviving and coping, through the "hard" task of speaking openly about her feelings to others, to understanding that she was struggling and needed to get help. The important audience for this narrative shift was the other contributors in the series with whom the mutual sharing of stories allowed her to recognise her own difficulties and re-evaluate them:

> I didn't realise why I was waking in the night and having nightmares and then when I started talking to the guys on the programme and understanding a little bit about them and them not want to get out of bed in the morning and that waking up and just feeling overwhelmed before you start the day, I started realising that actually I was, I was struggling.

Sarah presented hearing the stories of other people who have mental health difficulties as a turning point in her own story, allowing her to see her own situation differently. She explained how this led her to seek out and receive additional clinical help through the NHS which "helped me massively". The benefits of being able to hear from and learn from the experience of others who have or are experiencing mental distress is well documented within research into peer support both in health care settings (Nurser et al., 2018; Watson, 2019) and through informal support networks (Naslund et al., 2014). Sarah's account supports the benefits of mutually sharing stories with peers. She constructed the support from other contributors as more relevant than the professional psychological support provided during the production process, professing that she didn't use the psychologist available as a result: "I didn't really cos I just use everybody else really as my sort of therapy and for advice".

The relevance of meeting other people with shared experience who "understand" was a significant part of several of the other contributors' interview accounts as well. Whilst not all interviewees framed this as overtly in terms of sharing stories as Sarah did, all the interviewees who took part in television projects which involved spending time with other contributors referenced the importance of the friendships made, often again employing the transformative language of the quest genre. George for example exclaimed "the friendships changed my life". Ali too, explained that she felt the therapy she received on-screen was ultimately unsuccessful, but what she got from the experience "was friends for life". She framed these friendships in terms of people who understood her in a way she had not been understood before. The importance of these

friendships can be conceptualised as providing a new receptive audience offering mutual understanding and recognition for their stories of mental distress.

In addition to learning from other people's stories, Sarah also described being asked to talk about her own experiences on the television series as something that helped her to process past events and emotions. She described a scene where she talked on camera about her feelings about her bereavement:

> To sit there and….actually say I blame myself and get upset, that upset my mum, because I've never said that out loud and actually I don't even know if I thought it out loud, like thought it before so it did bring a lot of things to the forefront of what I was fighting really and by actually saying it out loud made it real I suppose

There is a sophisticated level of complexity in how Sarah constructed this opportunity to speak about her story. Sarah implies that by sharing her story she revealed to herself things about herself she did not know before and unlocked alternative ways of making sense of the past. In referring to how saying something can "make it real" Sarah seems to perceive that the way someone chooses to express something can have direct implications for their self-understanding and identity. This is a point that narrative theorists have also emphasised (e.g. McAdams, 1993; Crossley, 2000). Griffin and Phoenix (2014) in their case study of one woman's narrative around aging and running argue that by hearing our self-narrated stories told back to us we come to recognise and understand our stories better. This would seem to be the case with Sarah.

Chloe's interview account also centred around the therapeutic benefits of telling her story. She used phrases such as "the experience was quite uplifting for myself, quite a healing point" and "the actual process of asking the questions was therapeutic". The context in which Chloe led in and out of the idea of the therapeutic process of telling her story is revealing, in that she juxtaposed the help and attention she received through the production, with the lack of support she has normally:

> I was sort of like what's the word, coming to terms with you know, I'd got the flat the way it was and people were helping me you know I wasn't being left on my own like……. when I asked for help off the family, I didn't get any so it was like, having these strangers getting involved, helping me out and then doing the clean, with the filming as well there was something quite therapeutic.

By including “the filming as well” in her description Chloe implied that “the therapeutic” aspect was more than the practical support and also the whole process of filming. Her narrative constructed a transition from a place of being ignored and unsupported to being heard and understood and getting the help she needed, with the crew and intervention providers as the supportive audience which was missing from her life. As she went on to say:

> I’m like helping everybody else out and nobody’s helping me out so then when [the cleaners] turned up and the camera crew, you know, asking me questions like ‘why had I got into this situation?’ it was kind of like a therapy side of it for me.

This quote demonstrates the significance Chloe placed on having people who are concerned about her and ready to hear her story of how she got where she is. This seems fundamental to understanding why she considers telling her story therapeutic. Between the production team and the cleaners Chloe depicted a ready audience who “were very interested themselves but very respectful for what I was dealing with.” The implication is that not all the potential audiences for Chloe’s story have been as respectful or attentive, as demonstrated by her comments reported earlier about negative criticism she has faced in the past. For Chloe, the production team appeared to offer a receptive audience which has not always been available to her locally.

The relevance of the television crew as a new, supportive audience was evident in Robin’s account as well. She took part in a hoarding programme which also involved house clearance but no therapy. Her narrative linked together the clearance process “that was my therapy”, with the ongoing crew support “they kept me going” and the process of telling her story to “teach herself a lesson” as therapeutically significant, presenting this as what allowed her to move forward: “I learnt a lot about myself while I was doing it, why, how I’d got into this situation in the first place and I’ve been using that ever since to carry on and not do it again!” Whilst Robin presented herself firmly as the hero of her story who has overcome all obstacles to complete her quest, she constructed the moral support she received as crucial to her success in carrying out her mission to clear her house:

> there was always somebody there that I could speak to, you know, when I was faltering and I couldn't do any more and I thought I would never be able to do it, you know, there was always someone there to say but you can.

In the context of her quest narrative, the supportive crew were the 'magic helpers' (Propp, 1968) who have aided her to reach her transformative ending. Research with production teams working with vulnerable contributors have documented how crew members can find themselves interacting with contributors in a grey area where they are friend, therapist and film-maker (Rees, 2019). This can place significant emotional demand on crew members and has the potential for conflicts of interest between programme requirements and the needs of both groups involved in this dynamic. However, Chloe and Robin's accounts illustrated that from a contributors' perspective, their relationship with the production team was perceived as rewarding, with the crew providing a valued audience. Many other contributors also praised the support they received from the production teams.

In summary, Sarah, Chloe and Robin constructed quest narratives where the production process had led to beneficial changes to their wellbeing. Their accounts support the benefits of having a space to voice experience and the relevance of a receptive (and accepting audience for their stories). This has been documented in clinical therapy spaces (White & Epston, 1990) and other settings such as peer support and recovery (Nurser et al., 2018; Watson, 2019). Whilst television production is a very different framework for the sharing of stories, with a distinct agenda, the opportunity to hear from others and be heard in this unusual context is presented as therapeutically significant.

7.5.3 From being silenced - through listening to each other's version of stories to new collective stories and understanding

> It changed my relationship with my mum and dad, changed my relationship with my sister (Sarah)

I asked all the contributors about the reactions of friends and family to their television participation and their answers established the importance on this specific audience as another source of validation for their decision to share their stories. Phrases like "proud of me" (Dom) were typical. Kate and Sarah however both narrated quest storylines around their families' reactions which demonstrate how storytelling is a co-construction between tellers and audiences. Both their accounts developed the transformative effects of telling their stories beyond their own self-growth and extended it to their families. They presented their television participation as having a considerable effect

on their families' collective attitudes to talking about mental health, positioning their involvement as an important catalyst for allowing them to understand and relate to each other differently as a family.

Kate implied that her parents went on a journey of discovery with her. She set up a narrative arc where at the beginning their attitude was to discourage her talking openly about her mental health and they opposed her involvement in the television series, saying "you have to be joking, you can't do this". However, by the end of the television project they were entirely supportive of her sharing her story: "my mum eventually was like I'm so proud of you" and would actively encourage her to speak publicly: "Before it was very much like 'you can't tell anyone about it'…and then [it] was like 'ooh, and you can tell all my friends about it!'". Kate depicted a transformative shift within her family's attitudes from mental health being an unspoken topic (implying shame) to openly discussed (implying acceptance). She connected this in turn to positive improvements to their relationships.

Kate attributed this change to the way that the interviews filmed with both herself and her parents allowed each other to say and importantly *hear* previously unspoken and often difficult thoughts and feelings:

> my parents found it quite hard to kind of listen to the interviews I was doing and watch the programme and stuff like that because I think at the time of me going through the various early stages of my [mental health problems] they very much like kind of covered their ears and didn't want to hear about, they helped me like obviously…but I don't think they understood the extent of it, and so [the programme] kind of forced them to listen in a way.

Kate chose strong symbolic imagery to convey a narrative shift from a position of being silenced and voiceless to finally being heard and understood. The implication was that the programme acted as a conduit to tell a different, more challenging story to the previously accepted collective family story of her experience. In the process her parents were transformed into a more receptive audience. Sarah, likewise, emphasised how some of things she said on camera, which she had not verbalised to anyone, had a significant impact on her parents: "it had a real effect on them. I think they hadn't realised what I've been going through." She depicted this as changing their relationships by opening the way for greater understanding between them:

> I never cry in front of my mum and dad, however bad things have been, so to see me show weakness on that program was probably the hardest bit for me. But actually is probably what I gained the most, from people seeing that actually she does wear a mask and it's, she is struggling inside. And I can't believe she hates herself. She's never told us that but actually she does. So it did have a massive effect in that way, all very positive really.

Sarah's use of the third person to discuss herself here illustrates the importance of social context for what stories we are able to tell. She is presenting her story as seen through the eyes of her audience, one for whom she had previously shaped a narrative which shielded them from the more difficult parts of her experience. Other contributors also echoed how the narratives presented on screen had the potential to reveal parts of their experience which they had previously protected their families from, and which would be difficult to hear. Dom for example said how he chose not to watch the programme with his family because "I knew there was going to be those moments in it where I say things that maybe might upset my family". And George acknowledged that it was hard for his family to watch some of the more emotional on-screen therapy saying "I think it's sad for them to watch it on TV". In the example of Sarah and Kate they depicted how telling a new more challenging story (mediated by television) which did not shy away from the difficult parts had positive consequences for their relationships with family and friends.

Both Sarah and Kate also discussed how the process allowed them to hear from their parents in a way they had not previously. Sarah explained how the series acted as a catalyst for her parents to express their pride in her in a way that they had not previously verbalised: "They were just so proud of me…something they've never told me, that they're proud of me and it's the first time they really said, you know, we're just so proud." Kate also described the impact of hearing her parents talk about her during their television interview:

> I think even though you know they love you and they're proud of you and all that stuff, you never, they never like "oh I think my child is this, I think my child is that" you quite often hear them criticise you but! So that was quite nice and it definitely, the whole thing definitely made my relationship with my parents a lot stronger.

Kate captures here one of the unique aspects of being involved in a television project. The format conventions, as realised through production practices, encourage

contributors to deliver a type of performance where the articulation of thoughts and feelings about selves and others, may be different from an individual or groups' norms of communication. Kate and Sarah's accounts suggested that in this re-telling of experience, as well as altering their individual stories, they were re-writing the story they told and shared with each other as a family. Whilst they constructed this as a successful quest story, sharing stories in such a public forum is unpredictable. Chloe's narrative demonstrated how problems can occur when the story, or audience response does not turn out as hoped and has unforeseen consequences. Whilst Chloe presented her involvement for the most part as a personal success story, one caveat she made is her family's lack of support for her openly discussing her problems on television. She relayed some of her family's response that demonstrated that taking part was a source of significant family tension and led to difficult and upsetting conversations:

> They then said 'didn't you consider anyone else in the family?' and I was like 'well, no, you all do stuff you never consider me.' And at the end of the day I was doing it for myself and not for them.

Chloe positions herself as defiant here in the face of family criticism, staking her right to be involved. However, despite Chloe's apparent defiance she came back to her "anger" and "upset" that her family did not support her several times, explaining "I thought I was going to have some backing from the family and I never did". This suggested that it remained a source of significant hurt and negative feelings. One explanation for why Chloe found that her family were not receptive to her sharing her story on television is because it was a challenge to the stories that they were happy to share publicly. Chloe explained "they don't tell their friends or colleagues or anything like that they're dealing in the same situation, you know and they didn't like that I'd put it out there so to speak." This demonstrates how where there are discrepancies between the versions of stories that different family members adhere to, this can be problematic (Papathomas et al., 2015). These examples highlight that the kinds of stories people tell of mental distress do not happen in a vacuum but are social in nature and function (Riessman, 2008). Story telling involves a negotiation with other people as both co-storytellers and potential audiences who can choose to support, validate or discount our stories.

7.6 Summary

This analysis of how contributors narrated the experience of taking part in mental health intervention television suggests that one way they made sense of their involvement was to construct their participation as a quest to share their stories. In doing so, they emphasised being motivated by helping others and challenging media misrepresentations of mental distress, rather than seeking help for themselves. As in the television series narratives, their interview accounts described a transformative journey of self-discovery and healing, however these positive outcomes to their wellbeing were linked to the process of sharing their stories as much, if not more than, the therapeutic interventions provided as part of the television series. Their accounts connected taking the brave step of speaking out about their challenges with mental health to finally feeling heard and understood. Speaking openly about mental distress was portrayed as beneficial for their relationships and self-esteem.

My analysis sets out how at the core of these stories of transformation is the contributors' conceptualisation and engagement with the audiences of their stories, both real and imagined. The audience described was multi-faceted – ranging from other contributors, crew, family, the viewing public and social media. Some had a more central role than others, depending on the narrator. In essence another way of conceptualising this whole analysis would be to frame it not around the contributors' experience of telling their stories, but the experience of having an audience. Audiences were the key to validating their stories, however as the last example demonstrates, also had the potential to disrupt the stories contributors wanted to tell. In the following chapter I will develop this further by looking at other audience responses that caused difficulties for contributors. I will consider what tensions within, and digressions from, this dominant transformative narrative of sharing stories reveals about the experience of taking part in mental health intervention television.

Chapter 8: Experience is more than a quest story

8.1 Introduction

In this chapter I develop further two aspects of the contributors' interview narratives, which demonstrated areas of tension within the overriding narrative plot, where their experiences were less easily contained within a quest narrative. The first was how contributors' narratives managed the tensions presented by **audience responses** that were unpredicted or challenging. As the reaction of Chloe's family discussed at the end of the last chapter demonstrated, the audience reception may be different from the one the narrator intended, and this can create difficulties for the stories narrators want to construct. This chapter will delve deeper into what this can tell us about both the experience of being on television, and the power of audiences. The second theme relates to how contributors constructed their role in shaping the stories told on screen and the relevance of **control over the way they tell their stories** to their evaluation of their television experience. I explore how contributors' accounts made sense of the mediation of their stories, and the implications of living up to a quest story.

8.2 This was not the audience response I was looking for

The previous chapter has demonstrated how imagined audiences were central to the transformations narrated by contributors and an integral part of the quest story structure. However there are aspects across all the interviews which indicated the complexity of audience reception and the potential for difficulties when there was a clash between television mediated narratives, personal narratives and audience perception. Specifically two things stood out in the interview accounts; firstly how contributors managed the pressures of being a role model and having others look to them for help, and secondly the potential of social media to open them up to a wide range of direct negative feedback.

8.2.1 The pressures of being a role model

> So the positive stuff was overwhelmingly positive, lots of literally lots of like you know …'you have saved my life' and stuff like that, really like intense positivity which is lovely but also fucking hell! It felt pressured (George).

The positive feedback from audience members who had been helped or inspired by their stories was a central part of the narrative payoff for contributors' quest to tell their stories. As they mentioned to me, helping others was both the incentive and the reward for daring to share their difficult and often stigmatising experiences of mental distress publicly. Many of the interviewees enthusiastically gave examples of being contacted by audience members thanking them for representing their own experiences, for giving them hope, or the encouragement needed to seek help. However, the contributors' narratives also showed that being hailed as role models also created some pressures. A specific challenge that was described by many was the significant numbers of audience members contacting them either asking for advice or disclosing their own mental distress. Ali described dealing with these messages:

> One or two just clearly needed to speak to someone professional. And it was the whole thing of do we reply? If we don't reply, does that make it worse? If we reply, does that also make it worse? …But it definitely stresses you out because you feel a bit responsible. (Ali).

Ali powerfully conveyed the burden of managing intimate disclosures with limited preparation or understanding of how to respond to them. In telling their stories on a venerated cultural platform, the contributors gain the authoritative status of "celebrity service user" (Lakeman et al., 2007, p. 14), a position that comes with increased influence but as these interviewees express, pressures to act accordingly.

George gave the most extreme examples of dealing with cries for help from members of the public:

> George: I've got really more comfortable then I expected to be to be able to get used to dealing with people telling me they gonna kill themselves. I had it last night even, it's regular…
>
> INTERVIEWER: really?
>
> GEORGE: yeah, regularly people being like 'I just want to say you know you've got me through some really dark times, you know I'm killing myself soon but I just wanted to say….' And it's sort of, I will do the right

> things, I'll do the, I know how to deal with it, I know that if there's a way of checking on them or sending someone to check on them or if I know, if they mention where they work or where they're from, I know they're sort of asking for that, errm, but then also I kind of, this sounds horrendous, I don't, I don't lose sleep over it in that manner any more because I can't affect it.

George was very matter of fact and unemotional in his delivery, given the sensitive content of this disclosure. We went on to discuss in some detail his approach to dealing with these kind of messages, in which he elaborated on how his approach evolved over time, and that he learnt to recognise the limits to his personal responsibility. His tone was neutral, almost professional – it sounded like the rhetoric a therapist might produce about the boundaries between work and personal accountability. However, he also mentioned how he still checks in on one particular person on special holidays. His narrative suggested that with the benefit of distance, he learnt how to manage these interactions and willingly accepted this task as part of the identity he took on following the series, where he has continued to speak publicly about mental distress and positioned himself as a mental health advocate. It is an indication that he located himself as no longer the victim but the hero of his story, now passing on his expertise.

Sarah also elaborated on the pressure of taking on other people's problems and whilst like George she positioned this as something that she willingly engaged with, her account suggested that this has at times been personally very challenging for her own mental wellbeing. She explained how after her programme aired she spent a lot of time being approached by strangers who "thought they knew me". Sarah attested to finding this attention overwhelming and attributed this to making her anxiety worse, albeit temporarily. She went on to depict how following the broadcast, due to her increased agoraphobia she did not leave her house for a period of time, concluding:

> I can imagine some people see that they are now famous and probably thrive on that aspect of it. For me that was the worst part of it. You know, I loved people recognizing my story and thinking I'd helped them but I didn't like people recognizing me and I can remember saying to my husband several times how we got a glimpse of what it's like to be famous and you can see how people in that public eye can't cope because I really, really struggled with it.

Sarah makes an interesting distinction here between her story and self, centred on an ambivalent investment in the power of being recognised. On the one hand, she framed

having her story recognised as positive in term of helping others (which she presented as a core objective of her participation); on the other being literally recognised and approached was a source of significant anxiety for her, made worse given the context of her pre-existing mental health problems. Sarah's choice of words is a reminder that as Craib has argued there is a difference between "a life as lived and a life as told" (2000, p. 65). There was the story Sarah wanted to share publicly which had a specific goal and purpose, but there were other aspects of her experience and identity that are potentially at odds with a television mediated master narrative of *overcoming mental distress*. This tension was brought into being where Sarah was confronted with direct contact with audience members, who brought their own interpretation and expectations of the person they have seen on screen, as illustrated by an example that Sarah gave of being approached at a concert by people who had seen the series:

> There's several people recognized me but this man came over and started crying and telling me all his story about his loss. And I think a lot of people think because you've spoken on TV that you're quite solid like you're quite hardened to it so you can have everything about you but obviously things like that do have an effect on you.

In sharing publicly her experiences of trauma, Sarah has created an anticipation with some audience members that she is open to their mutual disclosure. She conveyed that in a setting, removed from the television programme, there was still an expectation to perform the identity and discourses of openness represented on screen, when she would prefer to revert to a more private version of self. There are similarities between Sarah's account and those provided by the patients turned media participants in the study by Ytreberg & Thorbjørnsrud, (2020). These patients testified how unsought after audience disclosures, especially once they had themselves moved on from the rawness of their own publicly shared declarations, could have the effect of pulling them back into past traumas, which they did not want to revisit. In addition they reported on the emotional burden of being entrusted with such personal revelations. Likewise, Sarah conveyed a struggle between her desire to help and inspire and the emotional burden this placed on her: "it was really hard at times because you were, people were there looking onto you and you wanted to give them hope so then you put a lot of pressure on yourself." Part of the pressure that Sarah articulated seemed to relate directly to a

pressure to tell a certain kind of *hopeful* story, which is at times at odds with the messier "reality external to narrative" (Craib, 2000, p. 65) in which it is grounded.

Importantly, Sarah's account highlights how even when the audience response is extremely positive, the intense focus and pressure not to let anyone down can be experienced as overwhelming. Whilst many of the contributors presented their engagement with the audience as something they undertook willingly and part of the reward, their accounts also highlighted the potential challenges of finding themselves reframed as role models and advisors, with little experience to guide them in these new roles.

8.2.2 The curse of social media – dealing with negative audience feedback

> People are very judgey very quickly and I think that they think if somebody's put on TV they own you (George).

One element of audience engagement that was discussed by all the contributors was how taking part in the series opened them up to a direct avenue of contact via social media platforms. Contributors reported receiving significant amounts of highly personal communications. The extent to which contributors engaged with social media, and the emphasis placed on it varied however, depending on factors such as their level of engagement with social media more generally. On some productions contributors reported being advised to stay away from social media but this advice was not necessarily followed. George said: "they suggested that maybe delete your social media for a bit, I didn't, none of us did!". Several people discussed the Twitter feed for the series they were in and indicated that they had followed quite closely the responses. In keeping with their quest narratives, this engagement with audience members via social media was mainly presented as welcome and reinforcing their sense of achievement in speaking up. Dom for example exclaimed: "I did need that little bit of validation I did need that bit of reinforcement to say like yeah that was right what you did and as soon as I saw the general reaction I was sure that I made the right decision." As in Ytreberg & Thorbjørnsrud's (2020) study, many people reported engaging with online messages and even developing some online relationships over time, and this was presented as a rewarding source of affirmation.

Not all social media feedback was supportive and several contributors reported receiving some highly derogatory or even abusive messages. For example Laura described how on social media platforms she "got a few like random, you know 'jump off a bridge freaks!'". This would seem to represent a problem for the triumphant plot outcomes of their quest narratives, however there was several different ways that contributors managed this aspect in their interview accounts, so as not to disrupt their quest stories. Many contributors constructed negative messages as to be expected, downplaying any personal impact, and focussing on how many people reached out to them to them to express how it had helped. Ali said:

> So and there was a lot of positive social media. I mean, you always get negative media response but 95% was very positive, people saying, "I finally told my friends now" or you, a lot of we'd get individual responses to whoever's OCD matched someone else's. And it was a lot about your, "you explain how I feel, exactly. And I've now gone to the doctors for it", and it seemed to help a lot of people. You obviously get people who are just ignorant but that's fine. So yeah it was all very positive feedback from people which was good.

Ali sandwiched negative points between firm emphasis on the fact that the majority of social media feedback extremely positive. By saying 'obviously' and 'always' she dismissed negative responses as inevitable and unimportant. George however was more graphic about the extreme nature of the negative responses he received:

> Umm, lots of 'you're faking', a lot, a lot, hundreds, hundreds, I'd say I must of read 'kill yourself' two hundred times [shocked face by interviewer]. Yeah! [laughs] Errm lots of and then lots of misinformed questions and they were the best ones, they were great ['how can you do this but not that?'] and I loved that because they're the questions I want to be asked.

George delivered this information with a wry smile and a laugh as if such extreme reactions are not that important to him. He moved on to discuss how he engaged extensively with misinformed questions, the implication being that the outright "trolling" was not important to him, instead he suggested he viewed the social media response as a further opportunity to challenge people's understanding and explain about the reality of his mental health problems. For George, the online forum appeared to be an opportunity to extend his quest and continue telling his story.

Another reaction was defiance towards detractors. Chloe presented this attitude:

> There was some good and some bad comments I mean, you know but even then there was some of them that were calling me a slob, you know, the same again, I eventually will get upset but it's not enough to stop me from doing another film or stop me from talking about it…if people have got opinions and the want to cuss me down, that's their opinion, it's not going to upset me, I'll just think well you don't actually know who I am, you're a stranger, you've seen a video.

Chloe's comments demonstrate the complex, multifaceted relationship that contributors had with their onscreen presentation. At first there appears to be a contradiction between her insistence that she will not be silenced by people who "don't actually know who I am" and how Chloe has professed that the series has helped her by allowing her to explain herself. However, as discussed earlier, her emphasis on 'explaining' was aimed at a more specific audience – the people in her local environment. It demonstrates that contributors could take different subject positions depending on the imagined audience and manage more than one way of relating to their participation and outcomes generated by it. Chloe appeared to manage the impact of negative feedback by explaining it away as part of one particular audience type that she was not interested in. George and Ali did something similar in how they presented their response to different types of audience feedback. Taken at face value, it demonstrates that negative audience feedback did not have to have an adverse impact if contributors could find ways of compartmentalising or explaining particular responses, even if how they did this seemed contradictory on the surface. If the story they told about it made sense to them, they could buffer themselves against negative audience reactions.

However, Laura's account of her reactions to social media illustrates that it was not always possible for everyone to discount negative feedback. When I ask her about appearing on television she responded:

> Umm [laughs] I'm very positive about the whole experience, it was positive, like it was really good. But I found that a lot more daunting then actually just being out there and confronting my biggest fears because I almost…I'm wary to say that [my mental health got worse] when it was out on TV because that sounds like it was then negative, it wasn't negative. But…. when the programme came out I then started to worry… I became quite conscious of how I was perceived to the general public.

Laura went on to explain about some of the specific comments she received and how they increased her anxiety. What is clear from how she framed the impact of the audience response on her mental health, is how strongly she wanted to convey that overall her participation was immensely positive. Any difficulties that she personally experienced are presented as a side issue, a necessary obstacle to be surmounted on the ultimately positive quest of telling her story. Laura was also clear in her account that she had the necessary support from the production to get her through this. Her example however supports the findings of Lånkan & Thorbjørnsrud, (2022) who found a minority of participants in a documentary attributed a decline in their mental health to the anxiety surrounding their appearance on television. The contributors accounts illustrate that there can be risks attached to participating in such a wide reaching and culturally significant forum as television, particularly in a digital age which allows audiences more ways for public comment and to potentially reach out directly to contributors.

Another point that several of the research interviews raised was that the audience members comments related to topics beyond the scope of the series itself and the mental health problems under discussion. Laura gave examples of social media content that questioned her relationships with other contributors or highly personal comments about her appearance. Other contributors reported receiving intrusive comments about who they were dating or even sexual propositions. Both Laura and George referenced how negative social media comments also impacted on their friends and family, who were shocked and cross on their behalf and wanted to defend them online. Laura said she had to say to some friends “please don’t argue my battles on Twitter!”. This illustrates how placing themselves on television, opened up parts of their life to public scrutiny that they had not expected. The audience response could not be controlled and they could choose to interpret stories in ways the contributors (and the production) did not intend.

In summary, the contributors’ accounts demonstrated that even positive audience feedback could be experienced as challenging. In addition, some contributors also had to contend with abusive audience responses. Negative feedback did not necessarily disrupt their quest stories, if anything it reinforced narratively that they took a brave step in speaking out. However in the shadows of this storyline of perseverance and defiance were some more difficult audience engagements that suggested that the

stories they wanted to tell were at risk of being disrupted by others. The impact of challenging audience perceptions was potentially amplified by how social media has changed the way that audiences engage with television, providing a route for direct feedback from a vast number of viewers, beyond those responses encountered through traditional media or the people they might meet in person.

8.3 Control over my story (constructing the narrative)

The active investment by contributors in how their stories were constructed and perceived stood out throughout their research interviews. Specifically, my analysis establishes that the importance of contributors' perceived control over, and success in telling their preferred stories was central to their evaluation of their television experience. This was in part tied up to whether they were able to tell a successful quest story. Contributors described how they negotiated their stories and how they engaged with the filming and editorial process to try and achieve their preferred representations. This activity in turn was linked in their narratives to their trust in the production to tell the right story. Crucially, a small number of interview accounts described losing control of my story. Their examples demonstrated the importance of perceived control by revealing potential difficulties and tensions where they are not able to construct the story to their liking. The key background mediator in this process was again the audience, both real and imagined. In reflecting on constructing their story, contributors clearly had the audience in mind, which was central to how they made sense of this process.

8.3.1 Negotiating my story

> Sometimes the [mental health problem] was too much for me or other people and they would really want to film and we'd say no, I'm not comfortable with that. And they would try and push a bit to film, but ultimately, they respected our decision and didn't. (Ali)

Like other research with documentary participants the contributors constructed themselves as active collaborators in the process of telling their stories (Nash, 2012; Sanders, 2012). As the quote above illustrates, throughout their research interviews they recounted various discussions with production crew about storylines, opinions about what was being filmed, and conversations about what they were happy and not happy to share with the viewing public. For the most part contributors reported that the

crew respected their boundaries. However, retaining control over the process and their representation was presented as an active process. George explained how he would question what the director was filming:

> for the first bit I was very standoffish I suppose with [the director] who was handling the questions just because he was the one I was trying to suss out the most so I think I spent a lot of time maybe errr, there was a few times when he's ask a question and I'd be like 'why are you asking that?' before I answered it which must have made it a bit difficult [laughs]

George here implies an awareness that he was delivering a performance, rather than the filmmaking simply capturing some authentic 'reality' as it unfolded. He is also acknowledging that the construction of this performance is not entirely in his hands. He suggested that he was actively policing what kind of story the production team were trying to tell about him. Susie likewise gave some revealing examples of negotiating how she presented herself on camera with the production crew during filming:

> And I said, "Oh, you know, I just want to put some lipstick on." "Oh, you look fine as you are." "No, I just want to go and put some lipstick on. I'm going on national TV here, and I want to be, you know, the person that I want to portray is a person that I would normally have lipstick on in front of a camera." You know, if I was presenting at anything, I would have put my mascara and lipstick on. Because it helped give me, it's not a mask, it's just I felt better with lipstick and mascara on.

This quote illustrates how Susie recognised that she was presenting to the audience one possible version of her identity – she talks about herself in the third person – "the person that I want to portray" almost as if she is an actor or presenter. By drawing a parallel between her television performance and previous work presentations, she suggested that she was viewing her appearance within the television series almost in the context of a professional engagement. However there appeared to be a tension between how she viewed her role and the television format conventions for this genre of programme making, which emphasise natural and unrehearsed performances of self as hallmarks of authenticity. She explored this contradiction further:

> And so at some point, he would say, "Just a little bit less presenter, Susie." So I'm like, "Look, sorry. You know, this is how I am. You know, I'm admitting to the world that I'm a hoarder. But I'm not going to be ashamed of it." So I'm not going to come across as this little timid, like, "Oh my God", you know? I'm going to come across as someone that's done some work on myself.

Susie above rejects the claim that her performance is not authentic, however she is acknowledging that she is actively engaging with how to present herself. Her words hint at the personal journey she has gone through to get to the point where she is ready to admit 'to the world' about her mental health difficulties. In part, this reinforced her quest story whereby she has taking the brave stance of speaking up and shaking off shame. In taking the step of putting her private experience in public view, she articulated repeatedly that she wanted some control about how she will be portrayed within her story. One potential reading is that by envisaging her participation as almost a professional engagement as is suggested in the quotes above, she was protecting herself by creating some separation between the persona she is willing to enact publicly "on stage" and the parts of her story and affective states that she wants to keep "back stage" (Goffman, 1959). Susie went on to make this distinction between the televisual version of herself and her more private reality very starkly:

> However unhappy I'm being, if you ask me questions, or you want me to, not perform, not to present, you won't see any of the sadness underneath. You will see me being in control, handling it, knowing what I'm doing, having a bit of a laugh. And then going, when all the cameras have gone, it's like, 'Oh, shit. I've got all of this stuff. I'm sitting on my settee, all the stuff around me'."

Susie's quote demonstrates the complexity of the interplay between layers (or versions) of her narrative self and how she could manage these multiple stories despite apparent contradictions. She indicated that she distinguishes perfectly between what the story she wants to tell publicly is, and her more messy reality of how she feels and views herself. This appeared to include experiences and emotions that were more difficult to narrate publicly and were less containable within a quest narrative. There is also an implication that there may be some friction between her self as narrative and her self as more than narrative (Craib, 2000), and her expectation of being able to live up to the former. Susie's narrative demonstrates that the negotiation of control with the crew went further than protecting sensitive information but was about control over the image and story she wanted to project publicly about herself.

8.3.2 Trusting others to tell my story

> There was very much a trust element of that. Because I was very much, you know, "I don't want you to make me look stupid or ridiculous", "We're not going to do that." (Susie)

In lieu of control, many of the contributors' accounts referenced having trust in the individual crew and the aims of the production as being an important aspect enabling them to tell their stories in a way they were comfortable with. Laura explained: "I properly trusted them with what they would actually pick up on and show". This supports other research that has indicated that a belief in shared ideals and time invested by crew members in developing trusting relationships is central to obtaining the right conditions for disclosure on camera (Lånkan & Thorbjørnsrud, 2022; Melzer, 2019; Nash, 2012). Dom's research interview returned many times to how his trust in the production gave him the confidence to tell the story that he wanted to. He constructed a narrative arc of learning to trust the crew. He started by recalling his initial doubts and mistrust of television, then described at length a day when the crew turned up to film when he was struggling with his mental health, and the crew were solicitous and totally supportive of his request not to be filmed after all. He related this back to being able to fully commit to the process of having his story told:

> I knew then it was accurate, it was supposed to be accurate, they're going to tell these stories and yeah they were going to do it in a way that showed us respect. That was the moment for me where I felt like I can actually give myself to this now because I know their intentions are good, that was that moment yeah.

Dom conveyed the idea that he is a co-collaborator, working with the crew to tell the right story. He represented his decision to trust the crew as a choice he made based on considered judgement and direct experience, rather than naivety, thereby positioning himself as indirectly retaining some control over his mediated story. He had consciously placed himself in their hands. His expressed doubts also form part of the quest story he shaped in interview, underlining how he went on a journey in which he has navigated the potential perils of being open about his mental health, and reinforcing the ultimate triumph of successfully telling his story.

Like Dom, many contributors' accounts acknowledged the inherent power imbalance between themselves and the producers, especially once filming had finished and the

material was being edited. There was recognition that how their stories were constructed and whether the programmes focussed on mental health or veered towards the sensational was ultimately out of their hands. As Kate put it: "when it all comes together, you kind of just have to trust the process I guess". Notably, all the contributors I interviewed reported that they had an opportunity to view their sections of the finished programmes before broadcast. Contributors described their fears and anticipation about whether the programmes would accurately reflect them, and the stories they hope to share. George for example portrayed a scene towards the end of filming where the group of contributors involved were talking amongst themselves off camera about what had been filmed and how "everyone was worried about the story that was going to get told". George explained, "I did come back and thought that [the producers] had fucked it up, I think they were showing the wrong things." He gave a detailed example of one incident involving another contributor that he was worried was going to be overplayed and misrepresented. He explained that before the broadcast he shared his concerns with the director and was invited in to watch a cut of the programme:

> And they had got the story right and they was talking about OCD, and they were talking about therapy, they weren't trying to make a sort of, we didn't want it to be a happy go lucky story of look at these guys and now look how great they are, we wanted it to be something true.

George demonstrates his understanding that there are multiple ways to tells the story of their experience and shows his strong engagement with how he wants to be represented. His relief formed part of his quest story resolution, reinforcing that he had achieved his goal of showing an authentic story about his condition. Other contributors reflected the idea of a right or wrong story too, for example Ali said, "I was just glad it was a serious programme, that didn't exploit people". Retrospectively at least, the interviewees' accounts depicted them as highly television literate, with awareness of where their stories sit within wider factual genres and opinions on the strengths and weaknesses of the edits of their programmes. Significantly, the majority of the contributors I interviewed expressed approval of the way the final programmes were edited and reported that they felt they had been accurately represented. The sense of collaboration and trust being built with the production team that their accounts depicted appeared to be important in achieving this outcome.

8.3.3 Losing control of the story (this is not the story I want to tell)

> There were things in the film that I didn't want put in but I asked them, I sent them emails and they still ended up doing it which kind of got me angry (Chloe)

Whilst almost all the contributors conveyed support for their overall representations in television programmes, in a small number of accounts, there were moments of ambiguity, which disrupted the reading of their participation as straightforward successful quest stories. From analysing how these tensions appear in their narrative, a key issue that I have identified is the relevance of their perceptions of agency and success in delivering the story they want to tell. One example of the friction that can arise when contributors did not feel fully in control of their stories was provided by Chloe, who as the quote above demonstrates was very unhappy with one scene in the broadcast programme which she felt mispresented her relationship with a family member. Like the other contributors I interviewed, Chloe was shown a cut of the programme before it was broadcast. She reported that she asked to have this scene removed and it was left in, causing her considerable distress: "it was the way they'd edited it, so it made me very stressed to be honest and very down and depressed because my [family member] was like disappointed in what was said as well." Whilst other contributors indicated that they understood that they could give feedback but would not be given any final say over the edit, Chloe conveyed an expectation that they would remove the clip if she asked them. When I asked her how the production explained the discrepancy she said:

> They didn't do any explaining they just said 'oh we're very sorry', you know, I said I didn't want that in there and they go 'yeah o.k. and thank you for letting us know, bla blah bla' and then then when it went out I was like 'they'd still put it in there!'

The surprise and frustration that Chloe expressed on realising that she has no control over the final editorial version of her story suggests that she was under the impression that she had more control than she did in practice. Thorbjørnsrud & Lånkan's (2022) research with young adults filmed for a therapy documentary found that ambiguity between what participants were informally promised, and their formal rights to influence the content that ends up on screen led to a sense of loss of control and even betrayal when their expectations were not met. The study highlights specific difficulties

when it comes to the managing of information shared about third parties (i.e. friends and family) for which participants may feel responsible, as was the case for Chloe. Her example supports this research, indicating that when contributors felt powerless to tell their preferred story this could be distressing and have real consequences.

The fundamental importance of 'telling their preferred story' which seemed to underlay the contributors' evaluation of their television experience is demonstrated further by contrasting the interview accounts of Kate and Sarah. Sarah's account had all the hallmarks of the quest, presenting her participation as a story of triumph over adversity. Kate's account of her involvement was less straightforward. Parts of her narrative can be described as a quest, such as what she gained from speaking openly, as has been discussed in earlier sections, however the predominant plot in her account is best characterised as a story of failed opportunity. The widely different assessments of their experiences were linked by their respective perceptions of success and failure in the final tasks, which formed the pinnacle of the interventions, and relatedly, whether they achieved the narratives they are aiming for. Sarah successfully completed the final task set in her series and positioned this as having a fundamental effect on her self esteem and ability to let go of some for her negative feelings towards herself. She enthused: "It made me believe in myself!". Kate however could not complete the final challenge that was part of her programme due to unforeseen circumstances beyond her control. This failure was the central narrative thread that ran through her research interview which in her own words, fundamentally coloured how she felt about her involvement:

> This sounds really sad, but the thing that kept me going the most was that I really wanted to [do the final challenge], above anything else, I was like I want, and that was the one thing I didn't do… I want to like prove to myself that I actually can do it and I didn't do it so that's quite upsetting even now.

Kate became visibly emotional when she talked about her failure to complete the challenge. Despite a significant amount of time passing after the event, she still expressed strong feelings of self-blame and disappointment, exclaiming: "and now I'm just like I relay that whole situation in my head every day like, you... you literally had all the help you could possibly get and you still failed!" Crucially, this perceived failure has happened on a public stage. In the series her inability to complete the final challenge is

dealt with compassionately, with no attached blame, but this was not enough to change Kate's opinion that she had "embarrassed myself on television" and been "humiliated".

An awareness of the audience for their success of failure seemed central to how both Kate and Sarah made sense of their participation, however they framed the impact of this differently. Sarah connected her knowledge that the audience would see her take part as adding pressure to succeed in the intervention, but constructed this as a motivating force which ultimately challenged her to push herself further:

> If it wasn't for that programme, I would never have pushed myself to do that really, but knowing you're going on national TV does push you, you know, I think I lost a bit of weight as well because I was thinking well I am going on national TV, I think I even had a fake tan as well, I can't remember if I had a fake tan for the [final task]! But you know, but it does make you think god I've got to do it, you know, and it does make you determined as well then to show everyone that you know, you can do it.

Once recruited and committed to the project, she presented a feeling of being compelled to succeed, made stronger by the knowledge that her success or failure would be viewed by an audience. In Sarah's account her involvement with the television process was therefore an additional element that added to the success of the actual mental health intervention. However Sarah also spontaneously reflected on the possible consequences if she had failed to complete the final task, describing her fears when at one point it was not clear she would be able to:

> I can't imagine, if I hadn't finished that I think it could have made me worse potentially than I was before I started. Cos I'm really hard on myself. So yeah, I had a really good experience. I finished it. I loved it, if I hadn't started that [final task], I think it would have had a really detrimental effect of my mental well-being.

This avowal by Sarah of not being able to countenance being unable to complete the final challenge created a powerful impression of how important succeeding was to Sarah's self-story. According to my analysis, her account conveyed compellingly a need to see the quest narrative through to its conclusion, and thereby create a positive story out of her traumatic experiences. She linked the need to accomplish the final task to the issue that "everyone knew I was doing it". Thereby, whilst her awareness of the audience is presented as a motivating force, she also acknowledged that it added to the potential negative outcomes of failing.

In contrast to Sarah, Kate constructed her awareness of the fact that her performance would be viewed by others as having a negative impact on her mental health during filming:

> I was having like panic attacks all the time….when you are trying to get yourself into a good mental state as well and you've got millions of people watching you, it was horrible.

It is possible that if she had succeeded, Kate may have offered a different analysis retrospectively of the pressures of filming. However, in the context of her perceived failure, she linked the constant presence of the cameras directly to her negative emotional wellbeing. Behind this pressure appeared to be her conceptualisation of the imagined audience for this performance. She depicted herself as someone who "cares what people think of her". The desire to control how the audience perceived her is captured by her reflections on talking to people about being involved since:

> the more I'm meeting people that haven't watched it, like the better I feel about it, which sounds weird but, because I can be like "oh I was on this documentary and I [did all this great stuff] and they're like "oh my god that sounds amazing, like, can I watch it, where is it and I'm like "sorry is not available, you can't watch it, (laughs) but I'm like "trust me it's really cool" but then I meet people who have watched it and they're like "oh yeah you're the girl that cried on TV loads of times and didn't [do the challenge] and like you were the one that didn't [do it] and then I'm like "oh... god…"

Kate made a clear distinction between how she wanted to tell the story of her involvement (which highlights the good bits) and how she felt about the mediated story of her experiences being witnessed and interpreted by audiences. I would argue that much of Kate's negative attitudes towards appearing in the series were not only because she believes she has failed, but also because in doing so she lost control of the narrative that she wanted to be able to tell, to herself and others. What is interesting is how the disappointment that Kate articulated appeared to stem not just from her own expectations but from a related pressure that she expressed to tell a certain kind of story, as captured by this following interview exchange:

KATE: Yeah literally even even like as they were editing it at the end I was like I wonder if they could take me out of everything, that's how bad it was!

INTERVIEWER: OK [pause]

KATE: Um and God I'm really sorry if it is not what you want to hear! You probably wanted me to be like this was the best experience ever!

INTERVIEWER: No! I want you to tell me what it was like for you, exactly…

KATE: I'd love to like glamourize it and people are always "oh my god what", they are especially people I met since it aired "oh my God was it amazing was it the best thing ever?" and I'm always like 'No. Like I wish I hadn't done it.'

Kate actively resisted the interpretation of her participation as transformational, however this is something she expressed a need to apologise for, conveying the sense that she felt she was letting her audience down because she cannot deliver the quest story that people expected to hear. The pressure that she (and Sarah) articulated to tell a certain story is arguably added to by the genre conventions of mental health intervention television which is geared towards a positive resolution. In addition there is a broader pressure of dominant cultural discourses that value quest stories of difficult experiences over stories with more chaotic endings (Frank, 2013). Sarah achieved her desired ending, and the audience feedback she received is offered as a significant source of self-validation. For Kate, the belief she has failed to live up to a canonical quest narrative has had a significant influence on her negative evaluation of her participation. Both accounts highlight the potentially high stakes of failure in narrative terms for contributors' wellbeing.

Another interesting contrast in how contributors made sense of failure within the context of their narratives was provided by Ali's interview account. As mentioned briefly earlier, Ali suggested that the specific therapeutic intervention that she participated in did not make a significant difference to her mental health. However she remained unequivocal about the positive impact of the experience on her overall wellbeing, in the main due to the friendships she made and has sustained since. When I asked her about how she was affected by her lack of progress during the intervention she conceded that it was disheartening but then quickly steered away from this:

> It makes me a bit low sometimes and demoralised when I think mine hasn't changed at all. So that's quite hard. But then knowing that it changed all of their lives makes it worth it. And I know, I just see it as the therapy didn't help, but the therapy to me was meeting those people. And that's what helped me. I just see it as a positive in that way.

Regardless of not achieving the outcomes she wanted for her mental health, she was indisputably positive about her participation. She turned the conversation quickly around to what she has gained and the wider benefits of the series. Whilst these are all themes that Kate echoed too, in her account, they were not enough to shift the overall direction of her story. There are many possible reasons for the contrast in emphasis of their narratives, from the unique constructions and dynamics of the different series they participated in, to individual variations of experience and personality. One point of comparison that is interesting narratively however, is the difference between the focus of the series that they appeared in. Kate's non-completion of the final challenge was an explicit storyline in the series she participated in (albeit it represented compassionately and in the context of celebrating her successes). Ali's lack of progress during therapy was not an explicit storyline however. The overall narrative arc within the series Ali participated in was one of success, with the focus being more on members of the group who made the most significant improvements to their mental health. Therefore any perceived failure remained a private one.

8.4 Summary

The contributors accounts demonstrate that retrospectively at least, they were heavily invested in how their stories are told and depicted themselves as taking active roles in influencing the direction of their narratives. In part their presentation of their reflections on the telling of their stories can be read as a dimension of the quest structure of their interview accounts. The inclusion of their active engagement establishes them as the heroes of their stories, whilst any doubts and concerns expressed, help to build a plot of the potential perils and bravery in speaking out, therein reinforcing their achievement in telling their stories successfully.

However there are some parts where the experiences described exceed what can be neatly contained in a quest story, introducing elements of tension in their narratives. Some of the difficulties portrayed by contributors related to a sense of losing control of

their stories. My analysis shows that contributors framed themselves as collaborators with the production team, however their accounts acknowledged the inherent power differential created by production processes, and that ultimately they had to place their trust in the production team to tell their story well. Chloe's account demonstrates how there can be problems when there is a disconnect between expectations of control and what happens in practice.

In addition, the contributors' accounts established that audiences (both real and imagined) can present challenges when their feedback undermined how contributors wanted to have their stories understood. Interestingly, even positive audience engagement could cause difficulties. The downside of talking openly about mental health was how this disrupted normal privacy boundaries, creating an expectation that contributors were open to, and able to handle intrusive enquiries and self-disclosures from audience members. Some contributors depicted a pressure to tell, and live up to, a certain kind of story. In a small number of accounts there seemed to be tensions between the stories that contributors want to tell, and their lives and experiences as lived.

Chapter 9: Discussion: the ups and down of telling television stories about mental distress

9.1 Introduction

The narrative thread that ran through the contributors' interviews was that of telling their stories. As explained in chapters 7 and 8, telling their stories was central to how they presented their motivations to take part and in their assessment of the filming process. Their evaluation of whether telling their stories was a success seemed to be a fundamental factor in their overall conclusions about the positives or negatives of their participation. Contributors interview accounts partially echoed their mediated television "quest" narratives, talking in terms of transformation and life change. However, the impact of taking part was presented as going beyond the interventions provided on screen, with transformation stemming from appearing on television and sharing their stories itself. The lasting impact on their lives and wellbeing also pivoted around what they had gained or not gained from sharing their stories with the viewing public.

What was conveyed across the contributors' research interview narratives was how sharing their stories opened up new ways of talking and thinking about their mental distress with benefits for their wellbeing and impact on close relationships. At the heart of this was the importance of having a receptive audience, feeling heard and having their stories validated by their audiences. In some cases this audience was the other contributors and crew, for some it was family members. For all the interviewees their engagement with the wider public audience, particularly through social media, was a significant part of their evaluations of the impact on their wellbeing of their television participation. Whilst the audience, both real and imagined, held the key to validating their stories, its responses could also create challenges and was presented as having a negative impact on some contributors' wellbeing. Another key issue that my analysis identified was the relevance of perceived control over the telling of their stories to how contributors evaluated their experiences. Their accounts demonstrated that they were actively engaged with how they wanted to tell their stories however the pressure to tell a certain kind of story (from their own expectations or due to cultural or format constraints) created tensions and difficulties for some of them if they did not manage to

tell the story they wanted. My analysis shows that contributor agency is complex as there are many factors that limited their control over their stories from production practices and televisual conventions to cultural discourses and different audience interpretations.

The prominence of telling their story for how contributors describe their experience fits with the principles of narrative theory, namely the importance of telling stories to how people make sense of their lives and identities, and in parallel, the relevance of the social contexts and potential audiences for the stories told. This discussion chapter will apply some of these ideas to the ways in which contributors presented telling their stories to investigate my two aims of: exploring how television contributors understand and evaluate their experiences *and* identifying common themes and factors that make participation successful (or unsuccessful). Where relevant, I shall also draw on the analysis of production interviews, onscreen intervention providers and off-screen support providers.

Whilst my intention is to think beyond individual stories, I am conscious of the rich variation between contributors' accounts of their experience and important differences between the series they were involved in. Therefore, I am wary of drawing too broad conclusions and will retain some of the specifics of individual accounts when I discuss ways of interpreting my findings rather than implying that explanations can be generalised to all the contributors. The chapter presents five distinct but interconnected areas of discussion raised by my analysis: firstly I argue that for some contributors their participation may have provided an opportunity to **re-story their mental health experiences**. Secondly, I discuss the value of **being heard and understood**. Thirdly I look at the importance of **agency over personal narratives**. This is followed by a consideration of the vital **role of audiences**. Finally I reflect on the **interview process** itself as a site for narrative reconstruction.

9.2 (Re)storying myself as a helper, not a problem

One criticism that I have raised about MHITV is that it is potentially taking advantage of people who are struggling with their mental health and seeking help. However, whilst the contributors in my sample were looking for support, this was never given as the most important motivation for taking part in a television programme, and the level of assistance offered varied across series. This undermines the assumption that contributors are automatically vulnerable because they are likely to be unduly influenced by the offer of support that may not be available to them elsewhere (Woods, 2021). For example one house clearance that was filmed had been pre-arranged and paid for by the contributor, therefore arguably they were gaining nothing additional by allowing the cameras in. Rather than simply a vehicle to seek help, all the contributors emphasised that they wanted to use their struggles with mental health to help others by allowing their experiences to be filmed and shared so audiences can learn from them.

This corresponds with other research with television participants who have put forward altruistic ideals as a key starting point for speaking about their mental health publicly (Lånkan & Thorbjørnsrud, 2022; Thorbjørnsrud & Lånkan, 2022). Ytreberg and Thorbjørnsrud (2020, p. 6183) argue that sharing illness stories in the media is generally considered an "act of goodness" which affords patients turned participants "high moral status". Therefore there is potentially incentive for contributors to frame themselves as altruistic (and agentic) in their decision to participate, both in terms of their own story to self, and in how they construct their motivations to others in interview. Discourses of the benefits of being open about mental health also serve the interests of television productions and are a commonly used tactic in contributor recruitment material and initial dialogue when productions are seeking to secure participation. A discourse of helping others through openness suits both the production and to some extent, contributors, therefore. However this does not discount the possibility that contributors may be vulnerable to manipulation due to the asymmetry in power within the production dynamic, or that their aspiration to help others can be leveraged to encourage their ongoing participation.

Taken at face value, contributors framing of their motivation to turn their mental health experiences into something that will help others resonates with Frank's descriptions of

quest stories as one potential response to dealing with serious illness whereby a negative situation becomes a learning opportunity to be shared with others (Frank, 2013). In a similar vein, my research suggests that taking on the role of helping others, with the television project as a vehicle, has allowed the contributors to feel that their experiences have not been for nothing and for some provided a focus and sense of purpose. Carless & Douglas (2008) in their study of the narratives of men with severe mental illness who partake in organised sport, argue that sporting activities provided the men a way of re-storying more positive self-narratives about their mental health. Similarly, taking part in a television series, in itself an exciting and novel project, that takes people out of their normal situations, also framed as an act of philanthropy may have provided a gateway to alternatives ways of viewing themselves and their mental health journey. I would argue that the very act of participating has allowed some contributors an alternative way to reflect on their stories, providing a new lens to re-evaluate themselves away from someone with a problem to someone who can help others.

This interpretation corresponds with concepts from a mental health recovery framework which identifies having 'meaning in life' as one important aspect of recovery (Brown, 2008; Leamy et al., 2011; Stuart et al., 2017). Specifically this research emphasises the importance of feeling valued by society which may be through employment, volunteering, cultural involvement or other activities such as helping others. Research on the role of peer support workers in mental health practice links supporting others to improved self-esteem and confidence (Watson, 2019). One study found peer support workers identified sharing their stories as a specific mechanism that allowed them to see their own stories more clearly and re-evaluate their experiences in a more positive light (Moran et al., 2012). Whilst television is a very different context, these were all points made by my interviewees, whose narratives placed significance emphasis on their pride and self-affirmation at helping others. Presenting their experiences as quest stories which can help others is potentially therefore a way of re-directing their stories and relationships with their journeys through mental health towards a more constructive and self-fulfilling ending.

9.3 Being heard and understood

In addition to helping others, many of the contributors also discussed sharing their stories in the context of wider media discourses about mental distress and the need to challenge stigma and encourage open conversations about mental health. Inherent in some of the contributors' accounts was a sense of finding themselves at odds with how they wanted to be perceived and understood. This was particularly apparent for contributors who identified as having OCD or hoarding behaviours, two mental health issues of which televisual coverage has been controversial. This is consistent with arguments made by narrative theorists that one of the difficulties for people experiencing mental distress is that they may find their stories at odds with acceptable master narratives both in content and structure (Adame & Knudson, 2007; Baldwin, 2005; McLeod, 1997). My interviewees presented themselves as directly impacted and undermined by popular media narratives that reframe their mental health challenges as entertainment.

A disconnect between lived experience and dominant cultural narratives can lead to individuals and groups seeking to establish counter-narratives as has been seen with the psychiatric survivor movement which has used personal stories to put forward a challenge to the mainstream psychiatric narrative of mental distress as mental "illness" (Adame & Knudson, 2007). There is no suggestion within the contributors' accounts of an attempt to initiate change to conceptualisations of mental distress or challenge the mental health system. However, there is the impression that for some contributors, their involvement is viewed at least as an opportunity to create more authentic mental health narratives, grounded in their own experiences.

Baldwin (2005) theorises that serious mental health problems can deprive individuals of the important opportunity to have their stories heard, in part through a lack of a willing audience. The contributors' narratives conveyed a sense of wanting to be seen and heard as individuals. As Grindstaff (2012) argues, appearing on television is perceived as a culturally desirable indicator that enables participants "to feel like they matter in the world" (p. 31). Like the talk show guests she interviewed, I would argue that the contributors of my study were looking for the chance to feel that they are part of a public dialogue and have their difficult experiences validated. From a more critical perspective,

there have been growing objections raised over the co-opting of stories of lived experience in ways that reinforce neoliberal agendas and counteract the emancipatory origins and potential of these stories (Yeo et al., 2022). These are certainly claims that could be levied at mental health intervention television, which shares some of the genre conventions of lifestyle and talk show television which have been criticised for reinforcing self-governance and presenting market solutions to social problems (Ouellette & Hay, 2008; Palmer, 2008). These are valid concerns, however they were not shared by the contributors I interviewed. For my interviewees, it appeared that taking part in a television series was perceived as providing an impactful way to address a lack of recognition and represented a valued opportunity to voice their personal experiences.

9.4 Control over telling the story I want

Whilst sharing mental health stories has often been characterised as a positive endeavour for the individuals involved, other theorists have been more critical of the assumption that it is beneficial to disclose such highly personal stories, particularly in contexts where narrators are not in control of how their stories will be mediated, received or used, as alluded to above (Costa et al., 2012; Woods et al., 2019; Ytreberg & Thorbjørnsrud, 2020). Thorbjørnsrud and Lånkan (2022) argue that the power differential between participants and production, combined with commercial broadcasting agendas are not necessarily conducive to the conditions for participants to meaningfully represent themselves. The controversy discussed in Chapter three over the suicide of a participant filmed for the *Jeremy Kyle Show* (ITV) is one such example of what can go wrong when laypeople find themselves at the mercy of production practices that place them at a disadvantage in terms of prior knowledge and control over proceedings.

Given the above, it is therefore a notable finding in itself, that overall, the contributors I interviewed were positive about the way their stories were told. They universally presented the goal of educating and helping audiences depicted above as successful. There was only one interviewee who voiced considerable dissatisfaction with one part of their representation, whilst one other expressed regrets about taking part. It is essential however to consider this finding within the context of the limitations of my

sample size and the fact that it does not include all the contributors from each different series. It is therefore very likely that their depiction of predominantly positive experiences in sharing their stories does not reflect the views of all the contributors who took part, a limitation I shall discuss in my conclusion. However, it is still informative to understand why this set of contributors presented their experiences so positively.

One important aspect to understanding why they presented their experiences so positively may be how the contributors framed themselves as actively engaged in the process of telling their own stories. An important caveat is that their accounts to me after the event are a reconstruction of how they make sense of that experience, which would likely have differed considerably had I done interviews during the production process. It is impossible to separate out their answers now from their post-knowledge of the final pieces and the audience reception. That said, the contributors (retrospectively at least) showed considerable thought and had strong opinions about the practices of producing their story, and the kind of story they wanted to tell, as well as awareness about the wider media constructions of mental distress and where their stories might fit within that landscape. They demonstrated a fairly sophisticated understanding that they were involved in producing a mediated, edited account of their experience, and suggested active engagement and techniques to retain control of the production of their stories. Like the documentary participants in Nash's (2012) case studies, they presented themselves as co-collaborators. This is perhaps surprising given that it might be supposed that independent documentary directors have greater freedom to work collaboratively with the subjects of their films should they choose to (Thomas, 2012). In contrast popular factual television production, and reality TV specifically, is often characterised as deadline driven, high pressured, and commercially focussed, allowing little flexibility to engage in collaborative practices (Rees, 2019). Within my study however, contributors suggested they felt able to retain some agency over their stories and performances. They emphasised the importance of a trusting dynamic with crew members which allowed them to give up their story with the surety of belief in shared ideals and the integrity of the production team. This was mirrored in the production accounts that for the most part placed significant emphasis on collaborative storytelling and allowing contributors to feel in control of what they wanted to share.

The importance of agency in producing stories of lived experience has been emphasised by narrative theorists both in the context of narrative therapy (Singer & Rexhaj, 2006; White & Epston, 1990) and within opportunities to share recovery stories (Rennick-Egglestone et al., 2019). Roe & Davidson (2005) posit that facilitating people experiencing serious mental health difficulties to take back ownership of their stories is a key aspect of enabling them to take back control of their lives. Whilst it may be counterintuitive to assume television production allows contributors control over their own stories, my interviewees highlighted ways in which they were permitted to manage their involvement (or at least retain a sense of co-collaboration) such as being told they can stop filming and pre-viewing edited material. Similar allowances were reiterated in examples from production interviewees as well, who presented such measures as being part of a commitment to making sure that the mental health of contributors came before the needs of the programmes. These agreements tended to be informally made however, and research by Thorbjørnsrud and Lånkan (2022) demonstrates how a perception of control established through informal production practices can lead to difficulties when participants expectations are not met further down the line. In contrast, my interviewees were mostly positive about their negotiations and communication with the production crew. Whilst they acknowledged inherent tensions in the ultimately uneven playing field between themselves and the production when it comes to telling the story how they would like, they presented themselves as confident they could influence proceedings. This sense of perceived control is potentially one reason why they evaluated their experience of telling their stories as successful and rewarding.

This is further supported by a counter example provided by one interviewee. Chloe found her belief in her agency over her mediated story to be unfounded. Her loss of control is presented as causing her serious difficulties and adding to her mental distress. This is a reminder that the onus of power remains with the production company and broadcaster who have the capacity to both empower and disempower contributors. An important issue therefore is whether production practices allow for contributors to retain a sense of control over how their story is told. The inference within the production accounts however is “normal” production working practices and culture do not often allow collaborative practices. In emphasising their own moral approaches to

filmmaking, the producers invoked a counter story of on-going behaviours elsewhere within television production which disenfranchise and exploit contributors for their stories. An implication for practice is that if production teams can work collaboratively and sensitively with contributors, their experience is much more likely to be positive and could even be beneficial. However, where control is implied but not followed through this can cause significant distress and alienate contributors.

A related but distinct issue from that above, is the extent to which contributors can realistically retain control of their stories, given the restrictive narrative conventions of this genre of programme making and more broadly, the quest structure that it draws on. On the one hand, the quest format offers certain benefits to contributors in how they are represented on screen and how they choose to present themselves in the study interviews. I would argue that a narrative that shapes their experiences as a triumphant quest may be preferable as how they wish to be perceived by themselves and others, which may also be one reason they construct their experiences so positively in my interviews. The quest narrative allows them to be the heroes of their stories, and one possible inference from my analysis is that control may not be as important as satisfaction with the roles they are given within their own stories. Whilst the format of MHITV allows little room for nuance or difficulties that cannot be resolved, I would also argue that it may be more ethical to present the contributors journeys as successful rather than expose them as failing or stuck. On the other hand, the tight structure of the quest format in MHITV limits the type of stories that contributors are able to tell. There were moments of tension in some contributors' accounts where their experiences, or choices about how they wished to be represented, were not a good fit for what could be captured within such a limited narrative framework. These areas of tension suggest that some contributors experienced difficulties as they felt unable to live up to either their own expectations, or the canonical imperative, of telling a certain kind of story.

One such expectation was the requirement to tell a story with a particular emotional content and tone. Whilst many contributors depicted the benefits of openly discussing their mental health stories, there were suggestions in some accounts that the expectation to deliver a certain kind of raw, emotive, confessional performance during filming was felt as a burden. Like a small number of participants in other studies (Lånkan

& Thorbjørnsrud, 2022; Thorbjørnsrud & Lånkan, 2022), Kate articulated that she felt the pressure of cameras and awareness of the audience who will witness her performance, which made her mental distress worse. Similarly, the psychologists involved in delivering on-screen therapy also depicted the presence of cameras, carrying with it an awareness of a future audience, as interfering with the therapeutic process, undermining the normal assumption of privacy that is an enshrined principle of talking therapy. Outside the context of therapy, activists and academics writing in relation to recovery stories have also questioned the assumption that 'telling your story' is automatically healing or empowering, arguing that the downsides of disclosure are underplayed (Costa et al., 2012; Woods et al., 2019). They point to the emotional labour of producing stories of lived experience, something Kate's account would seem to support. They also highlight the expectation of telling a certain kind of recovery story, which must have the right emotional tone:

> The Recovery Narrative cannot, in its tone, content or delivery, be too disturbing, too dark, too angry; nor can it be too light, frivolous, or happy. It has to offer enough shade for the light of hope to be foregrounded, but not too much as to shroud it. (Woods et al., 2019, p. 235)

Like the recovery genre, mental health intervention television has certain expectations towards form and content, which create a pressure to tell a certain kind of story. The narrative arc of despair, challenge, and ultimately triumph that shapes the format added another layer of complexity to contributors' attempts to tell the story they want to. One criticism of the narratives of MHITV formats is that whilst the mental health representations are empathetic, they do not allow much space for alternative conceptualisations of mental distress, debate, or unsuccessful 'messy' mental health outcomes. Whilst this was not a complaint raised by the contributors, several of the on-screen intervention providers described their frustration at the reductionist format of MHITV to fully capture the complexity of the interventions, or the outcomes for contributors. Mental health intervention television places the heroic perseverance and self-help of the contributors at the heart of their story, however arguably the triumphant narrative arc of *I was ill – I got help – I am better* reinforces a medical based model of mental distress, which counter-intuitively have been shown to increase stigma (Read et al., 2006).

As well as implications for audiences this had specific ramifications for contributors, especially where there was a disconnect between the requirements of the format and the experience such as in Kate's case where she did not complete the final challenge. Frank (2013) problematises the too perfect quest story as setting a high bar for others to compare their story to. The potential for contributors to conceive themselves as failures are potentially intensified if they do not meet the requirement to tell a story whereby they emerge triumphant, as is the format convention of MHITV and the quest genre more broadly. In other words, the pressures of retaining control over their representation and stories are added to by the specific narrative structure of MHITV.

9.5 Transformation via the audience who will validate my experience

According to narrative theory it is not just the opportunity to share stories that matters, but how the stories we tell are received. The stories of self we create happen within a social context and are co-constructed with the audiences we have available to us, whether real or imagined (Riessman, 2008). The feedback from audiences was crucial to contributors' evaluations of their involvement in the television series and arguably more fundamentally, the process of re-evaluating their mental health stories. This involved multiple audiences at different stages, from the crew during the production, their families and close friends, and the wider viewing audience, to myself as another audience with whom they are re-constructing the experience. The audience engagement was the catalyst for the transformation at the heart of their quest stories of telling their stories. However, their accounts also indicated how uncertainty over how audiences will receive stories can make the sharing of mental health stories an unpredictable venture.

Some accounts suggested they found attentive audiences in the guise of the production team who seemed to be filling the role of audience for their stories that they perhaps did not have day to day. They presented this as a highly positive and even 'therapeutic' interaction. It is worth noting that this 'supportive relationship' also served a more instrumental function of extracting a suitably open televisual performance from contributors (Rees, 2019). However, from the contributors' perspective, their relationships with crew members were presented as beneficial and a valued exchange, which formed part of their positive evaluation of their overall television experience. This

demonstrates the relevance of attending to the micro-level practices and interrelationships within television production. Whilst much media and cultural studies research frames television participants as small cogs in an inherently exploitative industry (Collins, 2008), their individual experience is shaped by more immediate interpersonal factors such as a friendly and supportive production team.

Importantly, the crew in the process of doing their job of producing contributors' stories were also a significant initial audience and co-constructor of how these stories were told and received. The level of sensitivity and care with which they gather, co-construct and respond to these stories potentially has the power to validate, enhance or undermine the contributors' own understanding of their stories. This has implications for how production teams work with contributors. Like previous research (Rees, 2019) my analysis of production interviews highlighted that working with vulnerable contributors can place significant ethical challenges on crew members responding to pressures to obtain sensitive material whilst also protect contributors needs. Given the relevance of crew as a potential 'therapeutic' audience for contributors it is essential that they have the right skills and production environment to successful manage this role.

Another audience during the production process on some series was other contributors. Sarah, in particular, presented how sharing and hearing stories with the other contributors involved, and on camera, was a process that helped her recognise her trauma and accept help. Other contributors emphasised the friendships made as hugely impactful. The benefits of peer support networks, both in person and online, for people experiencing mental distress has been widely documented (Bellamy et al., 2017; Fortuna et al., 2020; Watson, 2019). A literature review into the mechanisms underpinning peer support in mental health services suggests that one key mechanism behind successful interventions is that peer support workers explicitly share their lived experience, helping both to normalise difficult experiences and emotions, and promote hope (Watson, 2019). For similar reasons, the reciprocal sharing of recovery stories has been shown to have benefits for both the storyteller and the story recipient (Nurser et al., 2018). However, an important caveat is that there are also potentially negative outcomes of hearing and sharing stories, such as the potential to feel inadequate or burdened (Nurser et al., 2018; Rennick-Egglestone et al., 2019). Whilst a television production framework is a very specific context, my research supports the relevance of peer support

(and through it, accessing an understanding audience). The gains of the friendships made for contributor wellbeing would appear to be in addition to, or at the least a factor of, the impact of the formal interventions provided as part of the different series. Interestingly, two of the contributors who did not have the opportunity to meet other peers, reported that they actively sort out contact with each other after the series went out and stayed in touch.

The importance of family as one impactful audience in the lives of contributors was demonstrated by the ways in which they discuss the responses of this specific group to their mediated stories. Papathomas and colleagues (2015) demonstrate in their narrative analysis of a family dealing with a daughter with an eating disorder how family members may adhere to different narrative preferences to make sense of their experiences and possible future trajectories of their stories. In a similar vein, my contributors depicted how taking part in a television series meant revealing aspects of their stories which were a challenge to the version of events and feelings which had previously been recognised or acknowledged between certain family members. For Sarah and Kate, this process opened up new dialogue between themselves and their families and allowed them to understand and relate to each other differently. In the same way that family therapy may enable family members to reach new joint understandings (Dallos & Draper, 2015), arguably the process of telling stories for the series changed their family's collective storying of events.

There are huge differences however between the private, therapist-led spaces in which family therapy is conducted and the context of the production of a television show, where the production team are not trained therapists and have aims and responsibilities beyond facilitating more constructive family dynamics. The mediated television narratives produced also serve a very different and very public purpose. Chloe's account demonstrated how difficulties are created when the information shared by one family member has repercussions for the version of events that other family members adhere to publicly. It demonstrates how our stories are interconnected and there are grey areas between where our stories start and other people's begin. The study by Thorbjørnsrud and Lånkan (2022) of young people who took part in a Norwegian show involving therapy highlights how taking part in a television series involves not only establishing personal privacy boundaries but potentially considering collective privacy boundaries

for co-owned information. Sharing stories publicly has the potential to challenge and alter the stories others tell too. Whilst this may be empowering or well received there is also the possibility for stories to be rejected or seen as an imposition. In the context of a television series, this is further complicated by the contributors' lack of total control over the mediated version of their stories.

A substantial part of all the contributors' accounts focussed on their engagement with the wider television audience and finding themselves in the media spotlight. An important issue raised by my analysis was how their television appearances opened them up to avenues of substantial direct audience contact and social commentary via social media. This is an indicator of how audience engagement with television has irrevocably changed through the growth of social media platforms (Hallvard et al., 2016) with direct implications for ordinary people who participate in television, particularly when sharing highly personal information. The affordances of social media combined with multi-platform promotion and the on-selling of series to other online content channels can increase the longevity of public exposure (Mast, 2016). These developments bring the possibility for contributors to sustain a higher public profile should they wish to, and sometimes even when they do not.

My interviewees accounts suggested both benefits and disadvantages of being able to engage with audiences in this way. For many contributors their five minutes of fame appeared to have been rewarding and audience feedback is presented as a source of powerful affirmation, reinforcing the triumphant outcomes of their quest. My contributors accounts corroborate other research with participants who disclosed their mental health issues on television which equates greater openness to personal benefits to wellbeing such as the reduction of shame (Lånkan & Thorbjørnsrud, 2022). Like the media participants in the study by Ytreberg & Thorbjørnsrud (2020) some contributors cultivated continued audience engagement through on going public talks, further filming (and talking to me about the experience). The exposure on television helped one person to progress further in the media and get a publishing deal.

However some accounts also indicated the pressures of handling the, at times, overwhelming attention. Contributors indicated that the audience interaction placed a significant burden of accountability to respond to messages and opened them up to

difficult disclosures from audience members. Talking openly about their mental health appeared to have created an expectation with audiences that they are happy and able to continue to engage in ongoing discussions and manage other people sharing personal stories with them both in person and online. In these instances, the embodied experience of managing challenging audience feedback would appear to fit let easily into a quest narrative. It is also possible that the quest format of the mediated programmes which presents them as the conquering heroes of their mental health problems has added to their belief (and audience expectations) that they should put themselves forward as role models. This may increase the pressure to respond to audiences contact accordingly, and there were some indications of dissonance created when contributors felt they were not living up to the responsibility place on them.

Another issue was that not all attention was positive. Whilst not as high profile as shows such as *Love Island* (ITV) or *Bake Off* (BBC/Channel 4), the contributors have experienced some of the same aspects of micro-celebrity such as 'trolling' that have been the focus of the recent inquiry into reality TV participation. The impact of social media and wider mass media on the wellbeing of reality TV participants has been well documented (Marsh, 2019). This has implications for how contributors on MHITV are supported. Whilst the new OFCOM guidelines suggest that participants should be given guidance on social media, several of my contributors referenced ignoring advice on not engaging with it. There is potentially a contradiction between the advice provided and discourses of openness and helping others that the contributors aspire to, reinforced by production practices. This suggests that other measures may be needed to support contributors such as proactive monitoring of series related social media and direct intervention where necessary.

The important take away from my analysis is that whilst for the majority of contributors the public audience feedback was presented as the successful culmination of their participation, in a few cases the pressure of managing intrusive audience contact (whether positive or negative) was depicted as compounding existing mental health difficulties. These contributors framed this as a personal difficulty to be managed, which did not alter their belief in the overall benefits of their participation. It is however another reminder that discourses of the benefits of openness may downplay the potential negatives of an obligation to speak out about personal mental distress (Woods

et al., 2019). These discourses may also at times serve the interests of the organisations who have commissioned their stories, more than the individuals involved (Costa et al., 2012; Ytreberg & Thorbjørnsrud, 2020).

9.6 Coda - re-storying in interview

Mishler (1986) contends that the construction of interview narratives is a collaborative process and as such it is essential to pay attention to the interview context to arrive at a fuller understanding of respondents' meanings and life worlds. As such, I feel it is essential to reflect on my role in the construction of my contributors' accounts and my analysis. An important critical question that I have asked myself is whether the quest narrative of sharing stories that has formed an important part of my analysis of how contributors narrate their experience is a real phenomenon or a function of the interview process and analysis itself. It is possible that the interview questions I have asked, or the expectations that I have created, are what gave rise to such an emphasis on the sharing of their stories. My opening question was – 'tell me about the experience of taking part in…?' Other prompting questions encouraged them to describe what it was like to be filmed, or appear on television, however it is certainly the case that when the contributors introduced the idea of telling their stories, at times I encouraged them to reflect on this further. Therefore it is essential to acknowledge that the meta theme of 'telling stories' is not something that has been 'revealed' by my analysis but something that is a co-construction between the contributors and myself during the interview process.

This acknowledgement it not meant to imply that my findings are therefore invalid, rather as Mishler (1986) says, by paying attention to the context I hope to provide a fuller understanding of participants meanings. To elaborate on this, there were several key exchanges during my interviews which stood out to me as not only highlighting the collaborative process of narrative construction, but also reinforcing central points of my analysis such as the importance of audience, the cultural significance of quest narratives and the process of storytelling as a way of making meaning. One example of this was my interview with Robin, who clearly enjoyed the opportunity to talk about her experience. At the end of our interview she added effusively how talking to me had made her pleased all over again that she had taken part. The process of re-telling her

story had reaffirmed and reminded her what she got out of it. In a related but slightly difference way, Susie connected being interviewed for my PhD research study as an example of continued opportunities and impact as she sought to capitalise on her television appearance. My research had become part of the validation provided from telling her story.

Another highly illustrative example of co-construction was my interview with Kate. As I have already covered in my analysis, Kate apologised to me for not telling the 'transformative' story she believed I wanted to hear. This demonstrates the powerful cultural influence of the quest story and the relevance of the audience expectations (or imagined expectations). In addition, during our interview, Kate actively revised the story she was telling, from a tale focused on failure to one where it was (almost) worthwhile. Below is a section which captures the joint construction of this shift:

> **KATE:** it's mostly just me being negative to myself and a lot of negative, like at the beginning of our discussion, a lot of negative self talk, feeling like "why did you do that" […] you've embarrassed yourself, all that kind of stuff, but when I think about it more like I have today, you've probably seen me go full circle haven't you? [laughs]
>
> **INTERVIEWER:** a little bit
>
> **KATE:** Umm! I said I had a lot of mixed emotions!
>
> **INTERVIEWER:** Yeah, I know, absolutely!
>
> **KATE:** So yeah when I think about it a lot I can draw the positives out, so there's not many negatives
>
> **INTERVIEWER:** Would you do it again?
>
> **KATE::** Pause (sigh)...
>
> **INTERVIEWER:** With the benefit of…/
>
> **KATE::** I think like you want me to say yes but I'm going to say no/
>
> **INTERVIEWER:** No, I don't want you to say anything - with the benefit of hindsight?
>
> **KATE:** if I, if they were like, it depends on if I could [complete the final challenge] or not, that's the clincher I think, because so much of my negative emotions came from that, it wasn't the mental health stuff, it wasn't the being on tv stuff…

INTERVIEWER: OK

KATE:: But, I've never really thought of it like that actually. God that's a bit sad isn't it, it's not, it's never like, and I had this [final interview and they were] like "so what have you learnt?" a bit like this and I was like "oh it was never about [the final challenge] really, bla bla bla" but now in hindsight, I'm like if I could have [done that], it's a bit vain of me really but..yeah..I just feel very confused about it all really [laughs] yeah.

As with her apologetic stance, this extract highlights the asymmetrical power dynamic between interviewer and researcher (Brinkmann & Kvale, 2005). Although Kate resisted the answer she thought I wanted to hear, she clearly expressed a pressure to tell a certain story for me, where her participation was the right choice. This perhaps reflected something specific about how I explained my research to her, or a feature of our interview interaction and how I presented myself as a producer turned psychologist. However, it also fits with other extracts from the interview that imply the influence of wider canonical narratives on the expectation that she must tell a successful quest story. In addition, she finished her interview still deeply ambivalent about her involvement, however it seemed the process of talking it through led her to acknowledge some benefits and to form a new understanding of why she might view her experience a certain way. This extract demonstrates powerfully for me how stories are not static, but depend on the time of telling, the audience, and cultural contexts. Importantly it seems to capture how the process of telling stories is a way of making sense of and revising understandings of experience.

Chapter 10: Conclusion

10.1 Introduction

This chapter summarises the findings, implications, and contribution to knowledge of this thesis. In addition, it discusses the limitations of my project in practice, with ideas for future areas of investigation that address these. My PhD is original academic research that examines British television series involving mental health interventions as a specific group, from the perspective of both the contributors who take part and the production crew and professionals involved in their making. Any act of filming is a form of intervention and has consequences. As I have set out in my review of literature, the limited empirical research that addresses the repercussions for members of the public of taking part in and appearing on television highlights that the outcomes can be unpredictable, especially where sensitive subject matter and potentially vulnerable contributors are involved. Whilst the experience of being seen and heard can be rewarding for some, the exposure can also have a negative impact on people's lives and wellbeing. The tragedy of the high profile deaths of ex-reality television contestants in the UK discussed in chapters three and four demonstrates the potentially serious consequences of the complex variables at work when the aims and actions of individuals, production teams and audiences collide.

This thesis is premised on the contention that factual television programmes which involve contributors undertaking filmed therapeutic activities, raise an added set of ethical issues to those already created in the course of making television with 'ordinary people'. I have argued that despite differences between formats, the central premise of providing, filming, and broadcasting an on-screen intervention for individuals experiencing mental distress creates a distinct set of challenges for the television contributors involved and those working with them, which require critical investigation. 'Mental health intervention television' as I have labelled this style of programming, proclaims substantial positive changes for contributors. However, my PhD research establishes that these formats raise significant issues from the quality of the support contributors receive, the sustainability of any outcomes to wellbeing, to the ethics of putting vulnerable individuals through a public regime of therapy.

Given these issues, my project has identified a gap in current academic research and knowledge, and the imperative for studies examining in detail the outcomes for the people involved. In responding to this gap, my study adds to the small body of existing research into television and documentary participation, whilst uniquely exploring the specific dynamics, outcomes and ethics of MHITV. More broadly, this research addresses the lack of studies that consider television production practices from the perspective of contributors, a voice often missing from theorising about the ethics of participation. In addition, it provides an insight into the work of psychologists and other professionals charged with providing on screen interventions, or supporting contributors behind the scenes.

I have also presented a case for the benefits of exploring production dynamics at a micro level. Within media and cultural studies there has been a tendency to focus on wider market led principles as an explanatory framework for how television operates, whilst overlooking the role of individual actors and practices (Havens et al., 2009). My research applies a methodological approach combining theory from psychology alongside thinking from media and cultural studies to explore the ways in which the individuals at the heart of the production process present and make sense of their involvement. My analysis of contributors' experiences was led by concepts from narrative psychology. The narrative approach is an established method for researching questions around identity, mental health and recovery (Spector-Mersel & Knaifel, 2018), however it has not been applied to the context of ex-television contributors' stories of taking part in MHITV. My work therefore makes a contribution to existing knowledge through its interdisciplinary and multi perspective approach to investigating the practices and outcomes of this type of mental health programming.

10.2 Summary of findings

Given the lack of existing research, the first aim of this research was to explore via in-depth interviews with ex-television contributors; how they understand and evaluate their experiences of taking part in mental health intervention television. In addition, I conducted interviews with producers, on-screen intervention providers and behind the scenes psychologists to explore the contexts for the production processes and inter-relationships that shape the experiences of contributors. Both sets of interviews feed

into my second aim which was to identify some of the themes and factors that make participation successful or unsuccessful. Below I summarise four key findings that address these two aims. This will be followed by a subsection that considers the implications.

10.2.1 Understanding my story as a transformative quest

According to my analysis, 'telling their stories on national television' was the narrative thread that dominated the contributors' accounts. Whilst many of the contributors were keen to receive the help on offer through taking part, it was telling their stories to help others and challenge media representations of mental distress that were presented as the key objectives of becoming involved in a television series. It was the outcomes and perceived success of this endeavour, as represented by audience responses, which were central to how they evaluated their television experience. Telling their story was structured as a quest narrative – a challenging but ultimately transformative experience. Their accounts plotted journeys from difficult starting points, through taking the brave decision to speak out, to life changing benefits to their wellbeing, relationships and self-belief, leading from talking publicly about their mental health.

In my assessment, this narrative structure appeared to offer certain positive benefits for many of the contributors. Thinking about and telling their stories within a quest framework allowed them to be the hero of their stories, who have created something positive out of difficult life experiences. It provided some contributors a way to re-evaluate themselves as helpers, or to get recognition, and feel seen and witnessed. This fits with the principles of narrative psychology which equate the stories we are able to co-create between ourselves and others to our identities, and how we make sense of our lives. The goal of narrative therapy is to enable clients to form more constructive self-stories (White and Epston 1990). In this sense, for some contributors, their television experience may have created a unique set of circumstances – support, attention, personal reflection, sense of purpose – which at the point at which my interviews were conducted, had enabled positive changes in how contributors 'story' (and thereby make sense of) their mental distress. Crucially, as discussed next, it provided them with a receptive audience for their stories.

10.2.2 The impact of an audience for contributors' stories

Drawing on narrative theory, my analysis sets out how at the core of these stories of transformation was the contributors' conceptualisation and engagement with the audiences of their stories, both real and imagined. Perhaps most important of all to the contributors' evaluation of their television experience was whether they perceived their preferred stories to be affirmed or rejected by audiences. For some the audience was crew and other contributors, for others the key audience was family and friends. In addition, all contributors connected the wider public response for their stories to their evaluation of the success of their involvement. Supportive audience feedback was presented as a source of pride and validation, a catalyst for their transformation of self-perception. Whilst overwhelmingly positive, their accounts also illustrated how an awareness of the imagined audience creates pressures to tell a certain kind of 'success' story. Whilst this awareness could be an incentivising force, in one example, the pressure to succeed was connected in their account to considerable anxiety. In addition, the therapist accounts demonstrated an understanding that therapy was being 'performed' for a future audience who will be party to any disclosures. This vulnerability created by the danger of exposure was constructed as interfering with a normally private therapeutic relationship and process.

The expectations of a commitment to openness with audiences that is inherent within the process of taking part in MHITV was constructed as a double-edged sword. Whilst many accounts proclaimed the personal gains from speaking openly, some accounts point to the emotional work of being expected to share all, both during filming and after broadcast. A significant finding that has been less reported (the exception being (Ytreberg & Thorbjørnsrud, 2020) was how even positive audience feedback can be challenging in this sense. The accounts of some contributors conveyed how intimate audience disclosures and the pressure to live up to an expectation of being a role model created a substantial emotional burden. In addition, my analysis demonstrates the challenges of exposure to negative audience feedback, amplified by social media. Their accounts highlight how the stories we want to tell are always at risk of being disrupted by others. In essence another way of conceptualising this whole analysis would be to frame it not around the contributor's experience of telling their stories, but the experience of having an audience.

10.2.3 The importance of agency over stories

Central to their participation being perceived as a success was a perception of agency and whether contributors were able to retain a sense of control over the stories they wanted to tell. Contributors exhibited lively engagement with their mediated stories and suggested they were actively seeking to shape their television narratives and with it discourse about mental health. They emphasised working closely with production crew in constructing their stories and were generally positive about the informal level of control given to them over what they wanted to share. However, their accounts acknowledged that in practice there was an asymmetrical balance of power and they had to place their trust in the production teams to tell their story 'well', especially once filming was over. This position was reiterated in the production-side interviews. The production accounts emphasised collaborative story telling as essential to ensuring a positive experience and wellbeing for contributors. Whilst it may be surprising to suppose that television production practices allow space for meaningful agency over the mediated narratives, I premise that the perception of control and collaboration reported by my interviewees is one of the reasons that the majority of contributors evaluated their experience as successful and rewarding. This interpretation is supported by dissatisfaction reported where contributors did not feel in control of their narratives.

Despite an emphasis on collaboration, all three sets of accounts point to areas of tension over what, whose and how stories are told. My analysis indicates that production practices, format conventions and at a broader level, a commercially driven broadcasting environment can limit the stories that can be constructed about mental distress within the context of MHITV. At a cultural level too, the emphasis on quest stories which present personal difficulties as something that individuals can learn from and overcome leaves little room for messy therapeutic outcomes, or political and social challenge to concepts of mental distress. The challenges for contributors of retaining control over their representation and stories were therefore added to by the specific narrative structure of mental health intervention television. Where contributors perceived they had lost control over either how their stories were constructed or how audiences received their stories, their television experience was presented as less successful, and the outcomes as more ambivalent. My analysis establishes that when contributor experiences were not so easily contained within a quest story, creating

tensions between life as lived and life as storied, this was problematic, potentially adding to their mental distress. Whilst only one interviewee articulated serious doubts about their participation, an important finding is that three of the nine contributors reported aspects of losing control of how their story was told or received that negatively impacted their mental wellbeing.

10.2.4 So much more than the intervention

As I have set out in my introduction, when I designed my research brief for my PhD project, I made a conscious distinction between participation in documentary projects about mental distress and what I have defined as mental health intervention television, where contributors are provided with on-screen professional support for their wellbeing. Both the production interviewees and other professionals providing support stressed how there was something challenging but special about working with, and providing support for, contributors with mental health problems. Several of the therapist accounts raised important questions about the validity and ethics of the very premise of providing therapeutic interventions via on-screen interventions. The important implication is that the need to entertain audiences may always be at odds with the needs of contributors. In particular, the established prerequisites for effective therapy engagement such as the assurance of confidentiality are undermined by the requirement to document the process for a public audience.

However, whilst the interventions that formed part of the series were discussed in the contributor interviews, they did not feature as centrally in their narratives as may have been expected. Or at least, they did not seem to constitute a significant independent theme within my analysis of their experiences. Whilst the support received was presented as having a meaningful impact on many of the contributors' wellbeing, getting help was not framed as the main motivator for their participation, and there was ambivalence about specific outcomes in several accounts. An important way their interview accounts of their involvement differed from the television series narratives was that the presented outcomes for their mental wellbeing encompassed much more than the formal intervention. Their descriptions of the catalysts for change invariably went beyond the intervention itself, encompassing the friendships made, and the aftermath of taking part and from being on television. What stood out is how often their evaluations of the changes they went through were intimately tied with the experience

of telling their stories. In other words, the biggest intervention was letting the television crew in and allowing them to document their experiences for a public audience.

10.3 Implications

10.3.1 Television production practices – a cultural shift

My research suggests that it is not so much the intervention that is delivered that is important for contributors of MHITV but production practices that allow them to feel involved, heard and valued throughout their television experience. These findings are relevant to the DCMS inquiry into the treatment of reality TV participants (UK Parliament 2019). From the evidence provided at the inquiry, on paper the production companies and channels were able to provide credible accounts of seemingly detailed processes in place to protect contributors. Yet these production protocols were undermined by the testimonies given by contributors, as well as the failure to protect contributors that led to the inquiry in the first place. This indicates that there is a disconnect between paper mandates, what is happening on the ground and different players within the process. This thesis may offer some explanation for part of this discrepancy. The production interviewees differentiated themselves from normal practice by virtue, in part, of their more collaborative approach to filmmaking. The implication is that creating a positive experience for contributors goes beyond formal protocols or even aftercare and is about developing respectful relationships and giving contributors a sense that they have some say over what is filmed and how it will be used.

The focus on contributor care has led to additional guidelines from OFCOM (2020) and enhanced care packages for reality shows such as *Love Island* (ITV, 2021). These are to be welcomed, however, my research implies that a successful duty of care for television contributors calls for a cultural shift, rather than relying on changes that can be enacted through guidelines alone. It is perhaps too idealistic to suggest a move to a production ethos within reality TV and other factual programming that theorises contributors as co-collaborators in story telling rather than commodities. However, my study demonstrates that it is possible to engage in collaborative practices within television production that engender a sense of agency and shared goals, which may lead to better experiences for contributors. This is not something however which can be achieved easily within tight production schedules, restrictive formats or where there is too much pressure on crew

to deliver content. A change of ethos is necessary to allow crews to put contributors first and content second. This is a cultural shift that needs to be led from the top down by channel commissioners and production company management. This will in turn allow senior production staff to establish a working environment for their junior staff where the pressure is off to film at all costs and crew are empowered to raise ethical issues and any welfare concerns.

My research also supports other studies that have called for greater training for production staff working with vulnerable contributors (Rees, 2019; Wilkes et al., 2020). It provides a multi-perspective insight into the significance of the relationships between crew and contributors, demonstrating how production team members are a potentially beneficial therapeutic audience for contributors. However, the pressures of supporting contributors with mental health needs were described as considerable. My study highlights how the blurring of boundaries between friend, adviser and producer has implications both for the wellbeing of contributors and for production team members. It provides evidence of the importance of better formal support from crew members and structured training such as in mental first aid.

Given the importance of audience responses to contributor outcomes, another issue is how production companies anticipate and manage contributor-audience engagement. It has become routine for production companies to offer preparation, debriefing and post broadcast support to contributors with regards to audience feedback, especially around social media. My research demonstrates that it is not just high profile reality television shows that can attract significant audience attention and contact. In addition, it draws attention to the less reported pressures that even positive audience feedback can place on individual contributors. It demonstrates the significant burden placed on contributors who speak about their mental health on television of the intrusion of unsolicited audience disclosures or requests for help. This suggests that with MHITV, contributors require targeted support such as media training and the monitoring of public communications to help them manage not just negative contact, but also handle the expectations (both self and audience led) of acting as a mental health role model.

10.3.2 Telling stories about mental distress

Whilst a television production is a unique context, my thesis also has relevance to wider research and debate about the role of stories of lived experience of mental distress in mental health practice, recovery and culture. Some theorists have argued that serious mental health problems may limit the opportunities (and audiences) necessary to form constructive stories of self (Baldwin, 2005; Roe & Davidson, 2005) or create a disconnect between lived experience and canonical stories of mental distress (Adame & Knudson, 2007). Research into mental health recovery has emphasised providing spaces for people to both hear and share stories as one potential tool of recovery (Nurser et al., 2018). As well as the potential benefits of sharing narratives of lived experience, there have also been important criticisms of how recorded stories of lived experience are being used by the very establishments and clinical practices they sought to challenge, to serve other less emancipatory goals (Yeo et al., 2022). Concerns have been raised that the offering up of highly personal stories, which activists have referred to as "patient porn" (Costa et al., 2012) may have downsides that have been underplayed (Woods et al., 2019). Similarly, in the context of broadcast media, it has been argued that disclosing personal health stories may benefit the interests of production companies and broadcasters over those of participants (Thorbjørnsrud & Lånkan, 2022). The production of stories of mental distress can offer benefits for the subjects of those stories, but also presents potential pitfalls.

Mental health intervention television is one such context where it is possible to see these arguments played out. These series premise themselves as public mental health education and provide an influential platform for the sharing of stories of mental distress, however the control over these stories and their impact is questionable. My thesis provides a unique insight into this debate from the perspective of those directly involved. My work supports the importance of having opportunities to be heard and feel recognised, whilst also demonstrating the potential costs and limits of sharing mental health stories in contexts where narratives are heavily mediated. My analysis demonstrates that the complex interplay of multiple agendas and influences in the making of MHITV – such as television production cultures, genre conventions, and canonical discourses - constrain the kinds of stories that can be told about mental distress, and limit the control that individuals can retain over their stories. It supports

arguments that the pressure to tell a certain type of mental health story; one which is emotive, inspirational, and neat, may have a negative impact on those who cannot relate to, or meet these expectations (Rennick-Egglestone et al., 2019; Woods et al., 2019). Whilst no 'one' television series can be expected to capture all the diversity of stories of mental distress, the implication is that television has a part to play in providing space for a wider range of culturally available stories of mental distress which allow for complexity, uncertainty, and challenge.

Importantly, despite the limits identified above, it is essential to note that for the most part the contributors I interviewed were pragmatic about the mediation of their stories. Significantly, any downsides of exposure or loss of ownership over their stories seemed to be outweighed by the validation from having the opportunity to have their moment centre stage on such a culturally venerated platform as television. Participating in television appeared to offer powerful affirmation that their stories (and lives) mattered. My study also supports the importance of opportunities to share stories with others with lived experience of mental distress. My research participants emphasised similar themes to those documented in peer support research such as the value of mutual understanding, and the benefits of learning from others through the sharing of stories (Watson, 2019). For many of the contributors, the friendships made were an important part of what they took away from their television participation. My research supports the importance of opportunities to tell stories and have them affirmed by both more intimate local audiences and by a wider imagined audience.

10.4 Limitations

There are several significant constraints of my research design and focus that I have identified: my sample, the implications of anonymity, the scope of investigation and my choice of interpretative framework. A significant limitation of my methodology is my sample size and sourcing of interviewees. My recruitment of production-side interviewees was conducted predominantly by utilising my network of contacts developed through my previous work in factual television. Several production companies or psychologists that I contacted simply did not get back to me. Whilst only two of my interviewees were known to me in person, it is important to note that my sample is a small self-selecting group of producers and psychologists, often individuals

contacted through mutual contacts, who were comfortable talking to me about their production practices. Their willingness to speak openly is likely a reflection of their particular stance in interview, which emphasised high standards of contributor care, as reflected in my analysis.

Given these issues with sampling, the production accounts cannot be construed as representative of wider television practices or perspectives. Indeed, the eagerness of my interviewees to distance themselves from 'normal' practices of production in general supports the common perception that there are still many problems with contributor welfare. This may have become more of a focal point had I obtained access to a bigger sample of interviewees at various levels of seniority, across a broader range of productions. Due to the contentious topic of contributor care in the currently climate it is also likely that interviewees would want to distance themselves from more dubious practices. It is a reminder of the inherent limits of interviews as a research methodology in that there can be a distinct difference between what people say and what people do (Silverman, 2020). My findings would likely have been very different had I managed to obtain access to conduct an ethnographic study and observed production practices first hand, as was originally planned.

These issues also apply to my sample of contributor interviews. The contributors I interviewed were contacted through a range of methods. Some I approached via mental health organisations or events which ex-contributors were involved in. I also used a snowballing method, asking interviewees to put me in touch with other relevant people. However, I was not able to solicit an interview with every contributor on each series under consideration. This has important implications for my analysis. It is very possible that the contributors who were more accessible for interview have different perspectives and experiences to those contributors who were not. The emphasis of my interviewees on 'telling my story' is likely to reflect specific characteristics of this group that have in turn made them more available for interview – i.e. I could find them because they have either continued to speak publicly, or are involved with mental health organisations, or kept in touch with others. Had I the opportunity to talk to all contributors on every programme, including those who have not done any of the above, my analysis would have been different. Given my small sample size, just one or two other voices could have significantly changed the emphasis of my findings. Another

limitation of my sample and analysis is that it does not allow for a consideration of other intersectional factors such as class, race and gender that may play a role in contributor experience, agency and inter-relationships within MHITV.

The fact that several of my interviewees were known to each other and had stayed in touch is also important. I interviewed more people involved in some series then in others. It suggests that there is likely to be commonality between their experience or shared understanding of the goals and outcomes. I was conscious that I did not want my analysis to become dominated by any one sub-group of interviewees' experiences whilst ignoring other individual participants (who might seem like lone dissenting voices simply because they were the only representative of a particular series). I therefore attempted to keep this awareness of the interconnectedness of interviewees as I conducted my analysis. In practice, I believe that this added depth to my analysis as I could trace where there were commonalities and cross validation between narratives, or where there were tensions in how specific events were explained. This allowed me to see for example that the connections formed were one of the things that contributors took away from the experience.

The interconnections between interviewees also highlights another issue with my research design. I found that the necessity of protecting the anonymity of participants was at times in conflict with taking a narrative approach. Due to my small sample size and the sensitivity of data, it was important to take steps to provide as much anonymity for the research participants as possible. This limited my ability to expand on some of the specific details of individual cases where this might add explanatory power or build a clearer picture of where accounts supported each other. To some extent I had to skate over interesting differences between series so as not to be too specific. Whilst I considered the links and shared experiences in the background of my analysis, this is something I could only present abstractly and could not make an overt part of my presented findings in order to protect the identity of the individuals involved.

Another point that is important to acknowledge is how my decisions around what interpretative frameworks to apply to my data will have inhibited other interesting ways to explain my findings. One reflexive question I have asked myself throughout my analysis is - by concentrating on narratives what other possible interpretations have I

overlooked? In addition I have asked - what compromises have I made to make the data fit my theories? Spence (1986) refers to this as 'narrative smoothing' (p. 212). As I set out at the beginning of my analysis, I am attempting to capture what I interpret to be the 'meta narrative' of a small but highly diverse range of experiences. Whilst I have tried to keep in mind counter-examples and tricky data, I have skirted over certain intricate aspects of individual accounts to capture the bigger story. As an example, the friendships formed, and crew-contributor relationships within the making of MHITV are themes that I could have developed more within their own right. I have tried to capture their relevance in my analysis by considering friendships within the context of audiences, and the dynamics with crew within the context of agency over story telling. However by imposing these concepts from narrative theory, I am narrowing other psychologically interesting ways to approach these themes.

Given the limitations of my research, my analysis cannot be generalised to the experience of all contributors on MHITV, however a strength of the study is that the multiple perspectives captured allows for a degree of cross-validation and cross-examination. Exploring the specifics of each account, alongside the commonalities within how this group of interviewees make sense of their experience, can still provide an insight more broadly into the factors that may make participation more successful. It is possible to suggest for example, that the predominantly positive narratives recounted by this select group of contributors are directly linked to how they construct their motivations as stemming from wanting to tell their stories. I hypothesise that contributors who are motivated primarily by a motivation to get help however may be at greater risk of a less positive experience.

10.5 Suggestions for further research

There are a number of research directions that could build on my PhD study. Firstly, as identified above, further research with larger samples is important. My project provides an insightful starting point to investigate a previously neglected area of inquiry, however more extensive studies are needed to build a more complex understanding of contributor experiences across a wider range of programmes and scenarios. Ideally this is something that would be carried out with industry support in order to access harder to reach participants (both production and contributors) who may provide an interesting

counterpoint to those who were more readily available to speak about their experiences. Secondly, given that my interviews were carried out before the changes to the OFCOM Broadcasting Code which set out enhanced care measures for contributors, it is important to understand what these changes have meant in practice for both productions and contributor welfare and whether they are likely to be effective to protect contributors. Ethnographic research may be particularly valuable in this regard to move beyond what people say, to providing direct evidence of the practices and inter-relationships behind the scenes of production.

Another direction worth pursuing would be to extend studies beyond traditional broadcast television channels. The way in which television is accessed has changed dramatically with the growth of online streaming platforms such as Netflix and Amazon. These platforms are not necessarily subject to the same regulations as the main broadcast channels whilst broadcasting to far reaching international audiences. The implications for producers making content for these networks and the contributors featured are worthy of specific exploration. A related area is the growth in the production of self-produced audio-visual content relating to mental health on platforms such as You Tube and Instagram. There has been some academic interest in what audiences with mental health needs may get out of accessing these sites (MacLean et al., 2017). However, there is little research which has explored the implications for individuals who choose to post audio-visual mental health content on public forums. There has been considerable debate as to whether the growth in popularity of online platforms built around user-generated content represents an empowering opportunity for unmediated participation or a new form of audience exploitation (Hallvard et al., 2016). Understanding these debates in the context of potentially vulnerable individuals posting about their mental health is important. Whilst individuals producing their own content may be able to take control of their own stories and representations, there may also be greater risks, given that there are less protections than those governing television production (Ytreberg & Thorbjørnsrud, 2020). A cross comparison between broadcast media and individuals who are self-producing information on the internet may be an interesting way to explore these issues.

Another way to extend this thesis would be to conduct research with audiences. As my research has demonstrated, audience engagement was a crucial part of contributor

experience. My initial plan on beginning this thesis was to conduct additional direct audience research. Not only is this likely to add further context to understanding contributor experiences – it is important for understanding how these types of programmes fit within wider debate about constructions of mental distress. There has been very little research that examines how different audiences engage with this kind of mental health programming and whether they are effective as a tool of public mental health education. This is extremely relevant given that firstly, the mass media has often been implicated in the continuation of negative public opinion surrounding mental health (Zexin Ma, 2017); and secondly, there is continued academic debate centred around what constitutes effective public health communication to target the stigma attached to mental health problems (Holland, 2012; Walsh & Hallam Foster, 2021). Direct audience research therefore feels like the missing piece of the story.

10.6 Final thoughts - what story does my thesis tell about MHITV?

My thesis has made a case for the distinct characteristics and complexities of mental health intervention television as a specific and worthwhile area of investigation. It adds to broader debate about what constitutes appropriate contributor care in television by highlighting the stories of contributors and practitioners at the heart of the production process. My findings suggests that when production practices facilitate collaborative storytelling and aligned goals, participating in MHITV can be a positive experience for contributors which goes beyond the sum of the interventions provided. However, the complex interplay of individual contributor stories, production agendas and audience engagement mean that the outcomes of participating in MHITV are unpredictable. There is not just one story of what it means to participate in MHITV, instead there are multifaceted factors that may lead to different kinds of narratives of experience. Hopefully this study will be the starting point for further research and other stories of what it means to participate in mental health intervention television.

References

Abt, V., & Seesholtz, M. (1998). Talking us down: “The shameless world” revisited. *Journal of Popular Film & Television; Spring*, *26*(1), 42–48. https://doi.org/10.1080/01956059809602772

Adame, A. L., & Knudson, R. M. (2007). Beyond the counter-narrative Exploring alternative narratives of recovery from the psychiatric survivor movement. *Narrative Inquiry*, *17*(2), 157–178. https://doi.org/10.1075/ni.17.2.02ada

Aitken, M., Stevens, G., Wellens, B., Martin, A., & Brown, P. (2012). Therapeutic responses to families in crisis: From ‘ Family Rescue ’ to ‘ I Hate Mum ’ – a family therapy team’s experience of participating in a documentary for BBC television. *Context*, *April*, 36–41.

Andrejevic, M. (2004). *Reality TV: The Work of Being Watched*. Rowman & Littlefield Publishers.

Andrews, M., Squire, C., & Tamboukou, M. (2013). *Doing narrative research* (2nd ed.). SAGE.

Aufderheide, P. (2012). Perceived ethical conflicts in US documentary filmmaking: A field report. *New Review of Film and Television Studies*, *10*(3), 362–386. https://doi.org/10.1080/17400309.2012.691248

Baerger, D. R., & McAdams, D. P. (1999). Life Story Coherence and its Relation to Psychological Well-Being. *Narrative Inquiry*, *9*(1), 69–96. https://doi.org/10.1075/ni.9.1.05bae

Baldwin, C. (2005). Narrative, ethics and people with severe mental illness. *Australian and New Zealand Journal of Psychiatry*, *39*(11–12), 1022–1029. https://doi.org/10.1111/j.1440-1614.2005.01721.x

Bamberg, M. (2004). Talk, Small Stories, and Adolescent Identities. *Human Development*, *47*(6), 366–369. https://doi.org/10.1159/000081039

Bamberg, M. (2006). Stories: Big or small: Why do we care? *Narrative Inquiry*, *16*(1), 139–147. https://doi.org/10.1075/ni.16.1.18bam

Banks, M. J., Conor, B., & Mayer, V. (Eds.). (2016). *Production studies, the sequel: cultural studies of global media industries* (2nd ed.). Routledge, Taylor & Francis Group. https://doi.org/10.4324/9781315736471

Barker, C., Pistrang, N., Shapiro, D. A., Davies, S., & Shaw, I. (1993). You in Mind: A preventive mental health television series. *British Journal of Clinical Psychology*, *32*(3), 281–293. https://doi.org/10.1111/j.2044-8260.1993.tb01058.x

Bates, S., De Leonardis, A. J., Corrigan, P. W., & Chasson, G. S. (2020). Buried in stigma: Experimental investigation of the impact of hoarding depictions in reality television on public perception. *Journal of Obsessive-Compulsive and Related Disorders*, *26*, 100538. https://doi.org/10.1016/J.JOCRD.2020.100538

BBC. (2019 May 15). *'I was traumatised': Jeremy Kyle Show guests relives their appearances.* https://www.bbc.co.uk/news/entertainment-arts-48283943

BBC (2021, April). *Editorial Guidelines. Guidance: Working with contributors including vulnerable contributors or contributors at risk of vulnerability.* https://www.bbc.co.uk/editorialguidelines/guidance/vulnerable-contributors/

Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (Eighth). Oxford University Press .

Bellamy, C., Schmutte, T., & Davidson, L. (2017). An update on the growing evidence base for peer support. *Mental Health and Social Inclusion*, *21*(3), 161–167. https://doi.org/10.1108/MHSI-03-2017-0014

Ben-Zeev, D., Young, M. A., & Corrigan, P. W. (2010). DSM-V and the stigma of mental illness. *Journal of Mental Health*, *19*(August), 318–327. https://doi.org/10.3109/09638237.2010.492484

Birch, Michael. (2012). *Mediating Mental Health: Contexts , Debates and Analysis*. Ashgate.

Biressi, A., & Nunn, H. (2005). *Reality TV: realism and revelation*. Wallflower.

Biressi, A., & Nunn, H. (2008). Bad Citizens: The Class Politics of Lifestyle Television. In Gareth. Palmer (Ed.), *Exposing Lifestyle Television: The Big Reveal* (pp. 15–24). Ashgate.

Blaker, L. (2013). It's good to talk? Talking Cure and the ethics of on-screen psychotherapy. *Journal of Media Practice*, *14*(3), 193–209. https://doi.org/10.1386/jmpr.14.3.193

Blaker, L. (2017). *From "Talking Cure" to "Bedlam": A study of the factors impacting on the construction of UK factual psychotherapy programming 1999 to 2013* [Doctoral thesis, University of Salford]. http://usir.salford.ac.uk/43448/7/LESLEY BLAKER THESIS FINAL edited version.pdf

Bold, C. (2012). *Using narrative in research*. SAGE.

Bonner, Frances. (2003). *Ordinary television : analyzing popular TV*. Sage Publications.

Borg, M., & Davidson, L. (2008). The nature of recovery as lived in everyday experience. *Journal of Mental Health*, *17*(2), 129–140. https://doi.org/10.1080/09638230701498382

Boyle, S. (2019 May 14). 'I Can't live without you'. Jeremy Kyle guest died of a drug overdose after failing lie detector test that exposed cheating. *The Sun* https://www.thesun.co.uk/tvandshowbiz/9067960/jeremy-kyle-show-guest-death-drug-overdose/

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brenton, S., & Cohen, R. (2003). *Shooting people: adventures in reality TV*. Verso.

British Association for Counselling and Psychotherapy (2018, July 1). *Ethical Framework for the Counselling Professions.* https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/

British Psychological Society. (2021, December). *Psychology and Media Productions: Guidance for commissioners and producers.* https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Psychology%20and%20Media%20Productions%20-%20Guidance%20for%20Commissioners%20and%20Producers.pdf

Brown, W. (2008). Narratives of Mental Health Recovery. *Social Alternatives*, *27*(4), 42–49.

Bruner, J. (1987). Life as Narrative. *Social Research*, *54*(1), 11–32. http://www.jstor.org/stable/40970444

Bruner, J. (1990). *Acts of meaning*. Harvard University Press.

Bruner, J. (1991). The Narrative Construction of Reality. *Critical Inquiry*, *18*(1), 1–21. https://www.jstor.org/stable/1343711

Brunsdon, C., Johnson, C., Moseley, R., & Wheatley, H. (2001). Factual entertainment on British television: The Midlands TV Research Group's "8-9 Project." *European Journal of Cultural Studies*, *4*(1), 29–62. https://doi.org/10.1177/136754940100400102

Cadwalladr, C. (2008, September 7). Behind the scenes at Jeremy Kyle: when reality bites, it leaves deep scars. *The Guardian.* https://www.theguardian.com/media/2008/sep/07/itv.television

Campbell, J. (2008). *The hero with a thousand faces* (3rd ed.). New World Library. (Original work published 1949)

Campbell, P. (2006). Changing the mental health system – a survivor's view. *Journal of Psychiatric and Mental Health Nursing*, *13*, 578–580.

Carless, D., & Douglas, K. (2008). Narrative, identity and mental health: How men with serious mental illness re-story their lives through sport and exercise. *Psychology of Sport and Exercise*, *9*(5), 576–594. https://doi.org/10.1016/j.psychsport.2007.08.002

Chapman, J. (2015). A new history of British documentary. In *A New History of British Documentary*. https://doi.org/10.1057/9780230392878

Chrz, V., Hiles, D., & Cermák, I. (2017). Narrative Inquiry. In C. Willig & W. S. Rogers (Eds.), *The SAGE Handbook of Qualitative Research in Psychology* (2nd ed., pp. 157–175). SAGE Publications.

Collins, S. (2008). Making the Most out of 15 Minutes: Reality TV's Dispensable Celebrity. *Television & New Media*, *9*(2), 87–110. https://doi.org/10.1177/1527476407313814

Corner, J. (2002). Performing the Real Documentary Diversions. *Television & New Media*, *3*(3), 255–269.

Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology*, *25*(8), 875–884.

Costa, L., Voronka, J., Landry, D., Reid, J., Mcfarlane, B., Reville, D., & Church, K. (2012). "Recovering our Stories": A Small Act of Resistance. *Studies in Social Justice*, *6*(1), 85–101. https://doi.org/10.26522/ssj.v6i1.1070

Couldry, N. (2003). *Media rituals: a critical approach*. Routledge.

Craib, I. (2000). Narratives as bad faith. In M. Andrews, S. Day Sclater, C. Squire, & A. Treacher (Eds.), *Lines of narrative: psychosocial perspectives* (pp. 64–74). Routledge.

Creeber, G. (Ed.). (2015). *The Television Genre Book* (3rd ed.). British Film Institute.

Crisp, A. (2000). Changing minds: every family in the land: An update on the College's campaign. *Psychiatric Bulletin*, *24*, 267–268. https://doi.org/10.1192/pb.25.11.444

Crisp, A., Gelder, M., Rix, S., Meltzer, H., & Rowlands, O. (2000). Stigmatisation of people with mental illnesses. *The British Journal of Psychiatry*, *177*(1), 4–7. https://doi.org/DOI: 10.1192/bjp.177.1.4

Cromby, J., Harper, D., & Reavey, P. (2013). *Psychology, mental health and distress*. Palgrave Macmillan.

Cross, S. (2010). *Mediating madness : mental distress and cultural representation*. Palgrave Macmillan.

Crossley, M. L. (2000). *Introducing narrative psychology : self, trauma and the construction of meaning*. Open University Press.

Crossley, N. (2006). *Contesting psychiatry: social movements in mental health*. Routledge.

Channel 4 (n.d.). *Producers Handbook: Fairness and Contributors.* Retrieved March 30, 2022, from: https://www.channel4.com/producers-handbook/ofcom-broadcasting-code/fairness/fairness-and-contributors

Curnutt, H. (2009). "A Fan Crashing the Party." *Television & New Media*, *10*(3), 251–266. https://doi.org/10.1177/1527476409334017

Dallos, R., & Draper, R. (2015). *An introduction to family therapy: systemic theory and practice* (Fourth). Open University Press . https://go.exlibris.link/vwgF7rY5

Dare, H. (2019, June). *Written evidence submitted by Wellbeing Mental health Ltd. RTV0049.* UK Parliament, Digital, Culture, Media and Sport Committee, Reality tv inquiry – publications. https://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/digital-culture-media-and-sport-committee/reality-tv/written/103258.pdf

Dare, H. & Wood, H. (2019, October 31). *Joint submission by specialist advisers to reality tv inquiry*. UK Parliament, Digital, Culture, Media and Sport Committee, Reality tv inquiry – publications. https://old.parliament.uk/documents/commons-committees/culture-

media-and-sport/Joint%20submission%20by%20specialist%20advisers%20-%20Reality%20tv.pdf

De Fina, A. (2016). Storytelling and audience reactions in social media. *Language in Society*, *45*(04), 473–498. https://doi.org/10.1017/s0047404516000051

De Fina, A., & Georgakopoulou, A. (2008). Analysing narratives as practices. *Qualitative Research*, *8*(3), 379–387. https://doi.org/10.1177/1468794106093634

Deacon, B. J. (2013). The biomedical model of mental disorder : A critical analysis of its validity , utility , and effects on psychotherapy research. *Clinical Psychology Review*, *33*(7), 846–861. https://doi.org/10.1016/j.cpr.2012.09.007

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2009). Researching sensitive topics: qualitative research as emotion work. *Qualitative Research*, *9*(1), 61–79. https://doi.org/10.1177/1468794108098031

Dimaggio, G. (2006). Disorganized Narratives in Clinical Practice. *Journal of Constructivist Psychology*, *19*(2), 103–108. https://doi.org/10.1080/10720530500508696

Directors UK. (2019, September 23). *OFCOM consultation on new broadcasting rules: Protecting participants in TV and radio programmes*. Retrieved from OFCOM. https://www.ofcom.org.uk/__data/assets/pdf_file/0028/175654/directors-uk.pdf

Declutter Divas [@Declutterdivas]. (2019, September 06). *Could you help other people by sharing your hoarding story and get your home back at the same time?* [Image attached] [Tweet]. Twitter. https://twitter.com/Declutterdivas/status/1169900326935093249

Dosani, S. (2005). The House of Obsessive Compulsives. *BMJ*, *331*(7513), 409. https://doi.org/10.1136/bmj.331.7513.409

Dovey, J. (2000). *Freakshow: first person media and factual television*. Pluto.

Ellis, J. (2003). Channel Four Innovation in Form and Content? In M. Hilmes (Ed.), *The Television History Book* (pp. 95–98). British Film Institute.

Ellis, J. (2012). *Documentary: Witness and Self-Revelation*. Routledge.

Ellis, J. (2019). Filming for Television: How a 16mm Film Crew Worked Together. *VIEW Journal of European Television History and Culture*, *8*(15), 91–110. https://doi.org/10.18146/2213-0969.2019.jethc167

Ellison, M. L., Belanger, L. K., Niles, B. L., Evans, L. C., & Bauer, M. S. (2018). Explication and Definition of Mental Health Recovery: A Systematic Review. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(1), 91–102. https://doi.org/10.1007/s10488-016-0767-9

Eriksen, C. (2017). Research Ethics, Trauma and Self-care: reflections on disaster geographies. *Australian Geographer*, *48*(2), 273–278. https://doi.org/10.1080/00049182.2016.1230001

Etherington, K. (2017). Personal experience and critical reflexivity in counselling and psychotherapy research. *Counselling and Psychotherapy Research*, *17*(2), 85–94. https://doi.org/10.1002/capr.12080

Fergie, G., Hunt, K., & Hilton, S. (2016). Social media as a space for support: Young adults' perspectives on producing and consuming user-generated content about diabetes and mental health. *Social Science and Medicine*, *170*, 46–54. https://doi.org/10.1016/j.socscimed.2016.10.006

Fisher, P., & Lees, J. (2016). Narrative approaches in mental health: Preserving the emancipatory tradition. *Health (United Kingdom)*, *20*(6), 599–615. https://doi.org/10.1177/1363459315600774

Fortuna, K. L., Naslund, J. A., LaCroix, J. M., Bianco, C. L., Brooks, J. M., Zisman-Ilani, Y., Muralidharan, A., & Deegan, P. (2020). Digital peer support mental health interventions for people with a lived experience of a serious mental illness: Systematic review. *JMIR Mental Health*, *7*(4). https://doi.org/10.2196/16460

Frank, A. W. (2013). *The wounded storyteller: body, illness, and ethics* (Second). The University of Chicago Press.

Frost, B. G., Tirupati, S., Johnston, S., Turrell, M., Lewin, T. J., Sly, K. A., & Conrad, A. M. (2017). An Integrated Recovery-oriented Model (IRM) for mental health services: Evolution and challenges. *BMC Psychiatry*, *17*(1). https://doi.org/10.1186/s12888-016-1164-3

Frost, N. (2009). "Do you know what I mean?": The use of a pluralistic narrative analysis approach in the interpretation of an interview. *Qualitative Research*, *9*(1), 9–29. https://doi.org/10.1177/1468794108094867

Füredi, F. (2004). *Therapy culture: cultivating vulnerability in an uncertain age*. Routledge.

Gamson, J. (1998). *Freaks Talk Back Tabloid Talk Shows and Sexual Nonconformity*. University of Chicago Press.

Gee, J. P. (1991). A Linguistic Approach to Narrative. *Journal of Narrative and Life History*, *1*(1), 15–39.

Georgakopoulou, A. (2008). 'On MSN with buff boys': Self- and other-identity claims in the context of small stories. *Journal of Sociolinguistics*, *12*(5), 597–626. https://doi.org/10.1111/j.1467-9841.2008.00384.x

Georgakopoulou, A. (2014). Between narrative analysis and narrative inquiry: The long story of small stories research. In *Working Papers in Urban Language and Literacies* (No. 131). https://www.kcl.ac.uk/innovation/groups/ldc/publications/workingpapers/the-papers/WP105-Tusting-2013-Literacy-studies-as-linguistic-ethnography.pdf

Gergen, K.J. & Gergen, M.M. (1986). Narrative Form and the Construction of Psychological Science. In T. R. Sarbin (Ed.), *Narrative Psychology: The Storied Nature of Human Conduct* (pp. 211–232). Praeger.

Gergen, K. J. (1991). *The saturated self: dilemmas of identity in contemporary life*. Basic Books.

Gergen, K. J. (2015). *An invitation to social construction* (3rd ed.). SAGE.

Goffman, E. (1959). *The presentation of self in everyday life*. Penguin.

Grant, A. (2011). Reality TV gets positive: Psychological reflections on Making Australia Happy. *International Coaching Psychology Review*, *6*(2), 222–238.

Grazian, D. (2010). Neoliberalism and the Realities of Reality Television. *Contexts*, *9*, 68–71. https://doi.org/10.1525/ctx.2010.9.2.68

Griffin, M., & Phoenix, C. (2014). Learning to run from narrative foreclosure: One woman's story of aging and physical activity. *Journal of Aging and Physical Activity*, *22*(3), 393–404. https://doi.org/10.1123/JAPA.2012-0300

Grindstaff, L. (2009). Self-Serve Celebrity: The Production of Ordinariness and the Ordinariness of Production in Reality Television. In V. Mayer, A. D. Lotz, & J. T. Caldwell (Eds.), *Production Studies: Cultural Studies of Media Industries* (1st ed., pp. 44–57). Routledge.

Grindstaff, L. (2012). Reality TV and the Production of "Ordinary Celebrity": notes from the Field. *Berkeley Journal of Sociology: A Critical Review*, *56*(56), 22–40. https://www.jstor.org/stable/23345258

Grindstaff, Laura. (2002). *The money shot : trash, class, and the making of TV talk shows*. University of Chicago Press.

Hallvard, M., Poell, Thomas., & van Dijck, Jose. (2016). Rearticulating Audience Engagement: Social Media and Television. *Television & New Media*, *17*(2), 99–107. https://doi.org/10.1177/1527476415616194

Hanna, P. (2012). Using internet technologies (such as Skype) as a research medium: A research note. *Qualitative Research*, *12*(2), 239–242. https://doi.org/10.1177/1468794111426607

Harper, S. (2009). *Madness, Power and the Media*. https://doi.org/10.1057/9780230249509

Harper, S. M. (2008). Understanding mental distress in film and media: a new agenda? *Journal of the Royal Society for the Promotion of Health*, *128*(4), 170–174. https://doi.org/10.1177/1466424008092232

Harvey, S. (1994). Channel 4 television: From Annan to Grade. In S. Hood (Ed.), *Behind the screens: The structure of British Television in the nineties* (pp. 102–132). Lawrence and Wishart.

Havens, T., Lotz, A. D., & Tinic, S. (2009). Critical Media Industry Studies: A Research Approach. *Communication, Culture & Critique*, *2*(2), 234–253. https://doi.org/10.1111/j.1753-9137.2009.01037.x

Hearn, A. (2014). Producing “Reality”: Branded Content, Branded Selves, Precarious Futures. In L. Ouellette (Ed.), *A Companion to Reality Television* (1st ed., pp. 437–455). John Wiley & Sons.

Henderson, C., & Gronholm, P. (2018). Mental health related stigma as a ‘wicked problem’: The need to address stigma and consider the consequences. *International Journal of Environmental Research and Public Health*, *15*(6). https://doi.org/10.3390/ijerph15061158

Henderson, L. (1996). Selling Suffering: Mental Illness and Media Values. In G. Philo (Ed.), *Media and Mental Distress* (pp. 18–36). Longman.

Henderson, L. (2018). Popular television and public mental health: creating media entertainment from mental distress. *Critical Public Health*, *28*(1), 106–117. https://doi.org/10.1080/09581596.2017.1309007

Henson, L., & Parameswaran, R. E. (2008). Getting Real With “Tell It Like It Is” Talk Therapy: Hegemonic Masculinity and the Dr. Phil Show. *Communication, Culture & Critique*, *1*, 287–310. https://doi.org/10.1111/j.1753-9137.2008.00024.x

Hibberd, M., Kilborn, R., McNair, B., Marriot, S., & Schlesinger, P. (2000). *Consenting adults?* Broadcasting Standards Commission.

Hill, A. (2007). *Restyling factual TV: audiences and news, documentary and reality genres*. Routledge.

Hill, A. (2015). Makeover Shows. In G. Creeber (Ed.), *The Television Genre Book* (pp. 172–173). British Film Institute.

Hill, A., Askanius, T., & Kondo, K. (2019). Live reality television: Care structures within the production and reception of talent shows. *Critical Studies in Television*, *14*(1), 7–21. https://doi.org/10.1177/1749602018774458

Hill, D. W. (2015). Class, trust and confessional media in Austerity Britain. *Media, Culture and Society*, *37*(4), 566–580. https://doi.org/10.1177/0163443714566900

Hochschild, A. R. (2012). *The managed heart: commercialization of human feeling* (Updat). University of California Press .

Holland, K. (2012). The unintended consequences of campaigns designed to challenge stigmatising representations of mental illness in the media. *Social Semiotics*, *22:3*, 217–236.

Holland, P. (2006). *The Angry Buzz: This Week and Current Affairs Television*. I.B. Tauris.

Holstein, J. A., & Gubrium, J. F. (2000). *The self we live by: narrative identity in a postmodern world*. Oxford University Press.

Holt, A. (2010). Using the telephone for narrative interviewing: a research note. *Qualitative Research*, *10*(1), 113–121. https://doi.org/10.1177/1468794109348686

Hollway, W., & Jefferson, T. (2013). *Doing qualitative research differently: a psychosocial approach* (2nd ed.). SAGE. https://doi.org/10.4135/9781526402233

Iacono, V. Lo, Symonds, P., & Brown, D. H. K. (2016). Skype as a tool for qualitative research interviews. *Sociological Research Online*, *21*(2), 103–117. https://doi.org/10.5153/sro.3952

Inthorn, S., & Boyce, T. (2010). 'It's disgusting how much salt you eat!' *International Journal of Cultural Studies*, *13*(1), 83–100. https://doi.org/10.1177/1367877909348540

ITV (2021, June 16). *Love Island confirms duty of care protocols.* https://www.itv.com/presscentre/press-releases/love-island-confirms-duty-care-protocols ITV. (2021, December). *ITV Producers Handbook.* https://assets.ctfassets.net/870j9u9p7ed7/7ae0u8tamITS89qV21gVB5/752f32fba27023e7d9a0f9bffd2a4b87/Producers_Handbook_-_Dec_2021.pdf

Janoušková, M., Tušková, E., Weissová, A., Trančík, P., Pasz, J., Evans-Lacko, S., & Winkler, P. (2017). Can video interventions be used to effectively destigmatize mental illness among young people? A systematic review. *European Psychiatry*, *41*, 1–9. https://doi.org/10.1016/j.eurpsy.2016.09.008

Johnstone, L. (2000). *Users and abusers of psychiatry: a critical look at psychiatric practice* (2nd ed.). Routledge.

Josselson, R. (2004). The hermeneutics of faith and the hermeneutics of suspicion. *Narrative Inquiry*, *14*(1), 1–28. https://doi.org/10.1075/ni.14.1.01jos

Josselson, R. (2011). Narrative Research: Constructing, Deconstructing, and Reconstructing Story. In F. Wertz, K. Charmaz, L. McMullen, R. Josselson, R. Anderson, & M. Emalinda (Eds.), *Five Ways of Doing Qualitative Analysis: Phenomenological Psychology, Grounded Theory, Discourse Analysis, Narrative Research, and Intuitive Inquiry* (pp. 224–242). Guilford Press.

Kaplan, D. (2014). Hoarding memories: The work of nostalgia in two reality tv shows. *Journal of Popular Culture*, *47*(6), 1077–1091. https://doi.org/10.1111/jpcu.12197

Kavka, M. (2014). A Matter of Feeling: Mediated Affect in Reality Television. In L. Ouellette (Ed.), *A Companion to Reality Television* (1st ed., pp. 459–477). John Wiley & Sons.

Keogh, B., & Daly, L. (2009). The ethics of conducting research with mental health service users. *British Journal of Nursing*, *18*(5), 277–281. https://doi.org/10.12968/bjon.2009.18.5.40539

Kilborn, R. W. (2003). *Staging the real: factual TV programming in the age of Big Brother*. Manchester University Press.

Kim, J.-H. (2016). *Understanding narrative inquiry: the crafting and analysis of stories as research*. SAGE.

Kimmerle, J., & Cress, U. (2013). The effects of TV and film exposure on knowledge about and attitudes toward mental disorders. *Journal of Community Psychology*, *41*(8), 931–943. https://doi.org/10.1002/jcop.21581

King, K. E., Schlichthorst, M., Spittal, M. J., Phelps, A., & Pirkis, J. (2018). Can a documentary increase help-seeking intentions in men? A randomised controlled trial. *Journal of Epidemiology and Community Health*, *72*(1), 86–92. https://doi.org/10.1136/jech-2017-209502

Kirkpatrick, H. (2008). A Narrative Framework for Understanding Experiences of People With Severe Mental Illnesses. *Archives of Psychiatric Nursing*, *22*(2), 61–68. https://doi.org/10.1016/j.apnu.2007.12.002

Klein, B., & Coleman, S. (2021). Look at me, I'm on TV: the political dimensions of reality television participation. *Media, Culture and Society*. https://doi.org/10.1177/01634437211036979

Lacey, N. (2000). *Narrative and genre: key concepts in media studies*. Macmillan.

Lakeman, R., McGowan, P., & Walsh, J. (2007). Service users, authority, power and protest: A call for renewed activism. *Mental Health Practice*, *11*(4), 12–16. https://doi.org/10.7748/mhp2007.12.11.4.12.c6332

Langdridge, D. (2007). *Phenomenological psychology: theory, research and method*. Pearson Education.

Lånkan, K. B., & Thorbjørnsrud, K. (2022). TV Inside the Psychiatric Hospital : Patient Experiences. *International Journal of Communication*, *16*, 130–147.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *British Journal of Psychiatry*, *199*(6), 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Lepselter, S. (2011). The Disorder of Things: Hoarding Narratives in Popular Media. *Anthropological Quarterly*, *84*(4), 919–947. https://doi.org/10.1353/anq.2011.0053

Lewis, T. (2009). *TV transformations: revealing the makeover show*. Routledge.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative Research: Reading, Analysis and Interpretation*. Sage Publications.

Livingstone, S. M., & Lunt, P. K. (1994). *Talk on television: audience participation and public debate* . Routledge .

Llewellyn-Beardsley, J., Rennick-Egglestone, S., Callard, F., Crawford, P., Farkas, M., Hui, A., Manley, D., McGranahan, R., Pollock, K., Ramsay, A., Tore Saelor, K., Wright, N., & Slade, M. (2019). Characteristics of mental health recovery narratives : Systematic review and narrative synthesis. *PLoS ONE*, *14*(3), 1–31. https://doi.org/10.1371/journal.pone.0214678

Long, V. (2014). *Destigmatising mental illness? Professional politics and public education 1870-1970*. Manchester University Press.

Lunt, P. (2009). Little Angels; The mediation of parenting. In T. Lewis (Ed.), *TV Transformations: Revealing the Makeover Show* (pp. 97–106). Routledge.

Lysaker, P. H., Clements, C. A., Plascak-Hallberg, C. D., Knipscheer, S. J., & Wright, D. E. (2003). Insight and Personal Narratives of Illness in Schizophrenia. *Psychiatry: Interpersonal and Biological Processes*, *65*(3), 197–206. https://doi.org/10.1521/psyc.65.3.197.20174

MacLean, S. A., Basch, C. H., Reeves, R., & Basch, C. E. (2017). Portrayal of generalized anxiety disorder in YouTube™ videos. *International Journal of Social Psychiatry*, *63*(8), 792–795. https://doi.org/10.1177/0020764017728967

Marsh, S. (2019, March 20). Reality TV 'must do more to protect the mental health of participants*. The Guardian.* https://www.theguardian.com/tv-and-radio/2019/mar/20/reality-tv-must-do-more-to-protect-mental-health-of-participants

Mast, J. (2016). The Dark Side of Reality TV : Professional Ethics and the Treatment of Reality Show Participants. *International Journal of Communication*, *10*, 2179–2200.

McAdams, D. P. (1997). *The stories we live by: personal myths and the making of the self*. Guilford Press.

McAdams, D. P., Josselson, R., & Lieblich, A. (2006). *Identity and story: creating self in narrative* (Vol. 4). American Psychological Association.

McCall, C. (2019, July 22) *ITV supplementary – written evidence RTV0053.*UK Parliament, Digital, Culture, Media and Sport Committee, Reality tv inquiry – publications. https://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/digital-culture-media-and-sport-committee/reality-tv/written/103841.pdf

McGowan, A. S. (1993). Cable television as a counseling service and a PR tool: A forum for mental health counselors. *Journal of Mental Health Counseling*, *15*(3), 347–354.

McLeod, J. (1997). *Narrative and psychotherapy*. SAGE.

McMurria, J. (2008). Desperate Citizens and Good Samaritans: Neoliberalism and Makeover Reality TV. *Television & New Media*, *9*(4), 305–332. https://doi.org/10.1177/1527476408315115

McTernan, N., Ryan, F., Williamson, E., Chambers, D., & Arensman, E. (2020). Using a television programme as a tool to increase perceived awareness of mental health and well-being – findings from 'Our Mental Health' survey. *Irish Journal of Psychological Medicine*. https://doi.org/10.1017/ipm.2020.19

Melzer, K. (2019). Vicarious trauma and emotion work in documentary filmmaking. *Studies in Documentary Film*, *13*(1), 38–52. https://doi.org/10.1080/17503280.2018.1535685

Miller, L. M., Deacon, B. J., & Valentiner, D. P. (2015). The OCD Project : Educational or Sensational? *Journal of Cognitive Psychotherapy*, *29*(2), 116–123. https://doi.org/10.1891/0889-8391.29.2.116

Mishler, E. G. (1986). *Research interviewing: Context and Narrative*. Harvard University Press.

Moncrieff, J. (2008). *The myth of the chemical cure: a critique of psychiatric drug treatment*. Palgrave Macmillan.

Moore, D. D., Cooper, C., & Zwierstra, K. (2017). Life After NBC ’s "The Biggest Loser”: The Experiences and Perspectives of Former Reality TV Contestants. *The Qualitative Report*, *22*(3), 683–711. http://nsuworks.nova.edu/ tqr/vol22/iss3/2

Moran, G. S., Russinova, Z., Gidugu, V., Yim, J. Y., & Sprague, C. (2012). Benefits and Mechanisms of Recovery Among Peer Providers With Psychiatric Illnesses. *Qualitative Health Research*, *22*(3), 304–319. https://doi.org/10.1177/1049732311420578

Morris, G. (2006). *Mental health issues and the media : an introduction for health professionals*. Routledge.

Morris, S. (2020, November 20). Jeremy Kyle may have ‘caused or contributed’ to death of TV guest. *The Guardian* https://www.theguardian.com/media/2020/nov/20/jeremy-kyle-may-have-caused-or-contributed-to-death-of-tv-guest-who-failed-lie-test

Morrison, L. J. (2005). *Talking back to psychiatry: The psychiatric consumer/survivor/ex-patient movement*. Routledge. https://doi.org/10.4324/9780203958704

Moseley, R. (2000). Makeover takeover on British television. *Screen*, *41*(3), 299–314.

Murray, M. (2015). Narrative Psychology. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods.* (3rd ed., pp. 85–107). SAGE.

Murray, S., & Ouellette, L. (2009). *Reality TV : remaking television culture*. New York University Press.

Nash, K. (2009). *Beyond the Frame: A Study in Observational Documentary Ethics* [Doctoral thesis]. University of New England.

Nash, K. (2012). Telling stories: The narrative study of documentary ethics. *New Review of Film and Television Studies*, *10*(3), 318–331. https://doi.org/10.1080/17400309.2012.693765

Naslund, J. A., Grande, S. W., Aschbrenner, K. A., & Elwyn, G. (2014). Naturally occurring peer support through social media: The experiences of individuals with severe mental illness using you tube. *PLoS ONE*, *9*(10). https://doi.org/10.1371/journal.pone.0110171

Neimeyer, R. A., Herrero, O., & Botella, L. (2006). Chaos To Coherence: Psychotherapeutic Integration Of Traumatic Loss. *Journal of Constructivist Psychology*, *19*(2), 127–145. https://doi.org/10.1080/10720530500508738

NHS (2022, July 22) *Treatment – phobias* https://www.nhs.uk/mental-health/conditions/phobias/treatment/

Nichols, B. (1991). *Representing reality: issues and concepts in documentary*. Indiana University Press.

Nichols, B. (2017). *Introduction to documentary* (Third). Indiana University Press.

Nurser, K. P., Rushworth, I., Shakespeare, T., & Williams, D. (2018). Personal storytelling in mental health recovery. *Mental Health Review Journal*, *23*(1), 25–36. https://doi.org/10.1108/MHRJ-08-2017-0034

Oates, J. (2019, May 17). Jeremy Kyle Show: a psychologist explains the risks in reality TV and how aftercare should be done. *The Conversation.* https://theconversation.com/jeremy-kyle-show-a-psychologist-explains-the-risks-in-reality-tv-and-how-aftercare-should-be-done-117287

OFCOM (2013, March 18). *Ofcom Broadcast Bulletin Issue no 226*. [PDF]. OFCOM Broadcasting and on demand sanction decisions. https://www.ofcom.org.uk/about-ofcom/latest/bulletins/content-sanctions-adjudications

OFCOM. (2017, April 3). *Procedures for the consideration and adjudication of fairness and privacy complaints.* https://www.ofcom.org.uk/__data/assets/pdf_file/0031/57388/fairness-privacy-complaints.pdf

OFCOM (2017, September 14) Penalty guidelines. https://www.ofcom.org.uk/about-ofcom/policies-and-guidelines/penalty-guidelines

OFCOM. (2020, December 18). *Statement: Protecting participants in TV and radio programmes.* https://www.ofcom.org.uk/consultations-and-statements/category-2/protecting-tv-radio-participants?showall=1?showall=1

OFCOM. (2020, December 31). *The Ofcom Broadcasting Code (with the Cross-promotion code and the On Demand Programme Service Rules).* https://www.ofcom.org.uk/tv-radio-and-on-demand/broadcast-codes/broadcast-code

OFCOM. (2021, January 6). *Section eight: Privacy.* https://www.ofcom.org.uk/tv-radio-and-on-demand/broadcast-codes/broadcast-code/section-eight-privacy

OFCOM. (2021, March 3). *Guidance notes on Section Seven: Fairness.* https://www.ofcom.org.uk/__data/assets/pdf_file/0017/24713/section7.pdf

OFCOM. (2021, April 29). *Section seven: Fairness.* https://www.ofcom.org.uk/tv-radio-and-on-demand/broadcast-codes/broadcast-code/section-seven-fairness

Ogden, L. P. (2014). “My Life as it is Has Value.” *Qualitative Health Research*, *24*(10), 1342–1355. https://doi.org/10.1177/1049732314546752

O’Malley, T. (2003). Satellite, Cable and New Channels in the UK (Rupert Murdoch). In M. Hilmes (Ed.), *The Television History Book* (pp. 59–62). British Film Institute.

Ouellette, L., & Hay, J. (2008). *Better living through reality TV: television and post-welfare citizenship*. Blackwell. Palmer, Gareth. (2008). *Exposing lifestyle television: the big reveal*. Ashgate.

Papathomas, A., Smith, B., & Lavallee, D. (2015). Family experiences of living with an eating disorder: A narrative analysis. *Journal of Health Psychology*, *20*(3), 313–325. https://doi.org/10.1177/1359105314566608

Paterson, C., Lee, D., Saha, A., & Zoellner, A. (Eds.). (2016). *Advancing Media Production Research: Shifting Sites, Methods, and Politics*. Palgrave Macmillan.

Patterson, N. (2015). Sabotaging Reality: Exploring Canadian Women's Participation on Neoliberal Reality TV. *Canadian Journal of Communication*, *40*(2), 281.

Philo, G. (1996). *Media and mental distress*. Longman.

Polkinghorne, D. E. (1988). *Narrative Knowing and the Human Sciences*. State University of New York.

Polkinghorne, D. E. (2007). Validity in Narrative Research. *Qualitative Inquiry*, 471–486.

Porter, R. (2002). *Madness: a brief history*. Oxford University Press.

Propp, V. (1968). *Morphology of the folktale* (L.Wagner, Ed & L.Scott, Trans.) (2nd ed.). University of Texas Press. (Original work published 1928)

Pye. L. (2019, September 3). *Written evidence submitted by Livia Pye RTV0023.* UK Parliament, Digital, Culture, Media and Sport Committee, Reality tv inquiry – publications. https://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/digital-culture-media-and-sport-committee/reality-tv/written/103010.pdf

Radio Times (28 December 1956) *The Hurt Mind. 1: Put Away*, BBC Programme Index https://genome.ch.bbc.co.uk/6dcc346f545541bdbd1b73e004129d90

Rajan, A. (2019 May 15). *Why the Jeremy Kyle show was scrapped*. BBC. https://www.bbc.co.uk/news/entertainment-arts-48285032

Rapley, M., Moncrieff, J., & Dillon, J. (2011). *De-medicalizing misery: psychiatry, psychology and the human condition*. Palgrave Macmillan.

Rasmussen, E. E., & Ewoldsen, D. R. (2016). Treatment via Television: The Relation Between Watching Dr. Phil and Viewers' Intentions to Seek Mental Health Treatment. *Journal of Health Communication*, *21*(6), 611–619. https://doi.org/10.1080/10810730.2015.1114054

Read, J., & Dillon, J. (Eds.). (2013). *Models of Madness: Psychological, Social and Biological Approaches to Psychosis* (2nd ed.). Routledge.

Read, J., Haslam, N., Sayce, L., Davies, E., & Prejudice, D. E. (2006). Prejudice and schizophrenia: A review of the "mental illness is an illness like any other" approach.

Acta Psychiatrica Scandinavica, *114*(5), 303–318. https://doi.org/10.1111/j.1600-0447.2006.00824.x

Recovery in the Bin (2017, November). *RITB - Key principles.* https://recoveryinthebin.org/ritbkeyprinciples/

Redden, G. (2017). Is Reality TV Neoliberal? *Television & New Media*, *00*(0), 1–16. https://doi.org/10.1177/1527476417728377

Rees, G. (2019). *Occupational Distress in UK Factual Television: A report supported by Wellcome* (Issue June). www.dartcentre.org

Rennick-Egglestone, S., Ramsay, A., McGranahan, R., Llewellyn-Beardsley, J., Hui, A., Pollock, K., Repper, J., Yeo, C., Ng, F., Roe, J., Gillard, S., Thornicroft, G., Booth, S., & Slade, M. (2019). The impact of mental health recovery narratives on recipients experiencing mental health problems: Qualitative analysis and change model. *PLoS ONE*, *14*(12), 1–23. https://doi.org/10.1371/journal.pone.0226201

Reynolds, E. (n.d.). "It was the most toxic environment I've ever been in": how reality TV affects the mental health of its stars. *The Stylist*. Retrieved January 2022, https://www.stylist.co.uk/life/jeremy-kyle-show-suicide-love-island-mental-health-after-care-geordie-shore-reality-tv-stars-vulnerable-contestants/265419

Rhodes, P., & De Jager, A. (2014). Narrative studies of recovery: A critical resource for clinicians. *Clinical Psychologist*, *18*(3), 99–107. https://doi.org/10.1111/cp.12021

Rich, E. (2011). "I see her being obesed!": Public pedagogy, reality media and the obesity crisis. *Health*, *15*(1), 3–21. https://doi.org/10.1177/1363459309358127

Ricoeur, Paul., & Savage, Denis. (1970). *Freud and philosophy: an essay on interpretation*. Yale U.P.

Riessman, C. K. (1993). *Narrative analysis* (Vol. 30). Sage Publications.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage.

Robinson, E. J., & Henderson, C. (2019). Public knowledge, attitudes, social distance and reporting contact with people with mental illness 2009-2017. *Psychological Medicine*, *49*(16), 2717–2726. https://doi.org/10.1017/S0033291718003677

Roe, D., & Davidson, L. (2005). Self and narrative in schizophrenia: Time to author a new story. *Medical Humanities*, *31*(2), 89–94. https://doi.org/10.1136/jmh.2005.000214

Rogers, A., & Pilgrim, D. (2001). *Mental Health Policy in Britain: A Critical Introduction*. Palgrave.

Rose, D. (1998). Television, madness and community care. *Journal of Community & Applied Social Psychology*, *8*(3), 213–228. https://doi.org/10.1002/(SICI)1099-1298(199805/06)8:3<213::AID-CASP449>3.0.CO;2-C

Sanders, W. (2012). *Participatory Spaces: Negotiating Cooperation and Conflict in Documentary Projects* [Doctoral thesis]. Utrecht University.

Sanders, W. (2016). Production Studies and Documentary Participants: A Method. In C. Patterson, D. Lee, A. Saha, & A. Zoellner (Eds.), *Advancing Media Production Research: Shifting Sites, Methods, and Politics* (pp. 200–216). Palgrave Macmillan.

Sarbin, T. R. (1986). *Narrative psychology: the storied nature of human conduct*. Praeger.

Sayce, L. (2000). *From psychiatric patient to citizen: overcoming discrimination and social exclusion* . MacMillan .

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, *125*(6), 440–452. https://doi.org/10.1111/j.1600-0447.2012.01826.x

Sexton, J. (2003). "Televerite" hits Britain: documentary, drama and the growth of 16mm filmmaking in British television. *Screen*, *44*(4), 429–444.

Shattuc, J. (1997). *The talking cure: TV talk shows and women* . Routledge .

Shufeldt, M., & Gale, K. (2007). Under the (Glue) Gun: Containing and Constructing Reality in Home Makeover TV. *Popular Communication*, *5*(4), 263–282. https://doi.org/10.1080/15405700701608980

Silverman, D. (2020). *Interpreting qualitative data* (6e.). SAGE.

Singer, J. A., & Rexhaj, B. (2006). Narrative coherence and psychotherapy: A commentary. *Journal of Constructivist Psychology*, *19*(2), 209–217. https://doi.org/10.1080/10720530500508944

Singleton, A., Abeles, P., & Smith, I. C. (2016). Online social networking and psychological experiences: The perceptions of young people with mental health difficulties. *Computers in Human Behavior*, *61*, 394–403. https://doi.org/10.1016/j.chb.2016.03.011

Skeggs, B., & Wood, H. (2011). *Reality television and class*. Palgrave Macmillan.

Slade, M., & Longden, E. (2015). Empirical evidence about recovery and mental health. *BMC Psychiatry*, *15*(1), 1–15. https://doi.org/10.1186/s12888-015-0678-4

Smith, B., & Sparkes, A. C. (2006). Narrative inquiry in psychology: exploring the tensions within. *Qualitative Research in Psychology*, *3*(May), 169–192. https://doi.org/10.1191/1478088706qrp068oa

Sools, A. M., Murray, M., & Westerhof, G. J. (2015). Narrative health psychology: Once more unto the breach. *Journal of Health Psychology*, *20*(3), 239–245. https://doi.org/10.1177/1359105314566616

Spector-Mersel, G., & Knaifel, E. (2018). Narrative research on mental health recovery: two sister paradigms. *Journal of Mental Health*, *27*(4), 298–306. https://doi.org/10.1080/09638237.2017.1340607

Spence, D. (1986). Narrative Smoothing and Clinical Wisdom. In T. R. Sarbin (Ed.), *Narrative Psychology: The Storied Nature of Human Conduct* (pp. 211–232). Praeger.

Squire, C. (2013). From experience-centred to socioculturally-oriented approaches to narrative. In M. Andrews, C. Squire, & M. Tamboukou (Eds.), *Doing narrative research* (2nd ed., pp. 41–63). SAGE.

Stuart, H. (2006). Media portrayals of mental illness and its treatments: What effect does it have on people with mental illness? *CNS Drugs*, *20*(2), 99–106. https://doi.org/10.2165/00023210-200620020-00002

Stuart, S. R., Tansey, L., & Quayle, E. (2017). What we talk about when we talk about recovery: a systematic review and best-fit framework synthesis of qualitative literature. *Journal of Mental Health*, *26*(3), 291–304. https://doi.org/10.1080/09638237.2016.1222056

Sukhan, T. (2013). Bootcamp, brides, and BMI: Biopedagogical narratives of health and belonging on canadian size-transformation television. *Television and New Media*, *14*(3), 194–210. https://doi.org/10.1177/1527476412457995

Syvertsen, T. (2001). Ordinary people in extraordinary circumstances: A study of participants in television dating games. *Media, Culture and Society*, *23*(3), 319–337. https://doi.org/10.1177/016344301023003003

Svend Brinkmann & Steinar Kvale. (2005). Confronting the ethics of qualitative research. *Journal of Constructivist Psychology*, 18:2, 157-181, DOI: 10.1080/10720530590914789

The Association of Clinical Psychologists UK. (2019, June 25). *Written Evidence RTV0019.* UK Parliament, Digital, Culture, Media and Sport Committee, Reality tv inquiry – publications. https://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/digital-culture-media-and-sport-committee/reality-tv/written/102976.pdf

Thomas, B. (2016). *Narrative: the basics*. Routledge.

Thomas, S. (2012). Collaboration and ethics in documentary filmmaking – a case study. *New Review of Film and Television Studies*, *10*(3), 332–343. https://doi.org/10.1080/17400309.2012.695979

Thorbjørnsrud, K., & Lånkan, K. B. (2022). 'Someone should have looked after us': the boundary work of mental health disclosure on TV. *Media, Culture and Society*, *44*(5), 935–950. https://doi.org/10.1177/01634437211069970

Thornhill, H., Clare, L., & May, R. (2004). Escape, enlightenment and endurance. *Anthropology & Medicine*, *11*(2), 181–199. https://doi.org/10.1080/13648470410001678677

Tian, Y., & Yoo, J. H. (2015). Connecting With The Biggest Loser: An Extended Model of Parasocial Interaction and Identification in Health-Related Reality TV Shows. *Health Communication*, *30*(1), 1–7. https://doi.org/10.1080/10410236.2013.836733

Tsaousi, C. (2017). How to organise your body 101: postfeminism and the (re)construction of the female body through How to Look Good Naked. *Media, Culture and Society*, *39*(2), 145–158. https://doi.org/10.1177/0163443715608258

Turner, G. (2010). *Ordinary people and the media: the demotic turn*. SAGE.

Turner, G. (2013). *Understanding Celebrity* (2nd ed.). SAGE.

Turner, G. (2014). Reality Television and the Demotic Turn. In L. Ouellette (Ed.), *A Companion to Reality Television* (1st ed., pp. 309–323). John Wiley & Sons.

Turner, N., Foley, S. R., Kinsella, A., O'Callaghan, E., & Clarke, M. (2014). Putting television's portrayal of schizophrenia into reverse: An evaluation of the impact on public opinion. *Early Intervention in Psychiatry*, *8*(4), 366–374. https://doi.org/10.1111/eip.12056

UK Parliament. (2019a). Digital, Culture, Media and Sport Committee, Reality tv inquiry – publications https://old.parliament.uk/business/committees/committees-a-z/commons-select/digital-culture-media-and-sport-committee/inquiries/parliament-2017/realitytv/publications/

UK Parliament. (2019b, May 15) *Committee announces inquiry into reality TV*. https://committees.parliament.uk/committee/378/digital-culture-media-and-sport-committee/news/103566/committee-announces-inquiry-into-reality-tv/

van Agteren, J., Iasiello, M., Ali, K., Fassnacht, D. B., Furber, G., Woodyatt, L., Howard, A., & Kyrios, M. (2021). Using the Intervention Mapping Approach to Develop a Mental Health Intervention : A Case Study on Improving the Reporting Standards for Developing Psychological Interventions. *Frontiers in Psychology*, *12*(October), 1–30. https://doi.org/10.3389/fpsyg.2021.648678

Viding, E. (2018, April). 'Opting out is not the answer' in Psychologists and the media – opportunities and challenges. *the psychologist*, vol 31, 36-51 https://thepsychologist.bps.org.uk/volume-31/april-2018/psychologists-and-media-opportunities-and-challenges

Walsh, D. A. B., & Hallam Foster, J. L. (2021). A Call to Action . A Critical Review of Mental Health Related Anti-stigma Campaigns. *Frontiers in Public Health*, *8*(January), 1–15. https://doi.org/10.3389/fpubh.2020.569539

Ward, K., Gott, M., & Hoare, K. (2015). Participants' views of telephone interviews within a grounded theory study. *Journal of Advanced Nursing*, *71*(12), 2775–2785. https://doi.org/10.1111/jan.12748

Waterson, J. (2019, May 14). 'That show has ruined my life': Jeremy Kyle guest speaks out. *The Guardian*. https://www.theguardian.com/media/2019/may/14/jeremy-kyle-show-ruined-life-guest-speaks-out

Watson, E. (2019). The mechanisms underpinning peer support: a literature review. *Journal of Mental Health*, *28*(6), 677–688. https://doi.org/10.1080/09638237.2017.1417559

Weber, B. R. (2009). *Makeover TV: selfhood, citizenship, and celebrity*. Duke University Press.

Wheatley, H. (2003). ITV: 1955-89: Populism and Experimentation. In M. Hilmes (Ed.), *The Television History Book* (pp. 76–81). British Film Institute.

White, M. (1992). *Tele-advising: Therapeutic discourse in American television*. The University of North Carolina Press.

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

Whitley, R., Shepherd, G., & Slade, M. (2019). Recovery colleges as a mental health innovation. *World Psychiatry*, *18*(2), 141–142. https://doi.org/10.1002/wps.20620

Whitley, R., & Wang, J. W. (2017). Television coverage of mental illness in Canada: 2013–2015. *Social Psychiatry and Psychiatric Epidemiology*, *52*(2). https://doi.org/10.1007/s00127-016-1330-4

Wild, J. (2006). Moving into the house to get out. *The Psychologist*, *19*(12), 2006.

Wilkes, M., Carey, H., & Florisson, R. (2020). *The Looking Glass: Mental health in the UK film, TV and cinema industry*. https://doi.org/10.1093/nq/s3-IV.79.15-a

Willig, C. (2013). *Introducing qualitative research in psychology* (Third). Open University Press.

Wilson, Julie. A. (2014). Reality Television Celebrity: Star Consumption and Self-Promotion in Media Culture. In L. Ouellette (Ed.), *A Companion to Reality Television* (1st ed., pp. 421–436). John Wiley & Sons.

Winston, B. (1995). *Claiming the real: the Griersonian documentary and its legitimations*. British Film Institute.

Winston, B. (2000). *Lies, damn lies and documentaries*. British Film Institute.

Woods, A., Hart, A., & Spandler, H. (2019). The Recovery Narrative: Politics and Possibilities of a Genre. *Culture, Medicine and Psychiatry*, 9–15. https://doi.org/10.1007/s11013-019-09623-y

Wood, H. (2021, August 3). 'Grafting' on Love Island: Ethics, entertainment and reality TV work. *The Sociological Review* [online]. https://doi.org/10.51428/tsr.nqpj9303

Wright, K. (2008). Theorizing therapeutic culture: Past influences, future directions. *Journal of Sociology*, *44*(4), 321–336. https://doi.org/10.1177/1440783308097124

Yeo, C., Rennick-Egglestone, S., Armstrong, V., Borg, M., Franklin, D., Klevan, T., Llewellyn-Beardsley, J., Newby, C., Ng, F., Thorpe, N., Voronka, J., & Slade, M. (2022). Uses and Misuses of Recorded Mental Health Lived Experience Narratives in Healthcare and Community Settings: Systematic Review. *Schizophrenia Bulletin*, *48*(1), 134–144. https://doi.org/10.1093/schbul/sbab097

Ytreberg, E., & Thorbjørnsrud, K. (2020). Agencies and Experiences of the “Good Participant”: The Long-Term Trajectories of Patients Turned Media Participants. *International Journal of Communication*, *14*, 6182–6198.

Zexin Ma. (2017). How the media cover mental illnesses: a review. *Health Education*, *117*(1), 90–109. https://doi.org/http://dx.doi.org/10.1108/MRR-09-2015-0216

List of UK programmes

see Appendix B for mental health intervention television programmes

Big Brother (2000-2010, Channel 4; 2011-2018, Channel 5), Endemol
Britain's Got Talent (2007-2022), ITV, Syco Entertainment and Talkback/Thames
Controversy, Ep 6: The Myth of Mental Illness (1972, 2/10), BBC2
Disguises: A Place of Safety (1993, 2 episodes 25/2, 4/3), ITV, Granada TV
Freddie Flintoff: Living with Bulimia (2020, 28/9), BBC1, South Shore Productions
Grapevine (1977, 13/6), BBC2
Honey, we're killing the kids [UK version](2005 - 2007), BBC3
I Hate Mum And Dad (2010, 9/2), BBC1, ZKK
Insanity or Illness (1959, 28/01), ITV
Jeremy Kyle Show: Death on Daytime (2022, 13/3) Channel 4, Blast!
Losing it: Our mental health emergency, (2020, 4 episodes starting 21/1), Channel 4, Story Films
Love Island, (2005-2006; 2015-2022) ITV, ITV studios
Man Alive: Out of Sight, Out of Mind 1: Up in Middlewood (1974, 5/6), BBC2
Man Alive: Out of Sight, Out of Mind 2: Who's Mad? (1974, 12/6), BBC2
Man Alive: Put Away (1979, 27/3), BBC2
Man Alive: Treatment for Fear (1978, 12/12), BBC2
Nadiya: Anxiety and Me (2019, 15/05), BBC1, Raw Factual Ltd
Out of Our Minds (1986), Channel 4, Television History Workshop
Panorama: On mental illness (1966, 16/5), BBC
Shabby Treatment (1996, 4/11), Channel 4, IPTV
States of Mind: The Enemy Within (1995, 6 episodes starting 23/4), BBC2
Supernanny (2004-2008), Channel 4, Ricochet
The Great British Bake Off (2010-2013, BBC2; 2014-2016, BBC1; 2017-2022, Channel 4), Love Productions
The Hurt Mind (1957, 5 episodes starting 1/1), BBC
The Jeremy Kyle Show, (2005-2019), ITV, ITV studios
The Talking Cure (1999, 6 episodes starting 2/11), BBC2
The truth about improving your mental health (2021, 20/1), BBC1
This Week: Mental Illness in Great Britain (1964, 09/10), ITV
Trisha (1998-2004), ITV, Anglia
Video Diaries: Mad, Bad or Sad (1994, 14/9), BBC2, Community Programmes Unit
We're Not Mad, We're Angry (1986), Channel 4, Eleventh Hour
World in Action: Ward 13 (1968, 20/5), ITV, Granada Television
You in Mind (1987, 7 episodes starting 2/2), BBC One

International programmes referenced

Canada's next top model (2006-2009), Citytv/CTV, Temple Street Productions, [Canada]
Five days Inside (2015-2020), NRK, [Norway],
Making Australia Happy (2010), ABC, [Australia]
Molly and Mobarak (2003), Tom Zubrycki, [Australia]
Popstars (2001), CTV, [Canada]
The Biggest Loser (2004-2016), NBC, [America]
True Selfie (2016, 2018), NRK, Anti, [Norway]

Appendix A: Complaining to OFCOM

:

OFCOM is a 'post-broadcast regulator' which means that complaints can only be made once programmes have aired. Participants, organisations or their authorised representatives have a limited time period to submit complaint with reference to the Broadcasting Code (OFCOM, 2020). In the case of television participants this would be under a breach of the code related to fairness or privacy. OFCOM decides if there are enough grounds to investigate and rules whether a complaint is upheld. The full details and outcomes of investigations are published on the OFCOM website and for serious breaches, OFCOM may impose financial sanctions (OFCOM, 2017).

To give an example related to mental health intervention television – in 2013 an official complaint was submitted to OFCOM for unfair treatment and invasion of privacy, by a participant from the Channel 4 series The Hoarder Next Door (OFCOM, 2013). Amongst the participant's concerns was that she had been led to believe it was a serious documentary about the treatment for hoarders when: "Instead, the programme showed very little of the treatment, sensationalised the issues and exploited her vulnerability" (OFCOM, 2013, p. 54). The complainant also believed she had been misrepresented as a "bad, uncaring mother and lazy, filthy slob" (p. 55). Channel 4 submitted in its defence evidence including; the programme information that was on the consent form, the psychological support received by the participants before and after the show, the fact the participant had been allowed to view the programme, and that some suggested changes were taken on board. The Channel also suggested that the participant has seemed comfortable with the programme at the time of broadcast. The complaint was not upheld by OFCOM.

This example illustrates two key points. Whilst the participant signed a consent form which included a description of the series, there can be a disconnect between how participants envisage a series and the end product, especially when producers are keen to highlight the positives (Mast, 2016). Secondly; despite psychological support, a programme preview, and the fact that the participant appeared not to object to the programme at the time of broadcast, at some point after, they decided that they had been mis-used and were unhappy with their involvement. It is not clear what changed

for this participant, however it demonstrates how participants' relationships with their involvement are not static and that consent is contentious because the full outcomes for participants cannot been known in advance (Thomas, 2012). There is a crucial difference between taking part in the making of a television series and appearing on-screen. In this case, it would seem that the help they received did not compensate enough for the reality of seeing themselves on television.

Appendix B: MHITV series reference table

UK Mental Health Intervention Television and related series reference table

Name	Channel & Production Company	Series & episodes aired	Premise	Intervention/Expert	Links
Our Dementia choir	BBC1 Curve Media	Series 1 – 2 episodes May 2019 Series 2 – 2 episodes October 2022 One hour episodes	Vicky McClure puts together a choir for people who have dementia. In the follow up series she revisits the choir and they record a single	Singing – with music coaches Also collaborating with University research team	https://www.bbc.co.uk/programmes/m0004pyg
Hoarder Homes	Channel 5 Crackit Television	2019 - 2022 Two seasons of one hour programmes 11 episodes	Hoarding - each programme features several different homes of people with hoarding behaviours	Various levels of intervention – mainly house clearance but some brief advice from specialist declutterers or single sessions with therapist	https://www.channel5.com/show/hoarders/season-1 https://www.channel5.com/show/hoarders/season-2
The restaurant that makes mistakes	Channel 4 CPL Productions	June 2019 4 part series	Pop up restaurant staffed by 14 volunteers who all have dementia. Under guidance of Michelin starred chef	Work intervention – idea is to challenge work based stigma but by providing employment – also offer purpose, self esteem, friendships etc.	https://www.alzheimers.org.uk/restaurant-that-makes-mistakes#:~:text=The%20Restaurant%20That%20Makes%20Mistakes%20is%20a%20Channel%204%20series,to%20make%20viewers%20think%20again.
Call the Cleaners	ITV Curve Media	Series 1 - 2017 Series 2 - 2019 12 episodes (30 mins)	Follows different cleaner specialists tackling properties for residents who have lost control including hoarders who are featured.	House clearance/cleaning	https://www.mirror.co.uk/news/weird-news/hoarder-hadnt-seen-floor-four-10673781

Name	Channel & Production Company	Series & episodes aired	Premise	Intervention/Expert	Links
Britain's Biggest Hoarders	Channel 4 Blink Films	2017 1 episode	Hoarding – featuring two participants over several months	Therapy and support from declutterers	
Mind over Marathon	BBC1 Made by BBC Bristol	April 2017 2 one hour episodes	People with various mental health issues brought together to train for and run the London marathon for Heads Together charity	Running – supported by motivational coaches with personal experiences of mental health. Also nutritionist.	**http://www.bbc.co.uk/programmes/p04yy0r8**
Obsessive Compulsive Cleaners Obsessive Compulsive Country House Cleaners	Channel 4 Betty TV	5 series 2 series 2015 & 2016 6 episodes 4 x 60 April 2017	People obsessed with cleaning (some who have OCD diagnosis) team up to sort out some of Britain's dirtiest homes (many of whom appear to have hoarding tendencies or other mental health needs) Follow up series featured large country houses	No experts – the self proclaimed cleaning obsessives carry out the intervention (cleaning/clearance)	http://metro.co.uk/2015/05/31/channel-4s-obsessive-compulsive-cleaners-made-these-two-more-obsessed-with-cleaning-5222640/ OCD UK – comments of various series including Obsessive Compulsive Cleaners: http://media1235.rssing.com/chan-17987116/all_p1.html
Employable Me	BBC2 Optomen	Series 1 March 2016 2 one hour episodes Series 2 – 4 episodes December 2017	People with neurological conditions (series 1) and also disabilities (series 2) helped to see their potential and find work – featured contributors with autism, tourettes, stroke	Psychologist offering guidance/support sessions	http://www.bbc.co.uk/programmes/b09hlpl8 https://viewfromawalkingframe.co.uk/ http://www.huffingtonpost.co.uk/entry/taking-part-in-employable-me-was-the-most-important-personal-journey-of-my-life_uk_5a2515a0e4b03350e0b7bb9c

Name	Channel & Production Company	Series & episodes aired	Premise	Intervention/Expert	Links
Gareth Malone – Invictus choir	BBC1 Twenty Twenty	2016 2 one hour episodes	10-12 ex-service men and women medically discharged form a choir at have 7 weeks to perform at the Invictus games opening ceremony. About half have PTSD or other mental health problems	Singing – led by choir master	https://www.bbc.co.uk/programmes/b079yvr4
Hoarder SOS	Channel 4 Lion TV	Daytime – October 2016 15 episodes 45 mins	2 households per episode. They get help to declutter and clean and some stuff sold at auction to make cash. Stays away from mental health issues	Antiques expert and cleaners/declutterers	http://www.channel4.com/programmes/hoarder-sos http://www.mirror.co.uk/tv/tv-news/apprentice-2016-candidates-want-fame-9152207
The Hoarder Next Door	Channel 4 Twenty Twenty	2012 - Series 1 4 one hour episodes 2013 - Series 2 4 eps 2014 - Series 3 6 eps	Normally two people with hoarding behaviours each programme. Therapy plus help sorting house	Psychotherapy and Declutterers/cleaners	http://www.independent.co.uk/arts-entertainment/tv/reviews/grace-dent-on-television-the-hoarder-next-door-channel-4-7734441.html
The Vertigo Road Trip	BBC1	May 2014 1 one hour episode	5 people with vertigo taken around the world to progressively higher places! Presented by Mel Giedroyc	Psychologist led exposure and response prevention therapy (ERP)	https://www.bbc.co.uk/programmes/b0436rpk
Britain's compulsive shoppers	BBC1	2014 1 episode (one hour)	Stories of 3 people addicted to shopping. Jasmine Harman meets them at attempts to offer some moral support, ideas for change	No expert intervention – but Jasmine offers advice and support based on advice from addiction experts. She helps one lady clear her garden.	https://www.bbc.co.uk/programmes/b04fd8ns

Name	Channel & Production Company	Series & episodes aired	Premise	Intervention/Expert	Links
The Speakmans	ITV	2014 Daytime 20 episode series More recently – This Morning's resident therapists (ITV)	Husband and wife team provide interventions for people with mental health problems such as phobias, anxiety and OCD	Controversial therapy techniques developed and self-verified by the couple who have no mental health qualifications	https://www.theguardian.com/tv-and-radio/2014/jul/12/the-speakmans-this-morning-kerry-katona
Extreme OCD camp	BBC3 Watershed Television	October 2013 2 one hour episodes	Six young adults with OCD travel to America to take part in intensive treatment in the wilderness	American therapists - ERP	https://www.bbc.co.uk/programmes/b037wn0l http://theocdstories.com/podcast/peter-weiss-on-the-bbc-documentary-extreme-ocd-camp/ https://www.youtube.com/watch?v=r3bkg_ReIPs
Britain's Biggest Hoarders	BBC1 Two Four	2012/2013 1 hour programme followed by 3 part series following year	Presenter - Jasmine Harman tries to get help for her mum who has hoarding behaviours. In the follow up series she meets and helps other hoarders	Specialist declutters and some therapists sessions in some cases	https://www.bbc.co.uk/programmes/b01hllr3
Tourettes: Let me entertain you	BBC3 Leopard Films	2012 3 one hour episodes	6 young musicians with tourettes coached to put on a concert	Presenter - Reggie Yates plus vocal coaches	https://www.bbc.co.uk/programmes/p00wk639
Freaky Eaters	BBC3 Betty TV	2007 – 2009 3 series 23 episodes	Adults with food phobias undergoing therapy and challenges	Psychologist/psychological coach offering CBT based interventions and nutritionist	https://www.betty.co.uk/programmes/details/freaky-eaters-series-1-2-3

Name	Channel & Production Company	Series & episodes aired	Premise	Intervention/Expert	Links
The Panic Room	BBC3	2007 6 one hour episodes	Predominantly studio based fact ent show featuring people with phobias	Psychologist offering ERP in studio constructed set to expose them to fears	https://www.bbc.co.uk/programmes/b0074h4t
House of Agoraphobics	Channel 4 Monkey Kingdom	2006	3 individuals move in together for a 14 days of intensive exposure and response therapy	Team of clinical psychologists/therapists – mainly ERP	http://www.monkeykingdom.com/shows/house-agoraphobics https://www.youtube.com/watch?v=e-QRc3otwA4
House of Obsessive Compulsives	Channel 4 Monkey Kingdom	2005	3 individuals move in together for a 14 days of intensive exposure and response therapy	Team of clinical psychologists/therapists – mainly ERP	https://www.youtube.com/watch?v=z6bUMBhCphQ http://www.monkeykingdom.com/shows/house-obsessive-compulsives

Appendix C: Contributors interview schedule

Interviews with TV Contributors - exploring Mental Health Television

Introduce the research

- About the research
  - The research forms the basis of my psychology and media PhD at the University of Brighton and draws on my previous experience as a producer in television production. The project will explore TV series that involve 'tailored for television' therapeutic interventions for mental health. I am researching what it is like to be involved in these shows and how audiences respond to them.
- About the interview
  - Reminder about anonymity and confidentiality
  - Reminder about audio recording
  - Point out that there are no right or wrong answers, free to ask questions, tell me as we go a long if there is anything they are uncomfortable talking about and can stop and any time.
  - Any questions before we start

Start recording

Key Interview Questions:

Tell me about the experience of taking part in [PROGRAMME]?

- *You can start with whatever seems most relevant to you (or start at the beginning …)*

Has taking part in [PROGRAMME] made a difference to your life?

- *How/why/key aspects/how significant/wellbeing and mental health?*

Recruitment – can you tell me how you came to be involved in the series?

- *Describe the recruitment process?*
- *What were your expectations/motivations?*
- *Reactions of friends and families on telling them you were doing it?*

Production – can you share your experiences of the filming process?

- *Describe a typical filming day*
- *Memorable filming moment*
- *Awareness of camera/difference to behaviour*
- *Positives and negatives*
- *What level of control did you have? Things chose not to film*
- *What was it like working with a TV crew?*
- *Tell me about your relationship with the crew?*
- *How do you feel about the support you received?*

The intervention – describe the experience of [THE INTERVENTION]?

- *What was involved?*
- *How challenging was it?*
- *How do you feel about the support you received?*
- *Do they think it helped mental health? Why/how?*

Broadcast – can you describe the experience of being on television?

- *Describe watching it – where/who/when?*
- *How do you feel about the finished broadcast programmes?*
- *How do you feel about way events and people involved are represented?*
- *Reaction of friends and family, strangers?*

Now – looking back now, has involvement made a difference to your current life/how?

- *Repercussions – good and bad*
- *Do you have any thoughts on anything that could have been done differently? By the production/TV Channel/you?*
- *Would you recommend someone else taking part in a similar show?*

Background - Contextual information about themselves?

- *age, occupation, who they live with etc?*

Any other comments and questions

- Anything else participant would like to add that has not been covered
- Any questions for the researcher?

Appendix D: Crew and Intervention and Support Provider interview schedule

TV CREW Interview guide - Exploring Mental Health Television

Introduce the research

- About the research
  - The research forms the basis of my psychology and media PhD at the University of Brighton and draws on my previous experience as a producer in television production. The project will explore TV series that involve 'tailored for television' therapeutic interventions for mental health - such as BBC's 'Mind Over Marathon'. I am researching what it is like to be involved in these shows and how audiences respond to them.
- About the interview
  - Reminder about anonymity and confidentiality
  - Reminder about audio recording
  - Point out that there are no right or wrong answers, free to ask questions, tell me as we go a long if there is anything they are uncomfortable talking about and can stop and any time.
  - Any questions before we start
- Start recording

Key Interview Questions:

Can you tell me about your role on the series and what this involved?

Tell me about the experience of being part of [THE PROGRAMME]?

- You can start with whatever seems most relevant to you (or start at the beginning …)

Was making a series about mental health different from other projects you've been involved in?

- *Any specific preparations/allowances/support because mental health subject?*
- *Any particular challenges – personal/for the production/for contributors?*

Production – can you share your experiences of the filming process?

- *Describe a typical filming day*
- *Memorable filming moment*
- *Awareness of camera/difference to behaviour*
- *Positives and negatives/highs and lows*
- *What level of control did contributors have?*
- *Any times people didn't want to be filmed – how handled?*
- *Things chose not to film*
- *Tell me about your relationship with the PARTICIPANTS? Then/Now*
- *How do you feel about the support THEY received?*

Edit/broadcast – how do you feel about the final programmes?

- *Tell me about how you made decisions about what to include/leave out in the final programmes?*
- *How do you feel about way events and people involved are represented?*
- *What control did the contributors have over what was included?*
- *What preparation was done with contributors for the broadcast series?*
- *What was the response like to the series?*
- *How have contributors responded to the broadcast of the series - good and bad?*

Now – do you feel that taking part in the series has made a difference to the contributors' lives?

- *Expand – how/why/which part/long term?*
- *What do you think the production/crew did well?*
- *Anything would do differently?*
- *Would you recommend someone else taking part in a similar show?*

Background stuff if not covered above:

- *What did the recruitment process involve?*
- *Length of production period/amount of filming?*

Any other comments and questions

- Anything else participant would like to add that has not been covered
- Any questions for the researcher

Appendix E: Ethical Approval

University of Brighton

Social Sciences CREC

Watts Building
Brighton
BN2 4GJ

07/11/2018

Ref: 2018-0395-Selby Mental Health Interventions on television – a force for good?

Dear Hannah

Thank you for your resubmission to the Social Sciences CREC at the University of Brighton.

The committee feel you have now addressed all the issues raised and are happy to offer a favourable ethical opinion for this study.

Favourable ethical opinion is given on the basis of a project end date of 01/10/2020. If you need to request an extension, please complete a change request form. Please note that the decisions of the committee are made on the basis of the information provided in your application. The CREC must be informed of any changes to the research process after a favourable ethical opinion has been given. Research that is conducted without having been reviewed by the committee is not covered by the University research insurance cover. If you need to make changes to your proposal please complete and submit a change request form in order that the CREC can determine whether the changes will necessitate any further ethical review.

Once your research has been completed, please could you fill in a brief end of project report form. Finally please could I ask that you flag up any unexpected ethical issues, and report immediately any serious adverse events that arise during the conduct of this study.

We wish you all the best with your research and hope that your research study is successful. If the CREC can be of further assistance with your study please contact us again.

Best wishes

Dr Nichola Khan

Chair, Social Sciences CREC

Page 1 of 1

University of Brighton
Social Sciences CREC

Watts Building
Brighton
BN2 4GJ

27/02/2019

Ref: 2019-0395-Selby Mental Health Interventions on television – a force for good?

Dear Hannah

Thank you for submitting your change request form to the Social Sciences CRECat the University of Brighton.

The Social Sciences CREC feel you have addressed all the relevant issues and are happy to approve the proposed changes to your research protocol.

Best wishes

Dr Nichola Khan

Chair, Social Sciences CREC

Page 1 of 1

Appendix F: Participation Information Sheet (contributors)

Exploring Mental Health Television

I am a postgraduate researcher from the Psychology, Psychotherapy & Counselling Division in the School of Applied Social Science at the University of Brighton. I would like to invite you to take part in my study. Before you decide, please read this information sheet carefully. Feel free to ask any questions if anything is not clear or discuss it with other people.

What is the purpose of the study?

The focus of my research is factual TV series about mental health that involve people taking part in interventions. This could be therapy such as CBT, or it could be other activities like exercise, singing or decluttering. Examples include *Mind Over Marathon (BBC1)*, *The Hoarder Next Door (C4), Freaky Eaters (BBC3) and Obsessive Compulsive Cleaners (C4).* I am aiming to find out how TV participants find the experience of being filmed and appearing on television and explore any positives or negatives of taking part. I plan to talk to TV participants, production teams and therapists who have been involved in these kind of programmes and identify common factors that make participation successful and what the challenges may be.

Who can take part?

I would like to speak to people who have been a main participant in a TV series involving taking part in therapy or activities related to issues such as anxiety, hoarding, OCD or phobias. However if you are currently experiencing distress it may not be possible to include you in the study.

Do I have to take part?

No, taking part in the research is entirely voluntary. If you would like to be involved you will be asked to sign a consent form before any information is collected, however you can change your mind or withdraw from the study up to two months after taking part. In this case, I will ask whether any information already provided can still be used or whether it should be deleted. You are encouraged to talk about any concerns you might have at any time during the course of taking part in the research.

What is involved?

Taking part in the research involves being interviewed one-to-one by myself. The interviews will take 1-2 hours, but the time can be flexible depending on your needs. The interview will be arranged at a convenient location for yourself, or by skype if more suitable. Whilst there are some particular topics I am interested in and will ask questions about, the interviews will be informal, and you will be free to ask questions and talk about the things that are important to you. You can also let me know at any stage before or during the interview if there are any things you are uncomfortable talking about and we can move on to other topics.

All the interviews will be audio recorded as it is important I capture your thoughts and experiences in your own words. The audio recordings from interviews will be transferred from the digital recorder to a secure, password protected, space on the University of Brighton computer server. Only myself and my PhD supervisors will have access to the recordings. No information from the interviews will be shared with anyone else involved in the TV production.

What are the potential disadvantages or risks of taking part?

During the course of the research you may wish to talk about the mental health issues that led you to become involved in the television series and share your experiences of the support you received. Whilst it is hoped that this will be a positive process, there is

the possibility that you may find yourself reflecting on upsetting memories or distressing thoughts.

Before taking part in the research I will ask what mental health and/or other support you currently have available to you and encourage you to make them aware of your participation in the research in the event that you require additional support. I will be available to discuss any concerns you may have and will also provide you with contact details of organisations that may be able to help you if you experience any distress as a result of participating in the research.

What are the potential benefits of taking part?

This research is an opportunity to talk about your 'behind the scenes' experiences of taking part in a television show. The aim is to give a voice to television participants with mental health issues and has the potential to inform how television series are made in future.

Who will know I have taken part in the research?

It is up to you who you tell about your participation in the research. Any correspondence or interview will take place in private and your personal information will be treated as confidential. The only exception to this is if I have serious concerns for your welfare such as if you tell me of any intention to cause harm to yourself or someone else. In this case I will talk to you first about the best thing to do before taking any further action.

Your name or personal details will not be used in any documents based on the research findings without your permission. I will alter details that might identify you, for example each participant will be given a fictitious name to protect their anonymity.

What will happen to the results of the project?

The research will form the basis of my PhD studies. The study findings will be available online and I hope to publish articles, so the learning can be shared more widely.

Will I be paid for taking part?

I cannot pay you for your time however I can offer you a voucher for £10 towards any travel expenses.

Who is funding the research?

The research is being funded by the Economic Social Research Council.

What if there is a problem?

I hope that you will feel able to raise any concerns or questions with myself in the first instance, but if you would prefer to speak to someone else, then please contact Matthew Adams (PhD supervisor).

Thank you for reading this information. Please feel free to get in touch with any questions.

Lead Supervisor	Independent contact (not involved in the research)
Matthew Adams School of Applied Social Science Watson House, Falmer University of Brighton, BN1 9PH **Email:** **Matthew.Adams@brighton.ac.uk** **Tel:** 01273 644518	**Mark Erickson** School of Applied Social Science Watson House, Falmer University of Brighton, BN1 9PH **Email: mark.erickson@brighton.ac.uk** **Tel:** 01273 641085

This study has been reviewed and approved by the School of Applied Social Science Research Ethics and Governance Committee of the University of Brighton.

Where can I get help and support?

It is possible that the research will raise questions for you. Here is a list of helplines and support groups that you may find useful before or after taking part in this research study

Helplines offering emotional support services or information:

Samaritans.
Confidential support for people experiencing feelings of distress or despair.
Phone: **116 123** (free 24-hour helpline, 365 days a year)
Website: www.samaritans.org.uk

SANEline
Offers emotional support and information from 6pm–11pm, 365 days a year.
Phone: 0300 304 7000. Comfort and care via text message:
http://www.sane.org.uk/textcare
Peer support forum: www.sane.org.uk/supportforum website: www.sane.org.uk

CALM.
For men experiencing distressing thoughts and feelings, open from 5pm–midnight, 365 days a year. Phone: **0800 58 58 58**. Also have a webchat service if you're not comfortable talking on the phone. Website: www.thecalmzone.net

Switchboard, the LGBT+ helpline.
For people identifying as gay, lesbian, bisexual or transgender. Available from 10am–11pm, 365 days a year, to listen to any problems you're having. Phone operators all identify as LGBT+.
Phone: 0300 330 0630

Mind
Infoline open from 9am–6pm weekdays. Also lots of helpful information on their website
Phone: 0300 123 3393, **text 86463** or
email info@mind.org.uk. Website: www.mind.org.uk

Papyrus HOPEline.
Practical advice and support for people under 35 and struggling with suicidal feelings and self-harm, Open weekdays 10am–10pm, weekends 2pm–10pm and bank holidays 2pm–5pm.
Phone: 0800 068 4141, or text **07786 209 697**.

Problem-specific information and support:

Anxiety UK
Charity providing support if you've been diagnosed with an anxiety condition. Helpline weekdays 9.30am–5.30pm, on **08444 775 774**. www.anxietyuk.org.uk

No Panic
Helpline for people experiencing anxiety disorders, open 10am–10pm, 365 days a year,
Phone: 0844 967 4848. Website: www.nopanic.org.uk

OCD Action
Support and information for anybody affected by OCD. Help and information line weekdays 9.30-8pm
Phone: 0845 390 6232 or **020 7253 2664** Website: www.ocdaction.org.uk

OCD UK
A charity run by people with OCD, for people with OCD. Advice line weekdays 9am–5pm
Phone: 0845 120 3778, or you can email them at support@ocduk.org. Website: www.ocduk.org

Depression Alliance
Has a network of self-help groups for sufferers of depression. Website: www.depressionalliance.org

In an emergency:

For all serious medical emergencies (including mental health emergencies), to get face-to-face medical help quickly **call 999** or go to your nearest (A&E).

Appendix G: Participation Information Sheet (production)

Exploring Mental Health Television

I am a postgraduate researcher from the Psychology, Psychotherapy & Counselling Division in the School of Applied Social Science at the University of Brighton. I would like to invite you to take part in my study. Before you decide, I want to tell you why I am carrying out this research and what is involved in taking part. Please read this information sheet carefully. Feel free to ask any questions if anything is not clear or discuss it with other people.

What is the purpose of the study?
The focus of my research is factual TV series that involve people taking part in therapy, or other activities, designed to help them with their mental health and wellbeing. Examples include *Mind Over Marathon (BBC1)*, *The Hoarder Next Door (C4), Freaky Eaters (BBC3) and Obsessive Compulsive Cleaners (C4).* I am aiming to find out how TV participants find the experience of being filmed and appearing on television and about the support they have received. I plan to talk to TV participants, production teams and therapists who have been involved in these kind of shows and identify common themes and factors that make participation successful and what the challenges may be.

Why have I been invited to participate?
You have been invited to take part in the research because you were previously involved in the making of a TV series about mental health and wellbeing that is relevant to my research.

Do I have to take part?
No, taking part in the research is entirely voluntary. If you would like to be involved you will be asked to sign a consent form before any information is collected, however you can change your mind or withdraw from the study up to two months after taking part. In this case, I will ask whether any information already provided can still be used or whether it should be deleted. You are encouraged to talk about any concerns you might have at any time during the course of taking part in the research.

What is involved?
Taking part in the research involves being interviewed one on one by myself. The interviews will normally take 1-2 hours, but the time can be flexible depending on your needs. The interview can be arranged at a location that is convenient and comfortable for you or by Skype. Whilst there are some particular topics I am interested in and will ask questions about, the interviews will be informal, and you will be free to ask questions and talk about things that are meaningful and important to you.

All the interviews will be audio recorded as it is important I capture your thoughts and experiences in your own words. The audio recordings from interviews will be transferred from the digital recorder to a secure, password protected, space on the University of Brighton computer server. Only myself and my PhD supervisors will have access to the recordings. No information from the interviews will be shared with anyone else involved in the TV production.

What are the potential disadvantages or risks of taking part?
It is hoped that sharing your experiences about the making of the series will be a positive process however it may be that you find the experience a little uncomfortable or you may feel anxious about something you have said or done. You are encouraged to talk about any concerns you have during the research process with myself.

What are the potential benefits of taking part?
This research is an opportunity to share your first hand experiences of making the series. More broadly, it is hoped the research will give some insight into how best to provide support for people with mental health issues that are taking part in TV series.

Who will know I have taken part in the research?
It is up to you who you tell about your participation in the research. Any correspondence or interview will take place in private and your personal information will be treated as confidential. Your name or personal details will not be used in any documents based on the research findings without your permission. I will alter details that might identify you, for example each participant will be given a fictitious name to protect their anonymity.

What will happen to the results of the project?
The research will form the basis of my PhD studies. The study findings will be available online and I hope to publish articles, so the learning can be shared more widely.

Will I be paid for taking part?
I cannot pay you for your time however I can offer you a voucher for £10 towards any travel expenses

Who is funding the research?
The research is being funded by the Economic Social Research Council.

What if there is a problem?
I hope that you will feel able to raise any concerns or questions with myself in the first instance, but if you would prefer to speak to someone else, then please contact Matthew Adams (PhD supervisor).

Thank you for reading this information. Please feel free to get in touch with any questions.

Contact information

Researcher
Hannah Selby School of Applied Social Science Watson House, Falmer University of Brighton BN1 9PH **Email: h.selby@brighton.ac.uk Tel: 07811 379 084**

Lead Supervisor	**Independent contact (not involved in the research)**
Matthew Adams School of Applied Social Science Watson House, Falmer University of Brighton, BN1 9PH **Email:** **Matthew.Adams@brighton.ac.uk** **Tel:** 01273 644518	**Mark Erickson** School of Applied Social Science Watson House, Falmer University of Brighton, BN1 9PH **Email: mark.erickson@brighton.ac.uk** **Tel:** 01273 641085

This study has been reviewed and approved by the School of Applied Social Science Research Ethics and Governance Committee of the University of Brighton.

Appendix H: Participant Consent form

University of Brighton

Participant Consent Form: Exploring Mental Health Television

	Please initial or tick box
I have read and understood the information sheet for the above study, and have had the opportunity to consider the information and ask questions.	☐
The researcher has explained to my satisfaction the purpose of the study and what is involved in taking part	☐
I agree to take part in a one to one interview for this study about mental health television.	☐
I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving a reason	☐
Should I withdraw from the study, I understand that I can decide whether the researcher can use the information provided by me already, or to have it deleted.	☐
I understand how the data collected will be used, and that any confidential information will only be known to the researchers and her PhD supervisors and will not be revealed to anyone else. The only exception would be if the researcher was concerned someone may be at risk in which case she will talk to me first.	☐
I understand that the researcher will be audio recording interviews	☐

.....

Name of Participant, Date, Signature

.....

Name of Researcher, Date, Signature

Appendix I: Narrative analysis contributor stories summary table

Contributor	Programme	Core narrative	Tone	Genre
Sarah	Physical intervention	*"The happiness, the heartbreak, the hope"* Sharing my story to making up for the loss of loved ones	Optimistic Determined	Quest/triumph over adversity
Kate	Physical intervention	*"You literally had all the help you could possibly get and you still failed"* Dealing with failure on national television	Pessimistic Resentment	Quest/ tragedy
Dom	Physical intervention	*"I was just trying to enjoy this I knew I'd remember that experience forever"* Trust allowed me to embrace a unique experience	Optimistic Fun	Quest/ Adventure
George	Group therapy	*"I wanted for them to show that I was crying and shouting and screaming"* Getting recognition for the difficulties of mental distress	Optimistic Defiant	Quest/ manifesto
Laura	Group therapy	"We like literally speak every day" Friendships keep the therapy going (peer support)	Optimistic Fun	Quest/ adventure
Ali	Group therapy	*"It helped massively in that it gave me a group of friends"* It made me stronger now I am not alone (being understood for the first time)	Optimistic Fun	Quest/ adventure
Chloe	Hoarding	*"I can tell my story of why I ended up the way I am"* The therapeutic process of telling my story (recognition)	Enduring Defiant	Quest/ Tragedy
Susie	Hoarding	*"I'm in control of this. I want to be in control of this."* Taking back control – of my story and life	Optimistic Defiant	Quest/ rebirth
Robin	Hoarding	*"I learned a lot about myself whilst I was doing it"* The TV experience helped me move forward, I'm never going back	Optimistic Fun	Quest/ enlightenment