

**From ‘Talking Cure’ to ‘Bedlam’: A study of the factors
impacting on the construction of UK factual psychotherapy
programming 1999 to 2013.**

by

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Abstract

This thesis extends research on UK factual television by investigating programming that has not previously been studied, and by utilising a mixed-method research design that situates textual analysis within broader cultural, professional and industrial contexts. It presents the findings of research into how factual television constructs representations of the psychotherapeutic process. It examines how constructions of the psychotherapeutic process changed during the 2000s; specifically, how established ways of making factual psychotherapy programmes with the cooperation of psychotherapeutic institutions changed during this decade, leading to new kinds of representations of the psychotherapeutic process.

The study begins with a consideration of the contextual factors that led to this development. It identifies legislative, industrial, technological and professional developments in UK television, including the emergence of reality television programming, the introduction of new television channels, and the breakdown of traditional production roles and practices. It identifies influential developments within the psychotherapeutic domain, including the rise of cognitive behavioural therapy. This study argues that it is the combination of these factors that led to the psychotherapeutic process becoming more amenable and attractive to programme-makers and audiences.

The central section presents the results of detailed textual analysis of the sampled programmes, culminating in case studies that exemplify the phenomenon under study. This analysis identifies how representations of the psychotherapeutic process are constructed differently in programmes that are made without the direct involvement of psychotherapeutic institutions. The findings of this analysis reveal the emergence of new areas of tension, particularly around narrative closure.

The study concludes with an examination of how representations of the psychotherapeutic process have continued to evolve into the 2010s. It argues that while there was a return to programming that utilises the institutional setting, this development continues to reflect the changes that took place within factual psychotherapy programming during the mid-2000s.

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Chapter 1: Introduction

The impetus for this study came from the viewing of a single television programme broadcast on Channel 4 in 2005. The programme - titled *The House of Obsessive Compulsives* (Channel 4, 2005) - told the story of three individuals with long-term and life-disrupting obsessive compulsive disorder who were filmed undergoing psychotherapeutic treatment delivered by a team of psychotherapists from the Institute of Psychiatry at King's College London. What was distinctive about the programme was the setting in which the psychotherapy took place: in a so-called 'ordinary house' where they also lived while undergoing treatment. The 'psychotherapeutic project' of *The House of Obsessive Compulsives* is presented early in the first episode when the voice-over announces that, 'the three volunteers will live together...until they are cured of their obsessions'. The programme's lead psychotherapist explains that the treatment is 'intensive...we actually focus the time on a few days'; captions across the programme's two episodes show that the treatment takes place over nine consecutive days. The final episode concludes with an update on the progress of each volunteer, who have responded to the treatment with varying degrees of success, and by implication, failure.

The House of Obsessive Compulsives was not the first UK-originated factual television programme to feature psychotherapy in a non-institutional setting, but it was the first to fully extend the way it used the non-institutional setting, by renting a house and moving the volunteers into it to live while they were undergoing psychotherapy. This arrangement brought to mind Biressi and Nunn's observation that in contemporary popular factual television, emotional themes are frequently 'staged within the domestic space and/or with real families or temporary families of participants' (Biressi & Nunn, 2005, p. 21).

The programme's two episodes achieved high viewing figures: the first achieving 3.4 million (Broadcast, 2005, para. 2), and the second 2.3 million (The Guardian, 2005a, para. 12). The level of publicity surrounding the programme was significant. The broadcast of the first episode, on Monday 1st August 2005, was reviewed by every UK national newspaper. A number of specialist psychotherapeutic and medical journals carried reviews. There were numerous references to the *Big Brother* house: the property used in the programme was described as a 'very un-Big Brother-looking house' (Virtue,

2005, p. 36); while an article in a specialist community care magazine remarked that, ‘Putting wacky characters together in a house and watching how they get along has been a tried and tested route to success of television producers since the first series of *Big Brother*’ (Leason, 2005, para. 2); another article in the *British Medical Journal* commented that ‘They were treated in a house, not a hospital, but you could not help feeling that this was as much to suit the television production producers as the therapists’ (Dosani, 2005, p. 409). Responses to *The House Of Obsessive Compulsives* fell into two positions: those who viewed the programme as an example of exploitative reality television, and those who recognised the influence of reality television but felt this did not stop the programme doing good work.

1.1 Factual Psychotherapy Programming: An Overview

Factual psychotherapy programming is the term used in this study to refer to television programmes that feature psychotherapeutic actuality. Despite the many obstacles to filming psychotherapy, associated with the private and usually confidential nature of the psychotherapeutic process, the risk of stigma from being identified as having a mental health problem, and the considerable practical and ethical challenges facing programme-makers who want to access psychotherapy for the purposes of making a television programme, factual psychotherapy programmes still get made. This was illustrated recently in the case of *Bedlam* (Channel 4, 2013), a four-part series about a specialist mental health hospital, the South London and Maudsley NHS Foundation Trust. Mental health professionals were filmed working with individuals with a variety of mental health problems, in both the community and in institutional settings. The series was made following months of negotiation. The programme’s executive producer has described spending ‘four months meeting senior people in the Trust’ (Flanagan, 2013). The four-part series took over two years to make (Hall, 2013, para. 7).

This opening up of the psychotherapeutic process to television programme-makers by institutions such as hospitals, prisons, and mental health units illustrates a long-standing arrangement that typifies how factual television programmes about psychotherapy have been made. The negotiated, but mutually-beneficial, relationship between programme-makers and psychotherapeutically-orientated institutions is illustrated in how these institutions explain their motivation for getting involved with programme-makers. In the case of the South London and Maudsley Trust, it offered three reasons for its involvement with the programme *Bedlam*; ‘to promote public

awareness and understanding of mental health...to show people what we do and how it can make a real difference to the lives of the vulnerable people who use our services...(and) in an increasingly competitive environment with diminishing resources available, we can't afford to be shy and retiring about promoting our strengths, our services and our brand' (Charlton, 2013, paras. 6-7).

The first major factual television series about mental health problems and their treatment - *The Hurt Mind* (BBC One, 1957) - secured access to NHS psychiatric hospitals. Many other psychotherapeutically-orientated institutions have granted access to programme-makers over the years. There have been a number of programmes about Aycliffe School, a regional assessment and treatment centre for children with severe behavioural and mental health problems, and Peper Harow, an ex-approved school for boys, that became a therapeutic community. The Tavistock Clinic, the UK's largest NHS psychotherapy centre, granted access to programme-makers to make a six-part series, *Talking Cure* (BBC Two, 1999). I would also include programmes based at The Priory, a private psychiatric hospital. The most prolific relationship has been between programme-makers and the South London & Maudsley NHS Trust, which has granted access to programme-makers more than any other psychotherapeutically-orientated institution, both within my research timeline and before. Many other psychotherapeutically-orientated institutions - clinics, psychiatric hospitals, approved schools, mental health units - have granted access to television programme-makers on a one-off basis.

My own expertise in this subject has been informed by a long-standing interest in psychotherapy which led to the study of psychology at undergraduate level, the acquisition of qualifications in counselling skills, and through professional experience in television production and post-production during the 1980s. It was during my time as a researcher on the BBC current affairs series *Brass Tacks*, that I worked on a programme - *Terms of Abuse* (BBC Two, 1987) - that featured the filming of psychotherapeutic actuality. During the making of this programme - about the high levels of recidivism among sex offenders - I attended a shoot at Grendon Underwood psychiatric prison that included the filming of convicted sex offenders in a group psychotherapy session. From the protracted negotiations involved in securing access to this institution and its psychotherapy sessions, I learned how difficult it could be to secure permission to film psychotherapeutic treatment that takes place within an

institutional setting. However, this experience also showed me that there were institutions willing to grant access, often with the aim of either promoting or demystifying their work. This is illustrated clearly in the case of Grendon Underwood, about which a number of television programmes have been made in addition to the one on which I worked. The primary effect of this arrangement, historically at least, has been to locate British factual television's utilisation of psychotherapeutic actuality as programme content firmly within an institutional setting. It is against this programme-making backdrop that the emergence of the non-institutional factual psychotherapy programme must be situated.

1.2 Research Questions & Study Aims

This study identifies the factors that impacted on the construction of UK factual psychotherapy programming broadcast between 1999 and 2013. Behind this title is the suggestion of a new programming form, referred to in this study as non-institutional factual psychotherapy programming, that emerged in the mid-2000s and whose most distinctive characteristic is the delivery of psychotherapeutic treatment in the non-institutional setting. The primary aims of this study are to describe, analyse, contextualise, and explain the emergence of this new form of factual psychotherapy programming, and to identify the new constructions of the psychotherapeutic process it articulates. In order to capture the emergence of this new form of factual psychotherapy programming, the study considers programmes broadcast between 1999 and 2013. In order to identify the changing constructions of the psychotherapeutic process, comparisons will be made with institutionally-based programmes produced in the same period. To contextualise this research, the study looks at broader changes and developments within the television landscape and within the psychotherapeutic domain.

1.3 Existing Research & Study Contribution

‘When you’ve found a question that interests you, it’s also necessary to identify the texts that you think will be useful in trying to answer that question. Often, these two stages in the research occur at the same time - you come across a text that strikes you as interesting, that makes you think about processes of sense-making in a new way, and leads you on to a research track looking for other relevant texts’ (McKee, 2003, p. 91).

This quotation from Alan McKee encapsulates the approach taken to the combined activities of primary and secondary research conducted during the production of this study. Having identified a phenomenon that I wished to research, I looked at the literature to find work that would enable and inform my own research. In the first instance, because of the niche area I was researching, and because the programmes I had chosen had not been studied previously, there appeared to be a lack of directly relevant literature. However, as the research process progressed, it has become possible to identify a milieu for my study.

The literature on therapeutic culture will be used to provide a contextual framework for my research, for thinking about the wider context within which factual psychotherapy programmes are produced and consumed, and for explaining why programmes about psychology and the psychotherapeutic have long been popular on television. The complexities of the therapeutic culture literature, and the many positions that can be adopted by it, are not the focus of this study. What this literature brings to this study is a theoretical framework that facilitates discussion and explanation.

The other research fields identified here have a more obvious association with this study. The literature on how psychotherapy has been used within television programming, such as work on the daytime talk show, on the agony aunt and phone-in strands in daytime television programmes, and on the occasional experiments in psychotherapy-by-television provides an unexpected focus for my own research into non-institutional factual psychotherapy programming. This study makes use of the literature in the construction of ‘therapy talk’ in daytime talk shows and celebrity talk shows. It draws on work in confessional television and extends the scope of this literature to consider research from social psychology on self-disclosure. It makes use of the extensive field on representations of mental health problems in factual television and identifies the possibility of a small contribution to this research literature through the examination of how anxiety disorders are represented in the sampled programmes.

The literature on the construction of expertise in factual television has provided a useful framework for examining the construction of psychotherapeutic expertise in the sampled programmes, and for contextualising my findings of the differences in how expertise is constructed in both institutional and non-institutional settings. I include here work on representations of psychotherapists, even though this literature is heavily biased towards the study of fictional representations, and anticipate that there will be

scope to contribute to this literature my own research findings on how psychotherapists are represented in factual television. The examination of how expertise is constructed in the sampled programmes will also draw on the literature on reality television, lifestyle television and makeover programming that has extended the literature on expertise, and also for its relevance to understanding the changes and developments taking place in factual and popular factual television during the research timeline.

1.4 Terminology & Definitions

The term psychotherapy can be difficult to define, given the ‘vast realm of possibilities inherent within the term’ (Spinelli, 1994, p. 23). Karasu (1986) has estimated that there are over four hundred distinct models of counselling and psychotherapy. The psychotherapeutic scenario encompasses numerous scenarios; in practical terms, it can mean ‘a motley assortment, ranging from five days a week, 50 minutes a day, potentially interminable psychoanalysis, through brief psychotherapy, cognitive therapy, behavioural therapy, rational emotive therapy, and a whole variety of other therapeutic practices and sites’ (Rose, 2001, p. 2). The likelihood is that readers of this study will have their own ideas about what the term psychotherapy means or implies.

Throughout this study, I use the term *psychotherapy* in a general rather than specific way, to refer to any ‘psycho-dynamically or psychologically-informed practice’ (Rose, 2001, p. 2) where the broad aim is to ameliorate or resolve a mental health problem. My use of the term does not promote or privilege any particular psychotherapeutic modality but is used to represent all or any modality simultaneously. However, to counter criticism of the sort aimed at Furedi (2004) who, it is claimed, ‘tends to collapse all the different therapies under the same label as “the authoritarian world view” and fails to differentiate between the methods of CBT advocated by the government and those of psychoanalytic psychotherapy’ (Yates, 2011, p. 63), it should be noted that there will be occasions within this study when it is both appropriate and pertinent to refer to specific psychotherapeutic modalities.

The focus of this study is factual television programmes that feature filmed and edited sequences containing encounters between psychotherapists and volunteers. Here, psychotherapeutic treatment is delivered and received, irrespective of the mental health problem, the treatment modality, the setting, and the number of psychotherapists and volunteers involved. To define more precisely what qualifies as a psychotherapeutic encounter, I refer to the model presented by Spinelli (1994, p. 10) - based on the work

of Holmes and Lindley (1989) - that sets out three key characteristics for the psychotherapeutic encounter. First, it must take place in a specifically-designated environment, most typically in a clinical or institutional setting, but can be set in any environmental ‘frame’ deemed appropriate. Second, what is being presented as a psychotherapeutic encounter is done so according to a designated authority, such as a professional regulatory body. Third, the encounter is defined or perceived to be psychotherapeutic by at least one of its participants.

The practitioners who deliver the psychotherapeutic treatment are referred to in this study as psychotherapists and are defined as those who have undergone extensive professional training in the ‘psychosciences and disciplines – psychology, psychiatry, and their cognates’ (Rose, 1998, p. 2), a definition that covers ‘psychoanalysts, psychotherapists, clinical psychologists, counsellors...(and) psychiatrists’ (Dryden & Feltham, 1992, p. 5). To qualify for inclusion in this study’s research sample, programmes must feature psychotherapists who have contemporaneous membership of a UK-based professional body. The term *psychotherapist* is used to describe any professional who delivers psychotherapeutic treatment in one or more of the sampled programmes, even if this is not their official title, or how they would define themselves. Furthermore, I have excluded programmes that feature individuals who may call themselves psychotherapists but who do not fulfil the inclusion criteria.

For those individuals who agree to take part in filmed psychotherapeutic actuality, I use the term *volunteer* rather than *patient* or *client*. The term *volunteer* avoids the conservative or institutional connotations associated with terms such as *patient* or *client*. I have chosen the term *volunteer* because it foregrounds the fact that any individual who participates in filmed psychotherapeutic actuality must first have given their informed consent to be filmed. Their participation, therefore, can be regarded as voluntary in all instances. I reject the criticism that using the term ‘volunteer’ absolves programme-makers of responsibility for people who take part in television programmes (Wilson, 2005, para. 6). The value of the term volunteer is that it is equally applicable to a participant who has been recruited through an advert placed in a newspaper or online forum, and a participant who has been detained under the 1983 Mental Health Act and has agreed to be filmed during mandatory psychotherapeutic treatment. There are no programmes in the research sample where an individual has been filmed without their consent. In a few examples, the identity of a volunteer has been withheld. For example,

in *Bedlam: Anxiety*, the face of one volunteer is not revealed. Such an arrangement is likely to be the result of negotiations during the informed consent process, or perhaps as a result of information that came to light after filming had taken place. *Sectioned* (BBC Four, 2010) includes footage of the programme's three volunteers, all of whom are detained under the 1983 Mental Health Act, giving on-camera consent (Anthony, 2010).

The term used to represent the various so-called conditions, disorders and psychological problems experienced by volunteers in the sampled programmes are referred to, collectively, as *mental health problems*. This choice of the term reflects the outcome of a review of contemporary secondary sources, including specialist mental health publications, mental health websites, and online mental health forums, that discourage use of the term *mental illness*. There are, however, occasions within the study when specific mental health problems are referred to according to the classificatory titles given to them within established official mental health classificatory systems, such as the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder* (DSM), and the *World Health Organisation's International Classification of Diseases* (ICD). These publications are discussed further in Chapter 4. The terms obsessive compulsive disorder, hoarding disorder, and phobia are used frequently within this study in certain contexts. It is recognised that such categories are not fixed and absolute and that the definitions and boundaries of established mental health problems are routinely contested and redefined.

1.5 Research Ethics

A full account of my approach to research ethics is presented in Chapter 3. The nature of this study, and the research process which has involved the analysis of programmes that feature individuals with mental health problems has necessitated additional considerations about the ethical aspects of the research process. I have already explored the ethical concerns facing media practitioners who make programmes which feature psychotherapeutic actuality (Blaker, 2013). I now extend this consideration to the academic research process. Given that this study will become digitally available, the primary aim throughout the research process was to conduct the research process in ways that would not subject the programme volunteers to any additional and unnecessary exposure. The strategies adopted to minimise this possibility are discussed in Chapter 3.

Throughout the research process, I have remained aware that I am not a psychotherapeutic expert, and that my level of psychotherapeutic knowledge is, at best, that of informed amateur. Consequently, I have been vigilant to avoid any evaluations of represented psychotherapeutic practice or diagnosis. The stringent inclusion criteria of my research sample ensure that the psychotherapists who feature in the sampled programmes have all undertaken extensive professional training and have contemporaneous membership of a UK-based professional regulatory body. In this regard, they are all ‘qualified’ to deliver the psychotherapeutic treatment which is shown in the programmes, irrespective of the setting of the psychotherapy.

1.6 Thesis Structure

Chapter 2 reviews the literature that has provided a framework for the research carried out within this study, and identifies the work that has been influential on my research. In doing so, it positions the research undertaken and informs the research questions set within the study about the changing constructions of the psychotherapeutic process in different kinds of factual psychotherapy programming. The review adopts a television studies focus but reflects, to some extent, on the wider reading undertaken during the research process. The limited use of literature from psychotherapeutic studies is a signal that this is not intended to be viewed as a piece of cross-disciplinary research. The chapter is structured in terms of a review of the literature that is directly relevant to this study, including therapeutic culture, constructions of expertise on television, psychotherapeutic television programming, reality television, and work on televisual representations of the psychotherapeutic process, psychotherapists and mental health problems.

Chapter 3 sets out my research strategy and demonstrates how it has been informed by both my research questions and the literature. It provides a rationale for the use of a mixed-method approach that utilises both qualitative and quantitative analysis. It explains how the primary data sets generated for use within this study - factual television programmes and their associated materials - were generated, and reviews the research methodologies that are used to analyse them. In each instance, the strengths and potential limitations are critically evaluated.

Chapter 4 presents a set of contextual frameworks for situating the research findings presented in Chapters 5 and 6. It begins with a review of the UK television industry between 1999 and 2013. This review identifies legislative, technological,

industrial, and professional changes and developments that took place during the research timeline, and considers the impact of these changes and developments on programme-making practice. To a lesser extent, it reviews changes and developments taking place within the psychotherapeutic domain during the same period, with particular reference to developments affecting the use of particular psychotherapeutic modalities, or changes in mental health designations, that may have influenced constructions of the psychotherapeutic process in factual psychotherapy programming. The final section presents the results of a content analysis of the research sample intended as a contextualising framework for the programme analysis findings presented in Chapters 5 and 6.

Chapter 5 presents the results of a programme analysis of the research sample. The chapter is structured around four main themes - subject, setting, expertise, and outcome - that are used to focus the analysis and enable a comparative analysis of institutional and non-institutional factual psychotherapy programming. While this analysis will identify areas of similarity, the primary aim of the comparative analysis of institutional and non-institutional factual psychotherapy programming is to identify the key areas of difference between the two forms and to use these findings as the basis for a more detailed analysis in the following chapter.

Chapter 6 presents the remaining findings, generated through three case studies of non-institutional factual psychotherapy programmes that have been selected for their exemplary character. The programmes that have been selected for case study analysis are *House of Agoraphobics* (Channel 4, 2006), *The Panic Room* (BBC Three, 2007), and the first series of *The Hoarder Next Door* (Channel 4, 2012). These programmes, which have not previously been subject to academic study, have been selected because they exemplify, in different ways, the new form of factual psychotherapy programming referred to in this study as non-institutional factual psychotherapy programming. These case studies explore how each programme negotiates the departure from the institutional setting and how, in doing so, they devise new constructions of the psychotherapeutic process.

Chapter 7 concludes the study by revisiting its main aim - to identify and explain the changing constructions of the psychotherapeutic process in factual television between 1999 and 2013. It summarises the study's main research findings and reiterates the key finding that the single most important precondition for the emergence of these

new constructions of the psychotherapeutic process was the departure by programme-makers from the institutional setting. From this point, the study's focus is on analysing the character of those new constructions of the psychotherapeutic process as articulated in non-institutional factual psychotherapy programming. This chapter then reviews the study's research design and research methodologies, reflecting upon the research process and identifying potential limitations. Finally, it summarises the potential contributions made to the literature, which emanate from the decision to study a sample of programmes which have not previously been researched.

Chapter 2: Literature Review

The approach taken within this literature review has been shaped by the nature of the research I have decided to undertake. The purpose of the literature review has been to position the research undertaken in this study, and to inform my research questions about constructions of the psychotherapeutic process in different kinds of factual psychotherapy programming. The need to position my research within the broader academic landscape, to provide a theoretical framework for this research, and to identify areas where contributions may be made have driven this literature review. My reading across the eight years during which I have been working on this study was considerably broader than is represented here. My research has taken me on a journey through a number of different research fields, including television studies, cultural studies, psychotherapeutic studies and critical psychology. The limited use of literature from the psychotherapeutic studies field is intended as a signal that this is not a piece of cross-disciplinary research; this study is, first and foremost, a piece of television studies research. The narrowing of the literature to the most relevant and influential work has been the outcome of deliberations as to the nature and purpose of this study. This chapter, therefore, presents the work that has been most directly relevant to this study, which it surveys and critically evaluates. While the most up-to-date secondary sources have been identified, older sources are occasionally included where they have particular importance, or where they refer to time-specific developments. This review summarises the trends, agreements, debates, and gaps within these fields in order to position my own research.

2.1 Therapeutic Culture

In the early stages of my research, I consulted the literature on therapeutic culture. This provided a useful theoretical framework for thinking about the wider context within which factual psychotherapy programmes are produced and consumed. The construct of therapeutic culture has provided concepts and terminologies that facilitate discussion and explanation, providing coherence by linking the elements of relevance to this study. A range of alternative terms exists for this phenomenon: *therapeutic culture* (Richards, 2007; Wright, 2011), *therapy culture* (Furedi, 2004), and *therapeutic turn* (Yates, 2011).

The term *therapeutic culture*, and others like it, refer to a historically-specific stage in a society's development; Western capitalist liberal democracies in particular. It has been argued that culture becomes 'therapeutic' when psychological and psychotherapeutic discourses are its 'emblematic manifestations' (Wright, 2011, p. 1). Therapeutic cultures create a 'way of thinking' (Bellah et al., 1996, p. 113) that move far beyond the clinical consulting room and the relationship between individuals and psychotherapists 'to shaping public perceptions about a variety of issues' (Furedi, 2004, p. 22). Therapeutic cultures are said to encompass 'a multifaceted spectrum of discourses, social practices, and cultural artefacts that discursively and institutionally pervade social and cultural life' (Wright, 2011, p. 1). This is expressed through popular culture and the media in their offers to heal and be healed at every turn (Yates, 2011).

The emergence of therapeutic culture is widely accepted to be a twentieth-century phenomenon. Its literature is vast, having built gradually, and unevenly, over five decades, in different countries and within different academic traditions. The result may be a broadly coherent acceptance of the existence of therapeutic culture but with competing accounts and explanations of how and why therapeutic cultures emerge. For example, work produced in the 1960s and 1970s USA (e.g. Lasch, 1979; Reiff, 1966), that focuses on explanations centring around the decline of religion and the rise of narcissism; work produced in the late 1980s, 1990s and 2000s in the UK setting (e.g. Furedi, 2004; Rose, 1989, 1998, 2001), that gave rise to a body of work known as governmentality theory; and work produced in the 1990s UK produced by writers working within the sociological tradition on individualisation and reflexive modernity (e.g. Beck, 1992; Giddens, 1991); more recent work has looked to reframe discussions about therapeutic culture in ways that suggest its possible benefits (Apperley, Jacobs, & Jones, 2014; Aubry & Travis, 2015; Wright, 2011). The scope of this literature demonstrates that while the rise of therapeutic culture in contemporary societies is broadly acknowledged, there are disagreements about the nature of its influence and its role in shaping subjectivities. While 'myriad institutions, practices, and beliefs combine to form a therapeutic culture, and present a fairly predictable set of ideas about the relationship between the self and society', it is 'no monolith' (Aubry & Travis, 2015, pp. 18-19).

Similarly, there are different ways to position factual television programming within ideas drawn from the literature on therapeutic culture. One approach uses the

governmentality approach to frame popular cultural artefacts such as television programmes as one of the ways governance operates, ‘through the dispersal of techniques of the self through which individuals manage and control their own conduct’ (Lunt, 2008, p. 539). Another approach might focus on the way that factual television programmes promote psychotherapeutically-driven ideas that ‘use...the individual psyche to explain social phenomena, and the belief that social problems can be resolved with psychological management’ (Peck, 1995, p. 58). One might look at how factual television programming acts as a conduit for the language and terminology of therapeutic culture, which has been described as ‘a script through which emotional deficits “make their way into the cultural vernacular” and become available for ‘the construction of everyday reality’ (Gergen, 1990, p. 362), so much so that it,

extends beyond the consultation, the interview, the appointments; it has become part of the staple fare of the mass media of communication, in the magazine advice column and in documentaries and discussions on television. No financial exchange can be involved, for on live radio ‘phone-in’ programmes we may confess our most intimate problems for free and have them instantly analysed - or eavesdrop on the difficulties that so many of our fellow citizens appear to have conducting the business of their lives. (Rose, 1989, p. 218).

In this respect, factual psychotherapy programming may join with the confessional books, daytime talk shows, reality television series, tabloid newspaper columns, popular magazines, and online chat rooms that demonstrate the operation of therapeutic culture. The literature has shown that the operation of therapeutic culture has moved beyond the obviously psychotherapeutic - such as programmes that have overt psychotherapeutic content - and has, in fact, ‘infiltrated’ radio and television programming to become ‘ubiquitous’ (Brunvatne & Tolson, 2001, p. 140). It is argued that the operation of therapeutic culture is evident in factual television’s increasing preoccupation with approaches that ‘underscore the personal, sensational, the subjective, the confessional, the intimate’ (Dahlgren, 2005, p. 416); approaches that characterise ‘the changing nature of factual television brought about by the action of ‘first-person media’...(s)ubjective, autobiographical and confessional modes of expression (that) proliferated during the 1990s - across print journalism, literature, factual TV

programming and digital media' (Dovey, 2000, p. 1), leading to 'increasing attention to the subjective in documentary television' (Biressi & Nunn, 2005, p. 70). These developments have become so embedded in the way that factual television operates that it has been argued that the 'public disclosure and narrativisation of personal identity is a crucial ingredient of a revitalised (and economically viable) factual TV market' (Biressi & Nunn, 2005, p. 96).

As a researcher working with factual television programmes that feature the psychotherapeutic process, it was an unexpected discovery that these programmes had not yet been extensively analysed by other researchers. Research conducted on these programmes will complement the work already done on psychotherapeutically-orientated factual television programmes that, in the context of this study, are defined as quasi-psychotherapeutic, in the sense that they have been constructed to 'look' and 'behave' like psychotherapy but have no direct relationship to psychotherapy that actually took place. This includes work on the more therapeutically-orientated UK-originated daytime talk shows, such as *Trisha* (ITV, 1998-2004) and *Vanessa* (ITV, 1998-2004) (e.g. Tolson, 2001; Wood, 2009); to work on interview programmes that are constructed as psychotherapeutic conversation, such as *Face to Face* (BBC Two, 1959-1962; 1989-1998) (Holmes, 2008; Nunn & Biressi, 2010); to work on celebrity chat shows conducted by qualified psychotherapists, such as *Shrink Rap* (More4, 2007-2010) (Nunn & Biressi, 2010; Waddell, 2014); and parenting programmes that are presented by psychotherapists but operate within the sphere of 'guidance', such as *The House of Tiny Tearaways* (Lury, 2009) and *Little Angels* (Lunt, 2008).

2.2 Psychotherapeutic Expertise

Psychotherapeutic experts who appear on, or act as consultants on factual television programmes, are often referred to as *media psychologists*. Media psychology is a generic term used to refer to both the academic study of the mass media from a psychological perspective, and to 'the notion of media psychology as a practice' (Giles, 2003, p. 12). Psychotherapeutic experts associated with television programming can be 'difficult to categorize since some are regular and some appear intermittently. Some experts are so popular that they become regulars. They may even be institutionalised' (Bonner, 2003, p. 78). Those psychotherapists who make regular appearances on television are more likely to be classified as 'media psychologists'. In the US 'there has been a long tradition of psychologists appearing in the media in a variety of guises'

(Giles, 2003, p. 274) but in the UK setting, psychotherapeutic experts ‘have proved to be less attractive to media producers...or maybe less forthright in self-promotion (Giles, 2003, p. 273). Psychotherapists appear in most kinds of factual television programme, occupying a number of possible roles both on-screen and behind the camera. Their role may be to provide expert commentary, deliver expert practice or act as consultants behind the scenes. Whatever their role, it is likely that psychotherapists regard television as a space where they can promote their psychotherapeutic expertise in exchange for public visibility (Murdock, 1994).

The psychotherapists examined within this study are a distinct group of professionals, distinguished by their combined expert psychotherapeutic knowledge and expert psychotherapeutic practice. These are individuals who work as psychotherapists, often in institutional settings, and occasionally as academic researchers. This particular configuration of psychotherapeutic expertise was a consequence of my sampling strategy; it was a requirement that the psychotherapists who deliver the psychotherapeutic treatment within the sampled programmes had undertaken extensive professional training in a psychotherapeutic discipline, and be operating under the regulation of a UK-based professional psychotherapeutic body. One outcome of this decision is an opportunity to examine constructions of highly-specialised psychotherapeutic expertise within factual television programming that showcases their psychotherapeutic practice.

The literature on therapeutic culture has identified the emergence of ‘a whole new form of expertise, an expertise of subjectivity’ (Rose, 1998, p. 2). These new experts in subjectivity ‘have succeeded in colonizing the professions with their own vocabularies, images, evaluations and techniques...extending and increasing the sites for the operation of therapeutic encounters’ (Rose, 1989, p. 248). One aim of this study is to demonstrate how such psychotherapeutic experts ‘are positioned as holding expert bodies of knowledge, which are specific to them and their professional group’ (Edwards & Nicoll, 2006, p. 120). This study will identify how factual psychotherapy programming constructs such ‘specialized knowledge’ (Bonner, 2003, p. 86) and ‘institutional discourse’ (Tolson, 2001, p. 16).

What this study does not do, because it is not part of its remit, is examine constructions of psychotherapeutic expertise associated with lifestyle television and makeover shows, genres that, while making significant use of expert input (Bonner,

2003), are associated with psychotherapeutic experts who might be described as belonging to a 'loose coalition of self-help entrepreneurs and assorted therapists' (Palmer, 2008, p. 9). It has been suggested that experts who feature in reality television programming are more likely to characterise themselves as self-made authorities (Ouellette & Hay, 2008). Nor does this study refer to the literature on constructions of expertise in the daytime talk show - a genre that 'rel(ies) overwhelmingly on experts out of the mental health industry' (Shattuc, 1997, p. 112) - because this programme form, at least in the UK setting, does not feature psychotherapeutic actuality as defined within this study.

Where the literature on expertise is relevant is through its exploration of the ways that psychotherapeutic expertise has been diluted or undermined within factual television programming. Research into the management of psychotherapeutic experts on talk shows has shown that psychotherapists are often deprived of their expert discourse (Giles, 2003, p. 276) and that expert psychotherapeutic advice is often rejected and lay knowledge promoted (Livingstone & Lunt, 1994). Shattuc (1997, p. 115) has argued that the daytime talk show 'undercuts the rigors of therapeutic practices and reduces the power of the therapist or expert', primarily because these programmes are 'predicated on a belief in the individual's active cognition of his or her problems' (Shattuc, 1997, p. 115).

It has been argued that 'we are living in a time when professional authority is being questioned or even opposed. If we still use experts, we do so more cynically or cautiously than generations before us' (Pilgrim, 2002, p. 13). In television, as elsewhere, experts and expertise have become subject to greater accountability and distrust (Edwards & Nicoll, 2006). The literature on therapeutic culture has highlighted the paradoxical relationship between individual empowerment that can be delivered through engagement with the psychotherapeutic process, and the potentially manipulative role of the therapeutic expert (Apperley et al., 2014). The literature raises useful questions for this study, and for the examination of the constructions of psychotherapeutic expertise that will be undertaken. Specifically, it will determine how tensions between constructions of expertise that privilege psychotherapeutic knowledge and practice and the impetus to undermine such expertise are managed.

2.3 Psychotherapy on Television

In the early stages of the research process, the literature was consulted for material that had examined the use of psychotherapeutic actuality as programme content. The earliest coherent body of work that looked at mediated psychotherapy was the work on the US radio call-in programme, in which listeners call in for guidance or advice about a personal, emotional or psychological problem. The act of making contact - often by telephone, sometimes via letter - forms part of the programme content. The psychotherapist responds to the problem, often talking to the person live over the telephone. This programme category has generated a substantial body of published work primarily in the USA in the mid to late 1980s, where this programming genre developed (Bouhoutsos et al., 1991; Raviv, 1989). In the UK setting, this programme form did not develop. An associated television form is the call-in segment within the daytime programme, such as the Raj Persaud segment on the daytime programme *This Morning* (Jiwa, 2012). There have been few examples of this kind of direct psychotherapeutic intervention on UK television. One example is LBC's 'counselling hour' (Dryden, 1992; Hodges, 1998), a late-night programme, broadcast only in the London area, in which a psychotherapist engages in ten to twenty-minute psychotherapeutic exchanges with volunteers who have contacted the production team. This is the closest UK television has seen of the kind of programme identified by White as the 'therapy or counselling show' (White, 1992, p. 25), a programme category that proliferated in the 1980s and involved 're-enactment of therapy sessions or live sessions with an audience and a therapist' (White, 1992, p. 189). Holmes' work on British television in the 1950s has established the early stages of the development of 'problem programming' (Holmes, 2008, p. 119). The main body of work on television programming that utilises psychotherapeutic content is literature associated with the daytime talk show. Although the hosts of such programmes are usually unqualified, programme casts comprise 'psychologists, psychiatrists, psychotherapists, social workers... relationship counsellors...(and) writers of self-help books' (Shattuc, 1997, p. 113). A more recent development has been the emergence of parenting programmes such as *Little Angels* and *The House of Tiny Tearaways*, which are presented by psychotherapeutic experts, including psychotherapeutic professionals who had practised in the National Health Service (Lunt, 2008; Lury, 2009).

What stands out about these programmes is that they are all examples of programmes in which the ‘psychotherapeutic project’ is owned by television professionals rather than by psychotherapeutic professionals. Psychotherapists conduct the psychotherapy, and are likely to have imposed certain constraints over how they perform this service within the programmes, but the ownership of the programme’s psychotherapeutic project lies with the programme-makers. This key distinction has informed my research and led me to reconsider the way I configured my research sample. In those programmes that are filmed in the institutional setting, that are in essence observational documentaries about the psychotherapeutic process in its professional settings and environments, the psychotherapeutic project is ‘owned’ by the institution, and programme-makers negotiate access to it. Non-institutional factual psychotherapy programmes, that have departed from the institutional setting and made alternative arrangements for the management of the psychotherapeutic process, have transitioned into ‘television projects’, and claimed ownership of the programme’s psychotherapeutic project. In this context, non-institutional factual psychotherapy programming may have more in common with the kinds of programmes identified above than they do with their institutional counterparts.

2.4 Therapy Talk

This section draws on literature from different fields to explore the subject of *therapy talk* - the specialised form of talk that characterises the psychotherapeutic encounter. While the phrase *therapy talk* is not a specialised television studies term, it was popularised in television studies literature through its use in research into the daytime talk show (Brunvatne & Tolson, 2001). In the context of the daytime talk show, therapy talk is used to refer to the structured exchanges that take place in the television studio setting between guest, host, and, occasionally, psychotherapeutic expert, whereby ‘problematic experiences are presented as personal projects for individuals to work through beyond the confines of the show’ (Brunvatne & Tolson, 2001, p. 154). The subject matter of these exchanges has been summarised as ‘domestic issues: women’s health, relationship advice, issues around the family, and so on’ (Wood, 2009, p. 9). In cases where the subject gravitates beyond the personal and domestic, the framing of these subjects is always as ‘social issues in a personal perspective’ (Brunvatne & Tolson, 2001, p. 139); in other words the ‘use of the individual psyche to explain social phenomena’ (Peck, 1995, p. 58). During therapy talk exchanges, guests are encouraged

to disclose personal, often traumatic, information through the use of supportive listening behaviours and discursive strategies that facilitate talk (Haarman, 2001). One such strategy, characteristic of the therapeutically-orientated daytime talk show, is the use of the self-disclosure technique by the programme host, in which personal information is shared with the guest, 'lending credibility to her role as concerned and intimate friend who has herself suffered personal problems and now offers solidarity' (Haarman, 2001, p. 47). The exchanges in therapeutically-orientated daytime talk shows are constructed as if 'a rehearsal for proper therapy' (Brunvatne & Tolson, 2001, p. 150). The term therapy talk is also used to refer to the conversational exchanges that take place in celebrity talk shows (Nunn & Biressi, 2010; Waddell, 2014). In this context, therapy talk refers to,

intimate discussions between interviewer and guest in the confined space of a television or radio studio where the emphasis is upon an in-depth personal encounter that goes beyond the usual conventions of the chat show. (Nunn & Biressi, 2010, p. 55).

In such exchanges, interviewer and guest engage in conversational exchanges that overtly reference the psychotherapeutic, all the more so when the interviewer is a qualified psychotherapist who encourages the guest to tell 'the world about their illness, addiction, sex lives and personal hurts' (Furedi, 2004, p. 40).

The most significant consequence of engaging in televised exchanges that feature the disclosure of intimate and highly personal information in the psychotherapeutic mode is that the programme guest or contributor has given 'consent to undisguised and highly public exposure' (Marks, 2000, p. 76). The notion of confidentiality is a fundamental tenet of psychotherapy; the idea that 'what is said in the consulting room stays in the consulting room is utterly necessary for effective psychotherapy' (Yeo, 2003, p. 6). Unsurprisingly, the trading of confidentiality in exchange for the high levels of exposure offered by being part of a television series is viewed as a controversial matter. While one psychotherapist has commented that 'Neither psychotherapy nor psychoanalysis are spectator sports.... Therapy sessions, despite supervision and clinical seminars, are extremely private matters' (Orbach, 2000, para. 1), another has argued that while 'patient confidentiality was breached...it was this very breach that gave the

programme its impact - this was a real therapist doing real work with a real patient' (Marks, 2000, p. 75).

The obvious lack of confidentiality in the television setting, that is played down in quasi-psychotherapeutic televised exchanges, is likely to be a factor in why the authenticity of such exchanges is questioned. Myers has noted the accusations aimed at the producers of daytime talk shows of 'leading participants into insincere performances' (Myers, 2001, p. 73), particularly when programmes are recorded in front of an audience, as in the daytime talk show (Haarman, 2001; Shattuc, 1997) and the television chat show (Tolson, 1991). While 'personal experiences still remain the focus' (Tolson, 1991, p. 187) and an awareness of the audience, both in the studio and 'out there', does not preclude the possibility that these experiences will be recounted honestly and sincerely, 'equally they may be represented as constructions, even fabrications...for the 'game' which is 'good television'' (Tolson, 1991, p. 187).

Television programming that is characterised by '(t)he confession or the baring or private feelings and acts in public' (Shattuc, 2008, p. 167) has become increasingly commonplace. Furedi has used the term *self-disclosure television* (2004, p. 40) to describe such programming, in which 'emotionally injured individuals' share their pain and distress with others. He argues that within therapeutic cultures,

claims about the value of public disclosure of emotion have been so thoroughly assimilated into popular culture that its therapeutic significance is rarely contested. The very validation of individual feeling requires that it should be disclosed, preferably in public. (Furedi, 2004, p. 40).

The term *self-disclosure* is common in the literature around therapeutic culture and television, but its theoretical home is in the field of social psychological research, where the concept has been operationalised to facilitate the experimental study of self-disclosing behaviours. In this literature, all definitions of self-disclosure have at their centre the act of revealing the self to others (Chelune, 1987; Fitzpatrick, 1987; Jourard, 1971), and the act of 'mak(ing) known what was previously unpublished, deliberately held back or kept secret' (Safire, 1999) usually through the expression of 'strong and immediate feelings' (Archer, 1987, p. 332). Self-disclosure lies at the heart of psychotherapy (Stricker, 1990, p. 227). The consulting room is where clients 'disclose

their innermost thoughts' (Farber, 2006, p. 21). The dynamic of the psychotherapeutic encounter is clear: 'one person confesses and is known' (Furedi, 2004), while 'the other does not, remains secret, mysterious, merely hears the confession' (Rose, 2001, p. 3).

It has been argued that factual television is particularly amenable to the operation of therapeutic culture and psychotherapeutic discourse because of its reliance upon the confessional, 'the truthful rendering into speech of who one is and what one does' (Rose, 1998, p. 96), and that to 'engage in self-disclosure in the media is to position oneself in a pre-existing confessional space' (King, 2008, p. 123). King has written about '(t)he pressure to confess, or at least to engage in self-disclosure' (King, 2008, p. 115). However, contemporary forms of confession should not be understood as confession in the religious sense, as 'a personal inventory of the sins, flaws, impulses in the soul' (Rose, 1998, p. 267), but rather that 'those who speak out today are increasingly survivors bearing witness to the hidden injuries done to them by others – or by fate' (Rose, 1998, p. 267). Rose has observed that,

not only does confession in this sense characterize almost all the proliferating systems of psychotherapy and counselling. It also provides a potent technical form that has come to install itself in a range of other practices where the conduct of personal life is at stake, from the doctor's surgery to the radio phone-in, from the social work interview to the frank exchanges of lovers. (Rose, 1998, p. 96).

Self-disclosure is regarded as not just a positive, but also an essential, obligatory activity. The idea that people should self-disclose and that through doing so will cope better is supported in the literature (Coates & Winston, 1987). It has been argued, for example, that the 'authentic being manifested by healthier personalities takes the form of unselfconscious disclosure of self in words, decision and actions' (Jourard, 1968, p. 47). The idea that keeping secrets, particularly 'pathogenic secrets', has dysfunctional consequences for their keepers (Farber, 2006, p. 9) references the work of Ellenberger on the cathartic powers of revelation (Ellenberger, 1970).

Other writers have suggested that the social psychological literature on self-disclosure assumes an uncomplicated view of the motivations underlying self-disclosure. It has been proposed that self-disclosing people not only have multiple goals but are also constrained by individual and situational factors (Baxter, 1987, p. 158).

Goffman (1959) proposed that people present themselves according to a 'best-outcome' formula, presenting themselves in a way that 'maximises either others' views of them or...their own view of fitting in well with the norms of greater society' (Farber, 2006, p. 10). For example, a person's goal might be to appear to be a high-discloser, particularly if they understand that being uncomfortable with self-disclosing sends out negative messages. Livingstone and Lunt have argued that a distinction should be made between 'revealing consensually defined 'personal' facts or taboos about oneself (concerning sex, relationships, illness, money) from revealing facts which, for whatever idiosyncratic reason, are emotionally difficult to say' (Livingstone & Lunt, 1994, p. 167). They have argued that there will always be boundaries on what can be said within a television programme, partly because of legal or ethical regulations, and partly because of personal, social or moral boundaries. Furthermore,

(t)he difficulties...audiences may experience from hearing taboo issues aired in public, even though readily volunteered by the speaker may be difficult for the hearer, or from hearing facts which the speaker finds emotionally difficult to express. Self-disclosure may thus arouse emotions in the hearer or may make the hearer bear witness to emotions in the speaker. (Livingstone & Lunt, 1994, p. 167).

This useful reference to the negative effect that the self-disclosure of highly personal and traumatic experiences may have on the viewer is supported by the psychotherapeutic literature through the concept of counter-transference, that refers to 'situations where the patient's communications stir up unresolved problems of the therapist' (Aveline, 2002, p. 444). Parker (1996) uses the term *intellectualisation* to refer to the way that people undergoing psychotherapy may engage in apparently open and direct self-disclosure but at the same time manage to imply that their experiences are beyond the reach or understanding of others. He links this to the use of quasi-psychotherapeutic exchanges in television programming, arguing that,

What is striking about the ways in which confessing subjects are mobilised and displayed in these programmes is the way in which the talk appears to be open and direct but actually reproduces the idea that there are varieties of experience

too deep to be conveyed to others. The closest that one gets to ‘real communication’, we are led to believe as viewers, is when the subject of the programme baring their soul breaks down and cries. (Parker, 1996, p. 13).

This review of the literature on therapy talk, in both the context of factual television programming and the psychotherapeutic encounter, demonstrates its relevance to this study. It provides a context for thinking about how representations of the psychotherapeutic process are constructed in the sampled programmes.

2.5 Life Experiments & Transformation

The emergence of non-institutional factual psychotherapy programming in the mid-2000s, and the often fluid way in which this new programming form used elements of different factual television forms, drew the focus of attention to the literature on reality television. The literature contains a number of detailed accounts of reality television (Beck, Hellmueller, & Aeschbacher, 2012; Biressi & Nunn, 2005; Bonner, 2003; Hill, 2005; Holmes & Jermyn, 2004) and suggests a view of reality television as a meta-genre which includes various sub-genres (Beck et al., 2012). Despite the difficulties of pinning down this complex programme category, a number of its key characteristics, identified within the literature, has relevance for this study. The emergence of non-institutional factual psychotherapy programming in the mid-2000s, corresponding to reality television’s dominance of the UK’s television schedules during the 2000s, has been positioned as operating within the broad field of ‘documentary’ (Hill, 2005, p. 172) because of its incorporation of aspects of different factual forms, including of *docu-soap*, *game show*, *makeover* and *fly-on-the-wall* programming. This has led to factual television programming which routinely merges existing forms and genres.

The approach to the literature taken here has focused on those aspects of reality television literature which have the greatest relevance to this study, in terms of how they inform an understanding of non-institutional factual psychotherapy programming. The emergence of non-institutional factual psychotherapy programming must first be positioned against its institutional counterpart - the institutional factual psychotherapy programme - which has dominated how the psychotherapeutic process has been used within television programmes as programme content. Filmed observationally in hospitals, clinics and specialist units, institutional factual psychotherapy programmes

illustrate Corner's category of 'documentary as journalistic enquiry or exposition' (Corner, 2002, p. 259), which he argues is,

the most extensive use of documentary methods on television (at least, until very recently). Through in-camera presentation, or commentary voice-over, and perhaps with interviews interspersing either or both, the documentary work grounds itself...in...an idea of "reportage," which importantly includes an experience of looking at kinds of visual evidence, an experience of *witness* (original italics). (Corner, 2002, p. 259).

Accounts of reality television programming differ from classical documentaries in regard to their main intention: instead of stressing journalistic inquiry or intending to stimulate political debates, they are made primarily for entertainment and diversion (Corner, 2009, pp. 48-50). Within this study, the reality television literature provides a framework for contextualising the characteristics of non-institutional factual psychotherapy programming. The 'extensive borrowing of non-documentary kinds of look...by documentary, have complicated the rules for recognizing a documentary' (Corner, 2002, p. 263), but make sense when considering the ways in which reality television has impacted upon an existing programme form - in this case, institutional factual psychotherapy programming - as it transitions to the new programming form of non-institutional factual psychotherapy programming. Also relevant is its emphasis on entertainment and diversion (Corner, 2009, pp. 48-50); some versions of the genre can be seen as 'televisual arenas of formatted environments in which the more traditional observational rhetoric of documentary jostles for space with the discourses of display and performance' (Holmes & Jermyn, 2004, p. 5).

Other researchers have looked at the impact of reality television on existing programme forms. For example, Deller has examined the impact of reality television on religious programming, and considered the use of narratives of transformation within what she calls 'religious reality programmes' and their similarity to those constructed in other reality and makeover programming (Deller, 2015). Noonan has also examined the use of the transformative narrative within religious programming and suggests that 'religion, spirituality and faith lend themselves easily to be depicted through genres such as lifestyle television' (Noonan, 2011, p. 742).

Evidence of the impact of reality television on the development of non-institutional factual psychotherapy programming can be seen in the incorporation of certain key reality television characteristics. In the UK setting, reality television evolved through the *docu-soap*, a format in which ‘a chosen set of real life people were followed for a period of time’ (Bonner, 2003, p. 25). The influence of this can be seen in those programmes which bring together a group of people to live together as they embark on the psychotherapeutic process. There are explicit nods to *Big Brother* (Channel 4, 2000-2010) through the use of programme titles, and the placing of ‘real people in contrived situations observing what happens’ (Bonner, 2003, p. 26). Its influence is felt in the use of scenarios within non-institutional factual psychotherapy programmes in which ‘ordinary people (are) engaged in unscripted action and interaction’ (Nabi, 2007, p. 373), filmed at least for part of the programme in their home environment (the volunteers often make trips home during their treatment programme). Like reality television programmes, non-institutional factual psychotherapy programmes are set in ‘more or less staged or artificial environments’ (Corner, 2009, pp. 45-46). The programme ‘event’ - in this case, the provision of psychotherapeutic treatment - is organised and managed by programme-makers, rather than filmed observationally in the professional or clinical setting. In this sense, the programme-makers ‘create the situation for the purposes of the programme’ (Hill, 2007, p. 49).

The literature on lifestyle television and makeover programming points to the centrality of narratives of transformation (Hill, 2005). The literature demonstrates the extensive scope of the aspects of lifestyle which might be transformed as part of a television project: appearance, homes, gardens, career, love life, even beliefs. However, there has been little research into the use of transformative narratives in factual television programming which features psychotherapeutic actuality. Research into lifestyle television, a genre which emphasises guidance and advice for ‘a whole array of matters which are to do with the minutiae of how one leads a life’ (Rose, 2001, p. 12), provides a basis for thinking about non-institutional factual psychotherapy programmes. Hill has argued that as the makeover show has evolved, it has taken the idea of transformation to the limits of lifestyle. For example, she has described *How Clean Is Your House?* (Channel 4, 2003-2009) as ‘a hybrid of instructional programming and psychological drama’ (Hill, 2008, p. 143). She has devised the term *life experiment programme* to describe programmes that follow volunteers over time while they

‘experiment...with an alteration to their lives’ (Hill, 2007, p. 50). In this regard, many *makeover programmes* are quasi-psychotherapeutic, in the sense that they provide life coaching or motivational guidance to help people overcome their ‘lifestyle’ problems. While the majority of these programmes have been excluded from the research sample, *Spendaholics* (BBC Three, 2005-2007) and *Freaky Eaters* (BBC Three, 2007-2009) are included because they involve both the input of psychotherapists and psychotherapeutic actuality which meet the inclusion criteria.

It is evident that programming which centres on depictions of intervention in volunteers’ lives, leading to personal transformation, while called different things within the literature - reality television, lifestyle television, makeover programming, the life experiment, and the life intervention programme - is widely recognised within the literature. Dover and Hill (2007) have argued that the mid-2000s was when this kind of programming dominated UK television schedules, forming an important basis for contextualising my own findings about non-institutional factual psychotherapy programming which also emerged and peaked in the mid-2000s.

2.6 Representations of the Psychotherapeutic Process

This section reviews the literature which addresses how the the psychotherapeutic process, and aspects of it - including psychotherapists, mental health problems, and individuals with mental health problems - have been represented in factual television programming. I will consider briefly literature that focuses exclusively on the analysis of fictional television and cinema representations (e.g. Orchowski, Spickard, & McNamara, 2006; Wedding & Niemiec, 2003). I have prioritised work on factual television, particularly where that work has been produced within the UK setting (e.g. Cross, 2004, 2010; Harper, 2009; Philo, 1999). I include research into newspaper coverage where appropriate (Goulden et al., 2011; Thornton & Wahl, 1996).

The literature on representations of psychotherapists is dominated by work on fictional representations of psychotherapists. This approach focuses on the identification of certain core stereotypes that are used in the construction of fictional psychotherapists, as ‘either bumbling, villainous, or salvific.’ (Orchowski et al., 2006, p. 507). Case studies have been performed on the fictional psychotherapists in prominent television series, such as *The Sopranos* (HBO, 1999-2007) and *In Treatment* (HBO, 2008-2010). One writer has suggested that, ‘Perhaps the most significant point of reference after 1999 in media coverage of psychotherapy...is *The Sopranos*’ (Bainbridge, 2011, p. 45).

It has been noted that while ‘psychotherapy has expanded far beyond its psychoanalytic roots, movie portrayals most often represent psychologists in a customary psychoanalytic role - interpreting dream sequences and talking about the role of early childhood experiences’ (Orchowski et al., 2006, p. 509). Bainbridge (2011) studied representations of British psychoanalytic positions in UK newspapers and fictional television, through an analysis of a television drama series *Shrinks* (ITV, 1991) that was ‘roundly criticised by therapy professionals for its trivialisation of its patients’ problems and for creating unrealistic expectations around the timescale involved in facilitating a cure of any kind’ (Bainbridge, 2011, p. 39). Following criticisms from the psychotherapeutic community, the television company conducted a survey which showed that ‘38% of those questioned were of the opinion that real psychiatrists resembled the ones depicted in the TV drama’ (Bainbridge, 2011, p. 45). Much of the research in this field focuses on the impact of negative or unrealistic representations of the psychotherapist.

In a culture so influenced by the media, it is essential for therapists to maintain an awareness of the portrayal of psychotherapy in the cinema...As the current review depicts, a vast array of prototypical therapists have already reached the public through the experiences of cinema therapy, observed in the comfort of their living rooms or from cushioned movie-theatre chairs. (Orchowski et al., 2006, p. 512).

Other authors have argued that a curious tension arises when fictional television or cinema positions the psychotherapist at the heart of a programme or film, and that tensions arise associated with fashioning the character as a representation of the psychotherapeutic professions, though ‘dilut(ing) the complex ideas of psychotherapy in an attempt to make the figure more accessible, entertaining, and convincing (Huskinson & Waddell, 2014, p. 2).

In terms of work which focuses on representations of the psychotherapist in factual television, there is a limited body of work from which to draw. Shattuc has considered representations of psychotherapists on the talk show (Shattuc, 1997, pp. 123-128), noting that this programming genre uses predominantly female psychotherapists as expert guests. Her interest in these psychotherapists is less concerned with their construction as psychotherapeutic experts and more interested in how they promote a

feminist agenda within the programmes. There is little reference to the construction of expertise, except to identify the performative skills required within the studio context 'to nurture, interact, and solve dilemmas by offering short-term solutions' (Shattuc, 1997, p. 124).

In his case study of *Little Angels*, Lunt describes the programme's psychotherapist - clinical psychologist Dr Tanya Byron - as 'a prototypical young professional, neatly dressed, made up and wearing sunglasses as she drives her neat small car' (Lunt, 2008, p. 541). The psychotherapist is described as an 'external heroic figure...who deploys her special skills to enable the participants...to overcome their problems. As in many hero narratives, a series of three challenges are presented and the common focus on the participants going on a journey of self-discovery under the guidance of a guru/teacher is played out' (Lunt, 2008, p. 544). In *Shrink Rap*, the clinical psychologist who presents the programme - Dr Pamela Stephenson - is described as 'although not averse to passing out advice, is careful to distance herself from creating an authoritarian, combative, and potentially bullying persona' (Waddell, 2014, p. 134). Nunn and Biressi have commented on Stephenson's interview technique as 'exemplary...in terms of its detailed and explicit discussion of childhood trauma and adult dysfunction' (Nunn & Biressi, 2010, p. 58).

In contrast to the limited work on representations of psychotherapists and the psychotherapeutic process in factual television, there is a substantial body of work on representations of mental ill health and mental health problems in factual television. One body of work comes from US academics (e.g. Wahl, 1992, 2003), which is focused on the production of inaccurate and stereotypical representations across a range of media forms, including factual and fictional television. While inaccurate and discriminatory views of mental ill health have been found to be commonplace, it is the purported link between mental health problems and violence and criminality that is regarded as most stigmatising. In the UK setting, the work in this field has been dominated by the Glasgow Media Group (Philo, 1996, 1999), but is supported by more recent work by other UK-based researchers (Cross, 2004; Harper, 2009).

The position adopted unilaterally within the literature is that representations of serious mental health problems, such as schizophrenia and psychosis, used within television programming are overwhelmingly negative. Moreover, the repeated use of such representations leads to 'overwhelmingly dramatic and distorted images of mental

illness that emphasise dangerousness criminality and unpredictability, leading to fear, rejection, derision, and ridicule' (Stuart, 2006, p. 103). It has been argued that the situation has not improved over time. A review of UK newspaper coverage between 1992 and 2008 found no overall improvement in attitudes towards mental illness (Goulden et al., 2011). However, some writers have argued that assumptions of uniformity in how mental health problems are represented in media outputs can be misleading (Cross, 2004; Stout, Villegas, & Jennings, 2004). It has been argued, for example, that academic research into media portrayals of mental ill health has been characterised by poor research design, including a lack of precision in defining what mental health problems have been researched (Stout et al., 2004), for focusing on peak time programming to the neglect of programming scheduled at other times of the day (Stout et al., 2004), and for 'collaps(ing) all distinctions between factual and fictional representations and ignor(ing) differences between children's cartoons, teenage drama, soap opera, and films shown on TV' (Cross, 2004, p. 202).

Within the context of these observations, it is proposed that the research carried out within this study will complement the work already undertaken by researchers who have examined how mental ill health is represented in UK factual television programming. Reviewing work in this field, such as that carried out by Cross (2004, 2010) and Harper (2009), and considering the factual television programmes which have been analysed - e.g. *The Secret Life of the Manic Depressive* (BBC Two, 2006), *Cracking Up* (BBC Two, 2008), *The Doctor Who Hears Voices* (Channel 4, 2008), *My Crazy Parents* (Chanel 4, 2004), *Frank Bruno: Gloves Off* (BBC Three, 2013), *The Madness of Prince Charming* (Channel 4, 2003) - I have identified an opportunity to extend this research field through the programmes analysed within this study. Furthermore, the focus in these programmes is on mental health problems - such as obsessive compulsive disorder, hoarding disorder, and phobia - which have been marginalised by research which focuses on representations of 'serious' mental health conditions such as schizophrenia, psychosis and personality disorders.

This chapter has presented an account of the approach taken to the literature review, and of the way that this has been informed by the research I propose to undertake. The purpose of this literature review was to position my research and provide a theoretical framework for the study. The narrowing of the literature to the most relevant and influential work has been the outcome of deliberations as to the nature and

purpose of this study. This chapter has presented the work that has been most directly relevant, and has identified a number of areas where contributions may be possible. These will be critically evaluated in the thesis conclusion.

Chapter 3: Methodology

In the previous chapter, I reviewed the literature and identified work that provides a theoretical framework for positioning the research carried out in this study. In this chapter, I present an account of how my research has been conducted. My approach has been influenced by the discovery, established through the literature review, that the sample of factual television which forms the centrepiece of this study has not yet been studied by academic researchers. This has consolidated my intention to place the programme sample at the heart of this study, and to devise a research strategy that will result in the production of reliable and comprehensive findings that, in turn, will potentially make a contribution to certain fields within the literature. In the broadest sense, my initial approach to this study could be described as ‘bottom-up’, or inductive, in the sense that its existence is owed to a single observation - the viewing of a television programme - which led to the formation of an initial hypothesis that the ways that the psychotherapeutic process was being both utilised and represented within factual television programmes was changing significantly. In the first instance, the viability of this initial hypothesis was ‘tested’ against the literature, by identifying work which suggested such a development was likely. This consultation both informed and positioned my own research, and identified fields within the literature where my research might make a contribution.

In designing my research strategy, I recognised the usefulness of both qualitative and quantitative approaches and methodologies in the analysis of the programme sample. I considered the arguments against such a mixed-method design which, it has been suggested, is often derided as a ‘whatever works’ approach (Bryman, 2006), and the argument that mixing realist (quantitative) and relativist (qualitative) methods is thought to create epistemological tensions that, in turn, reduce reliability (Brannen, 2005). Furthermore, multi-method approaches are not typically found within television studies research, which has tended towards single-method approaches such as large-scale content analysis research (e.g. Bouhoutsos et al., 1986; Hill, 2005; Philo, 1999), conducted in order to identify trends (Dominick & Wimmer, 2003). This kind of large-scale empirical analysis is useful in providing a general picture of whatever phenomenon is under study, often generating numerical data (Davis, 2008, p. 57). Qualitative approaches, on the other hand, focus on detailed case studies of individual,

or small groups of programmes (e.g. Lunt, 2008; Lury, 2009), to produce research that is regarded as providing ‘more depth’ (Davis, 2008, p. 57).

In practice, I note that many television researchers, even when leaning towards single-method approaches, in practice employ both approaches in their research. In the context of my own study, the use of quantitative content analysis enables the generation of numerically-based empirical primary data which can be used to verify my hypothesis, and the use of non-empirical qualitative methodologies to identify the meaning systems operating within the programmes. Finally, all of this primary data will be contextualised as historically-specific artefacts through industry research. A mixed-method approach of this kind is informed by the recognition that a research strategy that favours one approach over another is not enough ‘to do justice to the complex array of themes, issues, debates, contexts and concerns’ (Creeber, 2006, p. 84) that are raised by my research sample. I, therefore, locate my study within the work of a ‘new generation of scholars... who can reconcile the differences’ (Miller, 2002, p. 4) between quantitative and qualitative methodologies. While the debate about mixed methodologies and epistemological tensions remains largely unresolved within the literature, I address this tension within my own research by taking a pragmatic stance which demonstrates that neither approach can produce the extensiveness of data that is required.

3.1 Terminology

One of the challenges of researching in a niche area of television programming, particularly one which is under-researched by academics and not explicitly recognised within the television industry, is the lack of available nomenclature and associated terminology. Other niche programming areas, such as parenting programmes (e.g. Lunt, 2008; Lury, 2009) and celebrity talk shows (e.g. King, 2008; Tolson, 2001), have acquired definitions and terminologies through ongoing academic research which are available to researchers who work in those fields. In the course of my research, as I collated my research sample, the need for suitable terminologies to represent the sampled programmes became a matter of urgency.

I considered a number of terms that included the word *therapy*, such as *therapeutic television* (Elsaesser, 2001, p. 196), *therapy genre* (Livingstone & Lunt, 1994, pp. 54-62), and *therapy show* (White, 1992, p. 25). These terms were discounted either because they referred to studio-based talk shows programmes, which are not represented in my research sample, or because they referred to programming found on

US rather than UK television, in which a presenter/psychotherapist delivers psychotherapeutic treatment to volunteers in front of a studio audience. I know of only one UK programme - *A Problem Aired* (ITV, 1987-92) - in which volunteers who had previously written into the production team were recorded having a psychotherapeutic encounter with a psychotherapist in a television studio setting (Dryden, 1992). I also rejected the term *therapy TV* which, while not found in the academic literature, has some currency journalistically, having been suggested as a suitable name for 'any programme which uses psychotherapy as the lynchpin of their format' (Draper, 2007). More recently, I encountered the term *reality television therapy*; although initially intriguing, with its definition of 'commercial programming that features therapeutic interventions with members of the public who have applied (or in some cases have been invited) to participate' (Hamilton, 2013, para. 1), I discounted the term after reviewing its illustrative examples drawn from US television, e.g. *Hoarders* (A&E, 2009-present). I considered the devised term *reality psychotherapy programming*, echoing the terminology used by other researchers, including *reality parenting programme* (Feasey, 2011) and *reality-television 'parenting' programme* (Lury, 2009) but rejected the term on the grounds that it did not adequately represent the programmes in the non-institutional factual psychotherapy programming category.

To avoid the introduction of a degree of imprecision to my terminology, I decided to devise my own terminology for use in this study. I considered the approach taken by Bonner (2006), who devised a new analytical category - ordinary television - to represent the programming that she was researching. Her research sample was unusually broad, so much so that no existing category - either academic or industrial - could represent it satisfactorily. The advantage of this approach was that this new category could be used as a container for grouping programming which would not normally be brought together for research purposes. The categorical term that I devised - *factual psychotherapy programming*, with its two prefixes *institutional* and *non-institutional* - has the advantage of being able to represent different kinds of factual television programming, irrespective of genre and other distinguishing features. It differentiates the sampled programmes from other programmes that have a psychotherapeutic 'feel', but which do not feature psychotherapeutic practice as defined in this study. The ultimate value of the terms *institutional factual psychotherapy programming* and *non-institutional factual psychotherapy programming* is their neutrality.

3.2 The Sample & Other Primary Data

In television studies research, primary data is generated from the study of television programmes and their internal structures and features, including narrative structure, their generic features, production practices and production techniques (camera, editing, graphics, sound recording, music and sound design). Primary resources may also be drawn from materials associated with television programmes, which have been generated by media professionals and media organisations; for example, publicity and marketing materials, broadcaster-generated websites, broadcaster codes of practice, published articles about programmes in journalistic or industry publications, and compliance reports. They may also include materials generated by media audiences, such as contributions to online forums, blogs, Twitter, and comments on video-sharing sites such as YouTube.

At the heart of this study is a sample of television programmes. This section sets out the methodological practices and techniques involved in the collation and selection of these programmes, and the decisions taken in the formation of the research sample. In the first instance, a research sample ‘should be a representative sample of the texts under consideration - enough to support wider conclusions’ (Davis, 2008, p. 57). My objective was to capture all UK-originated factual television programmes that feature on-screen psychotherapy as defined within this study, broadcast between 1999 and 2013. The research sample’s eligibility criteria have ensured the sample is representative by operating with clear definitions of psychotherapy, psychotherapists and the psychotherapeutic process, as set out in Chapter 1.

To be eligible for inclusion in the research sample, a programme had to be broadcast on UK television between 1999 and 2013. It had to contain sequences of psychotherapeutic actuality which featured encounters between psychotherapists and volunteers, in which psychotherapeutic treatment is delivered and received, irrespective of the mental health problem, the treatment modality, the setting, and the number of psychotherapists and volunteers involved. To qualify for inclusion in the research sample, programmes had to feature psychotherapists who were regulated by a UK-based professional body, membership of which is predicated by an appropriate level of training. Additional research was carried out on the psychotherapists who appeared in non-institutional factual psychotherapy programmes to ensure the remaining eligibility criteria were met. This included research to determine the professional status of

psychotherapists; information of this kind was easily accessible through Internet searches. Excluded from the research sample were programmes that featured individuals who called themselves psychotherapists but who did not meet the definition of psychotherapist as set out in Chapter 1. Excluded programmes included two series of *Spendaholics*, even though three series of the same programme were included in the research sample. Also excluded were programmes that featured psychotherapy-like activities, such as guidance and advice, including *Doctor, Doctor* (Five, 2005-2007), a studio-based programme recorded in front of an audience, in which a panel of experts from different fields of expertise, including psychotherapy, respond to viewers' questions about their physical and mental wellbeing, and parenting programmes in which psychotherapists offered parents advice on childcare. Quasi-psychotherapeutic programming was excluded, such as the celebrity talk show *Shrink Rap*, despite being hosted by a clinical psychologist. Programmes which featured psychiatric assessment were excluded, as were programmes in which the psychotherapeutic work was carried out by mental health professionals who did not qualify as psychotherapists within the research sample, leading to the exclusion of three episodes of the four-part series *Bedlam*. However, programmes which featured psychiatric assessment sessions which included sequences of protracted verbal interaction between psychotherapist and volunteer were included, a criterion which led to the inclusion of *Sectioned* in the research sample. Programmes were excluded if they featured psychotherapeutic treatment for conditions which are likely to have a physical basis, such as developmental disorders and disabilities, organic/medical conditions, substance-related disorders, and sexual and gender identity disorders. Programmes which featured reconstructions of the psychotherapeutic process were also excluded.

Programme research was conducted using a number of television programme databases including the British Universities Film & Video Council's online *TRILT* (Television and Radio Index for Teaching and Learning) database, the British Film Institute's television programme database, *Box of Broadcasts*, the online *BBC Genome Project*, and *Nexis Business & News* database. The main search categories were: *television PLUS psychology, psychologist, psychotherapy, psychotherapist, psychiatry, psychiatrist, clinical psychology, clinical psychologist, therapy, therapist, counsellor, counselling, CBT, cognitive behavioural therapy, mental illness, mental health, phobia, OCD, obsessive-compulsive disorder, agoraphobia, anxiety, anxiety disorders.*

Once a programme was identified, efforts were made to determine that it featured on-screen psychotherapy as defined within this study. This was straightforward when a viewing copy was immediately available. Where this was not the case, additional research was conducted - in newspaper reviews and articles, database and library descriptions, therapist websites, and forum discussions - to determine whether psychotherapeutic actuality was likely to be featured. This allowed for provisional inclusion which was confirmed after viewing had taken place. Obtaining viewing copies was straightforward for programmes broadcast after 2007, many of which are available through the *Box of Broadcasts* database. For those broadcast before 2007, obtaining viewing copies was more challenging. Some were obtained from the University of Salford's licence with the BUFVC. Some programmes were available on video-sharing sites, such as *YouTube* and occasionally *Vimeo*. However, the availability of UK television programmes on video-sharing sites - once a useful resource for programme research - has become increasingly limited due to copyright restrictions. It was possible to purchase copies of some programmes from production companies. Some programmes were recorded by the researcher at the time of broadcast. Programmes were excluded from the sample for the following reasons: a viewing copy was unavailable; the programme was not UK-originated; the programme did not include psychotherapeutic actuality; the programme was about a learning disability rather than a mental health problem; the psychotherapy was delivered by an individual who did not meet the research sample inclusion criteria; the programme was originally broadcast before 1999 or after 2013.

For the identification and collation of contextual materials associated with the sampled programmes, research was undertaken using *Nexis Business & News* database. This generated a body of published materials from newspapers and magazines associated with the sampled programmes, including programme previews and reviews, journalistic articles about the programme, programme-makers, volunteers, and psychotherapists. While this was useful as part of the general background research process, there were instances where the materials obtained provided useful information about the programme's production. Previews and reviews of programmes were useful resources which have been used throughout this study; these were particularly useful in the case studies conducted in Chapter 6. For programmes that were broadcast in the latter part of my research timeline, there were additional online resources, such as

programme-makers' websites and materials published by the institutions which took part in the programmes. On the whole, controversial or innovative programming generated a superfluity of contextual materials. Finally, I conducted searches of academic literature from other disciplines and searched for articles in specialist academic journals, such as psychological and psychotherapeutic publications, for articles which commented upon the sampled programmes.

Other materials used in this study were documents and publications created by media professionals and institutions including: broadcasting policies which regulate the practice of media professionals; broadcaster-produced guidelines, specifically the Ofcom Broadcasting Code and the BBC Editorial Guidelines; broadcaster annual reports; broadcaster-created websites; programme websites; publicity materials, including adverts, programme trails and photographs; Independent Television Commission (ITC) or Ofcom complaint bulletins; production company websites. In using such materials in my research, I recognised that such documents are not 'transparent representations of organisational routines, decision-making processes or professional practices' (Atkinson & Coffey, 2011, p. 79), but have been produced for specific purposes within specific institutional contexts. For this reason, I contextualise any references to such materials within my research.

Responses to the programmes were captured through a number of different resources. First, reviews written by television critics and other commentators, some of whom were writing for specialist psychotherapeutically-orientated publications. Second, information relating to viewing figures which is available through specialist industry publications such as *Broadcast* magazine. Viewer reactions to the sampled programmes were captured through the use of materials generated by viewers and posted on online forums. Specific sites referred to within this study include mental health forums, clinical psychology forums, and entertainment forums.

It has been noted that online environments have increasingly become a space where audiences discuss television programmes, and online environments have become a method for researching media audiences (Orgad, 2009). There are some distinct advantages to online research, including the relatively easy access to television audiences, and the availability of convenient electronic data (Bertrand & Hughes, 2005). However, there are difficulties associated with using these materials. For example, there are significant differences in the availability of online audience-generated materials

across the 1999 and 2013 period, and between the sampled programmes. Such inconsistencies potentially weaken the validity of the data that is available through online sources.

There are also specific ethical issues involved with using audience-generated materials associated with programmes about mental health problems. These issues influenced my decision not to approach users who contributed to online forums. My broad aim was to preserve the anonymity of individual forum users who might be referred to in my study in order to limit potentially sensitive material being recirculated in the public domain. In any event, the use of materials posted on many online forums is restricted by copyright and cannot be used without the written permission of the original author and forum moderator.

This study includes accounts by programme-makers associated with the sampled programmes. In this study, programme-makers are defined as those who are credited on the programme as having produced, produced/directed or produced/directed/filmed programmes within the research sample. This decision is supported by the argument that ‘(t)elelevision has long been regarded as a producer’s medium, meaning that the television producer has the predominant authority over and responsibility for television making’ (Bignell, 2013, p. 149). While this definition is clearly applicable to one-off single documentary-type programmes, which promote the notion of authorship by the producer/director, the definition becomes less viable with other kinds of programmes. For example, in a programme series, each episode may have its own producer/director but there will be a series producer who has overall control of the programme style and content. For this reason, I have widened the definition of programme-maker to include executive producer and series producer.

Primary research involving media practitioners is common within ‘production studies’ research within television studies (e.g. Zoellner, 2009). I have utilised materials that are already in the public domain, including interviews published in academic books, journalistic or industry publications, recorded interviews on programme websites, blogs, and personal websites. These materials are supplemented with the primary data generated through my research questionnaire. Practitioner accounts are included within my research to provide insight into ‘the meanings people attribute to their experiences and social worlds’ (Miller & Glassner, 2011, p. 133).

3.3 Research Questionnaire

My research questionnaire (see Appendix E) was designed to elicit from programme-makers more detailed information about the production practices involved with the programmes in my research sample. The targeted respondents are individuals who are credited on at least one programme in my research sample.

In preparing to conduct this primary research, I sought advice on how to approach programme-makers. One factual television producer /director (not otherwise involved in my research) advised me to take a personalised approach with the programme-makers, indicating in my correspondence that I had seen their programme. This informed the manner in which I made initial contact with programme-makers, using a personalised introductory email. It also influenced the research questionnaire design, in that this enabled me to exclude basic factual information such as the programme title and duration, channel and year of broadcast, and production company.

Before sending out the questionnaire, I piloted the research questionnaire with a number of ex-factual television producer/directors who teach on media production courses at the University of Salford (and who are not otherwise involved in my research). The design of the questionnaire went through various drafts. The questionnaire was designed to elicit both general and detailed information about the programme-makers' experiences of working on factual psychotherapy programmes. Some questions were designed to capture specific information about the practicalities of filming the psychotherapeutic process, including: What techniques did you use to find and select programme participants? Were these any different from your usual techniques?; What locations (e.g. consulting room, studio set, public spaces) were used for the filming of the psychotherapy? What advantages and disadvantages did these present?; Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?; What production challenges did you face making a programme or series which featured psychotherapy? In your experience, how does filming psychotherapy differ from other kinds of actuality?; Was any psychological screening of the programme participants required before filming began? Other questions were designed to capture a more general impression of the programme-making experience, including: How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?; Thinking about the programme(s) you were involved with, and others you may have seen, do you think

psychotherapy is a good subject for factual television?; With your particular programme(s), was the intention to reach a wide audience or a niche audience?

The securing of informed consent was managed through a section at the end of the questionnaire in which respondents were required to confirm that they had received and read the *research participant information sheet* (see Appendix D), and that they had been given the opportunity to ask questions and had received satisfactory answers. It was stated that any extracts from their completed questionnaire used within the study would be anonymised, and that any identifying details about the programme or the volunteers would be excluded from the study.

The initial list of approximately fifty potential research questionnaire respondents was generated from programme credits drawn from the research sample. Some programmes generated more than one name; for example, there might be separate producing and directing credits. Series typically featured a series producer, and a number of producer/directors some of whom worked only on one episode. On some series, producer/directors worked on several episodes. I created a list which represented a cross-section of programmes, dates, and channels. Locating contact details was more challenging than originally anticipated. Only two of the selected programme-makers had their own websites which provided a link for making contact. While others were listed online as working for independent production companies, it was not possible to make direct contact; production companies offer a single email contact address only (and no telephone number). Messages sent to these email addresses often produce an automatic reply stating that the company does not respond to every email. A number of the potential respondents were not contactable; some appeared to have left the industry.

I found a number of potential respondents through *LinkedIn* and *Talent Manager* databases. While I was able to register on both, I was not able to send direct messages because this service is only available to premium account holders. However, both *LinkedIn* and *Talent Manager* offer a free trial of their premium accounts (*LinkedIn* one month; *Talent Manager* one week). I signed up for these and sent out direct messages, along with direct messages to personal websites or through messages to production companies. I made initial contact with thirty-one programme-makers during November and December 2015. I sent a summary of my research, requesting that they respond to me on my university email account so that I could send them my research questionnaire and research participant information sheet. While this was an effective way of getting in

touch with the majority of my questionnaire respondents, it did add an extra tier of administration - each response had to be handled individually, and several respondents had questions that had to be responded to before proceeding to the next stage. In many instances, the initial response was positive; the respondents seemed interested in what I was doing and happy to get involved. Of the thirty-one individuals who were eventually contacted, fifteen did not make contact and sixteen did. The research questionnaire and the research participant information sheet was sent out to the sixteen programme-makers in December 2015. I suggested a completion date of 18 December 2015.

Getting back the completed questionnaires presented considerable challenges. Despite the initial enthusiasm from respondents, only one completed questionnaire was returned by 18 December 2015. I sent polite reminders in January, February, and March 2016, each producing a couple of completed questionnaires. After the final request, I had a total of eleven completed questionnaires. However, one completed questionnaire is unusable because the consent section has not been completed, and a follow-up request for this section to be completed was ignored. A total of five programme-makers did not complete the questionnaire. The ten completed questionnaires covered programmes made between 2000 and 2013, broadcast on BBC One, BBC Three, BBC Four and Channel 4, and represented both institutional and non-institutional factual psychotherapy programmes.

3.4 Research Ethics

My research ethics strategy has been approved by my university's ethics committee; a copy of my research ethics application is included in Appendix A. In its preparation, I consulted guidelines published by the Association of Internet Researchers (AOIR, 2002) and created a Data Management Plan to guide on how my data would be handled both during and after my research. I have produced a research participant information sheet which sets out the main details about my research, and the rights and protection offered to participants who take part. Given the sensitive nature of the programme content within my sample, one potential ethical scenario is exposing the volunteers who have appeared in the sampled programmes to negative consequences in the future. Explicit references to volunteers within my study could generate unnecessary, unwanted and unwarranted exposure in future Internet searches. Another risk associated with my research questionnaire is the production of information which has not previously been available due to constraints imposed by institutional confidentiality agreements made at

the time of broadcast. My research ethics application has addressed these possibilities and devised strategies to prevent their occurrence, offering maximum protection to those individuals who appeared in the sampled programme. Furthermore, programme-makers have been offered anonymity, with the additional proviso that I will exclude information from the research questionnaires if they unintentionally breach pre-existing confidentiality agreements, or provide sensitive information within the completed questionnaires. Removed items in the questionnaires (see Appendices RQ1-RQ10) - such as programme names, email addresses, telephone numbers, and volunteers' names - are signified by the use of [REMOVED].

3.5 Content Analysis

The content analysis method is used in this study to empirically analyse one hundred and five factual television programmes comprising the research sample. My content analysis is conducted within the framework of a multi-method research design; the results generated are not intended to be conclusive or absolute but should be seen within the context of my other research findings, presented in the following three chapters. The content analysis methodology used in this chapter follows the procedure as set out in Robson (2011).

A clear-cut research question is a fundamental starting-point for most content analyses. While a content analysis method may be used to generate data that leads to the formation of research questions, it is more usual, and more methodologically rigorous, for research questions to shape how a content analysis is to be conducted. While the data generated by the content analysis will be used throughout the study, particularly to support the programme analysis and case studies in Chapters 5 and 6, its primary purpose is to identify and determine the patterns or regularities in the research sample which support my initial observation that a new form of factual psychotherapy programming had emerged in the mid-2000s. In content analyses, the unit or event being counted is often the written or spoken word; in this study, the event being counted is the broadcast of factual psychotherapy programmes as defined within this study. The content analysis method is used to capture specific data relating to the broadcast of the sampled programmes: the year, day, time and channel of broadcast; the form of delivery, i.e. whether a single, one-off programme or an episode of a series; and, most importantly, data relating to the programmes classification as either *institutional* or *non-institutional*. The definition of a programme as institutional or non-institutional was

made according to the following criteria: irrespective of the amount of psychotherapeutic actuality in the programme, a programme was categorised as institutional if it featured psychotherapeutic actuality filmed in an explicitly institutional setting, signified through the use of official signage. This included the use of private hospital settings, such as The Priory, but did not include the use of private sector consulting rooms which were categorised as non-institutional settings for the purposes of this study. For a programme to be categorised as non-institutional, it displayed no explicit visual association with a psychotherapeutically-orientated institution. The clear distinction between the institutional and non-institutional factual psychotherapy programme was necessary to ensure each programme could only be counted once, and that consistent decisions were taken throughout the research process. A spreadsheet was created to capture the key data relating to each programme (see Appendix B). Charts were created from an analysis of this data, using Excel. The results of the content analysis method is used in Chapters 4 and 5.

The value of the content analysis method to this study is the production of primary data which can be used to target and explore specific aspects of the study's research questions. One positive aspect of the content analysis method is the ready availability of the raw data; in this instance, television programmes and other materials relating to them, including spreadsheets. Once generated, this data remain in a fixed and permanent form throughout the research process and can be revisited and re-analysed if necessary (Woodrum, 1984). However, the resultant data must be scrutinised to identify all possible explanations for the results, before any conclusions are reached.

There are some inherent problems with the content analysis method. For example, while the creation of categories for quantification can be straightforward - such as in the case of the programme's broadcast day, time and year - other categories may be less clear-cut, as in the case of the distinction between *institutional* and *non-institutional*. The reason for this is that the raw data which forms the research sample - television programmes - were not generated by the researcher exclusively for academic research purposes but were produced for an entirely different purpose, with the result that some categories will always retain a degree of ambiguity. One solution is to devise alternative categories; in this study, the use of other categories was considered but rejected because alternative categories seemed to exacerbate rather than ameliorate the problem. A clear rationale is required in such moments.

In any case, it was always intended that any data generated through the content analysis would be used in conjunction with data generated from other research methods. The primary purpose of my content analysis was to identify trends within the research sample which were pertinent to my research questions. One suggested advantage of the content analysis method is its avoidance of the production of ‘impressionistic observations’ (Prasad, 2008, p. 7). However, such impressionistic observations can be valuable tools in the research process, and formed part of the early formulations of this study’s rationale. In the end, however, the content analysis method has been used to subject these impressionistic observations to rigorous analysis so they can be confirmed or refuted.

3.6 Production Analysis

Production analysis is the study of the processes, practices, techniques and technologies used by practitioners within the broadcasting industry. Studying these aspects of television programmes leads to a ‘deeper understanding of television institutions, programmes and how meanings are made’ (Bignell, 2013, pp. 172-173). Evidence for this aspect of the research is drawn from two primary data sources - the programme analysis and practitioner accounts embodied in responses to the study’s research questionnaire, and from secondary sources that take a production studies approach, or that furnish data relating to the industrial production of programming.

This approach considers the production process as broken down into its traditional industrial parts of pre-production, production and post-production (Bignell, 2013). Pre-production covers specific practices which relate to how the volunteers were found and selected, and considers the use of the Internet and the employment of casting producers. This is considered in the case studies contained in Chapter 6. A consideration of the production stage of programme-making considers aspects of the filming process, including the availability of new camera technologies - compact, lightweight, less intrusive and technologically simple - as a key area of change during the 1999 to 2013 timeline; a development which led to the emergence of new location-based production roles including ‘self-shooting’ producer/directors and researchers, and DV directors, which, it will be suggested, has implications for the production of factual psychotherapy programming. Post-production covers the editing and post-production treatment of programme materials. While no major developments relating to post-production practice are expected to be identified between 1999 and 2013, the study will consider the editing

of formatted series, and the practice of condensing psychotherapeutic actuality into a fraction of its original duration.

The advantage of using production analysis methodology in the study of television programmes is the resultant data which can be integrated into, and synthesised with, other data produced through the programme analysis. This will be demonstrated in Chapters 5 and 6. I would suggest that analysis of television programmes within a study such as this would be incomplete without the use of the production analysis method. However, this approach is potentially problematic. Practitioner accounts of production practice cannot be taken as privileged factual statements of intent but rather as accounts of practice which have been mediated through professional and institutional discourses, and influenced by historically-specific developments. The use of the production analysis method in this study is informed by the researcher's own experience as a television professional. While I have made use of this experience within my programme analysis, I have sought to evidence any claims through concrete examples, and use such expert knowledge circumspectly.

3.7 Narrative Analysis

Corner has argued that 'narrative satisfactions are a property of nearly all formats, connecting with a broader aesthetics of time and of duration (with its vectors of becoming, of process and transition) that underlies, in different ways the forms of television' (2003, p. 99). Narrative analysis as a methodology is employed within this study as one of several methods used to analyse the sampled programmes. Its specific role is in the analysis of programme endings which, as it will be shown in Chapters 5 and 6, present unique challenges for the producers of non-institutional factual psychotherapy programmes in particular. The approach taken here operates from the observation that both forms of factual psychotherapy programme have similar narrative structures, regardless of any additional differences in format or genre. These shared narratives centre around stories about volunteers who embark on psychotherapeutic treatment at a critical point in their mental health experience. In this sense, all factual psychotherapy programmes begin with a statement of the status quo, in which the volunteer's life is presented as problematic and requiring urgent intervention; the intervention comes in the form of psychotherapeutic treatment. In this respect, both forms of factual psychotherapy programme utilise versions of the same 'plot'. Where the differences emerge is in regard to programme endings.

The narrative analysis of programme endings involves a consideration of two simultaneous but separate, and often contradictory, strands: the construction of the programme ending itself, including the use of techniques which provide updates about the volunteers' ongoing progress, and the construction of the psychotherapeutic outcome, i.e. the concluding statement about the outcome of the psychotherapeutic treatment. In order to explore these two related but distinct aspects of narrative endings in factual psychotherapy programming, comparisons are made between the institutional and non-institutional forms in order to identify 'both uniting and separating features' (Alasuutari, 1995, pp. 74-75). This is achieved by abstracting structural elements of the programme narratives and presenting appropriate illustrative examples. The narrative analysis method is also to develop an understanding of how 'image(s) and sound sequences are organised in factual television programmes' (Lury, 2005, p. 115). This addresses the way that sequences of programme content - including actuality, interview and voice-over - are constructed and positioned within the programme narrative. As Corner has observed, 'it is clearly in the practices of editing that narrative design is realized' (2003, p. 99).

In terms of the potential limitations of the narrative analysis method, it should be acknowledged that narratives may be structurally more complex than initially assumed (Lury, 2005). The complexity of many factual psychotherapy narratives - the individual backstories of multiple volunteers, their individual psychotherapeutic narratives - can lead to programme narratives comprising multiple interweaving narrative strands, structured to maximise dramatic value. A narrative analysis method which sought to standardise such narratives may eliminate some of their nuances. There may also be tensions associated with recognising the intentions of the programme-maker and editor in the manipulation and structuring of programme content using common programme-making techniques and devices. This was something of which I was particularly aware, given my earlier training as a film editor.

3.8 Textual Analysis

The programme analysis in Chapters 5 and 6 draws its methods from a textual analysis methodology to analyse representations of the psychotherapeutic process. It conducts close readings of programme texts to examine constructions of setting and expertise in order to identify how representations of the psychotherapeutic process are constructed.

This, in turn, enables the identification of the key differences between the institutional and non-institutional forms of factual psychotherapy programming.

Textual analysis is a broad term used to represent a variety of analytical techniques to identify and explain the ways that texts - in this case, television programmes - produce meaning. Within this study, textual analysis is applied to different aspects of the sampled programmes: image analysis, sequence analysis, and the analysis of extracts of transcribed programme content. The approach involves an examination of the 'technological make-up of television images and sounds with a careful description of the style and formal operations of different television programmes' (Lury, 2005: 1); it uses accepted terminologies for descriptions of image size, framing, camera moves, sound design elements, and editing techniques, which are then used as a basis for the identification of the potential meanings which are produced within complete or partial programme texts. Within the analysis, the focus is primarily on the analysis of sequences - the building block of factual television programming - that, from a programme-making point-of-view, are treated as discrete entities with specific functions within the programme structure. Potential tensions can emerge between readings which privilege the programme-makers intention and readings which privilege the academic researcher's interpretations.

Common criticisms of the textual analysis method are that it may be vulnerable to the influence of researcher subjectivity, motivated by the need to generate findings to support a research hypothesis, or to the privileging of one reading over another without sufficient or explicit rationale. To minimise the possibility of all of these scenarios, safeguards have been built into the textual analysis carried out in this study. For example, throughout the programme analysis, there are references to intertexts - 'publically circulated texts that are explicitly linked to the text you're interested in' (McKee, 2003, p. 97) - including other factual television programmes and cinema films, which contextualise and support particular readings. Where possible, the analysis includes at least two examples drawn from different programmes to illustrate the point being made. The textual analysis also makes use of genre, 'a powerful tool for making sense of texts' (McKee, 2003, p. 95), and one which provides a range of readily-available terms with which to identify, describe and analyse television programming. One advantage of genre is its currency among academics, industry professionals, TV guides, promotional material, and in the way that viewers talk about television (Bonner,

2003, p. 8). It also facilitates the identification of production elements which are often regarded as signifiers of genre, including lighting, filming styles, sound effects and music (Hansen, 1998). The use of genre within textual analysis recognises that generic categorisations are both historically-specific and context-specific, and may even be relatively unstable. This is certainly the case for many non-institutional factual psychotherapy programmes which are not straightforwardly recognisable in generic terms, but rather as a 'mixture (or hybrid) of a number of different genres' (Creeber, 2008a, p. 1). This study adopts a nuanced view of television genre, which positions genre analysis as 'a system of organising the world that is always open to debate, discussion and critical interpretation' (Creeber, 2008a, p. 1). Finally, the findings produced from the textual analysis are situated where possible within 'the wider public context in which a text is circulated' (McKee, 2003, p. 99), particularly in Chapter 6's case studies.

3.9 Case Study

The case study is a commonly-used methodology within television research. Research which centres on case studies of television programmes can be found across television studies research of relevance to this study; for example, *Little Angels* (Lunt, 2008), *The House of Tiny Tearaways* (Lury, 2009), *Shrink Rap* (Nunn & Biressi, 2010), and *Is This Your Problem?* (Holmes, 2008).

The case study methodology used within this study has been informed by the work of Yin (2009, 2014) and Robson (2011). Robson has described the case study method as a 'strategy for doing research which involves an empirical investigation of particular contemporary phenomenon within its real-life context using multiple sources of evidence' (2011, p. 136). The multiple sources of evidence used within my case studies, as set out earlier in this chapter, include: the programme itself; published newspaper reviews and articles about the programme; specialist professional journals which comment on the programme; online materials, including broadcaster websites, audience-generated forum posts; programme-maker blogs and websites; broadcaster promotional materials; production documentation, including recruitment advertisements.

Chapter 6 features three case studies presented consecutively and in chronological order. These are not intended to be read as discrete units of analysis, but rather as analyses that interact, and comment on each other. The structure of each case study is

broadly similar: the programme is introduced, with information relating to its broadcast, scheduling, promotion, production, and reception. Each case study uses all of the methodologies described above in the analysis of the programmes, and uses the themes of setting, expertise, and outcomes as articulated in Chapter 5, as the basis for the programme analysis. The case study method is well-suited to research into television programming. However, there is a danger that programmes may be shoe-horned into a predefined analytical structure. For this reason, the case studies in this study will be handled flexibly, in ways which allowed the distinctive characteristics of each programme to be prioritised. Another issue with the case study methodology relates to the availability of materials in addition to the programme itself. This can exert influence over which case studies to conduct, and can impact on the quality of individual case studies in terms of the richness of available data. The effects of this variability can be reduced to an extent by the order of presentation, and by allowing for some flexibility in how each case study is articulated.

This chapter has reviewed the research design and research methodologies that have been used within this study. It has presented the case for the use of a mixed-method approach, involving both quantitative and qualitative methods, in the analysis of the programme sample. It has argued that the decision to use a mixed-method research design is in order to maximise the findings generated within the study. It has reviewed the strengths and limitations of each methodology in order that these can be accounted for later in the study, when evaluating the research findings. I will return to these questions at the end of the process and review the decision taken in the thesis conclusion.

Chapter 4: Contexts

The previous chapter presented an account of the research strategy designed for use within this study, evaluated the research methodologies used for gathering and analysing primary research data. This chapter presents contextual materials within which the study's research findings can be situated, in order that industry-specific and historically-specific developments which are relevant to the phenomenon under study can be identified. The first section presents an account of the industrial and professional context within which the sampled television programmes were produced, broadcast and viewed. The second section identifies developments within the UK's psychotherapeutic domain that, it is proposed, have influenced constructions of the psychotherapeutic process in factual psychotherapy programming. The third section provides the results of a content analysis of the research sample intended to act as a contextual framework for the programme analysis findings presented in Chapters 5 and 6.

4.1 Television Contexts

This contextual analysis focuses on the television production process and its associated practices, situating it within its professional, legislative, technological, industrial and cultural contexts. It recognises the importance of facilitating an understanding of the character of the actual programmes the television industry produces (Turner, 2002, p. 48). The focus here is on developments within broadcasting legislation, broadcasting regulation, media industry organisation and technological developments which have impacted most directly on programme-making practice within the UK factual television context, and on developments between 1999 and 2013. There are occasional references to events prior to 1999 in order to identify events that led to changes within the 1999 to 2013 period, and also to include the pre-production stages of the earliest programmes in the sample, which will have been in process for up to a year, or even longer, prior to 1999. A variety of sources has been used, including broadcaster-generated materials such as annual reports, website content and marketing materials; broadcasting legislation; producer guidelines; published interviews with programme-makers and other television personnel.

Many of the changes and developments which are identified in this section are the result of three pieces of legislation: the 1990 Broadcasting Act, the 1996 Broadcasting Act, and the 2003 Communications Act. The developments which took place in the

period leading up to the beginning of my research timeline, instigated by the 1990 Broadcasting Act, include the formal separation of Channel 4 from ITV in 1992, the launch of Channel 5 in 1997, the replacement of the Independent Broadcasting Authority and Cable Authority with the Independent Television Commission in 1991, and a requirement, from 1990 onwards, that all public service broadcasters commission at least 25% of their (non-news) programming from independent producers (Ofcom, 2005). The 1990 and 1996 Broadcasting Acts continued to impact upon the television industry across all levels throughout the 2000s. Other significant developments were the creation of the conditions for digital terrestrial television, embodied in the 1996 Broadcasting Act, and the establishment of the Office of Communication (Ofcom) in 2003, through the 2003 Communications Act, as the new regulator of UK television.

A retrospective snapshot of how UK television was organised in 1999 provides a baseline for understanding the extent of change that characterised the UK television landscape between 1999 and 2013. For most viewers in 1999, UK television meant four to five analogue terrestrial channels - BBC One, BBC Two, ITV, Channel 4, and Channel 5, all accessed through a rooftop aerial; for many viewers, Channel 5 reception was patchy in the early 2000s. A small number of subscribers had access to television programmes through the UK's first digital television platform, ONDigital, a pay platform offering a mix of free-to-air channels (i.e. analogue terrestrial channels) and pay channels (sports channels and programmes made by Granada and Carlton); this service was accessed through a digital box (Smith, 1999). Other viewers could access UK television through Sky Digital, the UK's first subscription-based direct-to-home satellite delivery network. While this provided access to the UK's terrestrial television channels, it did not include ITV programmes until 2001 (Milmo, 2001). In the same year, ONDigital was rebranded as ITV Digital, broadcasting free-to-air only, but ceased permanently in 2002, after which the technology was taken over by a consortium, including the BBC and BskyB, and launched as Freeview in 2002 (Gibson, 2002). From 2002, viewers could access the five terrestrial television channels - BBC One, BBC Two, ITV, Channel 4, and Channel 5 - through both analogue and digital platforms. However, the transition from analogue to digital television was both slow and patchy during the early 2000s, so much so that the UK government's planned digital switchover date of 2006 had to be revised (Bignell, 2013, p. 34).

The launch of BBC Three in 2003 - a year after the launch of BBC Four - is a significant development for this study. These two digital-only channels, available only through Freeview and Sky Digital, broadcast UK-originated programming; viewers who had not transitioned to a digital platform could not access their output. Access to BBC Three programming improved following the BBC's launch of the BBC iPlayer in 2007, when BBC Three programming would become available online. While there is often a 'slow technology uptake' (Green, 2010, p. 74) with technological innovations, the BBC reported significant growth in download and streaming of its programming (Sandison, 2008). ITV and Channel 4 had joined the Freeview consortium in 2005. In 2009, Freeview upgraded to ensure proper reception of Channel 5 (Freeview, 2009). By the end of 2010, penetration of digital television services in the UK was in excess of eighty per cent (Bennett, 2011, p. 2). By 2013, the UK's seven terrestrial channels - BBC One, BBC Two, BBC Three, BBC Four, ITV1, Channel 4 and Channel 5 - were transmitting digital rather than analogue signals. Programme output was available via a number of platforms: free-to-air digital terrestrial (main provider Freeview); free-to-air satellite (main provider Freesat); subscription-based direct-to-home satellite (main provider Sky); subscription-based cable television (main provider Virgin Media). Programming was also available through online streaming, such as BBC iPlayer and 4oD. This overview identifies certain developments that are likely to have impacted upon the sampled programmes. It shows that while access to some sampled programmes might have been variable - e.g. *Spendaholics* (BBC Three, 2005-2007), *Too Ugly For Love* (BBC Three, 2006), *Extreme Phobias* (Five, 2003), and *Obsessions Run My Life* (Five, 2005) - the availability of the remaining sampled programmes is not likely to have been affected.

It has been argued that the 'expansion of digital channels has had a variety of effects on the kind of programmes produced and their scheduling. High budget peak-time programmes... still get made...but they are potentially much less visible amongst the increased volume of low budget 'ordinary television' which is required to fill this expanded air-time' (Arthurs, 2010, p. 174). This claim is supported by the findings of my content analysis which demonstrates an increase in the broadcasting of multi-episode formatted factual television series from the mid-2000s onwards. With the launch of BBC Three, and a corresponding need for UK-originated programming was created. This included the commissioning of the first series of *Spendaholics* in 2005, and the first series of *Freaky Eaters* and *The Panic Room* in 2007, all examples of multi-

episode formatted non-institutional factual psychotherapy programming. One of the research questionnaire respondents has reported that work of this kind ‘was intended to get people interested in watching the new Channel’ (Appendix RQ4, q. 3).

The increasingly competitive broadcast environment, with its concomitant decrease in visibility for the individual programme, placed pressure on programme-makers and broadcasters to produce programmes which were more visible, or attractive, to the viewing audience. The desire to reach as wide an audience as possible is evident in the responses to the question in my research questionnaires, With your particular programme(s), was the intention to reach a wide audience or a niche audience? (see Appendices RQ1-RQ10, q.3). Another development that impacted on the visibility of the individual television programme was through changes in the way that programme information was made available to the viewer. For programmes made in the early years of the research timeline, the primary mechanism for programme information was the TV listings published in newspapers and specialist publications like the *Radio Times* and *TV Times*. For programmes made from the mid-2000s onwards, electronic programme guides (EPGs) became increasingly commonplace (Jones, 2002). By 2007, the UK was reported to be ‘the most developed and innovative EPG market in Western Europe...with 70 percent of UK TV households already hav(ing) EPGs’ (International Television Expert Group, 2007-2010, para. 5). This led to changes in the way that programmes were titled. As one television producer has observed, ‘TV bosses think viewers will particularly notice an arresting, attention-seeking or grabby title when they are flicking through the EPG – so will always respond to a clever title when it’s attached to a pitch. A title that teases, tantalises or promises more is the Holy Grail’ (Hooper, 2014). The use of eye-catching programme titles is regarded as a necessity, given the competitive schedules, with a senior Channel 4 executive arguing that ‘People have got it into their heads that we use excessively provocative titles. It’s just a function of getting noticed. Without them the key audience wouldn’t see them’ (Broadcast, 2004, para. 1). A review of the research sample demonstrates the use of titles that might be described as ‘provocative’, including *Britain’s Weirdest Phobias* (ITV 2008), *I Hate Mum* (BBC One, 2010), *The House of Obsessive Compulsives*, *Addicted to Asda* (Five, 2007), and *Too Ugly For Love*. It is unusual for discussions about programme titles to be aired publicly, but this did happen over the choice of *Bedlam* as the title for the 2013 Channel

4 series about the South London and Maudsley NHS Foundation Trust, only this time it was instigated by the institution itself:

The choice of Bedlam for the title of the series provoked concern and criticism because of what some people feel are the negative, stigmatising associations with the term. From our perspective, the working title of *The Maudsley* or *Inside the Maudsley* didn't really cut it...Another important factor was that Channel 4 wanted a title that would create interest and attract viewers. So did we. We took part because we wanted to try and help shift public attitudes about mental health. You can't do that if nobody is watching. By their own admission, the channel has a liking for edgy titles that get people talking and encourage them to watch. But they were very clear they would only go with a title that we signed up to...And, yes, it is provocative. (Charlton, 2013, paras. 11-21)

All of the sampled programmes were broadcast by television companies constitutionally defined as public service broadcasters. Developments taking place between 1999 and 2013 suggest that a weakening of the public service remit among UK broadcasters took place, leading to the the commissioning of more entertainment-driven programming. However, it has been argued that the general principles that guide the concept of public service broadcasting have evolved over time but essentially remain the same (Price & Raboy, 2003). While the values inherent in the idea may hold true, the degree to which they were applied, or prioritised, within the context of UK television between 1999 and 2013 has been variable. This is despite the fact that a commitment to public service values is a legal requirement for the UK's four public service broadcasters (BBC, ITV, Channel 4 and Channel 5).

There was no change in the constitutional requirements of the BBC's or Channel 4's commitment to public service remit during my research timeline. However, Channel 4's position as a public service alternative to the BBC, with its remit to commission and broadcast programming for minorities and the arts, was threatened by developments during the 2000s, after the channel projected a £100 million funding gap following the digital switchover. In 2009, it was reported that the channel's programme budget of £530 million was already £100 million down on the previous year, making it the lowest it had been since 2002 (Lords Select Committee, 2009, p. 51, q.179). There were

debates during my research which questioned whether the channel would ‘remain sustainable without additional public support...suggest(ing) that Channel 4 would not be able to sustain its public service broadcasting commitments in the long term’ (Select Committee on Communications, 2009, p. 12).

Since its inception, ITV has been mandated to fulfil public service broadcasting in its local news coverage, religious, and arts programming. However, since the mid-2000s, ITV has lobbied to have its public service commitment reduced (e.g. Culture Media and Sport Committee, 2010, p. 108), arguing that it should be able to reduce what it viewed as unprofitable public service programming in the increased digital and multichannel landscape. Ofcom’s response was that, ‘shareholder-funded broadcasters - ITV and Five - will need to respond competitively or else they will diminish as investment engines for originated British content. They will continue to make a significant contribution to what we define as the purposes and characteristics of PSB...However, our regulatory approach to them needs to evolve. It is widely recognised...that...their public service broadcasting obligations will become commercially unviable’ (Ofcom, 2008, p. 3). The relevance of public service broadcasting for this study relates to the historical position of factual psychotherapy programming and its traditional role in delivering informative and insightful programming about the delivery of psychotherapy in institutional settings. The emergence of non-institutional factual psychotherapy programming, with its departure from that institutional setting and its greater emphasis on entertainment, does not necessarily contradict public service values.

In terms of developments that have a more direct impact on programme-making practice, this section considers the changes and developments in how programme-making was regulated. In 1999, commercial television - ITV, Channel 4, and Channel 5 - was regulated by the Independent Television Commission (ITC). The ITC’s Programme Code, stipulated within the 1990 and 1996 Broadcasting Acts, set out the editorial standards for programme-makers working for UK commercial television. Regulation of this was carried out by the Broadcasting Standards Commission. One of its duties was to draw up the Code on Fairness and Privacy, effective from 1998 and revised in 2000, which set out additional programme-making practice guidelines (Communications Commission, 2004). While the BBC came under the jurisdiction of the Broadcasting Standards Commission, its regulation, programme content and

programme-making practice was managed by the BBC's Board of Governors. The BBC has its own set of programme-making guidelines, originally called the *Producers' Guidelines*, which addresses BBC programme-making standards, including changes to programme-making practice in factual and documentary programmes.

In 2003, as a result of the 2003 Communications Act, commercial television channels were licensed by the Office of Communications (Ofcom); the BBC became jointly regulated by the BBC Trust and Ofcom. Following this, UK television became subject to new regulatory requirements as set out in the Ofcom Broadcasting Code. This code set standards for all broadcasters including the BBC. The BBC was subject to some but not all of the requirements of the Ofcom Broadcasting Code, retaining 'final editorial control over all BBC versions of programmes including all associated online and interactive elements commissioned from independent producers' (BBC, n.d., para. 2.1). There were revisions to the Ofcom Broadcasting Code in 2005, 2008 and 2009. The BBC's *Producer Guidelines* were revised in 2005, and renamed as the *Editorial Guidelines* in 2005, and revised again in 2010.

An examination of how the regulation of broadcasting filters down through programme-making guidelines to the practice of television professionals is of particular interest here. Volunteers who appear in factual psychotherapy programming are categorised as 'vulnerable' programme contributors, defined in the Ofcom Broadcasting Code as including '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, 2013, p. 43). Factual psychotherapy programmes involve the participation of individuals with often severe mental health problems who are filmed undergoing psychotherapeutic treatment. For programmes made in institutional settings, there will be additional regulatory constraints imposed by the institution as part of the agreement reached. The self-shooting director of *Sectioned*, filmed in a psychiatric assessment unit, reported that,

It was absolutely crucial that anyone who might take part was well enough to make a decision about being filmed. Before I shot a single frame, lawyers from the BBC and the NHS Trust drew up a rigorous protocol. A key staff member treating each potential contributor would sign a form to confirm the patient had the mental capacity to consent to filming and that they understood what it would

entail. The contributors themselves had to give three levels of consent - in writing, on-camera (which you see in the programme) and then at the end once they'd seen the final film. We checked in with staff every time we wanted to film and they had the power to stop us at any time. Once these safeguards were in place, we could begin to tell their stories. (Anthony, 2010).

In her work on the production of programmes about mental health issues, Henderson discusses the negotiations involved in the production of a series of films about a community health team. The programme producer reports that 'although the filming process involved a series of compromises and negotiations, it was still ultimately easier for the production team to record the experiences of people in psychiatric care than other groups of people in distress' (Henderson, 2007, p. 110). This suggests that making factual psychotherapy programmes within the institutional setting may have benefits for the programme-maker when it comes to the matter of compliance. Responses to my research questionnaire provide an insight into how regulatory guidelines may operate in the non-institutional setting. One respondent has reported that 'Due to different incidents in the past it's now obligatory for TV companies to have contributors assessed by a psychologist if the programme might raise issues or stressful challenges. Which I believe is essential' (Appendix RQ4, q.9). Nine of my questionnaire respondents reported that the volunteers in their programmes were psychotherapeutically assessed before participation in their programmes. However, three respondents, all working on non-institutional factual psychotherapy programmes, reported feeling a sense of personal responsibility towards the programme's volunteers during and after filming (see Appendices RQ4, RQ6, RQ9, q. 8). One respondent reports that the 'filming played heavily on my mind because of the long term repercussions on the patient. It wasn't only about being there at the time, but how would the patient feel seeing them at their lowest point on television' (Appendix RQ6, q.8). It has been argued that 'whereas regulation in the past has maintained a tight control over the content of broadcasting, Ofcom's primary task has been redefined by the government as economic regulation to promote competition' (Arthurs, 2010, p. 3). The production of non-institutional factual psychotherapy programming provides an insight into how more light-touch regulation might impact on both volunteers and programme-makers.

By 1999, factual television programme-making in the UK had transitioned to the use of digital technology, and digital video had almost completely replaced analogue technology (such as film) for most types of factual television programme-making (Ellis & McLane, 2005, p. 258). Digital cameras and non-linear digital editing systems formed the core programme-making technology. Leading manufacturers had arrived at a common tape format in 1995 - DV - which was used in the manufacture of both professional DV cameras, such as Panasonic's DVC Pro and Sony's DVCam, for use in television production, as well as non-professional or domestic cameras aimed at the corporate and low-end broadcast and domestic markets. The running costs of this new generation of DV cameras were considerably cheaper than the previously ubiquitous Betacam SP. As the cost of the domestic versions of these cameras was so low, it became common practice for production teams to buy them as part of programme budgets. The small size and low weight of the domestic cameras increased the scope for filming in environments where access was restricted. Despite some poor results (lack of operator expertise, inadequate ancillary equipment, unsuitability of the camera for the task), production companies began to use them routinely on productions.

Cheap tape, such as DV, encourages over-shooting, with some programmes reporting unusually high shooting ratios (ratio of material filmed to material broadcast). One documentary filmmaker describing the impact of digital tape, stated that 'shooting ratios have gone up about 400 per cent...caus(ing) trouble down the track in the amount of time you've got to spend dealing with that amount of material' (Malloy, 2005, paras. 15-16). However, there are clear advantages for the filming of psychotherapeutic actuality, where an individual psychotherapy session typically lasts for sixty minutes, and where several sessions are recorded during the production process. The research questionnaire responses indicate that it was common practice to film multiple sessions of psychotherapeutic actuality; only three of the ten questionnaires reported not doing so (see Appendices RQ1-10, q.7). However, it has been argued - by documentary filmmaker Roger Graef - that the impact of new technologies has had negative impacts on programme-makers because,

there is the economic reductionist pressure of very tight budgets: because technology allows you to shoot and edit quicker, the accountants who look at the budgets say in that case we must shorten the budget and shorten the schedule. In

my experience with documentaries, especially open-ended ones which are not scripted in advance, very often the best things happen on the very last day... That flexibility - the investment and the open-ended process - has really eroded big time. (Lords Select Committee, 2009, q. 688).

The sampled programmes were made by personnel employed either within the in-house production arms of vertically-integrated broadcasters such as the BBC and ITV (Doyle & Paterson, 2008), or by people employed by independent production companies which had been commissioned to make programmes for the BBC, ITV, Channel 4 or Channel 5. The UK television independent production sector, which developed following the launch of Channel Four in 1982, expanded again after the establishment of the twenty five per cent quota for independent productions by the BBC and ITV in the mid-1990s (Felix, 2000). Further expansion came with the system known as ‘producer choice’ - in which BBC producers were no longer obliged to use in-house resources. Within this evolving media professional culture, programme-makers might move between broadcasters as freelancers or employees on contract, rather than be tied to the production cycle of a particular broadcaster. During the research timeline, many television professionals would have been freelancers employed on a daily or weekly rate or contracted temporarily for the duration, or part-duration, of a programme’s production schedule. Increased casualisation of the television profession became the norm within the television industry, particularly among producer/directors working in factual television, with short contracts increasingly common. As early as the 1990s, it was observed that while producer/directors welcomed greater independence through the development of freelance opportunities, with hindsight, this development has, in fact, come to be seen as an obstacle to producer freedom and creativity (Cornford & Robins, 1992). A scenario has emerged in which producer/directors ‘pursue broadcast organizations for project commissions. If the commissioners like the project proposal, they accept it but haggle over total price, over who should pay what element, and over copyright’ (Ursell, 2000, p. 811). It has also been argued, for example, that one consequence of such structural changes to the status of professionals within the television industry has been the rise of broadcast executive power concurrent with a demise in programme-maker autonomy. This has particular relevance to multi-episode formatted series - such as *Spendaholics*, *Freaky Eaters*, *The Panic Room*, *Britain’s Biggest*

Hoarders (BBC One, 2012-2013), and *The Hoarder Next Door* where the traditional role of producer/director as programme-maker has been replaced with a system where series producers and directors have overall responsibility for the programme's content and look. The research questionnaire responses show that in only two cases were programme-makers directly involved in developing the project idea (see Appendices RQ7 & RQ8, q.1). In the remaining cases, programme-makers were brought in at a later stage, once the programme idea had already been developed.

The role of producer/director as programme-maker remains a familiar fixture in the production of single documentaries, and this is certainly reflected in the research sample. However, the role of producer/director has been displaced to an extent by the emergence of new production roles. These include the self-shooting producer/director, a role which adds a significant production role - filming - to the producer/director role, signified by a combined credit for *filmed, produced and directed by*. The role of self-shooting producer/director appears on five programmes within the research sample broadcast between 2006 and 2013. In *Too Ugly For Love*, the self-shooting producer/director also presented the programme, opening up possibilities for a greater sense of authorship. However, while the addition of filming to the producer/role might appear to enhance the producer/director's sense of ownership and authorship of a programme, and even create a greater sense of intimacy due to the smaller crew size, it is also possible that the additional responsibilities on location might impact upon the producer/director's relationship with programme contributors. Other roles that impact on this arrangement include the role of DV director, and the use of additional crews involving self-shooting researchers or assistant producers. By 2013, these developments were well-established, and most commonly seen in multi-episode formatted programmes in which production is broken down into units and the process comes closer to the concept of the industrial production line.

The issues raised within this contextualisation of television programme-making during the research timeline has identified developments that are likely to have impacted upon the sampled programmes. For programme-makers, 'concern is that new way of working appears to demote them as being mere 'suppliers of footage' and to deprive them of any significant involvement in the crucially important editing process. This raises important questions about the authorial status of what is finally transmitted' (Kilborn, 1998, p. 211).

4.2 Psychotherapeutic Contexts

This section presents an account of developments within the UK psychotherapeutic domain during the research timeline which it is suggested have been a contributory factor in the emergence of non-institutional factual psychotherapy programming. This account is not intended as a comprehensive narrative of developments within the UK psychotherapeutic domain between 1999 and 2013, but rather is a summary of developments that are directly relevant to this study. In order to contextualise the developments identified here, I refer to Pilgrim's description of the UK psychotherapeutic landscape in the early 2000s as a 'jumble of coexisting types of therapy, coexisting disciplines and coexisting professionalization processes' (2002, p. 11). To an extent, this description seems applicable to the research sample, and therefore provides a context for understanding the range of psychotherapeutic modalities which are represented in the sampled programmes. However, Pilgrim goes on to describe the UK psychotherapeutic domain of the early 2000s as a space where, 'credentialism burgeons, an obsession with registration continues and relatively simple communicable models (for example, person-centred counselling, cognitive-behaviour therapy or cognitive-analytic therapy) have become elaborate hierarchies of graded exclusive competence, defined by longer and longer training periods' (Pilgrim, 2002: 12).

It will be shown in Chapter 5 that two psychotherapeutic modalities dominate the research sample. The first is child or family psychotherapy; a distinctive and highly recognisable modality which involves the simultaneous participation of whole families and at least two psychotherapists. The sampled programmes which feature child or family psychotherapy are always filmed in the institutional setting; for presumably ethical reasons, there are no non-institutional factual psychotherapy programmes involving child or family therapy. The second modality which dominates the sample is cognitive behavioural therapy which features in both institutional and non-institutional factual psychotherapy programmes, but is particularly popular with programme-makers working in the non-institutional setting. For this reason, this study is most interested in the popularity of cognitive behavioural therapy in the sampled programmes and will consider, in Chapter 5, how constructions of cognitive behavioural therapy are different in institutional and non-institutional factual psychotherapy programming forms.

The use of cognitive models for the treatment of anxiety disorders is not a recent development; they have been in use since the mid-1980s in the UK setting, with a long-standing association with the academic research setting (Moorey, 2002, p. 296). However, by the early 2000s, cognitive behavioural therapy had become a ‘major component of clinical psychology courses and psychiatrists in training (were) also expected to have some experience of this form of therapy’ (Moorey, 2002, p. 296). A significant development, in terms of raising the visibility of cognitive behavioural therapy, was the publication in 2006, of an influential report known colloquially as the ‘Layard Report’ (London School of Economics, 2006). The report led to a number of initiatives, including the Increasing Access to Psychological Therapies (IAPT) programme, which focused on the delivery of psychotherapeutic treatment for common mental health problems, including anxiety and depression. The modality recommended within the IAPT programme was cognitive behavioural therapy (Marzillier & Hall, 2009). In 2007, the UK government invested £173 million to train three thousand six hundred UK-based cognitive behavioural therapists (Clark et al., 2009). The high visibility of psychotherapists using cognitive behavioural therapy in the sampled programmes, particularly from the mid-2000s onwards, is likely to have been influenced by these developments.

As a psychotherapeutic modality, cognitive behavioural therapy has been described as ‘the dominant force in psychotherapy across much of the world’ (Herbert & Forman, 2011, p. 3). Its rise to prominence has been explained by a preference for evidence-based psychotherapeutic practice, particularly in terms of outcomes. The research-based literature, produced since the mid-1980s, has placed cognitive behavioural therapy in a unique position to dominate the field of psychotherapy and has come to be seen as something of a miracle cure within the NHS setting (Pollock, 2008).

The dominance of cognitive behavioural therapy in the psychotherapeutic domain is reflected in its dominance of the research sample. Through its increasingly common representation in factual psychotherapy programming, this modality with its distinctive activity-based approach, which initially looked odd in comparison to talk-based psychotherapeutic modalities, has become increasingly recognisable and familiar. One consequence of this is that other modalities have become marginalised. As I will demonstrate in Chapter 5, constructions of cognitive behavioural therapy within the sampled programmes have become so focused on emphasising its activity-based

character, that those programmes featuring primarily talk-based modalities are beginning to appear as less explicit and less accessible to readings.

The second development relates to changes in the way that mental health problems are defined and classified, officially within psychotherapeutic classificatory systems, and unofficially within popular culture. The identification and diagnosis of mental health problems in the UK is based on two classificatory systems. The first is the *ICD-10 Classification of Mental and Behavioural Disorders*, published by the World Health Organisation, which is used within the NHS for diagnosing and classifying mental health problems. The ICD-10 is intended for ‘use by mental health professionals’ (World Health Organization, 1992, p. 1), as well as medical practitioners, it is intended as a descriptive classification system carrying ‘no theoretical implications’ (World Health Organization, 1992, p. 2). The second system is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association, which was published in its fourth version (DSM-IV) for the majority of the research timeline. The latest version, DSM-V was published in May 2013. The DSM is the standard classification of mental health problems used by mental health professionals in the United States but is also influential on how mental ill health is thought about and treated in the UK setting. The DSM-IV is used by ‘clinicians and researchers of many different orientations (e.g. biological, psychodynamic, cognitive, behavioural, interpersonal, family systems’ (Sadler, 2005, p. 73).

One example of how changes to such classificatory systems have impacted upon the sampled programmes is in relation to the emergence of hoarding disorder as a discrete mental health problem. Until recently, within mental health classificatory systems, hoarding was not recognised as a discrete mental health disorder but rather as a sub-type of obsessive-compulsive disorder. Its classification changed with the publication of DSM-V in 2013, in which compulsive hoarding was re-designated as a mental health disorder in its own right, called hoarding disorder. The ongoing revision of these two classificatory systems shows that definitions of mental health problems evolve over time. This re-designation was a consequence of a campaign by academic researchers (Mataix-Cols et al., 2010). It is likely that this campaign to have hoarding recognised as a discrete mental health problem was a factor in the cycle of programmes about hoarding disorder which were broadcast in 2012 and 2013. For example, the lead academic researcher behind the push to have hoarding disorder recognised - David

Mataix-Cols - actually appeared in one of the sampled programmes, *My Hoarder Mum And Me* (BBC One, 2011). Busfield (2012) has suggested that the expanding and evolving field of mental health classifications can make it appear that mental ill health is on the rise, and may be a contributory factor in the general perception that mental ill health is on the increase and mental wellbeing is in decline (Hooker, 2010).

4.3 Factual Psychotherapy Programming - A Content Analysis

This section presents the findings of a content analysis conducted on the research sample, and these findings provide a framework for contextualising the findings presented in Chapters 5 and 6. Chapter 3 presented an account of how the content analysis method is used within this study. A summary of the raw data used in this analysis is available in Appendix B. The research sample comprises one hundred and five factual psychotherapy programmes, broadcast between 1999 and 2013, on the seven UK (analogue or digital) terrestrial television channels - BBC One, BBC Two, BBC Three, BBC Four, ITV, Channel 4, and Channel 5/five/5. Cable and satellite channels have been excluded from this study on the grounds that they were not commissioners or producers of UK-originated content (other than sport). The study timeframe covers the emergence of digital terrestrial television in the UK, the launch of Freeview in 2002, the launch of BBC Four in 2002, and BBC Three in 2003, and the analogue switch off in 2012.

Figure 1 shows the distribution of the programmes across the research timeline.

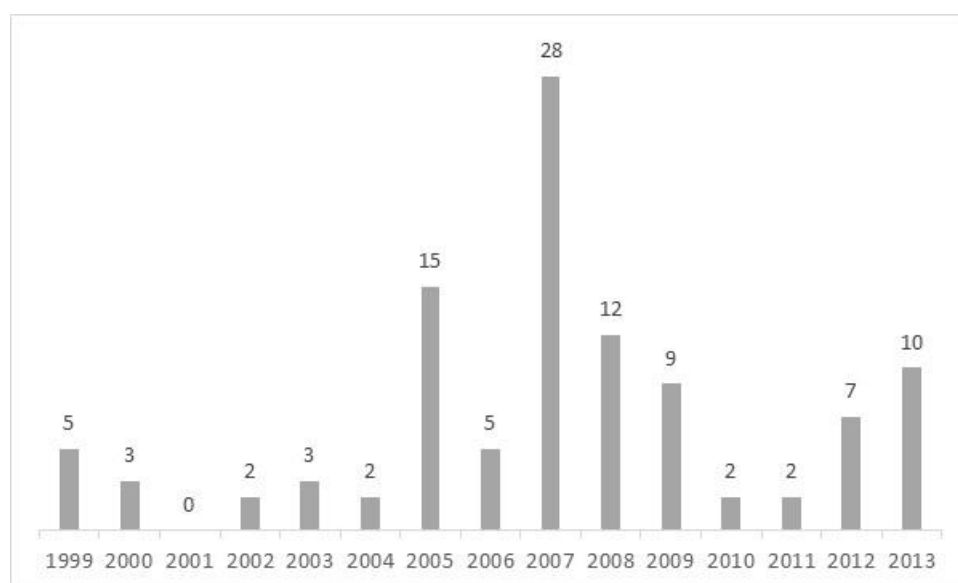


Figure 1 Sampled Programmes by Year of Broadcast

Figure 1 does not differentiate between institutional and non-institutional factual psychotherapy programmes. It simply records how many factual psychotherapy programmes, as defined within this study, were broadcast in each year within the research timeline. This chart was generated in order to identify any patterns or trends across the research timeline. The following observations have been made:

- there is a pronounced factual psychotherapy programming ‘spike’ between 2005 and 2009;
- there appears to be the beginning of a second broadcasting ‘spike’ in 2012 and 2013;
- 2007 was a prolific year for the broadcasting of factual psychotherapy programming;
- there was a fall in the number of factual psychotherapy programming in 2006, which will be accounted for;
- no factual psychotherapy programmes, as defined within this study, were broadcast in 2001;
- the remaining years show that between two and five factual psychotherapy programmes were broadcast, establishing a notional ‘steady state’.

The broadcasting ‘spike’ in factual psychotherapy programming between 2005 and 2009 captures the broadcast of *The House of Obsessive Compulsives* in 2005, and suggests that this programme’s broadcast, regarded as significant within this study, marked the beginning of a distinct cycle in the broadcasting of factual psychotherapy programming. The fall in numbers for 2006, which seems to reverse the trend momentarily, can be accounted for by changing circumstances surrounding the broadcast of the series *Spendaholics*, which broadcast one eligible series of ten episodes in 2005 and two eligible series totalling 12 episodes in 2007, but which broadcast only one series of six episodes in 2006 which had to be excluded from the research sample because of a change in the programme’s psychotherapist which made it ineligible for inclusion in the research sample. One of the series broadcast in 2005 was excluded for the same reason. Had the 2006 series of *Spendaholics* been eligible for the research sample, this would have raised the 2006 count to eleven programmes. The high number of programmes in

2007 is explained by the broadcast of three multi-episode series: *Spendaholics*, *Freaky Eaters* and *The Panic Room*; these three programmes combined accounted for twenty five programmes broadcast in 2007. The chart shows what appears to be the beginning of a second ‘spike’ of factual psychotherapy programming in 2012, which is accounted for by the trend for programmes about hoarding. Other than 2001, a year in which there were no recorded programmes, there was a steady state of between two and five programmes per year.

Figure 2 shows the distribution of the sampled programmes according to the broadcast channel.

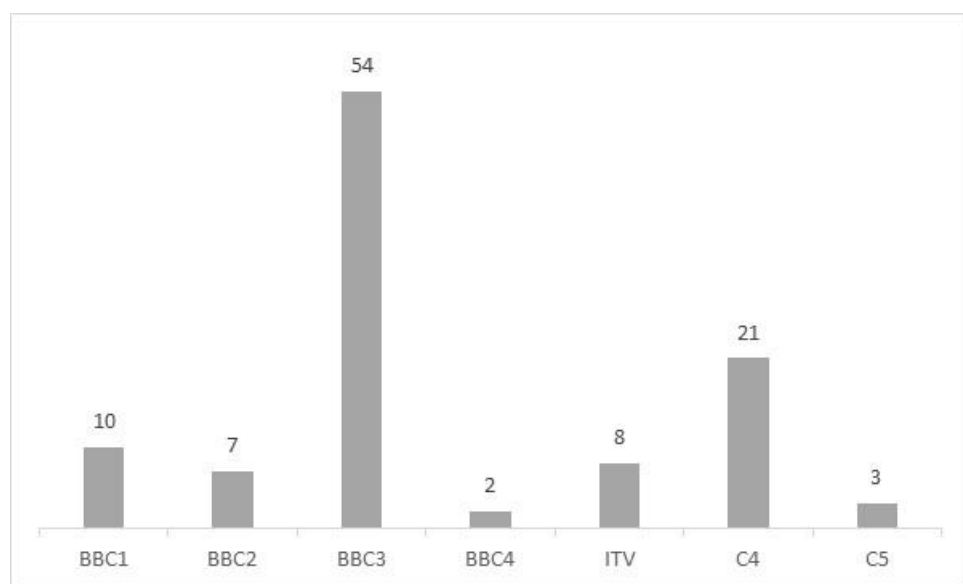


Figure 2 Sampled Programmes by Broadcast Channel

The findings presented in Figure 2 do not distinguish between institutional and non-institutional factual psychotherapy programmes, but simply record the overall numbers of factual psychotherapy programmes broadcast on each UK terrestrial channel. The findings show that:

- more factual psychotherapy programmes were broadcast on BBC Three than all of the other channels combined;
- taken together, BBC Three and Channel 4 broadcast over seventy per cent of the sampled programmes;
- very few factual psychotherapy programmes were broadcast on BBC Four or Channel 5.

These findings demonstrate that the channels most associated with the broadcast of factual psychotherapy programmes are BBC Three and Channel 4. The explanation for the high number of factual psychotherapy programmes broadcast on BBC Three programmes is explained by the channel's preference for multi-episode formatted series. The programmes broadcast on Channel 4 are among the most high-profile and innovative factual psychotherapy programmes, particularly those made in the non-institutional setting. One explanation for the small number of programmes broadcast on Channel 5, all single popular factual documentaries broadcast in 2003, 2005, and 2007, suggest a possible mini commissioning trend which did not develop. An explanation of the small number of programmes broadcast on BBC Four may be related to the fact that the two programmes broadcast on this channel were made in association with the Open University.

Figure 3 shows how the sampled programmes are distributed using both channel and year of broadcast.

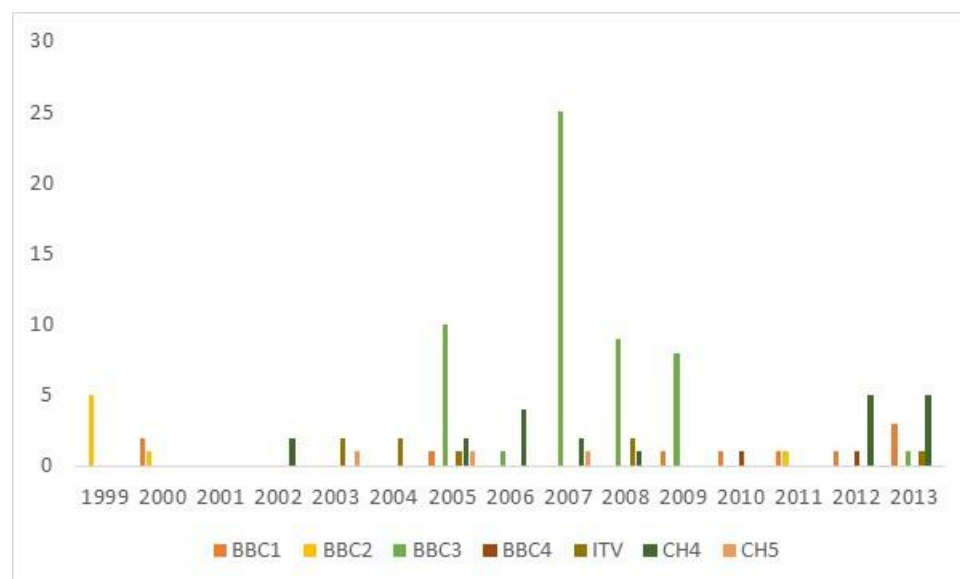


Figure 3 Sampled Programmes By Year of Broadcast and Channel

Figure 3 shows that:

- BBC Three's programming is concentrated primarily between 2005 and 2009;

- Channel 4 had broadcast more factual psychotherapy programming in 2006, at the beginning of the proposed spike, and in 2012 and 2013, after the spike had happened;
- BBC Two had a strong year in 1999;
- BBC One spiked early and late in the research timeline, in 2000 and 2013.

These findings suggest that in the early years of the research timeline, BBC One and BBC Two were the home of factual psychotherapy programming. The broadcast ‘spike’, driven by the emergence of BBC Three, dominates the research timeline between 2005 and 2009. The mid-2000s trend for multi-episode, formatted, studio-based programmes such as *Spendaholics*, *Freaky Eaters*, and *The Panic Room* - all broadcast on BBC Three - account for the dominance of BBC Three within the research sample. The broadcasting of this kind of non-institutional factual psychotherapy programming on BBC Three tails off sharply after 2009. Channel 4’s programming is more evenly distributed, with three strong years in 2006, at the earlier stages of the trend for factual psychotherapy programming, and again in 2012 and 2013, when it devised its own multi-episode, formatted series *The Hoarder Next Door*.

Figure 4 shows the breakdown of the sampled programmes by year of broadcast and by single/episode classification.

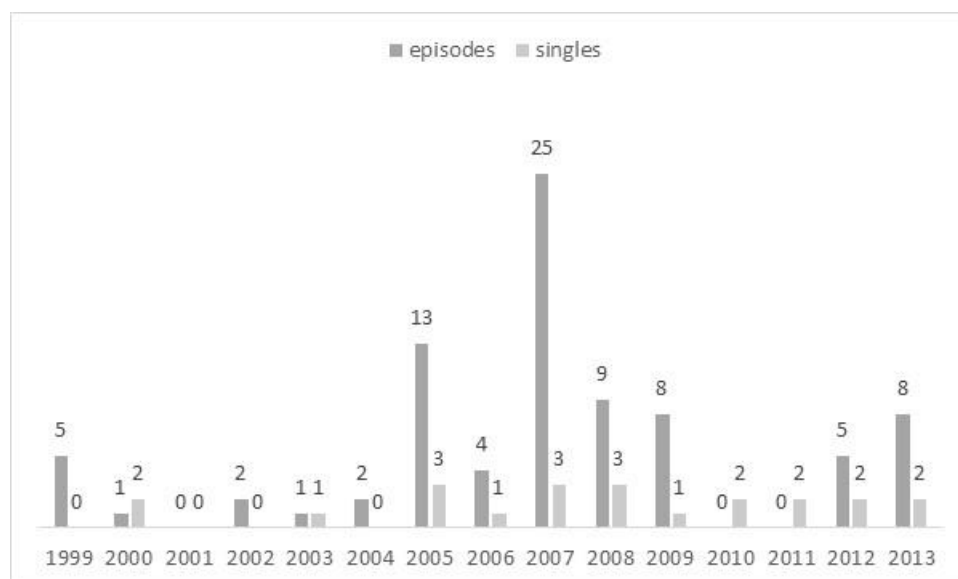


Figure 4 Programmes by Year of Broadcast & Single/Episode Classification

Figure 4 shows that:

- programmes which are classified as ‘singles’ are broadcast at a steady rate across the research timeline;
- what dominates the sample, particularly in the 2005 to 2009 ‘spike’ is the ‘episodic’ programme.

With regard to the mode of delivery, the sample contains two categories of programme. Programmes were defined as ‘singles’ if they were self-contained and did not connect to any other programme, apart from being presented as part of a factual/documentary strand (e.g. *Real Lives*, *Cutting Edge*). Programmes were defined as ‘episodes’ if they connected to other programmes via one of the following mechanisms: they were self-contained programmes which were scheduled as part of a series (e.g. *Bedlam*, *Talking Cure*, *Phobias*); they were self-contained programmes which were scheduled as part of a multi-episode formatted series (e.g. *Freaky Eaters*, *Spendaholics*, *The Panic Room*, *The Test* (ITV, 2003-2004)); they were non-self-contained programmes which were presented chronologically within a short (usually two-part) series (e.g. *The House of Obsessive Compulsives*, *House of Agoraphobics*).

The findings presented in Figure 4 show a relatively steady broadcast of *singles* - self-contained, stand-alone programmes - across the research timeline. They show a notable increase in the broadcast of *episodes* in 2005 and 2007, particularly an increase in *formatted episodes* (e.g. *Freaky Eaters*, *Spendaholics*, *The Panic Room*).

Figures 5 and 6 (see overleaf) show the breakdown of the research sample according to day and time of broadcast.

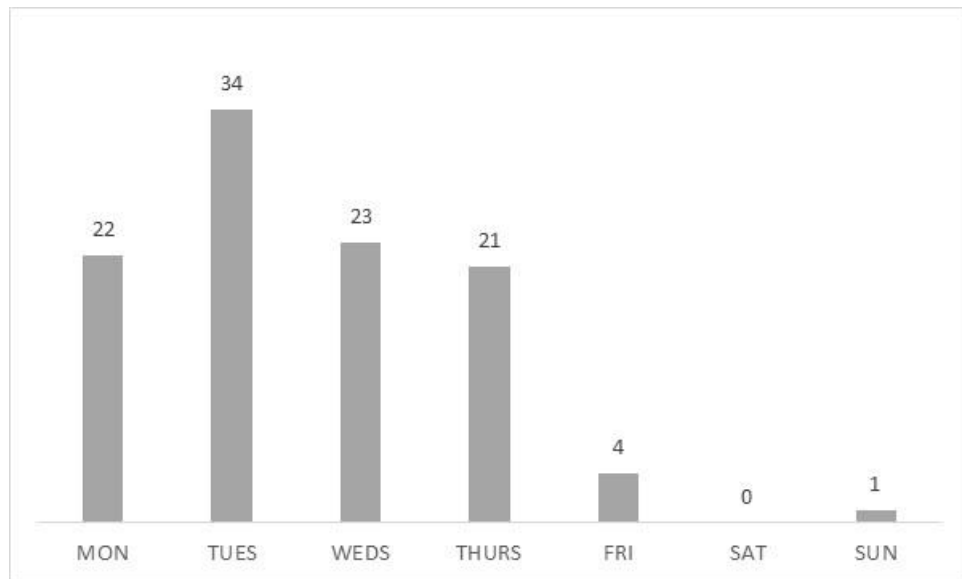


Figure 5 Programmes by Day of Broadcast

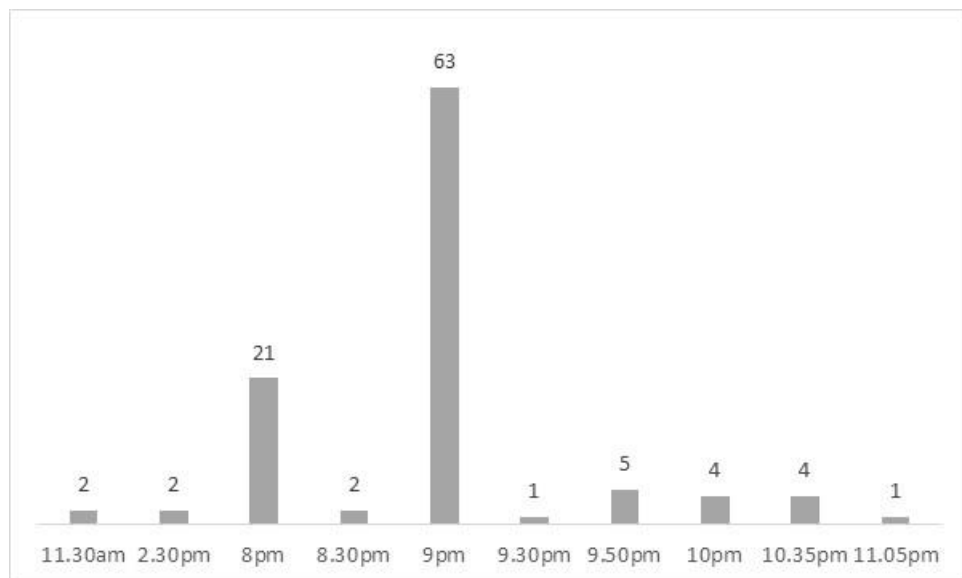


Figure 6 Programmes by Broadcast Slot

These findings show that:

- factual psychotherapy programmes are broadcast on weekdays, between Monday and Thursday;
- the most common day is Tuesday;
- it is rare for factual psychotherapy programmes to be broadcast over the weekend;
- the most commonly-used slots are 9 p.m. and 8 p.m.

This category uses data drawn from the sampled programmes' original broadcast slots (day, time). From this it is possible to identify trends in how factual psychotherapy programmes are scheduled. In particular, I was interested in the degree to which the sampled programmes could be categorised as being scheduled in peak-time slots, defined as 'the part of the day's television schedule when the greatest number of viewers may be watching' (Bignell, 2013, p. 182). For example, peak-time hours on the BBC's television services are listed as 6 p.m. to 10.30 p.m., but divide further into early peak-time (5.30 p.m. to 8 p.m.) and late peak-time (8 p.m. to 11 p.m.).

The findings presented in Figures 5 and 6 indicate that 9 p.m. on a weekday, excluding Friday, is the most commonly-used slot for factual psychotherapy programming. This positions factual psychotherapy programming, both its institutional and non-institutional forms, as being programmes deemed to be appropriate for peak-time scheduling. It supports the findings of previous research which has shown that factual television programming and documentaries are prominent on all channels on weekdays between 8 p.m. and 11 p.m. (Hill, 2007, p. 34). However, scheduling is not just about the positioning of programmes across a twenty-four hour period. It is also about 'the ways that programmes...follow one another in an unbroken sequence across that part of the day, and the experience of watching the sequence of programmes, advertisements, trailers' (Bignell & Orlebar, 2005, p. 309). A detailed analysis of programme scheduling is carried out in the Chapter 6 case studies. My research questionnaire responses show that reaching the largest possible audience is a priority for all programme-makers, irrespective of the scheduled slot. 'Most TV programmes set out to reach a wide audience' (Appendix RQ10, q.3); 'We wanted to reach as wide an audience as possible to make people realise that Hoarding is a mental disorder that could affect anyone of us' (Appendix RQ9, q.3). 'The intention was to reach as wide an audience as possible, whilst making a film that did justice to those we were filming and what we were seeing' (Appendix RQ5, q.3). 'This is TV, we are always looking to tell the story to as wide an audience as possible. But within that we have to do justice to the complexity of the stories involved' (Appendix RQ1, q.3).

Figure 7 (overleaf) shows a breakdown of the sampled programmes according to year of broadcast and institutional/non-institutional classification.

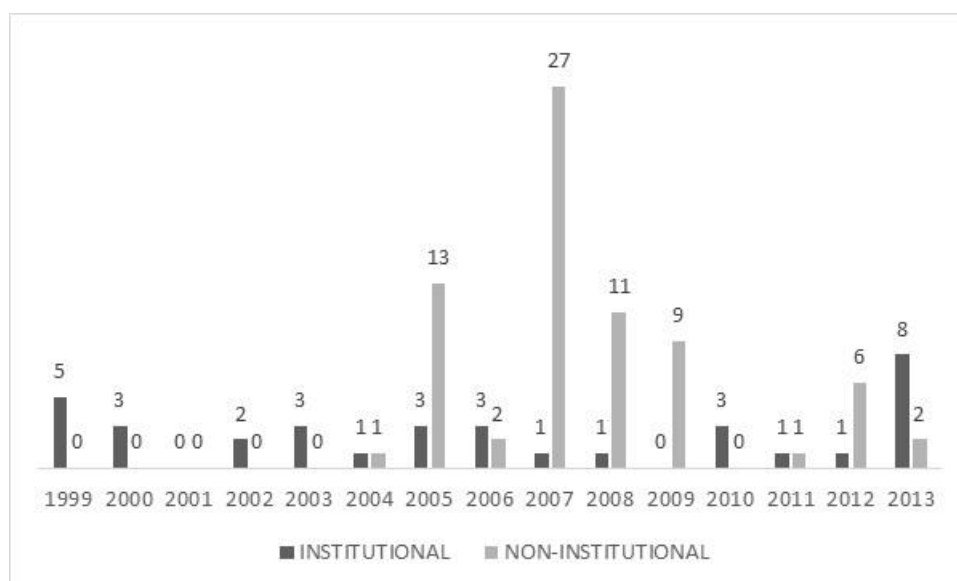


Figure 7 Year of Broadcast & Institutional/Non-Institutional Classification

Figure 7 shows that:

- institutional factual psychotherapy programmes are broadcast steadily across the research timeline;
- non-institutional factual psychotherapy programmes begin to appear in 2004;
- 2005, 2007, 2008, 2009, and 2012 are years in which non-institutional factual psychotherapy programming dominated;
- there was a significant drop in 2006;
- there was increase in institutional factual psychotherapy programming in 2013, which exceeded the numbers at the start of the research timeline.

The method for distinguishing between institutional and non-institutional factual psychotherapy programming was set out in Chapter 3. The findings presented in Figure 7 show that the broadcast of non-institutional factual psychotherapy programming maps to the broadcast of episodes identified in Figure 4, and maps to the distribution of BBC Three and Channel 4 programming identified in Figure 3. Figure 7 contains some unexpected findings. The rise in institutional factual psychotherapy programmes in 2013, which is partly the result of the re-designation of *The Hoarder Next Door* from non-institutional to institutional factual psychotherapy programme. This is discussed further in Chapter 6. It is also the result of the broadcast of two prominent institutional factual psychotherapy programmes - *OCD Ward* (ITV, 2013) and *Bedlam: Anxiety* - making 2013

a year when institutional factual psychotherapy programming regained some ground from its non-institutional counterparts. It is tempting to develop this idea, to see this development as the beginning of a new trend away from factual psychotherapy programmes made in non-institutional settings, to those made in the institutional setting, even suggesting that access to psychotherapeutic institutions may have become less difficult. However, there are other factors to consider. As it has been discussed in Chapter 1, the Channel 4 series *Bedlam* took over two years to make, with extensive negotiations during the pre-production stage.

This chapter has presented three sets of contextual materials within which the study's research findings can be situated. The first section presented an account of the industrial and professional context within which the sampled television programmes were produced, broadcast and consumed. The second section identified developments within the UK's psychotherapeutic domain which, it is proposed, have influenced constructions of the psychotherapeutic process in factual psychotherapy programming. The third section provides the results of a content analysis of the research sample intended to act as a contextual framework for the programme analysis findings presented in Chapters 5 and 6.

Chapter 5: The Programmes

The previous chapter considered the legal, technological, industrial, and professional contexts of UK television programme-making between 1999 and 2013. It identified a number of significant developments which impacted directly on the production of factual television programmes. However, in the specific case of factual psychotherapy programming, an understanding of changes within the television domain is not sufficient to account for the emergence, in the 2000s, of a new form of factual psychotherapy programme. In order to explain this phenomenon fully, it is necessary to consider simultaneous developments in the UK psychotherapeutic domain. The conclusion of Chapter 4 is that it is the combination of factors emerging from these two domains - television and psychotherapy - which have created the possibility of a new form of factual psychotherapy programming and, within it, the construction of new representations of the psychotherapeutic process within factual television.

Building on these interacting and intersecting contextual factors, and drawing upon concepts and themes generated by the literature review, this chapter presents the first set of research findings based on an analysis of the sampled programmes. While these identify the similarities between the established and new form of factual psychotherapy programming and facilitate the first concrete step in mapping a previously under-researched programme type, the primary aim of this chapter is to identify the key areas of difference between the two forms, and to use these findings as the basis for more detailed analysis in the next chapter. Chapter 6 presents the remaining results of the programme analysis, generated through three case studies of non-institutional factual psychotherapy programmes that have been selected for their exemplary character.

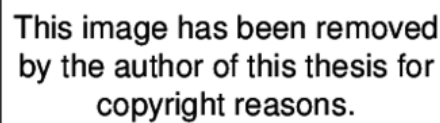
My analysis of representations of the psychotherapeutic process in factual psychotherapy programming begins with an acknowledgement that the psychotherapeutic actuality which features in the sampled programmes cannot be taken as a straightforward reflection of the psychotherapy it purports to represent. The making of factual television involves a series of transformations, leading to particular ways of shaping and structuring the actuality they represent (Corner, 1996, 2008a). This includes a range of programme-making interventions, such as decisions about setting,

volunteers, programme content, filming style, and editing, which all contribute to the construction of representations of the psychotherapeutic process.

Recorded actuality footage is inevitably influenced by the presence of camera equipment and production crew during filming. This has significant implications for programmes which feature psychotherapeutic treatment, and may even impact on the outcomes of the psychotherapeutic process. Awareness of this possibility is evident in responses to my research questionnaire. One programme-maker notes that ‘the confidentiality that comes as a vital condition in a therapeutic setting is not there. Having a camera there will alter reality, and working hard to have as little impact as possible on treatment is vital’ (Appendix RQ5, q.2). Another programme-maker notes that the ‘main challenge was to make sure that the psychotherapy sessions were going to be of some use/benefit to the patient even with the cameras present’ (Appendix RQ2, q.8). Despite such concerns among programme-makers, it is likely, inevitable even, that the presence of cameras and crew will have impacted upon the psychotherapeutic process. Research into the impact of cameras during the psychotherapeutic process found that patients/clients visualised themselves on a television screen, or imagined an audience viewing what had been filmed, although the research findings suggest that any initial discomfort appeared to fade with repeated exposure (Ford, 2008). Research into the perceptions of trainee psychotherapists of the effects of being filmed found that the experience was anxiety-promoting and interfered with trainees’ ability to be ‘completely present’ in the psychotherapeutic encounter; again, this reaction appeared to recede through repeated exposure (Gossman & Miller, 2012). In any event, the use of cameras in the consulting room setting is not unusual, and filming is routinely used during psychotherapists’ training. For example, the practice is well-established in the training of family therapists (Schwartz, 2000). Furthermore, some psychotherapeutic specialisms routinely use the practice of filming psychotherapeutic encounters, as illustrated in *Talking Cure* and *I Hate Mum*. It is, therefore, likely that at least some of the psychotherapists who appear in the sampled programmes will be familiar with the experience of being filmed, and will be more at ease with this arrangement than the volunteers.

There are instances in the sampled programmes, during sequences of psychotherapeutic actuality, where volunteers appear to be not only acutely aware of the camera’s presence but uncomfortable with being filmed. For example, in the third

episode of *Talking Cure*, a psychotherapeutic organisational consultant works with the teaching staff of a primary school where levels of stress are particularly high. Despite having initiated the psychotherapeutic intervention, the head teacher gradually finds himself being identified, by the psychotherapist, as the cause of the school's problems. During one of the group psychotherapy sessions, in which the psychotherapist speculates about what would happen if the head teacher was no longer running the school, the camera, instead of panning to the person who responds to his question, pans instead to the head teacher (see Figure 8).



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by the author of this thesis for
copyright reasons.

Figure 8 *Talking Cure* (BBC Two, 1999)

By the time the camera settles on him, the head teacher is already looking directly the into camera lens, suggesting that he is fully aware that the camera is waiting to capture his response. The shot is held for nearly thirty seconds, including a slow zoom into a close-up shot, during which the volunteer, looking uncomfortable, keeps looking into the camera lens. In such an evidently awkward moment, it is likely that the volunteer was attempting to manage his self-presentation according to some 'best-outcome' formula (Goffman, 1959; Jourard, 1971) and acts as a timely reminder that programme contributors may be motivated to present themselves in ways which 'maximises... others' views of them' (Farber, 2006, p. 10).

During the filming of psychotherapeutic actuality, it is more common for volunteers (and psychotherapists) to behave as if the camera is not there. In some programmes, this is facilitated through the use of remotely-controlled cameras, or by the filming of psychotherapeutic actuality through two-way mirrors, as evidenced in *Talking Cure* and *I Hate Mum*. One research questionnaire respondent reported that the use of '2 way mirrors...to get live action therapy...enabled the patients to feel relaxed and was less of an obstacle to the therapy session' (Appendix RQ7, q. 6). Another reported that

psychotherapeutic encounters were filmed by ‘two cameras... left...rolling in a locked off position and director and producer sat behind screens in the room so they wouldn’t be seen by the patient’ (Appendix RQ2, q. 8).

However, in many programmes, the camera is visible during the filming of psychotherapeutic actuality, requiring collusion between programme-maker, psychotherapist and volunteer to behave as if camera and crew are not there. This arrangement can be difficult to sustain, leading to unintended acknowledgements of the camera which would be edited out ordinarily. This practice contributes to constructions of the psychotherapeutic process which suggest it is unmediated, enabled further by an audio-visual ‘non-style’ characterised by ‘a literalism of representation, its compositions, framings, angles, lighting, colourings and movements designed to engage a kind of unselfconscious, realist assent, although its referentiality is always *performed through style*, however quietly’ (Corner, 2003, p. 96).

My programme analysis will show that this strategy of apparent non-intervention is most characteristic of institutional factual psychotherapy programming, while programmes made in non-institutional settings are more likely to make use of less naturalistic programme-making interventions, including the use of music, interpretive sequences, and structural devices such as pre-title teases and post-episode trails. My analysis starts from the assumption that the psychotherapeutic actuality which features in the sampled programmes is ‘no less a construction than any other processed version of a therapy session’ (Schwartz, 2000) or, indeed, any piece of television, including fictional representations of the psychotherapeutic process.

5.1 Subjects: Problems & People

This section examines how the people who are depicted as experiencing mental health problems - the volunteers - are represented in the sampled programmes. As it has been stated elsewhere, the purpose of this study is not to question or challenge the purported diagnoses of volunteers within the sampled programmes. The focus of this study is to identify and explain representations of the psychotherapeutic process, including the recipients of psychotherapeutic treatment, and their purported mental health problems. Representations of psychotherapeutic expertise are considered later in this chapter.

It has been argued that ‘televisual images...need careful attention if we are to understand the circumstances surrounding mentally ill people’s public representations’ (Cross, 2004, p. 204). Chapter 2 identified research literature which has studied

representations of mental health problems in factual television programming, which has concluded that mediated representations of mental health problems are overwhelmingly negative (Philo, 1999; Stout et al., 2004; Wahl, 1992, 2003). This analysis assesses the extent to which the representations found in the sampled programmes present ‘overwhelmingly dramatic and distorted images of mental illness that emphasise dangerousness criminality and unpredictability’ (Stuart, 2006, p. 99), and identifies any differences between institutional and non-institutional factual psychotherapy programming.

This analysis draws on existing research, presented in Chapter 2, which argues that definitions and categorisations of mental health change over time (Harper, 2009), to the extent that behaviours which, in earlier times, would not have been considered as indicative of mental health problems have since become pathologised (Furedi, 2004; Horwitz & Wakefield, 2007). It also draws on research which shows that public perceptions of what constitutes a mental health problem have changed over time (Stout et al., 2004). Within this context, factual psychotherapy programmes can be viewed as time-specific snapshots of how mental health problems are defined within particular settings and at particular times.

Taken collectively, the sampled programmes represent a range of mental health problems. In the majority of programmes, volunteers have named conditions or disorders, such as obsessive compulsive disorder, phobia, body dysmorphic disorder, hoarding disorder, schizophrenia, bipolar disorder, and personality disorder. The titles of these programmes may identify the mental health problem being treated, e.g. *Hypochondriacs: I Told You I Was Ill* (Channel 4, 2007), *The House of Obsessive Compulsives*, *OCD Ward*, *Britain’s Weirdest Phobias*, and *Britain’s Biggest Hoarders*. In the remaining programmes, volunteers are depicted as having unspecified psychological or emotional problems which are causing problems in their everyday lives, ranging from volunteers in prison (*Grendon*), awaiting adoption (*A Home For Maisie* (BBC Two, 2011), recovering from traumatic experiences (*Talking Cure*), or experiencing profound relationship difficulties (*I Want My Dad Back* (Channel 4, 2008), *I Hate Mum*). This category also includes volunteers who appear in programmes such as *Freaky Eaters* and *Spendaholics*, which frame the volunteer’s emotional and psychological difficulties through problematic eating and spending habits.

My findings show that two categories of mental health problem dominate the research sample: first, mental health problems collectively referred to as *anxiety disorders*, i.e. obsessive compulsive disorder, hypochondria, body dysmorphic disorder, phobia, and hoarding disorder; second, programmes about psychological or emotional problems in children. My analysis shows that there are differences in how these two categories are distributed across the research sample. While programmes about anxiety disorders are commonplace in both institutional and non-institutional settings, there is a marked preference for this category of mental health problem in programmes that are made in non-institutional settings. It is suggested that this preference is related to the use of activity-based psychotherapeutic practice in the treatment of anxiety disorders, which creates opportunities for more visually-articulated representations of the psychotherapeutic process. This is considered later in this chapter. My findings show that programmes about psychological or emotional problems in children are made exclusively in the institutional setting. The reason for this almost certainly relates to the legal and ethical constraints associated with using children as volunteers in television programmes. While this sub-category of programmes might be linked to academic interest in programmes about ‘problem’ children which have been categorised as *reality television parenting programmes* (Feasey, 2011; Lunt, 2008; Lury, 2009), my interest in this research remains marginal because those programmes do not qualify for inclusion in my research sample.

A central feature of factual psychotherapy programmes are sequences that are designed to communicate the experience of living with a mental health problem. It is through such sequences that the psychotherapeutic ‘otherness’ of the volunteer is established, using audio-visual evidence which both illustrates their particular mental health problem and provides physical evidence that justifies the inclusion of the volunteer within the programme. Two approaches are used by programme-makers in constructing such sequences. In the first, programme-makers use production techniques designed to capture *exteriorised* evidence of the volunteer’s mental health problem, including interviews with volunteers and psychotherapists, and psychotherapeutic and non-psychotherapeutic actuality footage. The second approach is *interpretive*, involving attempts by programme-makers to create or evoke, through the use of audio-visual techniques and devices, impressions or interpretations of the aspects of the volunteer’s subjectivity which are associated with their mental health problem.

In the first approach, the most common technique for presenting exteriorised evidence of a volunteer's subjective experience of a mental health problem is to use interview clips in which volunteers describe their experiences. Interviews are usually conducted by programme-makers. However, as discussed in Chapter 4, it became increasingly common between 1999 and 2013 for the filming of key programme content, including interviews, to be distributed across a bigger pool of production staff, including self-shooting researchers and DV directors, although this practice is more typical for multi-episode formatted series such as *Freaky Eaters*, *Spendaholics* and *The Panic Room*. Although difficult to quantify, such developments are likely to have impacted upon the traditional relationship between programme-maker and volunteer, and consequently upon the content and performance of interviews. Interviews may be filmed in familiar settings, such as the volunteer's home environment, or in less familiar settings, such as the volunteers' bedrooms in residential psychotherapeutic units or in the properties rented for the production of non-institutional programmes. For some volunteers, the experience of being interviewed in an unfamiliar environment is particularly challenging, such as those who have been diagnosed with agoraphobia for whom leaving home is, in itself, a traumatic experience, as illustrated in *House of Agoraphobics*. This is discussed further in Chapter 6.

In *The House of Obsessive Compulsives*, the first interviews with volunteers to feature in the programme were filmed in the familiar environment of the volunteer's home, resulting in relaxed, open interview performances. The impression of openness is further articulated through the positioning of the camera close to the line of action, resulting in shots which give full access to the volunteer's face, an effect which is enhanced further when close-up framing is used (see Figure 9). This shooting style simultaneously suggests an openness on the part of the volunteer - they have nothing to hide - and the use of the camera to visually interrogate the volunteer's face for exteriorised evidence of their mental health problem.

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Figure 9 *The House of Obsessive Compulsives* (Channel 4, 2005)

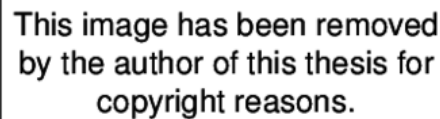
When this is combined with explicit interview content, the effect is particularly potent, as the example from *The House of Obsessive Compulsives* in which a volunteer says,

If someone said to me I guarantee you one hundred and ten per cent that if you chop your hand off right now with a bread knife and saw through, you will be rid of even fifty per cent of my OCD, I'd go into the kitchen right now and lift a bread knife and do it.

When subsequent interviews are filmed in unfamiliar settings, whether institutional or non-institutional, volunteers' interview performances can appear less confident, and the technique described above can appear to be intrusive. This is relevant for programmes which feature volunteers who are resident, voluntarily or involuntarily, in specialist treatment or assessment centres. For example, in *Sectioned*, a volunteer who has been detained under the Mental Health Act, is interviewed following his arrival on the unit. The camera films the volunteer head-on, framing him somewhere between mid-shot and medium close-up so that both face and upper body are captured in the shot. The interview is conducted by the programme-maker who is standing to the left of the camera, signified by the volunteer's eyeline which occasionally flicks in that direction. The volunteer also glances, occasionally, directly into the camera lens. The effect is disconcerting because the volunteer appears agitated, and his speech is slurred,

Volunteer: Hi. I'm [.....] and this is the room I'm in at the moment. Things aren't going too well, cos, like, this is a psychiatric ward. But hopefully I'll heal and get away from the drugs. Well, perhaps I will, perhaps I won't!

At the end of the interview extract, the sequence cuts to, and holds on, a close-up shot of the volunteer's face (see Figure 10), while the voice-over reports that 'after threatening his neighbour with a knife, [.....] has been sectioned for the sixth time'.



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Figure 10 *Sectioned* (Channel 4, 2010)

In this close-up shot, the volunteer's expression is particularly intense, and the close-up provides the viewer with an opportunity to scrutinise his face for signs of his yet-to-be-identified mental health problem. This is revealed shortly afterwards, when a psychotherapist states in interview that,

[.....]'s got a diagnosis of paranoid schizophrenia. Which means he has a combination of hallucinations, hearing voices and what we call delusional thinking. So he believes things that are untrue or unreal. But he believes them with a conviction, you know, that any ordinary person would have about their own thoughts.

Surprisingly, a technique which is virtually absent from the research sample is the video diary. This technique, which involves direct speech to camera and is, in effect, a kind of self-interview without the presence or intervention of production staff, might have expected to play a role in sequences which are constructed to communicate the subjective experience of mental health problems. Its absence was particularly surprising, given the frequent use of the video diary technique in factual television programmes about mental health (Harper, 2009) and in forms of transformational television, such as makeover programmes (Biressi & Nunn, 2005). One sampled programme which does use the video diary technique is *Fix My Fat Head*, in which the presenter/volunteer records her experiences as she tries to discover why she cannot lose weight. It is notable

that she does not use the diary to comment upon her psychotherapeutic treatment. One possible explanation for the relative absence of the video diary technique in factual psychotherapy programming is that it is made redundant by the presence of psychotherapeutic actuality, in which volunteers are depicted as revealing intimate details about their thoughts and feelings. Another explanation is that the inclusion of the video diary technique might appear to undermine the authority of the psychotherapeutic actuality, particularly if the volunteer was to reveal things that they had not revealed to their psychotherapist.

In addition to the use of interview material to capture *exteriorised* evidence of volunteers' mental health problems, the programmes use actuality footage which depicts the impact of mental health problems in the lives of the volunteers. The research sample comprises many sequences which could be used to illustrate this. For example, in *The Madness in Me* (BBC One, 2005), filmed in a therapeutic community described in the voice-over as 'the only place in the UK where the psychotherapists share their home with their patients', the programme's sole volunteer is depicted, in intricate detail, experiencing fits; sequences are filled with images of shaking, spasms, unconsciousness, and temporary paralysis (see Figure 11).

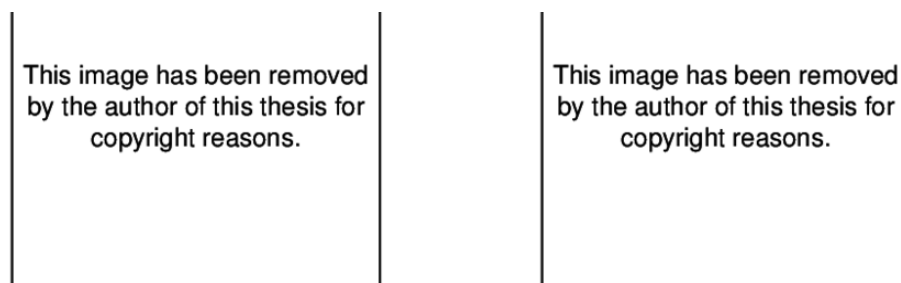


Figure 11 *The Madness in Me* (BBC One, 2005)

Bedlam: Anxiety features a sequence in which one of the volunteers takes the programme-maker for a walk in the area close to the residential unit where she is undergoing treatment. Filmed using the handheld camera technique, the camera operator follows the volunteer as she walks briskly through the streets, initially struggling to keep up but eventually managing to film her from the front (by walking backwards - a key camera operator skill), providing vital, unimpeded access to the volunteer's face. The use of handheld footage, and abrasive editing which it necessitates, contributes to the sense of the volunteer's growing sense of panic. During the sequence, the volunteer explains to

the programme-maker how her obsessive compulsive disorder impacts upon her daily life:

Volunteer: [looking around] I'm very aware of...people. And sort of watching where they are and where they're going. And so if suddenly someone disappeared round the corner, I'd probably be quite anxious that I'd done something to them to make them disappear. And...particularly because there's a bin there, there's a rubbish bin there, one there and there's one here [she points out green wheelie bins]. I know where they all are. So I'm worrying if I've put them in the bin.

Voice-over: [The volunteer] is thirty-three. A librarian at the [.....]. She obsesses about causing harm to strangers.

[A man passes by].

Volunteer: You see, just then...I couldn't see that guy for a minute. And I was quite scared. Oh, my God, he's vanished. But he's there. He's there? Yeah. Yeah. And now I'm thinking, is that the same man? And so on.

Programme-maker: You...you've been with us that whole time. So...if you said, have I done anything to that man, we could tell you no.

Volunteer: Yeah. It would help a little bit. But not...probably not absolutely, no. There's no rational... It's not rational at all like that, you know. I can't just explain it away to myself.

In this example, the mental health problem is constructed as being not immediately evident. In programmes about hoarding, the mental health problem is already visually manifest, with little need for additional elaboration. One succinct example can be seen in *World Of Compulsive Hoarders* (Channel Four, 2007), which includes a shot of the volunteer's bedroom which he shares with his (non-hoarding) wife. In the centre of the room is a double-bed, tidily made. The camera pans across the room from left to right. The left-hand side of the pan shows the area surrounding the woman's side of the bed, which is meticulously clean and tidy; at the other end of the pan, on the volunteer's side, the floor is covered with a cascade of detritus (see Figure 12).

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Figure 12 *World of Compulsive Hoarders* (Channel 4, 2007)

My findings suggest that, when it comes to the construction of sequences which are designed to communicate the subjective experience of mental health problems by exteriorised means, such as interviews and actuality, there is no significant difference between institutional and non-institutional factual psychotherapy programming. Similarly, both forms of factual psychotherapy programme emphasise the severity of their particular volunteers' mental health problems. For example, *OCD Ward* claims that its residents have 'the worst OCD in the UK', and that its unit is where 'the country's worst sufferers end up'. However, my findings show that the sampled programmes also contain many voice-over and interview statements about the relative normality of mental health problems, often supported through the use of statistical data. The kinds of statement that feature routinely in both institutional and non-institutional factual psychotherapy programmes include: obsessive-compulsive disorder 'affects nearly one million people in the UK' (*OCD Ward*); 'the whole planet...every single human has got a little bit of OCD' (*OCD Ward*); severe anxiety disorders 'could happen to anyone' (*Bedlam: Anxiety*); obsessive compulsive disorder 'affects one in thirty of us' (*Obsessions Run My Life*); 'one in a hundred people' have body dysmorphic disorder (*Too Ugly For Love*); 'two and a half million people in Britain (are) suffering from obsessive compulsive disorder' (*The House of Obsessive Compulsives*); 'behind closed doors, up to three million people are suffering' from hoarding disorder (*Britain's Biggest Hoarders*); anxiety is 'a condition all of us experience at some point in our lives but imagine if you woke up one day to find your anxiety had taken on a life of its own' (*Bedlam: Anxiety*). The psychotherapist in *The House of Obsessive Compulsives* states that:

In its most extreme case, OCD looks kind of weird and almost mad, but it's there in all of us. So, for example, you know, if you go on holiday, it's very common for people to check the gas multiple times, check that the door is locked. I mean,

sometimes seven or eight times, sometimes turning the car around, going back and checking again. And that's a version of what people with obsessive compulsive disorder experience.

Where my research findings reveal a significant difference between institutional and non-institutional factual psychotherapy programming is when it comes to the use of *interpretive* techniques in the depiction of subjective experiences of mental health problems. The interpretive approach involves the use of audio-visual and production techniques to construct sequences which offer interpretations of the aspects of subjectivity associated with the experience of having a mental health problem. While this approach is more characteristic of non-institutional factual psychotherapy programming, it was still used less than had been anticipated, presumably for the same reason that it is not characteristic of non-institutional factual psychotherapy programming where the preference is for production techniques which are characterised by minimal intervention.

Consequently, the relative rarity of the interpretive approach leads to sequences that stand out because of their overt manipulation using self-conscious filming and editing techniques. To illustrate the interpretive approach, my analysis focuses on *Too Ugly For Love*, which includes several sequences that demonstrate how programme-makers might construct sequences which evoke volunteers' subjective states. In this instance, *Too Ugly For Love*, which was categorised as an institutional programme in the content analysis because it contains a single sequence filmed in The Priory hospital, but it should be noted that the majority of psychotherapeutic actuality in this programme was filmed in a private sector consulting room setting. It is for this reason that its content is regarded as amenable for inclusion in the programme analysis which looks at both non-institutional and institutional psychotherapeutic actuality. In any case, none of the interpretive sequences in *Too Ugly For Love* involve the presence of psychotherapists, and all of the programme's psychotherapeutic actuality sequences observe the convention of using apparently minimal media interventions.

The subject of *Too Ugly For Love* is body dysmorphic disorder (BDD), a mental health condition that, according to the programme voice-over, leads those with the disorder to 'believe that they are grotesquely ugly'. The programme-maker's efforts to communicate how this might be experienced begin in the pre-title sequence, which

features several extreme close-ups of the programme's three volunteers (see Figure 13), some visually-distorted, with short interview clips in which the volunteers talk about how ugly they feel, accompanied by melancholy music.

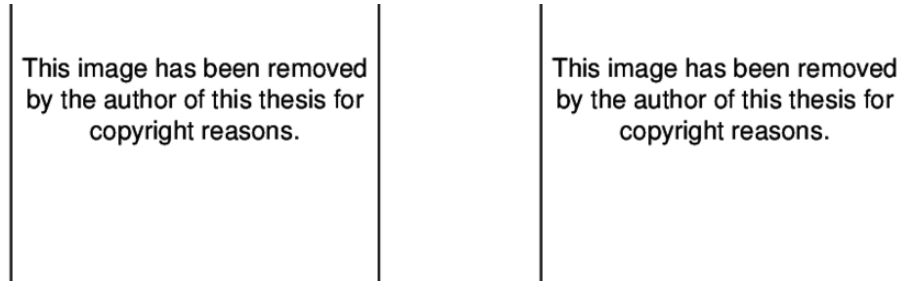


Figure 13 *Too Ugly For Love* (BBC Three, 2006)

This theme extends into the programme's opening sequence, shot in a fairground House of Mirrors, in which distorted images of the presenter (who is also the programme-maker) and random people are edited together in a sequence which offers a suggestion of how people with body dysmorphic disorder might view themselves.

The remaining sequences use different techniques to communicate the feelings of panic and terror experienced by volunteers when they find themselves in distressing situations. In one sequence, a volunteer becomes upset during a sequence in which she is getting ready to visit her psychotherapist. The filming of her sitting in front of a mirror doing her make-up starts unremarkably enough, but as the volunteer's anxiety begins to build, the editing gets faster and gradually develops into an impressionistic montage of big close-ups and abrasively-edited moving shots - whip pans and crash zooms - which, ordinarily, would not be considered usable. A second sequence attempts to capture the sense of panic experienced by another volunteer as he embarks on a stressful train journey. The focus of his distress is the station lighting, which he believes make him look particularly ugly. The sequence begins with a tracking shot following him into the station, and quickly develops into a montage sequence of close-ups and low-angle shots of the station lighting. Once on the train, the voice-over explains that 'the other hazard is his own reflection'. As the volunteer's panic continues to build, the editing becomes frenetic, incorporating close-ups shots of warning signs, an alarm emergency button, and lots of unstable camera shots, accompanied by a soundtrack of whooshing sound effects. The same filming and editing techniques are used in a sequence featuring the programme's third volunteer as she visits the cosmetics

hall in a large department store, which she describes as her ‘worst nightmare’. The abrasively-edited crash zooms and whip pans are accompanied by a soundtrack of discordant electronic music. The sequence also includes shots of people turning to look at the camera; these head-turns, most likely captured as customers noticed the camera, are used to evoke the volunteers’ sensation of being stared at because, she believes, she is so ugly.

My findings show that the interpretive approach to representing the subjective experience of mental health problems is not widely used across the research sample. Overall, programme-makers show a marked preference for unobtrusive audio-visual production techniques. However, this subject will be addressed in Chapter 6, in the case study analysis of *The Panic Room* series which utilises audio-visual production techniques in distinctive ways.

The final part of this section considers the representation of volunteers in terms of their demographic characteristics, and considers what these representations suggest about the causes of mental health problems. The research sample features one hundred and fifty three volunteers, of which 54% are female and 46% are male; thereby suggesting that representations of volunteers are not constructed along gender lines. (The raw data used to generate these findings is presented in Appendix C.) However, this finding is likely to be the result of the production practice of ‘casting’ volunteers in ways which emphasises demographic diversity. The practice of casting is well-known in fictional television but is less recognised as an aspect of factual television programme-making (Henderson, 2007). Furthermore, the data shows that it is common practice within individual programmes, whether one-offs or episodes, to feature at least two volunteers; consequently, in most factual psychotherapy programmes there is an opportunity to demonstrate demographic diversity. The programmes where the practice of recruiting volunteers according to the principle of demographic diversity is most evident are the multi-episode, multi-season series which utilise large numbers of volunteers. For example, *Spendaholics* features twelve female and ten male volunteers, *Freaky Eaters* features ten female and twelve male volunteers, and *Britain’s Biggest Hoarders* features five female and four male volunteers.

However, gender diversity is not achieved in all of the sampled multi-episode programmes. For example, *The Panic Room* feature nine female and three male volunteers, and *The Hoarder Next Door* features thirteen female and six male volunteers.

In such instances, there may have been insurmountable obstacles to achieving a better demographic mix. As one research questionnaire respondent has commented, about working on programmes about hoarding, ‘conventional methods of casting weren’t appropriate...Hoarders are by their very nature secretive. For the sufferers there’s a shame attached to the condition and most Hoarders don’t allow friends or family into their houses let alone a camera crew. So, finding the contributors was a lengthy process requiring great patience’ (Appendix RQ9, q. 4).

To find evidence from the programme analysis which suggests a gender basis for how mental health problems are constructed, it was necessary to look more closely at the data. One finding is that programmes about child psychotherapy, such as *Help Me Help My Child* (Channel 4, 2006), *I Hate Mum, I Want My Dad Back*, *Growing Children: OCD & Anorexia* (BBC Four, 2012), *Children Behaving Badly* (Channel 4, 2002), are more likely to feature male (child) volunteers, either exclusively or predominantly. It is difficult to draw any firm conclusions from this, particularly as one research questionnaire respondent, who has experience of working on programmes about child psychotherapy, has stated that, ‘(f)inding contributors was a much more lengthy process - and rightly so - since it involved parents thinking carefully about whether it was right for them and their child to appear on television talking about their child’s mental health problem...In many cases, families chose not to take part’ (Appendix RQ7, q. 4).

It is difficult to draw conclusions from my findings on this aspect of the research sample, partly because of the production practice of ‘casting’, which is likely to work against ‘biased’ representations of volunteers, and also because of the inherent difficulties in recruiting volunteers particularly for participation in non-institutional programming. This may explain why only eight per cent of the total volunteer count came from a Black and minority ethnic background. An examination of gender and psychotherapeutic expertise is conducted later in this chapter.

5.2 Setting: Constructing Psychotherapeutic Space

This section examines what happens to televisual representations of the psychotherapeutic process when the psychotherapy is removed from the institutional setting and delivered in settings with little or no association with the psychotherapeutic. From the outset, this development has been viewed as fundamental to understanding the emergence of new representations of the psychotherapeutic process, and of the evolution of a new form of non-institutional factual psychotherapy programme. Without

the break from the psychotherapeutically-orientated institutional setting, the developments identified within this study seem untenable.

5.2.1 The Institutional Setting

The removal of the psychotherapeutic process from the institutional setting has a significant impact on how representations of the psychotherapeutic setting are constructed within factual television programmes. Setting - locations and places used for the delivery of psychotherapeutic treatment - has been determined historically by the situating of psychotherapy within specialist mental health hospitals and clinics within the UK's National Health Service. This long-standing arrangement has established that the primary setting for psychotherapeutic treatment is within a psychotherapeutically-orientated institution, such as psychiatric hospitals and mental health units.

For example, the South London and Maudsley NHS Foundation Trust, a specialist NHS mental health provider, is the setting for five programmes in the research sample: *Help Me Help My Child* and *Growing Children: OCD* were filmed at its Michael Rutter Centre; psychotherapy sessions shown in *Phobias* (BBC One, 2000) and *Obsessions Run My Life* were filmed at the Maudsley Hospital; *Bedlam: Anxiety* (Channel 4, 2013) was filmed in its 18-bed Anxiety Disorders Residential Unit, situated in Bethlem Royal Hospital. Other programmes in the research sample which were made with the involvement of NHS institutions include: *Sectioned*, filmed at locations within the Nottinghamshire Mental Healthcare NHS Trust, including its Mental Health Intensive Care Unit; *OCD Ward* (ITV, 2013), filmed in the OCD unit of Springfield University Hospital London; the six-part series *Talking Cure* (BBC Two, 1999) was filmed in the Trauma Unit and Family Therapy Unit at the Tavistock Clinic in London; *My Child Won't Eat* (ITV, 2008) was filmed in Birmingham Children's Hospital's Feeding Unit; *I Hate Mum* was filmed at a family therapy clinic in Oxleas NHS Foundation's Children and Adolescent Mental Health Service (CAMHS). Some of the sampled programmes were made with the cooperation of specialist organisations which operate outside of the immediate NHS setting. For example, *A Home For Maisie* was filmed at Family Futures, a London-based adoption agency. A number of programmes feature psychotherapists working at London's Priory Hospital, including *The Man Who Loved the Number 12* (ITV, 2000), *Too Ugly For Love*, and *Looks That Kill* (BBC One, 2000).

The long-standing relationship between television programme-makers and psychotherapeutically-orientated institutions has led to the establishment of a body of

work which includes extensive footage of actuality filmed in institutional settings. A number of these programmes are included in the research sample and are characterised by the high visibility of their institutional ‘brands’. Sequences which construct setting in institutionally-based factual psychotherapy programmes almost always begin with establishing shots of building exteriors, filmed in ways that reveal the spatial relationship between buildings and their surrounding areas. In some cases, such as *Talking Cure* and *The Madness In Me*, they are depicted as being in close proximity to residential areas; in others, such as *OCD Ward* and *Bedlam: Anxiety*, as situated in extensive gardens or grounds, creating an impression of peaceful isolation; others, such as *My Child Won’t Eat*, are situated in busy urban environments. There is considerable variety in architectural style. In many programmes, including *Bedlam: Anxiety*, *Addicted to Asda*, *Extreme Phobias*, and *My Child Won’t Eat*, institutions are represented as old hospital buildings built in the nineteenth or early-twentieth century, or earlier. In other programmes, they are depicted as nondescript, mid to late twentieth-century buildings, more reminiscent of office blocks more than hospitals, such as the Tavistock Clinic in *Talking Cure*. In other examples, such as *A Home For Maisie* and *I Hate Mum*, the buildings look contemporary and purpose-built. The name of the institution always figures prominently, often accompanied by an NHS logo. Some buildings have historical connections of some significance. *Bedlam* is filmed in locations within the South London and Maudsley NHS Foundation Trust which has historical connections to Bethlem, or Bedlam, England’s first mental institution (Historic England, 2017). This connection is referenced, somewhat controversially, in the programme title (Sectioned, 2005), and is mentioned in the programme’s opening sequence. The Anna Freud Centre, which features in *Children Behaving Badly*, references the psychoanalyst daughter of Sigmund Freud. A shot of a statue of Sigmund Freud, filmed in the grounds of the Tavistock Clinic, features in *Talking Cure*. These sequences of establishing shots are frequently positioned before, or intercut with, footage of the volunteer’s first visit to the institution, as illustrated in *Talking Cure* and *A Home For Maisie*. The effect of editing the material in this way suggests that volunteer and viewer encounter the institution for the first time in the same moment.

While constructions of exterior settings in institutional factual psychotherapy programming are remarkably consistent, there are some notable exceptions. In *Sectioned*, a programme in which volunteers are already resident in a residential unit, having been

previously detained under the Mental Health Act, there is no sequence at the start of the programme to establish the exterior setting and surrounding area of the institution involved. The absence of a conventional establishing sequence at the start of the programme, I would suggest, contributes to the constructions of detention and containment that are so central to the programme. When, later in the programme, exterior footage of the institution is finally used, it is in sequences which show the volunteers leaving the unit for short periods in preparation for their possible release, signifying an end to confinement and a return to the ‘outside world’.

Another exception is the sequence in *Help Me Help My Child: OCD*, in which the volunteer family is shown arriving at the hospital for the first time. Their arrival through a narrow gap in a large security gate at the side of the hospital building, rather than via the main hospital entrance, is also captured in fuzzy black and white images on a hospital CCTV monitor. This image, with its suggestion of surveillance and security, is incongruent with how institutional exteriors are typically constructed, which is why, I suggest, a child’s teddy bear is stuck on the side of the CCTV monitor, contradicting any suggestion of institutional containment (see Figure 14).

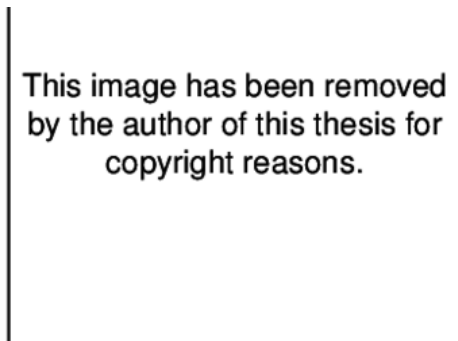


Figure 14 *Help Me Help My Child* (Channel 4, 2006)

The construction of psychotherapeutic setting also relates to how public areas within institutions are visually represented. Examples drawn from across the research sample, including *Talking Cure* and *Obsessions Run My Life*, show a consistency in approach to the construction of interior institutional settings. The first representations are constructed through sequences that show the arrival of the volunteer at the institution’s reception area or waiting-area, and other public areas, which are depicted as busy, bustling spaces. A common technique is the tracking shot which follows the volunteers as they navigate their way into the institution for the first time. In both *Talking Cure* and *I Hate Mum*, (see

Figure 15), the volunteers are filmed as they walk along long corridors punctuated with doors, which allude to both the scale of the institutions' psychotherapeutic project, and to the potentially bewildering experience of entering the institutional setting.

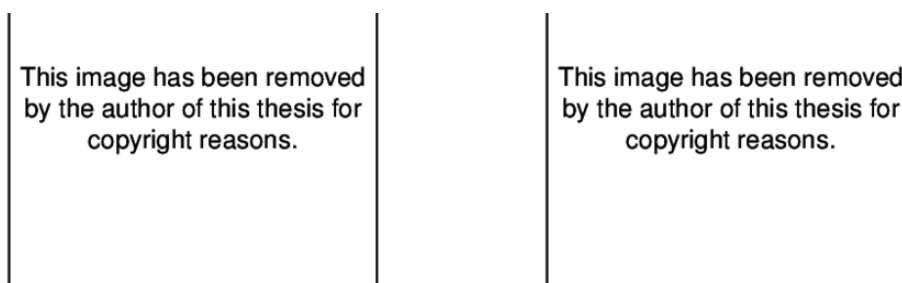


Figure 15 *Talking Cure* (BBC Two, 1999) / *I Hate Mum* (BBC One, 2010)

The immediate impression created by these constructions of interior institutional space is that we have entered medically-orientated institutions of some kind. The signifiers include their plain and neutral décor, the flowers and plants on the reception desk, the fire doors and fire escape signs, various types of signage, and staff wearing institutional ID cards hanging from blue NHS lanyards. Specific visual details, such as resuscitation kits and hand sanitisers, reinforce these general impressions. Occasionally, there are close-ups of details which point to the institution's specific psychotherapeutic purpose. For example, in *A Home For Maisie*, the arrival sequence is constructed around the child volunteer's reaction to a goldfish bowl situated on the reception desk. Another visual constant in the institutional setting is the framed artwork that decorates the otherwise plain walls. The specific character of this artwork is rarely established. One notable exception is the KEEP CALM AND CARRY ON poster in *A Home For Maisie*, which is held for several seconds after the volunteer family exit frame on their way to the consulting room.

The construction of the interior institutional setting is most elaborate when the majority of programme content is drawn from footage filmed in specialist residential units. Specialist residential units are discrete areas within the broader institutional setting, each unit having its own particular role or purpose within the psychotherapeutic process. The unique character of the specialist residential unit is used to inform how sequences may be visually constructed by programme-makers. A geographical map of the specialist unit is gradually established, at its heart the nurses' office, where the management of the unit is conducted. Footage captures, and is edited, to emphasise the

visual signifiers of institutional effort: office walls and surfaces covered with paperwork, clipboards and folders; whiteboards covered with handwriting; actuality extracts depicting phone calls being made, and data being entered on computers. These sequences play a key role in constructing a sense of the ‘real’ and ‘authentic’ quality of the institutional setting.

Each specialist residential unit has its own distinctive character, identified through the selection of particular visual signifiers. In *Sectioned*, where the purpose of the unit is detention (volunteers having been ‘sectioned’ under the Mental Health Act), one distinctive visual feature is the use of shots filmed through the cross-hatched reinforced safety glass used in the unit’s door panels and windows (see Figure 16). The decision to film shots in this way, strongly suggestive of containment, contributes significantly to building a sense of the unit’s purpose as a place where people are detained.

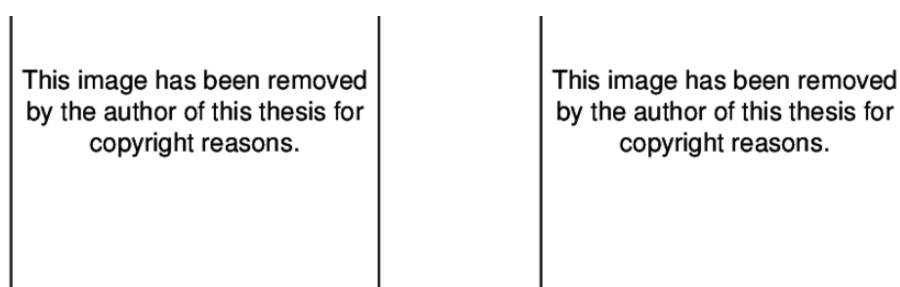


Figure 16 *Sectioned* (BBC Four, 2010)

On the other hand, in *OCD Ward*, where residents are voluntary patients, the key visual hallmarks of institutional setting are supplemented with signifiers of the unit’s unique character. Sequences depicting its communal areas include shots which emphasise the unit’s sense of order and cleanliness. The inclusion of a shot depicting a sign which says *OCD/BDD Services* contextualises the actuality extracts which show residents lying on the highly-polished parquet floor, feeling and stroking the walls, and washing their hands.

The consulting room is one of the most enduring signifiers of the psychotherapeutic scenario, and the visual dominance of the consulting room setting is evident across the research sample. The practice of using a consulting room for the purpose of psychotherapeutic treatment is strongly associated with the emergence of the psychoanalytic tradition in the early twentieth century. In its earliest configuration, the consulting room was a private, comfortable room in the psychotherapist's private

dwelling, or workplace, furnished with a sofa on which the ‘patient’ sits or lays (Spinelli, 1994, p. 84). This rather stereotypical description of the consulting room setting is not representative of the consulting rooms that are depicted as being typical of the institutional setting. However, the description is a reference point for the ways that consulting rooms are sometimes constructed in the non-institutional setting, which is discussed later in this section.

Consulting rooms which are situated in institutional settings, such as in NHS mental health clinics, centres or units, have a functional workplace ambience, decorated and furnished in a similar vein to the wider institutional setting, but lacking the personal touches that would suggest they are the workplace of individual psychotherapists. In NHS settings, consulting rooms rarely, if ever, look like the consulting rooms associated with the psychoanalytic tradition. The lack of personalising details signal that these are rooms that are shared by many professionals.

While constructions of the consulting room setting are generally characterised by signifiers which suggest they are spaces used by many, in a few examples they are depicted as the private working spaces of individual psychotherapists. Sequences that are filmed in the unshared consulting room are constructed to signify both the psychotherapist’s individuality and an impression of their hectic, busy schedules (see Figure 17). For example, in the first episode of *Talking Cure*, the consulting room is dominated by a desk covered with books, folders, and stacks of documents. There is a lamp which would be more suited to a living-room, a painting of trees, and several plants along the window ledge. In *Obsessions Run My Life*, the consulting room has a large untidy desk covered with documents, and a computer monitor dotted with yellow Post-It notes. There are several small filing cabinets, bookcases crammed with books, files, and untidy piles of papers. There is a whiteboard on the wall, covered in untidy handwriting. The psychotherapy takes place in two large leather armchairs; between them, on the floor, and the most dominant visual element in the room is a red Turkish rug.

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Figure 17 *Talking Cure* (BBC Two, 1999)/*Obsessions Run My Life* (Five, 2005)

Where the focus of the psychotherapy is on families or young children, consulting rooms are usually more spacious, furnished with large, comfortable sofas, and in some instances are brightly-decorated, reminiscent of a child's stereotypical bedroom. In specialist settings, consulting rooms can look very different to generic consulting rooms. For example, in *A Home For Maisie*, the consulting room is spacious and light, decorated in light neutral colours, furnished with large sofas covered with blankets and cushions. There are shelves stacked with toys, including a huge toy monkey big enough for a child to sit on (see Figure 18).

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Figure 18 *A Home For Maisie* (BBC Two, 2011)

One common representation of the institutional consulting room is of a small room which has sufficient space for psychotherapist and volunteer, but which appears cramped once a film crew is present. For example, in *I Want Mum*, a session between psychotherapist and teenage volunteer is conducted in a room which is so small that the camera can only capture shots of the volunteer and psychotherapist in profile, and does not have the physical space required to capture both parties at the same time, in an establishing wide shot. Their spatial relationship is established through an untidy pan between the two parties, and through single shots that are edited together to establish their matching eyelines. The resultant sequence suggests that the camera operator's

priority was to capture sync dialogue, rather than to create ‘usable’ footage. This demonstrates that while the construction of the consulting room setting is indeed constricted, and the ‘untidy’ camerawork impacts upon the construction of setting in its own way, sometimes it is the spoken content of the psychotherapeutic encounter that drives the sequence. *Extreme Phobias*, on the other hand, demonstrates that having greater freedom to position and manoeuvre the camera during a psychotherapeutic encounter does not necessarily result in a conventional construction of the consulting room setting either. In this programme, the consulting room is spacious, big enough to hold a group meeting, and sufficient room is available for the camera operator to capture the psychotherapeutic encounter in its spatial entirety. However, in this instance, the sequence does not begin with a wide shot of volunteer and psychotherapist to establish their spatial relationship; instead, it begins with a mid-shot of the seated volunteer in the process of listening to something being said by the (off-camera) psychotherapist. In both examples, it is the spoken content of the psychotherapeutic encounter, rather than the physical dimensions of the actual consulting room, which has the biggest impact on the construction of setting.

In the consulting room setting, a subtle but key visual characteristic is the depiction of a door that can be closed, signifying that the psychotherapeutic encounter taking place is both private and confidential. Of course, the presence of a film crew immediately renders this impossible, something that is not emphasised or considered in the programmes themselves. In any event, it has been argued that the notion of confidentiality, ‘has tended to become a kind of universalizing narrative, so accepted and acceptable precluding any need for critical review or careful reconsideration - it has achieved the status of a given’ (Wulff, 2011, p. 200); the authors point to the practice of recording psychotherapy for training purposes, or the practice of supervision, in which psychotherapists discuss their patients/clients with other psychotherapists, as evidence for why ‘true’ confidentiality is unachievable in any context. The findings of my programme analysis show that institutionally-based factual psychotherapy programmes contain sequences which show that the givens of privacy and confidentiality are frequently compromised. Consulting rooms often have doors with glass panels, large two-way mirrors, and built-in recording equipment.

For example, in the *Talking Cure* series, the consulting room setting is often depicted in the form of two adjoining rooms separated by a large two-way mirror. The

psychotherapeutic encounter takes place in one room; the adjacent room is used for observation purposes, and also houses a vision-mixing desk with feeds from fixed cameras positioned around the psychotherapy room. In the second and fourth episodes of the series, which focus on family therapy, consulting room sequences are built around these two-room settings, with the volunteer family and their psychotherapist(s) in one room and, in some instances, several psychotherapists observing the psychotherapeutic encounter from the other. This complex spatial arrangement is visually established early in the episode, using footage from both the built-in remote cameras and the programme's own camera. In the fourth episode, when a couple with a small child meet with two psychotherapists, their reflections are visible in the (two-way) mirror. This is followed by a shot of the vision-mixer in the adjacent unlit room, operating the mixing desk to control the movement of the built-in cameras. The fixed cameras produce unusually stable framing and smooth, mechanical camera moves which, when edited together, contrast with the programme camera's handheld and reactive footage. The programme camera can also manoeuvre in ways which then enable it to capture things that are inaccessible to the fixed remote cameras. In this example, the programme camera captures footage of the child as he unlocks a door (see Figure 19, right), which is not clearly visible from the fixed cameras (see Figure 19, left).

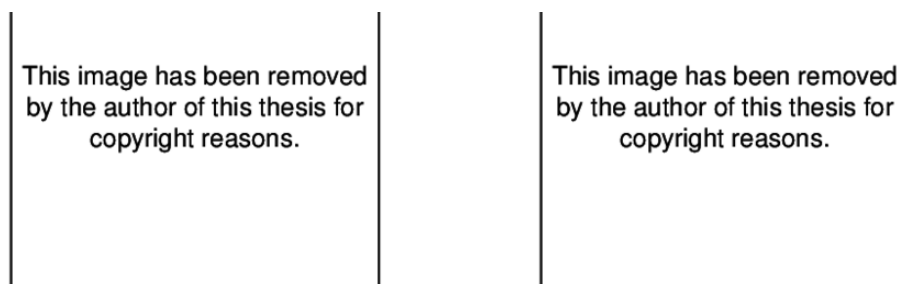


Figure 19 *Talking Cure* (BBC Two, 1999)

Like *Talking Cure* features a two-room setting (see Figure 20, right), *I Hate Mum* also features a consulting room setting comprising two adjoining rooms separated by a large two-way mirror (see Figure 20, left). In this example, the volunteer family and psychotherapist are being observed, but not recorded, by three psychotherapists in the adjoining room. The programme's camera moves around the observation room, initially filming from the back in order to establish the spatial relationship between the two

rooms and their occupants. One shot, in particular, captures the spatial geography in its entirety: the consulting room in the background, superimposed with reflections of the three psychotherapists in the two-way mirror.

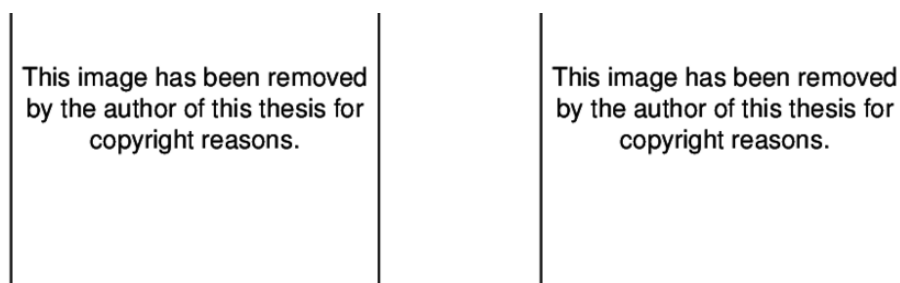


Figure 20 *I Hate Mum* (BBC One, 2010) / *Talking Cure* (BBC Two, 1999)

The use of technology during the psychotherapeutic process, and the extension of the notion of confidentiality required to permit such an intervention, are presented within the programmes as unproblematic. I would suggest that the inclusion of such material, particularly in the institutional setting, provides some justification for the presence of television personnel and filming equipment during the psychotherapeutic process for the purpose of generating television programme content.

These findings demonstrate how setting is depicted in institutionally-based factual psychotherapy programming, and argues that these representations are shaped by the long-standing relationship between psychotherapeutically-orientated institutions and programme-makers. The remainder of this section considers how constructions of setting change when programmes are made in non-institutional settings.

5.2.2 The Non-Institutional Setting

The findings of my programme analysis show that it is not necessary to move immediately to an analysis of non-institutional factual psychotherapy programme to observe how representations of setting began to change. Different kinds of representation of setting emerge in programmes which are made with the involvement of psychotherapists who work under the auspices of private psychotherapeutically-orientated hospitals. While such private psychotherapeutically-orientated institutions retain a connection to the NHS, their primary function is to deliver private psychotherapeutic treatment. An analysis of the programmes which feature psychotherapeutic actuality filmed at The Priory Hospital - *The Man Who Loved the Number 12*, *Too Ugly For Love*, and *Looks That Kill* - feature sequences which depict the

hospital - a late-eighteenth century Grade II* listed building, with striking architecture and surrounding parkland (Historic England, 2017). What is absent from these programmes are sequences which construct a sense of the hospital's purpose. There are no interior communal areas, such as hallways or waiting-rooms; there are no shots of busy reception areas or tracking shots down labyrinthine corridors of the sort that characterise the NHS-based institutional setting. Only one programme - *The Man Who Loved The Number 12* - features a sequence showing the arrival of the volunteer as he walks through the notably empty hospital grounds. These sequences are characterised by absence: absence of people and absence of activity. It is possible, of course, that restrictions on what could be filmed were placed on programme-makers. However, the minimalistic constructions of setting continue into the way that consulting rooms are represented. In *Looks That Kill* and *Too Ugly For Love*, there are sessions where it is difficult, because of a lack of establishing shots, to build a mental map of consulting room spatial geography. In the cases where sufficient visual information is given, the consulting rooms are depicted in ways which emphasise the difference to their NHS-based equivalents, such as the visual emphasis on spaciousness and elegance in *The Man Who Loved The Number 12*.

Finally, there are depictions of setting in programmes that use psychotherapists' private consulting rooms for the filming of psychotherapeutic actuality. These settings belong entirely to the private sector, and feature in a small number of programmes including *Fix My Fat Head* (BBC One, 2009), *Too Ugly For Love*, and *The Hoarder Next Door*. In these particular programmes, the sequences which depict the psychotherapeutic setting include one distinctive visual motif: shots of the volunteer sitting in an otherwise empty waiting-room, as illustrated in *Fix My Fat Head* and *The Hoarder Next Door*. Private consulting rooms are uniquely decorated - there is no visual identification with any institutional or corporate style; the décor is presented as being representative of the psychotherapist's personal taste. For example, in *Too Ugly For Love*, the consulting room has peach-coloured walls, stripped wooden floors, a large bookcase filled with books and decorated with greetings cards, and two armchairs facing each other across a low coffee table. The effect is not dissimilar to someone's home. The greater emphasis on individuality in constructions of setting in the private sector is explored further in Chapter 6, which includes a case study of *The Hoarder Next Door* in which the psychotherapist's distinctive private consulting room is analysed.

When programmes feature psychotherapeutic actuality that is filmed in settings which are divorced from the psychotherapeutic environment, there is initially an impression of a fairly random collection of places and spaces with little or no association with the psychotherapeutic. However, my findings show that there are three broad strategies for constructing representations of setting in the non-institutional context.

The first is the use of rented or borrowed, residential properties, such as those used in *Hypochondriacs: I Told You I Was Ill* and *The House of Obsessive Compulsives*. The property in *The House of Obsessive Compulsives* is described in the programme voice-over as ‘an ordinary house’ (see Figure 21). This playing-down of setting is in marked contrast to the way that institutional settings are routinely constructed as special or unique. This particular property - a London-based, detached townhouse, built in a late Victorian Gothic style - is ordinary only in the sense that it has no association with the psychotherapeutic. Shots of the house’s imposing and angular exterior, described in one newspaper review as ‘Addams Family architecture’ (The Guardian, 2005), are used throughout the programme; sometimes functionally, as bridging shots between sequences, or to signify the passage of time, but also in ways that signify the house’s importance to the psychotherapeutic project, reinforced by the programme title.

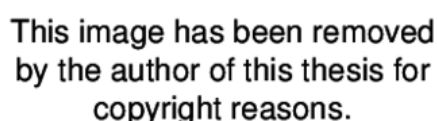


Figure 21 *The House of Obsessive Compulsives* (Channel 4, 2005)

In contrast, the property used in *Hypochondriacs: I Told You I Was Ill* is a large, modern detached house situated beside a quiet country road, described in the voice-over as ‘a remote country house, miles from the nearest hospital’. The property’s quiet rural exterior is contrasted with an interior sequence featuring the programme’s four volunteers having breakfast in an untidy kitchen, reminiscent of a scene from a family home, and illustrating reality television’s practice of staging its actuality in the

domestic, or quasi-domestic, setting. The bringing together of volunteers to live together while undergoing psychotherapeutic treatment is a hallmark of the non-institutional factual psychotherapy programme. There are similarities with how setting is constructed in specialist NHS residential units, such as the visual contrasting of public and private spaces, the centrality of shared spaces such as corridors and lounges, and signifiers of domesticity, such as the laundry room sequences in *OCD Ward*; these similarities, however, are superficial. While residents of specialist NHS residential units are shown to interact, it is rare for programme volunteers to be filmed interacting with each other. In non-institutional factual psychotherapy programmes, on the other hand, volunteer interaction is a central component of programme content. Consequently, setting has the additional function of creating spaces for the filming of volunteer interaction. In both *Hypochondriacs: I Told You I Was Ill* and *The House of Obsessive Compulsives*, the primary setting for volunteer interaction is the kitchen, where communal meals are prepared and eaten.

As non-institutional factual psychotherapy programmes often feature several volunteers, public rooms, such as lounges, dining rooms and studies, are required for use as consulting rooms for the filming of psychotherapeutic actuality. The addition of folders, and occasionally flipcharts, do little to professionalise what are essentially functional domestic spaces (see Figure 22).

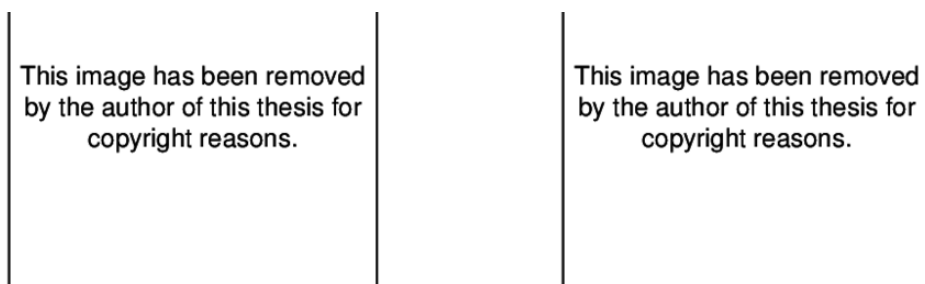


Figure 22 *The House of Obsessive Compulsives* (Channel 4, 2005) / *Hypochondriacs* (Channel 4, 2007)

The second approach to the construction of setting within non-institutional factual psychotherapy programming involves the use of real domestic spaces, specifically volunteers' homes. In the research sample, this approach is found in programmes about agoraphobia, including *House of Agoraphobics*, but is most typically associated in programmes about hoarding, including *My Hoarder Mum and Me*, *Britain's Biggest Hoarders*, *World of Compulsive Hoarders* and *The Hoarder Next Door*. A key sequence

in these programmes is the ‘guided tour’: a tour of the volunteer’s home, in which each room is visited, its function speculated upon, and the more extreme or bizarre details of the volunteer’s hoard picked out by the camera in close-up detail. These sequences sometimes include actuality showing the arrival of the psychotherapist at the volunteer’s home for the first time, capturing their impeded entry to the property. In *Britain’s Biggest Hoarders*, the psychotherapist has to carefully climb a cluttered staircase and push through a landing covered with stacks of hoarded materials. In another sequence, the psychotherapist is taken on a guided tour of the house by the volunteer. They enter a small room - the camera operator is already in there, crouching or sitting, and filming from a low-angle - capturing the psychotherapist, who is partially obscured by the volunteer, standing in the doorway looking round, ‘So which room’s this? It’s the bathroom. Toilet. Toilet. OK, got it’.

The guided tour sequences conclude with an impromptu psychotherapy session filmed in the volunteer’s home, in an area of the property that is still relatively accessible. In one sequence, psychotherapist and volunteer sit at the foot of a staircase, the psychotherapist perched on a stack of old newspapers. In another, psychotherapist and volunteer sit together in a dingily-lit study lined with dusty, overfilled bookcases (see Figure 23). This sequence visually contrasts the volunteer’s comfort at being in a familiar environment with the shots which emphasise the psychotherapist’s out-of-placedness - in one sequence, he conducts the psychotherapy session in his anorak. The use of the volunteer’s home in the construction of setting in non-institutional factual psychotherapy programming is examined further in Chapter 6, as part of the case study analysis of *The Hoarder Next Door*.

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Figure 23 *Britain's Biggest Hoarders* (BBC One, 2013)

The final approach used in the construction of setting in non-institutional factual psychotherapy programming is the design and construction of purpose-built sets. This approach is comparatively rare in the research sample; purpose-built sets feature in just three programmes: *Freaky Eaters*, *Spendaholics*, and *The Panic Room*. These programmes were all broadcast by BBC Three in the mid-2000s, suggesting that there may have been stylistic and pragmatic reasons why sets were used; the construction of sets can be both time-consuming and expensive, and justifiable only when sets are either a central component of programme content, or can be recycled or reused on future productions. In the case of *The Panic Room*, the studio-based set is a significant and fundamental component of the programme's premise and execution. This is examined in Chapter 6, in the case study analysis of *The Panic Room*.

Among those programmes which use sets, a more common approach is the use of sets in the construction of consulting rooms. *Freaky Eaters*, *Spendaholics*, and *The Panic Room* all feature small purpose-built consulting room sets. In *Freaky Eaters*, the consulting room sequence begins with the caption *What's Eating You?*, signifying the format point where the volunteer has their first one-to-one session with the programme's psychotherapist. Following the caption, and some generic shots of London - including familiar landmarks and street scenes - the sequence cuts to a high-angle wide shot of the consulting room. This establishing image is treated with visual effects to evoke the visual interference of a CCTV-type surveillance camera (see Figure 24, left); this visual effect is removed once volunteer and psychotherapist have entered the room and sat down. The consulting room has a white floor, white walls, and two white armchairs facing each other at an oblique angle; the white walls are constructed from square, padded tiles (see Figure 24, right). The effect strongly evokes the idea of the padded cell, suggesting that programme-makers have drawn upon stereotypical signifiers of the psychotherapeutic in designing this set.

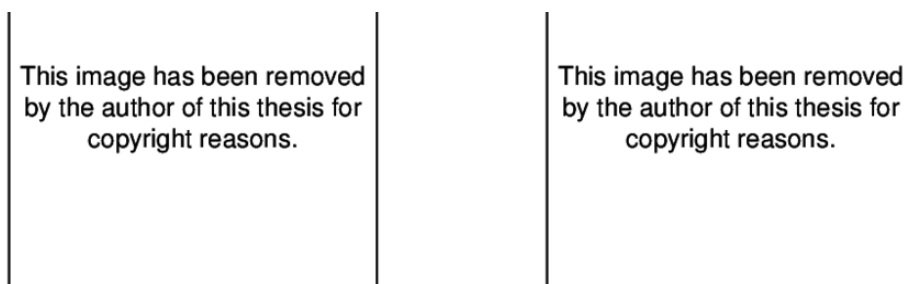


Figure 24 *Freaky Eaters* (BBC Three, 2007)

In contrast, the fourth and fifth series of *Spendaholics* create consulting room sets using a variety of props, panels and screens. The visually dominant panels and screens, decorated with contemporary patterns, and the use of plants and ornamental lights used to ‘dress’ the set, evoke a sense of generic rather than specifically psychotherapeutic setting. In these sets, the only overt reference to the psychotherapeutic setting are the two comfortable-looking chairs facing each other at an oblique angle.

This section has been structured primarily around establishing the differences between institutional and non-institutional constructions of psychotherapeutic setting. Before the analysis of setting is concluded, there are two remaining points about constructions of setting that have a bearing on the remaining sections of this chapter. The first is in regard to references made to the use of the toilet as a setting for the filming of psychotherapeutic actuality. This practice is an established experiment in cognitive behavioural therapy for the treatment of obsessive compulsive disorder, in which patients/clients are encouraged to touch toilets and then touch themselves - their faces, hair, bodies - with ‘contaminated’ hands, sometimes to lick their fingers or eat food without hand-washing first. Psychotherapists often perform these tasks as part of the experiment. When I first watched *The House of Obsessive Compulsives* in 2005, I found its use of the toilet sequence to be one of its most striking and shocking moments. It was commented on in newspaper reviews at the time (e.g. Betts, 2005; English, 2005; Sutcliffe, 2005). However, as my research progressed, it became clear that the toilet sequence is not exclusive to the non-institutional programme; it is also used in institutionally-based programming, including *Obsessions Run My Life*, *OCD Ward*, and *Bedlam: Anxiety*. While the toilet sequence might strike a provocative or controversial note, its use as a setting for psychotherapeutic actuality should not be read as a development associated with the departure from the institutional setting. Of course, this does not rule out the possibility that, even for programme-makers working in the institutional setting, the toilet sequence would be a desirable programme element. A discussion of the psychotherapeutic content of toilet-based actuality is considered in the following section.

The second point is in regard to the use of public and exterior settings for the delivery of psychotherapeutic treatment. A review of the research sample shows that, from the early 2000s onwards, institutionally-based programming featured sequences

which depict the delivery of psychotherapeutic treatment in public and exterior settings. For example, *The Test: Fear of Flying* features sequences in which the psychotherapist takes the volunteer, who has a fear of heights and flying, to the top of a tall building, to the middle of the Humber Bridge, to an airport, onto a flight simulator, and, finally, on a flight; in *Addicted To Asda*, the psychotherapist takes the volunteer supermarket shopping; in *Growing Children OCD*, a volunteer with intrusive thoughts about pushing strangers in front of trains is taken to a railway station; and in *Bedlam: Anxiety*, there is a supervised visit to a central London location for a volunteer with intrusive thoughts about harming strangers.

Public and exterior settings are used in similar ways in non-institutional factual psychotherapy programming, with volunteers taken to public and exterior locations for the delivery of psychotherapeutic treatment. For example, in *Britain's Weirdest Phobias*, psychotherapist and volunteer visit a windfarm and television mast to treat a volunteer's fear of heights; in *Hypochondriacs: I Told You I Was Ill*, volunteers are taken to a supermarket, a public toilet and a bar to work on different aspects of their hypochondria; in *Extreme Phobias*, which includes both institutional and non-institutional psychotherapeutic actuality, a volunteer with a bird phobia is taken to a bird sanctuary; in *The Panic Room*, volunteers are taken to exterior locations which have relevance to their particular phobias. In some non-institutional programmes - *The House of Obsessive Compulsives* and *Too Ugly For Love* - the psychotherapist is not present when the volunteers embark on their 'psychotherapeutic homework', some of which is set in public or exterior locations. In other non-institutional programmes - notably *Spendaholics* and *Freaky Eaters* - the link between the exterior location and the mental health problem at times seems tenuous, with the use of generic locations such as sporting venues and outdoor pursuit centres. The most extensive use of public and exterior settings in a non-institutional factual psychotherapy programme is in *House of Agoraphobics*, which is studied in more detail in Chapter 6.

This section has analysed how setting is constructed in both institutional and non-institutional factual psychotherapy programming. It has identified the programme-making strategies and approaches used in the construction of setting. It has examined the strategies used to create new or alternative spaces for the delivery of psychotherapeutic treatment, that became necessary following the departure of programme-makers from the institutional setting. The findings presented in this section

facilitate an understanding of new representations of setting which emerge in non-institutional factual psychotherapy programming. The remaining sections in this chapter - on expertise and outcomes - consider the impact of the decision to film psychotherapeutic actuality in non-institutional settings. While non-institutional factual psychotherapy programmes suggest that psychotherapy can be delivered in virtually any setting, including those with no association with the psychotherapeutic, and while this idea might appear to be supported by Spinelli, who has suggested that psychotherapy can take place within any 'frame' deemed appropriate by a psychotherapist (Spinelli, 1994), I would suggest that the removal of psychotherapy from its traditional institutional setting has potential consequences for the perceived authenticity of the psychotherapeutic project, and that 'adjustments' are made within programmes to mitigate against any potential loss of authenticity.

5.3 Expertise: Constructing Experts & Expert Practice

This section considers the impact of the departure from the institutional setting on constructions of expertise. The definition of psychotherapeutic expertise used in this study is set out in Chapter 1 and has been used to inform the eligibility criteria for the research sample as set out in Chapter 3. The psychotherapeutic experts who feature in the sampled programmes should be regarded as meeting certain minimum eligibility criteria relating to training, qualification and professional regulation, irrespective of their actual professional titles, their experience, their employment status, the psychotherapeutic modality employed, or the programme involved.

5.3.1 The Psychotherapeutic Expert

The programme content that offers the greatest opportunity to examine how psychotherapeutic expertise is constructed is actuality which shows psychotherapists at work. The research sample is a rich source of recorded evidence of psychotherapeutic actuality, showing psychotherapists utilising different modalities in a variety of settings. The majority of sampled programmes feature multiple sequences of psychotherapeutic actuality, positioned throughout the programme in chronological order. Occasionally, programmes include only one sequence, such as in *The Man Who Loved The Number 12* and *My Hoarder Mum and Me*, in which the programme's primary focus is on the impact of the mental health problem on the volunteer's life rather than on the psychotherapeutic process itself. Two-thirds of the sampled programmes show psychotherapists working

individually with individual volunteers, establishing the most common psychotherapeutic scenario across the research sample. Two exceptions are *The House of Obsessive Compulsives* and *House of Agoraphobics* which feature psychotherapists working in pairs to deliver psychotherapeutic treatment to individual volunteers. The remaining programmes, including *A Home For Maisie*, *Help Me Help My Child*, and *I Hate Mum*, show psychotherapists working in small teams with children and families. Only two programmes - *Talking Cure* and *Grendon* (BBC Two, 2000) - show psychotherapists working with groups of volunteers.

Although information about the duration of psychotherapeutic treatment varies across the research sample, and in some programmes is not specified at all, duration is a dimension of the construction of psychotherapeutic expertise. The findings indicate that programmes which specify that psychotherapy has been delivered over extended periods of time are made within the institutional setting, such as *A Home For Maisie* (six months), *Bedlam: Anxiety* (twelve weeks), *Addicted to Asda* (twenty sessions) and *I Hate Mum* (four months). In these programmes, constructions of expertise reference the psychotherapist's ability to recognise a volunteer's need for long-term treatment. For example, in *A Home For Maisie*, the psychotherapist states that 'it's going to take many months to get (the volunteer) to open up', having previously predicted that the volunteer's problem 'has to be contained within the next year, otherwise it will be dangerous'. On the other hand, programmes made in non-institutional settings are characterised by psychotherapy delivered over a short timescale, such as nine days (*The House of Obsessive Compulsives*), three days (*The Panic Room*), and over a weekend (*I Want My Dad Back*, *Hypochondriacs: I Told You I Was Ill*). In programmes where such brevity is specified, constructions of expertise utilise notions of specialist knowledge and confidence in treatment design. For example, in *The House of Obsessive Compulsives*, the psychotherapist states that 'we've been developing intensive treatments for OCD and other anxiety disorders where we actually focus the time into a few days', an approach described in the programme voice-over as 'a make or break treatment developed by Britain's leading expert on OCD'.

My findings show that constructions of expertise in institutional factual psychotherapy programmes emphasise the combined expertise of the psychotherapeutically-orientated institution and, in turn, the institution's professional standing within the psychotherapeutic domain. The primary mechanism for

communicating information about the status of the institution is through the programme voice-over, which describes each institution in terms of its unique or special characteristics. For example, the specialist unit which features in *Growing Children: OCD* is described as the ‘only national specialist clinic for young people with OCD’; the residential unit in *OCD Ward* is described as ‘Britain’s only 24/7 unit dedicated to the treatment of OCD’; the adoption agency in *A Home For Maisie* is described as a ‘unique therapy centre with an exceptional track record for healing some of the country’s most damaged children’; the hospital in *Help Me Help My Child* is described as ‘one of the UK’s top psychiatric hospitals’.

Within the institutional context, the professional standing and expertise of individual psychotherapists is rarely foregrounded; rather, they are presented as part of the combined expertise of the institution for which they work. In the programmes, psychotherapists are not singled out for special comment or commendation, even when they are the primary focus of sequences of psychotherapeutic actuality. For example, the psychotherapists who feature in *OCD Ward* are described collectively as ‘one of the most specialised teams in the world’. The expertise of individual psychotherapists is signified matter-of-factly through the use of their professional title, using voice-over or caption, or both. There is some variability in how programme-makers use the terminology of psychotherapeutic nomenclature. Psychotherapists of the same classification are described across the research sample as ‘consultant psychologist’ (*Addicted to Asda*), ‘consultant clinical psychologist’ (*Extreme Phobias*), and ‘clinical psychologist’ (*Growing Children: OCD*). The construction of psychotherapeutic expertise is filtered through the institution, with no apparent necessity to detail the training, qualifications and experience of individual psychotherapists. In other words, their individual expertise is presented as a given.

Constructions of expertise in non-institutional factual psychotherapy programming, on the other hand, emphasise the expertise and professional standing of the individual psychotherapist. For example, in *Britain’s Biggest Hoarders*, which features psychotherapeutic treatment delivered across a range of settings including institutional, private, and domestic, psychotherapists are described by both their professional titles - ‘psychologist’, ‘clinical psychologist’ - and also through claims relating to their professional standing and expertise, including phrases such as ‘one of Britain’s few hoarding experts’ and ‘one of Britain’s leading hoarding experts’. In *Too*

Ugly For Love, in which psychotherapeutic actuality is filmed in both hospital and private consulting room settings, one psychotherapist is described as ‘the UK’s leading BDD specialist’, another as ‘the UK’s leading expert on BDD’ and ‘a psychiatrist at the Institute of Psychiatry’. The reference to absent institutions is a common characteristic in the construction of psychotherapeutic expertise in non-institutional factual psychotherapy programmes; the referenced institution bringing a degree of credibility to the psychotherapeutic project. For example, in *Hypochondriacs: I Told You I Was Ill*, the voice-over states that the psychotherapist is ‘a consultant at London’s Maudsley Hospital’; in *The House Of Obsessive Compulsives*, the psychotherapist ‘(n)ormally...sees patients for an hour at a time at the Maudsley Hospital in London’.

Another area of difference between institutional and non-institutional factual psychotherapy programming to emerge in my findings relates to how gender is used in the construction of psychotherapeutic expertise. Research has shown that the UK’s main psychotherapeutic professions (clinical psychologist, psychotherapist and counsellor) are professions which are dominated by women to the extent that they are now widely regarded as ‘feminised’ professions (Morison et al., 2014). I noted an exception in the field of psychiatry, where the ratio of male to female psychiatrists is closer to fifty-fifty, but which drops to thirty two per cent for women for the category of consultant psychiatrist (Centre for Workforce Intelligence, 2014). I analysed the programmes to see whether their representations of psychotherapists reflect these statistics, or whether, as suggested by literature referenced in Chapter 2, the programmes construct representations of psychotherapeutic expertise that privilege male expertise (Peck, 1995; Shattuc, 1997). My findings show that of the eighty psychotherapists who feature in the sampled programmes, forty-five (56%) are male, and thirty-five (44%) are female; male psychotherapists are more likely to appear in programmes which feature only one psychotherapist; seventeen male psychotherapists appear as the sole psychotherapeutic expert across twelve programmes (including multi-season formatted series), in comparison to four female psychotherapists across four programmes; and male psychotherapists are also more likely to feature in non-institutional factual psychotherapy programmes; twenty male psychotherapists appear in thirteen non-institutional programmes, compared with seven female psychotherapists in five programmes. The raw data used in this analysis is available in Appendix C.

The data presented in this section supports rather than refutes the argument that male expertise is privileged within factual psychotherapy programming. However, a number of factors have been identified that are likely to have influenced the use of male rather than female psychotherapists. First, some programmes, such as *Grendon*, and *Sectioned*, are filmed in all-male environments where there may have been institutional constraints on the gender of psychotherapists. Second, in formatted programmes, such as *Freaky Eaters* and *Spendaholics*, the decision to use male psychotherapists may have been influenced by the decision to use female (non-psychotherapeutic) co-experts. It is common practice within factual television production to ‘cast’ programmes in ways which exploit demographic diversity, so that experts (and other programme contributors) express different demographic characteristics, such as their age, gender, and ethnicity. Evidence to support this can be seen in a number of programmes, including institutional programmes, such as *Extreme Phobias* and *The Madness in Me*, and non-institutional programmes, such as *The Panic Room* and *The House of Obsessive Compulsives*, which feature equal numbers of male and female psychotherapists. While representations of diversity may be a programme-making aim, it is not always possible to achieve for reasons outside of the programme-maker’s control. In any case, diversity can be expressed in different ways. For example, while *Sectioned* features four male psychotherapists and only one female, it is one of only four programmes within the research sample which features psychotherapists from minority ethnic backgrounds. (The other programmes are *A Home For Maisie*, *Growing Children: OCD*, and *Help Me Help My Child: Anorexia*). Third, a small number of psychotherapists appear in more than one sampled programme; the most prolific - who are both male - between them appeared in *The Panic Room*, *Freaky Eaters*, *Britain’s Biggest Hoarders*, *The House of Obsessive Compulsives*, *House of Agoraphobics*, *Obsessions Run My Life*, *Phobias*, and *The Test*. Their prior experience of working on factual psychotherapy programmes may have made them more attractive to programme-makers, particularly to those working in the non-institutional setting.

While these factors may have impacted on how psychotherapists are represented and, consequently, on the construction of psychotherapeutic expertise within factual psychotherapy programming, I would suggest that my findings support the claim that representations of psychotherapy in factual psychotherapy programming privilege male expertise. While there is certainly a strong visual presence of female psychotherapists in

high-profile institutionally-based programmes such as *OCD Ward*, and *Bedlam: Anxiety*, female psychotherapists are largely confined to programmes that focus on child or family psychotherapy, such as *My Child Won't Eat*, *Children Behaving Badly*, *Growing Children*, *A Home For Maisie*, and *Help Me Help My Child*.

It has been suggested that one factor which influences a psychotherapist's decision to take part in a television programme is the potential response of their peers (Giles, 2003). There is evidence that the psychotherapeutic community is divided on the matter of whether psychotherapy should be used as programme content. For example, after the broadcast of the series *Talking Cure*, one prominent psychotherapist remarked that 'it is quite a paradox that a first glimpse at the inside of a session from the Trauma Unit at the Tavistock comes from one made for a million people' (Orbach, 2000). Furthermore, psychotherapists who appeared in the series were subject to considerable scrutiny and sometimes negative comments in newspaper reviews, including one whose psychotherapeutic interventions were described as 'stirring (no other verb will do)...His jokiness seems privileged, detached, smug. It alarmed me' (Kellaway, 1999); another psychotherapist was described as a 'terrifying, posh witch-woman who is viciously mean to (the volunteer) and accuses him of flirting with her' (McGill, 1999). The relative absence of female psychotherapists in factual psychotherapy programmes, representing a professional field in which they are well-represented, may have been influenced by the possibility of negative consequences of participation. One conclusion that might be drawn here is that male psychotherapists are more likely to take such a risk in order to exploit the perceived benefits of taking part in a television programme, in a similar vein to those psychotherapeutically-orientated institutions that have used their involvement in a factual television programme to promote their 'strengths...services and... brand' (South London & Maudsley NHS Foundation Trust, 2013).

One emergent finding is an association between psychotherapists and ideas of non-conformity. The visual appearance of psychotherapists in the sampled programmes suggests a group of professionals who present themselves in ways which conform to institutional or professional notions of what psychotherapists should look like, but who do so in ways that suggest informality and non-conformist leanings. Like many professionals, psychotherapists are not required to wear uniforms in the institutional setting; ID cards on blue NHS lanyards, as illustrated in *OCD Ward*, are often the sole

signifier of institutional context. Psychotherapists wear clothes of their own choosing, subject to rules or guidelines in operation at their particular institution; their choice of clothing can, therefore, be read as signifiers of personal taste. For example, in *Grendon*, filmed in a psychotherapeutic prison, the male psychotherapist is immediately recognisable from his shirt and tie, in contrast to the male volunteers dressed predominantly in track suits, T-shirts, sweatshirts, jeans, sweatpants and trainers, and the male prison officer dressed in short-sleeved white shirt with black epaulettes, black tie and trousers. However, the psychotherapist's comparatively formal appearance is visually contradicted by his baggy cream chinos, long hair tied back in a ponytail, and silver bangle, suggesting that while the shirt and tie are a necessary concession to institutional rules, the chinos, ponytail and bangle reflect who he 'really is'. The idea that psychotherapists have non-conformist leanings is visually evident in the research sample. For example, in *A Home For Maisie*, the main female psychotherapist dresses in a style that might be described as 'bohemian': dark, loose clothing accessorised with bold and distinctive silver jewellery, suggestive of alternative lifestyles and creativity. The sole male psychotherapist looks out of place in his smart attire - jacket, pullover - that becomes increasingly casualised throughout the programme; in the final psychotherapy session, he wears a loose, open-necked polo shirt, as if he has finally acquired the dress code appropriate for this setting. In *Sectioned*, filmed in a psychiatric assessment unit, where the dress code is more formal than in other institutional settings, the male psychotherapists dress in suits. However, even here, signifiers of non-conformism are evident, such as their open-necked shirts, lack of tie, patterned or coloured shirts, and jackets which do not match trousers.

There are differences between how institutional and non-institutional factual psychotherapy programmes construct the psychotherapist expert using dress codes. The difference is less marked in those non-institutional programmes which feature psychotherapists who also work for an NHS institution, such as *The House of Obsessive Compulsives* and *Hypochondriacs: I Told You I Was Ill*. Where the differences really become apparent are in those programmes that feature psychotherapists from the private sector who work on formatted series which encourage the development of television personas, such as *Freaky Eaters*, *Spendaholics*, *The Panic Room*, and *The Hoarder Next Door*. This subject is revisited in Chapter 6, in the case study analyses of both *The Panic Room* and *The Hoarder Next Door*.

5.3.2 Expert Psychotherapeutic Practice

In the sampled programmes, the construction of expert psychotherapeutic practice is achieved primarily through sequences of psychotherapeutic actuality which depict psychotherapeutic practice, and constitute a significant element in the construction of psychotherapeutic expertise. In these sequences, a number of activities are used to signify psychotherapeutic practice: talking, listening, writing, and a variety of activity-based ‘behaviour experiments’ tailored to the specific needs of the volunteer.

Unsurprisingly, given the long-standing association between psychotherapy and talk (Launer, 2005), actuality sequences which feature verbal exchanges between psychotherapist and volunteer are a common and consistent feature across the research sample. Sequences built around verbal exchanges, which incorporate talking, listening and sometimes writing behaviours, are used within the sampled programmes to illustrate how psychotherapists employ their expert knowledge while conducting the specialised conversation that characterises the psychotherapeutic encounter.

Any analysis of how expertise is constructed through representations of talk within psychotherapeutic encounters should acknowledge that such representations are constrained by certain television production practices. For example, in the first episode of *Talking Cure*, the voice-over reveals that the volunteer has undergone four sixty-minute psychotherapy sessions. This amounts to two hundred and forty minutes of unedited footage; only twenty three minutes of this footage - approximately ten per cent - is used within the episode. The process of selecting and assembling actuality clips through the editing process must inevitably lead to the omission of potentially usable footage, and also to modifications to the original pacing, in order to meet the requirements of programme structure or duration. Despite these constraints, it is possible to identify the construction of expertise through depictions of psychotherapists’ practice. As one psychotherapist has observed, in relation to a programme in which he appeared, ‘(t)he things shown...were not in any sense a complete summary of what had happened but give some kind of idea of many things that happen in therapy’ (Salkovskis, 2006).

The first episode of *Talking Cure*, a series about the the Tavistock Clinic, the UK’s largest NHS psychotherapy centre, includes a sequence of talk-based psychotherapeutic actuality lasting seven minutes. The episode features a volunteer who is undertaking psychotherapy to help him come to terms with a fatal car accident that happened some

years previously. The session is captured by two cameras in fixed positions within the psychotherapist's consulting room, allowing for simultaneous recording of psychotherapist and volunteer during the sixty-minute session. The seven-minute edited sequence is not presented as a compressed summary of the entire session, showing its beginning and end, with extracts of its substantive content. Instead, it starts at a dramatic moment during the session:

Psychotherapist: So, you were driving too fast, you drove smack into this man and he died and you were injured.

Volunteer: Uh-huh.

Psychotherapist: And...it's, it's...in a way, you were then, you almost still are now, is wanting to think about anything except that.

Volunteer: [pause] Mmm.

Psychotherapist: Now look, I'm, I don't just want to rub your nose in it...

Volunteer: Mmm.

Psychotherapist: ...but I want to understand how you deal with it.

Volunteer: How I deal with it.

Psychotherapist: Yes.

The sequence continues with footage which features the ongoing dialogue between psychotherapist and volunteer until the conversation is steered, by the psychotherapist, to the subject of the volunteer's father:

Psychotherapist: What do you think it's about?

Volunteer: [long pause] I think a lot of that's...em...[long pause] a fear of facing the fact that he might just not be interested.

[Psychotherapist says nothing, sighs deeply.]

Volunteer: Em. [long pause] Or maybe that's just too much to deal with.

Psychotherapist: Mmm.

[Volunteer says nothing, looks down.]

[Psychotherapist says nothing, sighs deeply.]

Volunteer: [looks up] Mmm.

The construction of the seven-minute sequence, from which these extracts are taken, isolates a range of behaviours which are presented as fundamental to the psychotherapeutic skillset, including the ability to recognise and manage key moments during a psychotherapy session, such as when it is appropriate to speak, to wait, to allow significant silences to develop, and when to raise a difficult subject about which the volunteer does not want to speak. A similar construction is used, to different effect, in *Grendon*, a documentary about a psychotherapeutic prison where prisoners who have committed serious offences undertake voluntary group psychotherapy. The programme features five sequences of group psychotherapy during which the psychotherapist appears to do very little. He is silent throughout most of the selected extracts, although visually present through the use of listening shots. He is depicted as remaining silent even during a heated exchange between volunteers. However, the programme includes one sequence in which he is shown to engage in dialogue with a volunteer who has become angry:

Psychotherapist: How does it feel inside, besides anger?

Volunteer: [pause] Left out.

Psychotherapist: How does that feel?

Volunteer: [pause] It feels like the peoples not listening to me, Joe. I'm trying to explain how I feel and peoples not listening. You know, it's just, I feel like I'm just locked in a room and I can't get out of it and I'm banging the door and fucking peoples just don't want to listen and just walking past.

Psychotherapist: So you're saying you felt hurt.

Volunteer: Yeah. I felt hurt. I feel hurt.

After this exchange, the volunteer cries. One reading of this depiction is that the volunteer's reaction is the result of the psychotherapist's intervention: a nerve has been touched, an important matter identified - something that only the psychotherapist has the expertise to recognise. The inclusion of emotionally-charged moments of this kind - moments when the volunteer is silent, cries, becomes angry - are powerful signifiers of the operation of expert psychotherapeutic practice.

There are comparable sequences in non-institutional factual psychotherapy programming. However, the findings of my programme analysis suggest that different

meanings are generated when sequences of this kind are utilised by programmes made in the non-institutional setting. In non-institutional factual psychotherapy programmes, where there is a greater reliance on the expertise of the individual psychotherapist, the exposure of the psychotherapist to unpredictable, emotionally-charged situations has a greater potential to undermine professional credibility. For example, in an episode of *Freaky Eaters* (Series One, Episode Six), constructions of expert practice are shaped by an emergent tension between psychotherapist and volunteer during their first psychotherapeutic encounter:

Psychotherapist: Perhaps then we could talk a little bit about, you could just give me a little bit of history of your life.

Volunteer: I was in foster care for, like, the duration of my childhood. Lots of different foster carers.

Psychotherapist: Mmm.

Volunteer: But I'd rather just put that stuff in the past, move on, and live my life today because that's what's important. Not from what happened back then.

Psychotherapist: You're saying you're very focused on what happens in today, the present.

Volunteer: Yep.

Psychotherapist: And yet there is something in the present that you're not happy about...[the psychotherapist goes on to speculate about what the volunteer's childhood was like; the volunteer says nothing.]...Do you think it is possible that there could be any relationship between these two? The facts about your life.

Volunteer: You're right in the sense that, yeah, I haven't got loads of experience of being in a caring, nurturing, loving Waltons kind of family life - whatever... [she goes on to describe her experiences]...When I was going through all of that I was thinking, I can't wait to be on my own and get my own place and be happy. When I come home of a night I am happy to be where I am.

Psychotherapist: You leave work and you go home. As pleased as you are to go to your flat, as pleased as you are to get some peace and quiet and to be on your own, maybe that's when it really hits home that...

Volunteer: [shaking head] No. As I say I don't dwell on these things...

Psychotherapist: I know you don't dwell on it and I think if you did dwell on it, and was really thinking this, then you wouldn't be on autopilot buying crap food.

[The volunteer says nothing.]

Psychotherapist: Would you think about it for me?

Volunteer: I'll think about it. [theatrical pause] I've thought about it. I don't think so.

Psychotherapist: [laughs] Would you think about it a bit longer?

[They both laugh.]

This sequence is followed with an extract of video diary-style footage (it looks like a recorded Skype call), in which the volunteer says, 'I really have my hang-ups about [the psychotherapist] because I don't really like people like him. I find him actually pretty patronising'. Footage of this kind, in which a volunteer is depicted as being personally critical of their psychotherapist, is absent from institutionally-based programmes. The closest to it, within the research sample, is a sequence from *OCD Ward*, in which a volunteer is critical of his psychotherapist's recommendation that he use drug therapy while he is resident on the unit. However, the way this conflict is framed, including actuality footage of the volunteer kicking a door in anger after a meeting, appears to privilege the psychotherapist's standpoint. In *Freaky Eaters*, on the other hand, the actuality is used in ways that seem to privilege the volunteer's position. This reading is reinforced by the suggestion that the psychotherapist is failing to manage their psychotherapeutic relationship, demonstrated in the sequence when he arrives at the volunteer's home to collect her for filming, and the voice-over announces that the volunteer 'is refusing to leave her flat or communicate with the production team'.

Psychologist: [on his mobile phone] I'm actually outside your house. I'm wondering if maybe we could have a little chat?

Volunteer: [on speaker-phone] Wait, hang on. What, you're outside my house?

Psychotherapist: Yeah.

Volunteer: [on speaker-phone] You're outside my house right now?

Psychotherapist: Yeah, I'm right outside your house. I'm on your doorstep, pressing your doorbell.

Volunteer: [on speaker-phone] Right. I'll come down.

[The volunteer opens the front door.]

Psychotherapist: Hello! How are you?

The volunteer says nothing.

Psychotherapist: Em, do you want- [pause] Are you all right?

Volunteer: Yep.

Psychotherapist: How are you feeling?

Volunteer: Fine.

Psychotherapist: Em [long pause] Do you want to work with me today?

Volunteer: [backing into the house] Em. I don't particularly feel like anything really.

Psychotherapist: Mmm. It's going to make it really difficult for me to be able to, em, do what I suppose, what I, you know, I hoped to do with you on this programme, to help, you know.

The remainder of the sequence comprises footage of psychotherapist and volunteer, filmed from a distance, without audio. The voice-over reports that 'after discussing the reasons for her resistance, [the volunteer] agrees to continue with the process'. While this reported outcome implies the successful management of the situation, it has been done without visibly demonstrating the operation of expert psychotherapeutic practice. The use of actuality which depicts the psychotherapist struggling to build a psychotherapeutic relationship with the volunteer, informs a construction of expertise that questions the idea of expert knowledge. This conclusion is explored further in Chapter 6, in the case study analysis of *House of Agoraphobics*, which includes several sequences of this kind.

Representations of talk-based psychotherapy do not play a significant role in the construction of expert psychotherapeutic practice in non-institutional factual psychotherapy programming. My findings show that only one non-institutional factual psychotherapy programme focuses exclusively on talk-based psychotherapeutic practice - *Fix My Fat Head* - which tells the story of a journalist's journey to find out why she cannot lose weight. As I will demonstrate in Chapter 6, in my case study analysis of *House of Agoraphobics*, talk-based psychotherapeutic actuality is often relegated to a functional role in non-institutional factual psychotherapy programmes, as ways of leading into, and framing, sequences of activity-based psychotherapy.

The term *activity-based psychotherapy* is used within this study to refer to psychotherapeutic treatment that shifts the focus of expert psychotherapeutic practice from talk-based practice to supervised activities or exercises taking place both inside and outside the consulting room setting. To meet the definition of psychotherapy used within this study, activity-based psychotherapeutic actuality must depict psychotherapists supervising such activities; for this reason, activities conducted by volunteers between psychotherapy sessions, such as the filmed ‘homework’ exercises in *The House of Obsessive Compulsives* and *Too Ugly For Love*, are not included in this analysis.

Activity-based psychotherapeutic practice can refer to actuality of a generic sort, as any activity that externalises the psychotherapeutic process, including viewing exercises, in which volunteers are filmed while watching footage of themselves (*The House Of Obsessive Compulsives*, *I Want My Dad Back*), role play exercises (*Spendaholics*, *I Want My Dad Back*), and confidence-building exercises (*Spendaholics*, *Freaky Eaters*). It can also be defined with specific reference to the ‘behavioural experiment’ used in cognitive behavioural therapy, defined as ‘planned experiential activities...undertaken by patients in...cognitive therapy sessions’ (Bennett-Levy et al., 2004, p. 8), characterised by ‘graduated, repeated, and prolonged exposure to a feared stimulus...until such time as anxiety dies down’ (Bennett-Levy et al., 2004, p. 11).

My findings show that activity-based psychotherapeutic practice, particularly behaviour experiments involving exposure exercises, are depicted as being practised in the institutional setting; this is evidenced in sampled programmes which depict both adult and child volunteers undergoing exposure-based treatment for phobias and obsessive compulsive disorder in the institutional setting, such as *Phobias*, *Fear of Flying*, *Extreme Phobias*, *Obsessions Run My Life*, *OCD Ward*, *Bedlam: Anxiety*, *Help Me Help My Child OCD*, and *Growing Children OCD*. The contextualising of this particular kind of expert psychotherapeutic practice within the institutional setting brings credibility to these activities when they are practised within the non-institutional setting, as depicted in programmes such as *The House of Obsessive Compulsives*, *House of Agoraphobics*, *The Panic Room*, *Britain’s Weirdest Phobias*, and *Hypochondriacs: I Told You I Was Ill*.

My analysis of sequences of activity-based psychotherapeutic actuality shows that the behaviours and practices of psychotherapists during activity-based psychotherapy both look and sound different to those that characterise talk-based sessions. Activity-

based sessions are built around the volunteer's participation in, and successful completion of, a practical task. The psychotherapist's expertise is employed to guide the volunteer through the process, and to support them with appropriate behaviours and techniques. The consequence for representations of expert psychotherapeutic practice is significant. Constructions of psychotherapeutic expertise which emphasise the calm, measured and patient manner traditionally associated with talk-based psychotherapy are supplanted by constructions that emphasise a persuasive, directive, assertive, and sometimes forceful manner in the delivery of activity-based psychotherapeutic treatment.

My findings show that there is a marked preference for psychotherapeutic actuality sequences which feature exposure-based behavioural experiments, in both institutional and non-institutional factual psychotherapy programmes. I would suggest that this preference, in both cases, is directly related to the visual, dynamic and often dramatic quality of this kind of psychotherapeutic actuality footage. Among the many examples of activity-based psychotherapeutic practice that could be used to illustrate this section, I would suggest that the toilet-based behaviour experiment exemplifies it most effectively. The previous section introduced the toilet sequence in the context of the psychotherapeutic setting, arguing that, despite its seemingly sensationalist character, examples of its usage can be found in institutional as well as non-institutional factual psychotherapy programming. In toilet sequences, volunteers are depicted touching themselves after touching toilets, and eating food without having washed their hands. In some sequences, the toilet-based experiment is modified to reflect the specific nature of the volunteer's mental health problem. For example, in *OCD Ward*, the volunteer, who has a fear of contamination from urine, is required to handle bottles of fake urine, real urine, and ultimately to use a toilet without performing ritualistic behaviours. The volunteer in *Bedlam: Anxiety* is described in the voice-over as being obsessed that he will 'shit himself in public'. His behavioural experiments are designed to challenge his fears about toilets 'in the most extreme way', including a task in which he defecates, leaves the toilet without wiping himself, and remains in this state until he next needs to use the toilet.

When comparing constructions of expert psychotherapeutic practice in institutional and non-institutional factual psychotherapy programming, it is helpful to be able to compare similar psychotherapeutic practice conducted in both institutional and

non-institutional settings. There are few opportunities within the research sample to make direct comparisons across the research sample. However, it is possible to make this kind of direct comparison with sequences of toilet-based psychotherapeutic actuality. Representations of toilet-based behaviour experiments are found in five sampled programmes: three institutionally-based programmes - *Obsessions Run My Life*, *OCD Ward* and *Bedlam: Anxiety* - and two non-institutionally based programmes - *The House of Obsessive Compulsives* and *Hypochondriacs: I Told You I Was Ill*. Fortuitously, two of these programmes feature this form of activity-based psychotherapeutic practice, conducted by the same psychotherapist in programmes broadcast in the same year (2005). In *Obsessions Run My Life*, the psychotherapist supervises a toilet-based behaviour experiment at his clinic in the South London and Maudsley NHS Foundation Trust. In *The House of Obsessive Compulsives*, he supervises the experiment, with another psychotherapist, in the eponymous house rented by the production company. It was my expectation that the execution of the experiment would follow a similar trajectory in both programmes, as the psychotherapists who appear in the non-institutional programmes - *The House of Obsessive Compulsives* and *Hypochondriacs: I Told You I Was Ill* - work for NHS-based psychotherapeutic institutions. However, my findings identify significant differences.

The volunteer in institutionally-based *Obsessions Run My Life* is described in the voice-over as being ‘so scared of germs she won’t let her hands come into contact with anything she’s going to eat...Vegetables are dissected with a knife and fork. Insulated by Clingfilm. Skewered for washing. Anything to avoid touching food. And at every stage... endless hand washing’. The volunteer has two sessions at ‘one of a few specialist OCD centres in the country’. During the first session, the voice-over announces that the volunteer ‘has to go to the loo and not wash her hands. For someone who can’t even touch a door handle with her bare hands this is torment’.

Psychotherapist: How was that? You look a bit drawn.

Volunteer: Horrible.

[They talk through her anxieties.]

Psychotherapist: What went through your mind when you were doing that?

Volunteer: I just feel like everything I’m touching now I’m putting germs on myself now, so if I’m touching my clothes...

Psychotherapist: Can I ask you to touch the back of my hand there? Wipe your, give me, wipe your hands over it.

[The volunteer wipes the back of the psychotherapist's hand.]

Psychotherapist: And the other one. [the volunteer wipes the back of his other hand] Now what I'm going to do is [the psychotherapist licks the back of his hand].

[The volunteer groans.]

Psychotherapist: Do you think I am in any danger there?

Volunteer: You're in danger.

Psychotherapist: So why am I doing it?

Volunteer: I don't know. I don't understand why you're doing it.

At her second visit, the sequence begins with a tracking shot following the psychotherapist leading the volunteer to the toilet. It's a large disabled toilet; the door is left ajar, the camera operator filming from the doorway.

Psychotherapist: ...Right, OK, in a place like this where do you worry about contamination?

Volunteer: Everywhere.

Psychotherapist: Absolutely everywhere cos it's a loo. OK, so you just stand there. What what I'm going to do is touch a few things [he touches the toilet seat and other surfaces]. You are concerned that I am contaminated OK? OK, so would you think that I'm in danger?

[The volunteer nods].

Psychotherapist: OK, so what in particular, what danger would you be most worried about for me?

Volunteer: All of the germs, the germs everywhere.

Psychotherapist: I'm going to do something totally outrageous now, OK? Again, this is me not you, OK? What I'm going to do is [he dips hands in toilet water] and rub that on my hands [he rubs his wet hands together]. Right, what do you reckon to that?

[The volunteer says nothing.]

Psychotherapist: Do you think I'm foolish?

[The volunteer nods.]

Psychotherapist: Right, how many times do you think I've done that before?

Volunteer: A few. Ten.

Psychotherapist: Probably more like seventy to eight times, I think. OK, what I'm going to do now is lick my fingers [he licks his fingers]. And I've done that loads of times before too. What do you reckon? Do you reckon I'm very lucky? Do you think that's the way it works?

Volunteer: I think because you've done it so many times before your immune system is used to toilet water.

Psychotherapist: Right. Is that the only reason? Think I was only lucky the first few times? Actually, I've got a clinic full of colleagues who do the same thing and they're all alive and well. We, we haven't had a lot of fatalities. So the next question to ask is why am I doing this stuff? I mean why am I doing stuff like touching loos and [he opens a paper bag and starts eating a bread roll]. Things like that.

Volunteer: To prove a point.

Psychotherapist: Mmm. But what is the point I'm trying to prove?

Volunteer: That it can't do it any harm.

Psychotherapist: That's right, that is what I'm trying to do but why am I trying to prove that point?

Volunteer: To show me that you come to no harm from doing it.

Psychotherapist: To help you.

Volunteer: To help me.

Psychotherapist: Right.

Back in the psychotherapist's room, the consultation continues. He asks the volunteer to eat some crisps. Their conversation continues for several minutes before the volunteer finally eats one.

In the comparable sequence in the non-institutionally-based *The House of Obsessive Compulsives*, the construction of the toilet sequence suggests that the session has happened without any preparation, that the volunteer and her two psychotherapists have come straight from the group meeting depicted in the previous sequence. The voice-over announces that the psychotherapist has decided that the volunteer 'should confront

her biggest fear - germs - immediately'. The camera is already in position in the small domestic toilet when the volunteer and her two psychotherapists enter. The room is so crowded, the psychotherapist's back almost fills the frame, necessitating a cut to a shot with a clearer view of the activity. The lack of available space makes capturing the action quite difficult, necessitating some reactive handheld camera moves.

Psychotherapist A: Right, one loo. What's your suggestion?

Volunteer: Well, the white bit of the loo is contaminated with bacteria.

Psychotherapist A: Can I put my hand in the water?

Volunteer: [nodding] Mmm.

[Psychotherapist A puts his hand into the toilet water.]

Psychotherapist A: Is it OK if I wipe it on my trousers?

Volunteer: Well, I wouldn't if I were you.

Psychotherapist A: OK, so we've done a bit. Is there anything else you want to do before you try touching something here? What's your rating of anxiety now? Out of a hundred.

Volunteer: About nine.

Psychotherapist A: Ninety. Is that nine or ninety? Ninety OK.

[The sequence is interrupted with an interview clip with the psychotherapist].

Psychotherapist B: What does the toilet handle mean to you?

Volunteer: It's got bacteria on it.

Psychotherapist B: Bacteria on it.

Psychotherapist A: OK.

Volunteer: Thousands and millions of bacteria.

Psychotherapist A: Would you touch that then? Do you want to try and touch that?

Volunteer:...touch that.

[The volunteer reaches forward and tentatively touches the toilet flush handle.]

Psychotherapist A: OK, now, if you're going to do it, you're going to do it. You might as well do it, you know, properly. OK so do you want to have another go at that and try and do it like you really just haven't a care in the world?

[The volunteer touches the toilet flush handle again.]

Psychotherapist A: Other hand too, maybe?

[The volunteer touches the flush handle with her other hand.]

Psychotherapist B: That's good yeah.

Psychotherapist A: That was brilliant. That was brilliant. That was really nice and confident. Out of a hundred where are you?

Volunteer: [smiling] Okay.

[The sequence is interrupted by a number of other sequences, including a suggestion that twenty-four hours have passed.]

Psychotherapist A: Now, think, think about, think about what this is about. What's this really about? Why are we doing this? Why are we putting you through this horrid stuff?

Volunteer: Because it's worse to be doing all the checking.

Psychotherapist A: Because it's worse doing all the checking because actually, I reckon that when you get really deep into a wash, you feel even worse than you feel now. Is that right?

[The volunteer nods.]

Psychotherapist A: Whereas this is worth something, this is for something, this is to go [makes rude gesture] to your problem, isn't it?

[The volunteer nods].

Psychotherapist A: So take a deep breath, do everything-, now listen to that little voice, of OCD that's saying "do this, do this, do this" and do exactly the opposite. So come on!

[The psychotherapist reaches down and puts his hand into the toilet. The volunteer goes with him, putting her hand in too.]

Psychotherapist A: Brilliant!

Volunteer: I touched the white bit of the toilet.

Psychotherapist B: [touching the inside of the toilet bowl] So, here...

Psychotherapist A: She's quite bossy when she gets going isn't she?

[They all laugh.]

Psychotherapist B: [waving her hand about] What about if you touched any of your clothing?

Volunteer: I wouldn't be happy.

Psychotherapist B: Right, so that would make you feel worse. That's OCD saying to you, you've got something really horrendous happening on your hands. Oh, my God, this could kill you and your husband and your bunnies. The OCD's convincing you that this is a lethal weapon, that this is dangerous.

[The volunteer listens, nods but says nothing.]

Psychotherapist A: What's happening? Your anxiety is going up, isn't it?

Volunteer: I'm thinking I have to touch my hair or my clothes now.

Psychotherapist A: Why don't you just go with it? I mean, you don't have to do anything.

Volunteer: I can't wash for a week.

Psychotherapist A: Just do what the OCD-

[The volunteer touches her hair]

Psychotherapist A: Oh [.....], you're a superstar.

Psychotherapist B: You're so brave!

The sequence concludes with the voice-over announcement that the volunteer 'makes a pact with the therapist and goes downstairs to eat lunch without washing her toilet hands'. In the dining room, the psychotherapist offers her a packet of crisps; she takes one and eats it.

The findings from my analysis of the two sequences suggest a number of areas of difference in how activity-based psychotherapeutic actuality is used within institutional and non-institutional factual psychotherapy programming. The first difference relates to the allocation of screen time. In *Obsessions Run My Life*, the toilet sequence in its entirety, including the follow-up consultation and crisp-eating task, lasts for six minutes ten seconds, compared to just two minutes fifty-two seconds in *The House of Obsessive Compulsives*. When the time spent in the toilet location itself is compared, the sequence in *Obsessions Run My Life* lasts for two minutes twenty-four seconds presented as a single edited extract, compared to two minutes eight seconds for the three discrete extracts from *The House of Obsessive Compulsives*. The longer duration, and the suggestion, through the use of continuity editing, of continuous event in *Obsessions Run My Life*

results in a sequence that presents a more detailed and coherent account of the experiment, including the purpose of the post-task dialogue between volunteer and psychotherapist. In *The House of Obsessive Compulsives*, the experiment appears truncated by comparison, reduced to a series of toilet-touching tasks, and a sequence that prioritises spectacle, exploiting the dramatic visual quality of toilet-based actuality footage. The filming and editing techniques used to construct the two sequences further differentiate them. In *The House of Obsessive Compulsives*, the actuality extracts are more overtly edited, partly from necessity - the lack of space in the toilet makes it difficult for the camera operator to capture the action, leading to reactive and potentially unusable shots - and partly because of the way that the actuality has been broken down into shorter clips to service the programme narrative. In contrast, in *Obsessions Run My Life*, the editing style is less abrasive, facilitated by the availability of more usable footage and by an apparent intention to construct a sequence that delivers a 'realistic' account of the experiment.

A second difference relates to their constructions of expert psychotherapeutic practice. The inclusion of both activity-based and talk-based psychotherapeutic practice in the *Obsessions Run My Life* sequence results in a more complex construction of psychotherapeutic expertise and practice, in which the psychotherapist's practice is depicted as using a range of techniques, including the kind, measured manner associated with talk-based psychotherapy, and the persuasive, directive manner associated with the delivery of exposure-based psychotherapy. The addition of humourous moments results in the construction of well-rounded, multifaceted representation of psychotherapeutic expertise. In contrast, the lack of any significant talk-based actuality in the *The House of Obsessive Compulsives* sequence results in a construction of expertise that is less elaborated and which depicts primarily the use of the persuasive, directive manner that typifies activity-based psychotherapy, supplemented with morale-boosting encouragement. Based on an analysis of these two sequences in isolation, their constructions of expertise, based around the same psychotherapist, are significantly different.

These findings support my analysis of other programmes which feature the toilet-based behaviour experiment. In *OCD Ward*, filmed in a specialist residential NHS unit for people with severe obsessive-compulsive disorder, the toilet experiment is presented in the form of four discrete sequences. This approach is justified within the programme

by the psychotherapist's description of the volunteer, who is terrified of being contaminated by urine, as 'one of the most severe cases we've had'. The sequences construct psychotherapeutic expertise through the depiction of a range of techniques including the psychotherapist's focus on task, on her physical participation in the experiment, on her use of praise, persuasion, interrogation, and occasionally exhortation, supplemented with moments of humour. The construction of expertise in *Hypochondriacs: I Told You I Was Ill*, because four volunteers with hypochondria move into a rented house for the weekend to undergo psychotherapeutic treatment, is functional, designed to do little more than illustrate the psychotherapeutic techniques used in the management of behavioural experiments.

Further analysis of the toilet-based material suggests the possibility that the sequences in both programmes might have originally been more alike, but that *The House of Obsessive Compulsives* might have been edited to condense the actuality in order to emphasise the more dramatic aspects of the psychotherapeutic experiment, namely, the toilet-based actuality. The duration of the toilet-based material in *Obsessions Run My Life* is close to the durations of the combined extracts of toilet-based actuality in *The House of Obsessive Compulsives*, raising the question that this actuality may have been divided to represent the two sessions required for a successful outcome. This impression is supported by an examination of the continuity and mise-en-scène of the toilet-based actuality in *The House of Obsessive Compulsives*. Whereas the continuity in *Obsessions Run My Life* shows quite clearly, through the volunteer's and psychotherapists' different clothing, that the actuality was shot on different occasions, the same cannot be said of *The House of Obsessive Compulsives*, in which the volunteer and two psychotherapists are wearing the same clothes, and the camera is in the same position (see Figure 25). Furthermore, the reference to 'day two' is stated overtly on the preceding sequence, whereas the voice-over on this sequence is not time-specific, referring to progression in more general terms 'more work needing to be done.' Perhaps, most significantly, there is a contentious flashback sequence between the two sequences which shows the filmmakers breaking with linearity in the normal way.

Day One

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Day Two

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Figure 25 *The House of Obsessive Compulsives* (Channel 4, 2005)

Even if it were possible to produce definitive evidence that the programme-maker has distorted the timeline in the way suggested, I would not necessarily say that this produced a profound distortion of the psychotherapeutic process because the actuality extracts are still in the correct order. It might simply be an instance where actuality was considered too dull or too time-consuming to run as one sequence and has been portioned out in a more unconventional way. The programme film editor of the sequences in question is on record regarding the need for timeline management in film making. He writes,

Often the thorniest subject when it comes to truth in factual editing is timeline...(but) in the interests of storytelling and structure, some things filmed at different times have to move earlier or later. You should allow this as long as they are timeless events whose moving does not affect the larger truth...you must be brave and swap scenes that could go anywhere to make the programme stronger...if the sufferer at home is too boring, shorten it or just lose it because always remember as long as it is in the right story order, you can lose time

especially at the front where there is always that temptation to put in too much and keep in sequences shot early even though they are usually more boring. (Thirkell, 2014, p. 290).

Assuming that the two sequences in *The House of Obsessive Compulsives* were used in the way suggested, it should be noted that this could not have happened without the psychotherapists' knowledge and approval. This might suggest a closer partnership between psychotherapeutic experts and programme-maker than would be expected in an institutional setting, where one would expect there to be gatekeepers protecting the interests of the institution at various levels throughout its organisational hierarchy. Consequently, this difference in the construction of expert psychotherapeutic practice might suggest that there are more opportunities for individual psychotherapeutic experts to influence constructions of their own expertise outside of the institution.

5.4 Endings & Outcomes

Factual psychotherapy programmes can be challenging to conclude because of the unpredictable, non-linear, and open-ended nature of the psychotherapeutic process. This section examines the techniques and devices that are used by programme-makers to manage these aspects of the psychotherapeutic process in the construction of programme endings. My analysis acknowledges the fundamental role of narrative in 'the shaping process whereby the documentarist transforms the fragments of reality into an account which is directed at an audience of viewers' (Kilborn & Izod, 1997, p. 115). The nature of television production means that programme-makers usually know the outcome of the psychotherapeutic process before they edit their programme, and are therefore in a position to shape psychotherapeutic actuality footage in ways that maximise, subject to regulatory and ethical constraints, its dramatic potential. It is common practice, for example, for programme-makers to manipulate viewers' expectations of the psychotherapeutic outcome in order to create narrative tension, or introduce a sense of jeopardy into the programme narrative. For example, the construction of ending in *Bedlam: Anxiety* shows the programme's main volunteer, who is depicted throughout the programme narrative as struggling with the psychotherapeutic process, finally achieving a successful psychotherapeutic outcome. The sequence includes an interview extract in which the volunteer states that, 'I'm certainly the best I've ever been, since I've had OCD. I'm sort of getting there'. This is

followed with a voice-over update which reports that, ‘six months on, [the volunteer] has returned to university...to redo the first year of his drama degree. So far he’s kept his OCD in check, and is enjoying a life free from anxiety’. The reverse scenario is illustrated in *House of Agoraphobics*, when a volunteer who was seen to be making good progress and coping better than the other volunteers during the trip to Japan, says,

I cannot believe I’ve flown half way around the world and visited one of the busiest cities in the world. Two weeks ago if you’d ask me “do you fancy going to Japan in two weeks?” You’re off your fucking rocker. You’re mad, and now I’m looking at it thinking “bring it on”. I want more.

Three sequences later, there is a voice-over link stating that for this volunteer, ‘things have been more difficult. Just days after returning home he stopped going out again’. In an interview extract, filmed in his bedroom, the volunteer says, ‘I need to get out of here. I really need to get out of here. And yet now it’s the battle of which will is strong enough, my desire to get out and conquer this thing, or the panic. At the moment's it’s real loggerheads’. This is followed by an extract from an interview with the volunteer’s father who says, ‘I’m disappointed. I thought he’d be up and out and ready to move.’

My findings demonstrate that factual psychotherapy programmes can handle both positive and negative psychotherapeutic outcomes. Across the research sample as a whole, it is evident that factual psychotherapy programmes promote the idea that psychotherapy works, at least for the majority of the volunteers who appear in the sampled programmes. Furthermore, as programmes with two or more volunteers are well-represented within the sample, differential outcomes can be accommodated, and may even be desirable in terms of providing dramatic contrast.

The programme analysis shows that factual psychotherapy programmes use four main narrative techniques, devices or mechanisms for the construction of programme endings. More than one of these may feature within the same programme. Constructions of programme endings may have several stages. Endings not only conclude the process, but also provide updates on the volunteers. These updates are almost always restricted to the programme ending. There are only two examples in the research sample of programmes whose volunteers are updated in another programme: the first episode of

Britain's Biggest Hoarder updates *My Hoarder Mum and Me*. *Spendaholics Saved My Life* follows up some of the volunteers who featured in *Spendaholics*.

Of these techniques, the first uses a sequence depicting the final encounter between volunteer and psychotherapist in which it is determined whether the intended psychotherapeutic outcome has been achieved. This technique is common in programmes which feature activity-based behaviour experiments, and which use a final exposure session, in which the volunteer is shown to have overcome their anxiety; thereby establishing the psychotherapeutic outcome; for example, a volunteer with a bird phobia who visits an aviary, and a volunteer with a baked bean phobia who opens a tin of baked beans and heats them in a saucepan (*Extreme Phobias*). This technique is also used in programmes that feature talk-based psychotherapy in which volunteers are depicted having reached a new understanding of their mental health problems, such as the volunteer in the first episode of *Talking Cure* who, after struggling to engage in the psychotherapeutic process, is shown in a clip taken from his final psychotherapy session telling the psychotherapist 'If you can open...up, it is worth it. Going back to being alive, I suppose'.

The second technique uses extracts of volunteers' interviews with the programme-maker filmed after the completion of the psychotherapeutic process. These interviews are most typically used to reflect volunteers' positive reactions to the psychotherapeutic process. For example, in the final episode of *Talking Cure*, a married couple whose son died in a road traffic accident identify the positive impact of the psychotherapy on their marriage; in *Fix My Fat Head*, the volunteer, who wants to understand why she cannot lose weight, concludes that the psychotherapist's 'diet of straight talking and tough love has finally got me on the right track'. The post-psychotherapeutic interview is occasionally also used to reflect a volunteer's disappointment with their psychotherapeutic outcome, such as interviews with volunteers in *The House of Obsessive Compulsives* and *House of Agoraphobics*.

The third technique uses updates about volunteers' progress following the completion of the psychotherapeutic process. Updates are constructed in different ways, but almost always use a combination of captions, voice-over, stills, actuality clips, and music. For example, in *Britain's Biggest Hoarders*, updates are constructed using still images of the volunteers, framed within a black border, with accompanying music, and captions which state, for example, that one volunteer is 'continuing to have therapy for

her hoarding. She is still planning to deal with her hoard' or that another 'continues to clear his hoard. He started the first hoarding support group in [.....]'. Some programmes feature more than one update, such as *The House of Obsessive Compulsives* which updates at one and three months.

The fourth technique uses freshly-filmed actuality footage to construct sequences depicting volunteers embarking on new personal ventures which, it is implied, have been made possible because of the successful completion of their psychotherapy. For example, in *Too Ugly For Love*, one volunteer is filmed performing his music in a club; another volunteer is able to make a presentation to an advertising agency without wearing any make-up.

My findings identify additional, less common techniques which are used in the construction of programme endings. For example, two programmes in the research sample (*The House of Obsessive Compulsives* and *I Want My Dad Back*) use sequences in which volunteers are filmed watching footage of themselves filmed at the start of the psychotherapeutic process. In both instances, this is contextualised as part of the psychotherapeutic process, but these sequences do function as effective end-of-programme narrative devices. Presenter-led programmes (*Britain's Biggest Hoarders*, *The Test*, *Fix My Fat Head*) end with presenter-delivered pieces-to-camera which round off the process, or provide additional information about the volunteers, such as in *Britain's Biggest Hoarders*, when the presenter reports that one of the volunteers has finally told his sister about his hoarding. A final device is the sequence which shows volunteers who have been living together during the psychotherapeutic process say goodbye, which features in *The House of Obsessive Compulsives*, *The Panic Room*, and *Hypochondriacs: I Told You I Was Ill*. These less typical techniques are only used in non-institutional programmes.

I have argued in this study that the removal of the psychotherapeutic process from the institutional setting, and its relocation to the non-institutional setting, changes the 'ownership' of the psychotherapeutic project. For programmes made in the institutional setting, the psychotherapeutic project is owned, or managed, by the institution, in the sense that the programme-maker has had to negotiate access to that psychotherapy and is filming it under particular constraints which have been set by the institution. On the other hand, ownership of the psychotherapeutic process in non-institutional settings, despite the often extensive agreements made with individual

psychotherapists, lies with the television professionals. My findings show that the ownership of the psychotherapeutic project has the most significant implications for programme narratives, particularly in terms of how programmes end, because of the different vested interests of the two institutions.

I have already argued that factual psychotherapy programmes can handle both positive and negative psychotherapeutic outcomes. However, my findings also suggest that the way that negative and positive psychotherapeutic outcomes are handled in programme endings depends on the 'ownership' of the psychotherapeutic project. For programmes made in the institutional setting, for example, a negative outcome is accommodated more readily because the institutional setting provides a framework that contextualises failure as an inevitable dimension of the psychotherapeutic process. For example, in *OCD Ward*, which is filmed in a specialist residential unit for young people with severe obsessive compulsive disorder, the programme narrative follows the psychotherapeutic journeys of two volunteers, both young men in their late twenties. As is the norm in factual psychotherapy programming, the programme narrative intertwines their individual stories. In this particular construction, both volunteers are shown to be struggling with the process in different ways. However, when the programme enters its closing stages, one volunteer is seen to make a breakthrough, while the other falls into conflict with his psychotherapist. For one volunteer, 'the therapy is starting to show results'; for the other 'the demands of therapy were too much', and the voice-over reports that he has left the unit without completing his treatment. This construction carries through to the programme's final sequence which presents update captions that one volunteer 'has returned to work full-time and is planning to move into his own home', while the other 'is battling his OCD at home, supported by his mum'. The 'failure' of the psychotherapy for this particular volunteer is contextualised in a number of ways within the programme. In the programme's opening sequences, the unit manager recounts that the residents have 'tried medication. They've tried psychotherapy. They've tried psychology, maybe on one or two separate occasions, and they've failed. Then they come to us', adding later that, 'Hopefully, patients will stay six months...some will stay a day and say "To hell with this place; I am going home"'. These statements provide a context for understanding why psychotherapy does not always work.

In programmes made in non-institutional settings, where the ownership of the psychotherapeutic project has passed to the broadcaster, failure is not viewed quite so sanguinely. The removal of psychotherapy from its institutional setting creates particular pressures on programme-makers in terms of managing questions about the authenticity and validity of its psychotherapeutic projects, irrespective of the credentials of the psychotherapists involved. Negative psychotherapeutic outcomes are more difficult to accommodate because there is greater pressure for the television-owned psychotherapeutic project to succeed. For example, *The House of Obsessive Compulsives*, begins with a definitive statement that the volunteers will ‘confront their nightmares and help each other to overcome their illness once and for all’. The programme interweaves the psychotherapeutic narratives of three volunteers in ways that play with viewer expectations about the eventual psychotherapeutic outcomes. The closing section of the programme concludes with an interview clip from the programme’s lead psychotherapist who states that,

We’ve got what looks like a miracle cure, and it is a miracle cure in a sense but it’s a cure that’s contained here in the house and it’s a miracle cure where they have helped each other. They have drawn on their strengths of each other to take them to a place I don’t think they believed they could go to. Therapists have done a little bit on helping them as well but it isn’t the whole story. I mean this is here, and the miracle has to continue outside.

This is followed by an update using a combination of fresh actuality footage and voice-over which states that ‘a month after leaving the OCD house’, one volunteer is reported to be ‘struggl(ing) to put into practice the things he learned in the OCD house’. This is followed by an interview extract from this volunteer, who says that,

if you want to be brutally frank and honest about what I think’s going to happen, I think that I will never be free of the illness. I think it’s very, very difficult to combat it to the point where you completely obliterate it on the battlefield. I don’t think that will ever happen. I don’t think it will ever be totally defeated. I think it may be cowed and cowered in a corner but I don’t think it’ll ever be defeated and purged completely.

This construction of negative psychotherapeutic outcome is modified in a second update, captioned ‘three months on’, in which the same volunteer is described as having ‘continued to see [the programme’s psychotherapist] for follow-up sessions and he is doing much better’. Furthermore, the programme’s other volunteers are reported to be making good progress, with one having ‘just returned from a second honeymoon in Italy’ and the other to be ‘expecting her first baby’. The end credit sequence is used as the final element of the construction of the programme ending, in its use of actuality footage depicting volunteers and psychotherapists celebrating the end of the psychotherapy treatment in the back garden of the rented house, including an extract of the programme’s lead psychotherapist saying, ‘can we toast not needing therapists? The volunteers lift their glasses and say ‘not needing therapists!’ The programme ending in this non-institutional programme illustrates the difficulties of managing a negative psychotherapeutic outcome, in which the notion of failure is presented but is not addressed directly.

This chapter has presented the results of an analysis of the sampled programmes which has had the primary aim of identifying the key differences between institutional and non-institutional factual psychotherapy programming. The following chapter presents the final set of research findings, in the form of three case studies of non-institutional factual psychotherapy programmes which have been selected for their exemplary character. These case studies extend the analysis conducted in Chapter 5 by re-introducing both the legal, technological, industrial, and professional contexts of UK television and contemporaneous developments within the psychotherapeutic domain.

Chapter 6: Case Studies

This chapter presents the final set of research findings in the form of case studies of non-institutional factual psychotherapy programmes. The programmes selected for case study analysis are *House of Agoraphobics* (Channel 4, 2006), *The Panic Room* (BBC Three, 2007), and the first two series of *The Hoarder Next Door* (Channel 4, 2012-2013). These programmes, which have not previously been subjected to academic study, have been selected because they exemplify, in different ways, the new form of factual psychotherapy programming referred to in this study as non-institutional factual psychotherapy programming. From the outset, this study has identified a significant departure in the production of factual psychotherapy programming from the institutional to the non-institutional setting. These case studies explore how each programme negotiated this departure, and how they devised new constructions of setting which impacted on constructions of expertise and outcomes. *House of Agoraphobics* and *The Panic Room* were broadcast during the first, and biggest, broadcasting ‘spike’ of non-institutional factual psychotherapy programming that occurred, as shown in Chapter 4, between 2005 to 2009. *The Hoarder Next Door* represents the second, smaller, ‘spike’ that occurred in 2012 and 2013, and which is strongly associated with programmes about hoarding. An account of my case study methodology is set out in Chapter 3. The case studies are presented consecutively and chronologically, and are informed by the findings generated from the programme analysis presented in Chapter 5, by the identification of contextualising factors from the UK’s television and psychotherapy domains identified in Chapter 4, and by the academic research literature referenced in Chapter 2. Viewing copies of *The Hoarder Next Door* are available on *Box of Broadcasts*. DVD copies of *House of Agoraphobics* and *The Panic Room* are affixed to the back of the thesis.

6.1 *House of Agoraphobics* (Channel 4, 2006)

House of Agoraphobics (Channel 4, 2006) features three volunteers who move into a rented house where they live while undergoing psychotherapeutic treatment for agoraphobia. The psychotherapy, delivered by a well-established and highly-regarded psychotherapist, is designed primarily around a series of activity-based behaviour experiments that take place in a two week period, culminating in a trip to Japan.

The programme was broadcast on Channel 4 as a two-part series on the 19th and 20th December 2006. The programme was scheduled in a late peak-time slot of 10 p.m. and broadcast over two consecutive evenings - Tuesday and Wednesday. Its scheduling conforms to the scheduling profile for factual psychotherapy programming established in Chapter 4, with Monday to Thursday at 9 p.m. the most commonly-used broadcast slots. While the broadcasting of *House of Agoraphobics* over two consecutive nights is untypical for a two-part documentary series, this is likely to have been influenced by the closeness of the transmission dates to Christmas Day. When the programmes that precede and follow *House of Agoraphobics* are taken into account, the programme's scheduling as a popular factual programme becomes obvious. The positioning of the first episode between *Ramsay's Kitchen Nightmares* (a factual format about a celebrity chef visiting failing restaurants to save them from closure) and *Bringing Back the A-Team* (an entertainment format which 'reunite(s) the stars from some of the greatest TV shows and films of all time') (Channel 4, 2017). Similarly, the second episode's position between *Secret Millionaire* (a factual format about incognito millionaires visiting impoverished communities) and *Lantana* (Lawrence, 2001), a feature film about 'a famous, glamorous therapist...(who) goes missing' (Bradshaw, 2002) supports this designation. The popular factual classification is reinforced by the programmes association with Monkey Kingdom, the London-based independent production company which made the programme for Channel 4 and which was known for its controversial productions. Other Monkey Kingdom productions broadcast during 2006 include *Honey I Suckle The Kids* for Five, described in its promotional material as a film about couples who 'advocate breastfeeding beyond walking and talking age' (Monkey Kingdom, 2015-2017a), and *Transmission Impossible* for Channel 4, that 'presents footage from programmes which have never previously aired in the UK, as they pushed the boundaries of taste too far' (Monkey Kingdom, 2015-2017b). *House of Agoraphobics* achieved viewing figures of 1.3 million (Conlan, 2006; The Guardian, 2006), less than half the figure for *Ramsay's Kitchen Nightmares* and *Secret Millionaire*, which preceded *House of Agoraphobics*, broadcast at 9 p.m. achieving 3.2 million and 3.1 million respectively.

The subject of *House of Agoraphobics* - agoraphobia - is evident from the programme title but its psychotherapeutic purpose is initially unclear. However, the programme quickly presents its psychotherapeutic project in the opening episode's pre-

title sequence, which states that three volunteers are moving into ‘a South London house under the care of (a) leading agoraphobia expert...to see if...this pioneering treatment will cure their agoraphobia forever’. The voice-over provides an initial definition of agoraphobia as ‘an acute fear of the outside world’, which is quickly revised by the inclusion of an interview extract from the psychotherapist:

Typically people misunderstand agoraphobia, thinking it’s a fear of wide-open spaces. Whereas, in fact, it’s a fear of having a panic attack where something terrible will happen. So, if they react by retreating from their anxiety and trying to stop bad things from happening, that reinforces the way they feel and the agoraphobia then spreads. So, life becomes a constant seeking after safety.

The representation of agoraphobia as a mental health problem is constructed through the mutually-contradictory themes of normality and extremity. The representation of agoraphobia as a relatively commonplace, and by implication ‘normal’, mental health problem is constructed through the voice-over claim that there are ‘five million people in the UK suffering from agoraphobia’, supported by the psychotherapist’s observation that agoraphobia is ‘the kind of thing that you and I could experience at any time in our lives’. The presentation of details about the volunteers’ backstories establishes them as people who were once very different, and who become agoraphobic through unforeseen life circumstances. One volunteer is described in the voice-over as having been a ‘successful financial assistant in a stable relationship’, another was a ‘happy and flourishing graphic designer’, and the third volunteer is described by her husband in an interview extract as having been ‘an independent woman. In South Africa, she used to drive four hundred miles, so I thought when she comes to the UK she would be independent and would be roaming around independently’.

At the same time, the programme constructs agoraphobia as a severe and life-limiting mental health problem through voice-over descriptions, interview extracts, and actuality footage. For example, the voice-over reports that the daughter of the first volunteer ‘hasn’t been to school for weeks (because) her mum can’t get beyond the end of her road’; this is illustrated with actuality footage depicting the volunteer’s abortive attempt to walk her child to school, followed by an interview with the volunteer saying, ‘Very worst thing ever that you can’t take your child out. You know, I feel like I’ve let

her down as a mum'. The second volunteer is described in the voice-over as 'a thirty-one year old designer who...spends every day in his bedroom, imprisoned inside his parent's flat. He can't walk more than fifty yards from his home without panicking and running back. He's now totally reliant on his mum and dad', accompanied by shots of the volunteer in his bedroom, and an interview extract in which he says, 'I can't spend the rest of my life like this'. The final volunteer is described in the voice-over as a 'mother-to-be whose irrational fear of motorways is threatening her marriage', illustrated with actuality footage depicting her in the throes of a panic attack as the car she is in heads for the M25. The voice-over script is read by the actor John Simm, whose measured, evenly-paced delivery brings a sense of calm to the often frenetic psychotherapeutic actuality.

The programme's psychotherapist is on record as saying that he 'never fields his own patients, saying that they come to him for help, not to be on television' (Cassidy, 2006, para.17). This implies that the volunteers were found by the programme-maker or other production staff. There is evidence that suggests that *House of Agoraphobics* found at least some of its volunteers through recruitment advertisements placed on specialist mental health websites, e.g. *No More Panic* (No More Panic, 2006) and *Anxiety 2 Calm* (Anxiety 2 Calm, 2006), as well as generalist publications, such as local newspapers (e.g. Liverpool Echo, 2006). The programme's decision to feature three volunteers - two women, including one from a minority ethnic background, and one man - supports the observation that factual television programme-makers 'cast' contributors in similar ways to those working in fictional genres (Henderson, 2007). The recruitment of demographically-diverse volunteers is regarded as one key way to 'engage a broad audience' (Lygo, 2007). However, in the case of *House of Agoraphobics*, the apparent use of demographic diversity in the selection of volunteers is contradicted by a statement made during the first episode, where the psychotherapist claims that 'eighty per cent of agoraphobics are female'. While such a statement could justify the inclusion of *only* female volunteers, I would suggest that this option was disregarded in favour of an approach which favours the representation of demographic diversity.

The psychotherapeutic actuality which features in the *House of Agoraphobics* takes place in a range of non-institutional settings, including interior spaces within the rented house, and numerous exterior and public spaces including shops, roads and streets, and public transport. This emphasis on exterior, public space is justified within the

programme by its focus on agoraphobia, which also helps to justify the early positioning of sequences of dramatic psychotherapeutic actuality. Such sequences are typically held back in institutionally-based programmes, apart from extracts used in pre-title sequences. For example, in *Help Me Help My Child: OCD*, the first sequence of dramatic psychotherapeutic actuality is presented in the second part of the programme, and this is fairly typical. However, *House of Agoraphobics* also differs from other non-institutional factual psychotherapy programmes because the volunteers require psychotherapeutic treatment as a means of getting them to the location in the first place. In its first sequences of psychotherapeutic actuality, volunteers are prepared for their journey, in actuality filmed in the volunteers' homes, and in the vehicle that transports volunteer and psychotherapist(s) to the rented house. This relatively early positioning of sequences of psychotherapeutic actuality advances the programme's psychotherapeutic project, but it also serves to intensify the sense of drama. They also act as effective advertisements for the powerful psychotherapeutic actuality to come, in particular those sequences filmed in the vehicle which has become a portable consulting room, crowded with volunteer, psychotherapist, a member of the volunteer's family, driver, and camera operator, resulting in dramatic psychotherapeutic actuality (see Figure 26).

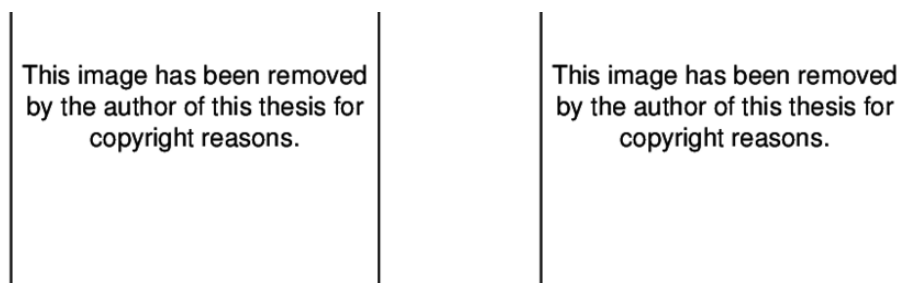


Figure 26 *House of Agoraphobics* (Channel 4, 2006)

In *House of Agoraphobics*, the primary setting for the psychotherapeutic treatment is a rented house, described in the voice-over as 'a South London house'. The location does not suggest the uniformity of purpose that is typical of institutional settings. The detached Victorian townhouse is built in the gothic architectural style. Its tall, angular shape, and dark curtain-less windows suggest foreboding and evoke the kind of houses used in horror movies. The impression is elaborated through the use of low-angled and Dutch tilts shots, and exterior night shots (see Figure 27).



Figure 27 *House of Agoraphobics* (Channel 4, 2006)

The house interior is introduced through a sequence which shows the arrival at the house of the programme's lead psychotherapist. The interior sequence uses a point-of-view handheld travelling shot which moves through the house, intercut with shots of a bedroom, living-room, and dining-room. The overall effect is reminiscent of the uncluttered, empty properties which feature in estate agent's promotional videos. The house interior is decorated in neutral colours and comfortable furnishings, creating an impression of middle-class gentility.

Following the arrival of the volunteers at the house, the contrast between exterior and interior spaces is visually exploited. The house interior is depicted as a sanctuary, a safe space the volunteers will not want to leave, signified by the use of shots of volunteers positioned at windows, looking out (see Figure 28).

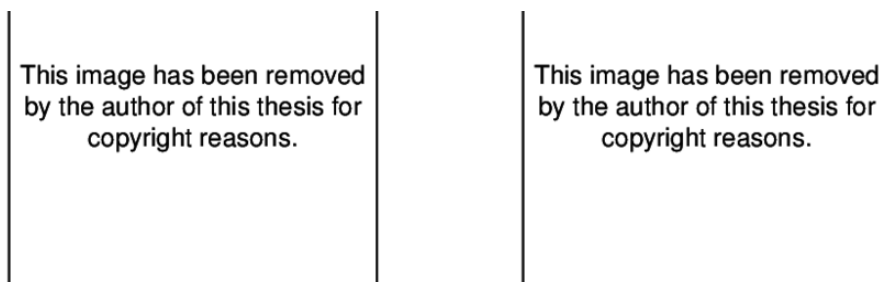


Figure 28 *The House of Agoraphobics* (Channel 4, 2006)

Individual talk-based psychotherapy sessions are filmed in two rooms designated as consulting rooms. The first, a small attic room with sloping ceilings, accommodates three chairs, one volunteer, two psychotherapists, a camera operator, and a whiteboard. The resulting footage looks awkwardly cramped; the camera has little room to manoeuvre, leading to oddly foregrounded and two-dimensional profile shots. The setting harks back to the cramped, ad hoc spaces that occasionally feature in NHS-based institutional settings. However, the second room, a spacious dining room, with patio doors leading to a garden, and dominated by a shiny, black dining-table, is too domestic to be convincing as a psychotherapeutic space.

The most distinctive aspect in the way *House of Agoraphobics* constructs setting is not through its use of interior space but through its use of public and exterior spaces. The extensive use of public and exterior settings in the programme, evident in sequences filmed in streets, supermarkets, bridges, underpasses, and public transport, makes effective use of the unpredictable, chaotic and potentially dangerous character of public spaces. In contrast to the relative security of the house, volunteers and psychotherapists engage in psychotherapeutic encounters in public spaces which are constructed to be viewed as unpredictable events. A heightened sense of danger may be seen as another product of the departure from the institutional setting. For example, the first episode features a sequence which constructs an account of what happens when a volunteer, accompanied by two psychotherapists, leaves the house for the first time. After a short walk along a quiet side street, they reach the junction of a busy road. The handheld camerawork has become increasingly shaky.

Psychotherapist A: What if you carried on a bit? Maybe even to the train station?

We'll wait here for you?

[Handheld close-ups of the volunteer, abrasively edited. Noisy traffic, sombre piano music.]

Volunteer: Are you mad? Sorry [.....]!

Psychotherapist B: What's the worst that could happen?

Volunteer: I have a panic attack.

Psychotherapist B: What would be the worst thing about that?

Volunteer: Nothing!

[The volunteer walks on alone, accompanied by the camera operator, who is walking backwards in order to film her head-on].

Volunteer: [speaking to the camera] Tell you what, we're going to go over this road, going to shoot through the traffic here, like this. [The volunteer sets off, runs across the road, cuts through stationary traffic - the camera follows - they reunite on the other side - the volunteer still walking - the camera following - there are raindrops on the camera lens]. But you know what? Fuck it. Fucking fuck it. Fuck it. If a panic comes, a panic comes, and I don't give a monkeys.' [The camera films the ground.]

Camera Operator: [subtitled] [...], you said that having [your daughter] was the last time you got excited.

Volunteer: It was! It was!

Camera Operator: And now?

Volunteer: [giddily] This is the last time, today! Tomorrow will be even better. Tomorrow will be better, definitely! Definitely! Tomorrow will be better...

[The camera moves around the volunteer in order to capture the backdrop of busy street, traffic, people filing past.] (see Figure 29)

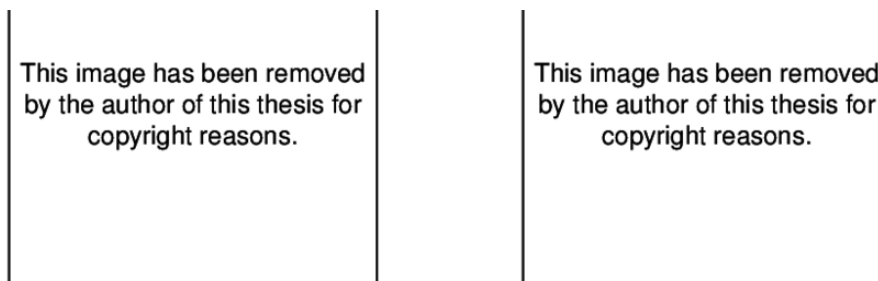


Figure 29 *House of Agoraphobics* (Channel 4, 2006)

The construction of public and exterior settings as spaces where unpredictable and risky things happen is utilised to dramatic effect when the three volunteers and their psychotherapists travel to Japan to complete their psychotherapeutic treatment. 'For the first time, a group of agoraphobics are being taken to a completely alien environment to see if this will overcome all their fears'. The first sequence of Japanese actuality is accompanied by voice-over which announces that, 'The three agoraphobics have managed to survive a thirteen hour flight to arrive in the most alien environment the [psychotherapist] can think of: Japan'. The sequence is visualised through a montage of

busy Tokyo street scenes: throngs of moving people, colourful billboards, giant electronic signs. The theme of unpredictability is invoked immediately when, upon their arrival in Japan, the voice-over reports that one of the volunteers was detained in immigration for two hours. The ensuing mini-bus journey into Tokyo is constructed to emphasise the volunteers' low, brittle mood. There are shaky travelling shots from the mini-bus window, with crash zooms left in to mirror their sense of unease. The compressed, slightly boomy acoustic quality of the car interior creates an oppressive atmosphere. The sense of immediacy is heightened by the use of handheld, slightly 'crashy' camerawork necessary to capture the dialogue between the volunteers and their psychotherapists. The patchy lighting, with some faces in shadow, the mini-bus interior's dull grey upholstery, the confined space, the misted windows, all add to the sombre mood, reinforced by the inclusion of a clip of actuality in which one of the psychotherapists blurts, 'I think if we sit in this van moaning the whole time about how terrible it's all been, it's inevitable that the whole trip is going to be crap'.

The representations of exterior and public settings as spaces that are inherently unpredictable and chaotic is most evident in the construction of the sequence depicting the volunteer's first activity-based behaviour experiment - a shopping expedition on 'one of the busiest shopping streets in Tokyo'. Only one of the volunteers is depicted as completing the task - the camera operator follows him down the narrow pedestrianised street; shaky handheld point-of-view shots that capture a sense of the street's chaotic business, are inserted to suggest how the volunteer is feeling. At the end of the task, the volunteer reports that he, 'panicked like a bastard but got through it'. The voice-over reports that the other two volunteers have refused to walk down the street, leading to impromptu psychotherapy sessions in the middle of the bustling scene, against a cacophony of background noise.

Representations of expertise in *House of Agoraphobics* are constructed around the notion that psychotherapeutic expertise includes the ability to manage the delivery of psychotherapeutic treatment in unpredictable and chaotic settings. The team of psychotherapists who feature in the programme are clinical psychologists who, at the time of the programme's broadcast, had professional associations with the Institute of Psychiatry at Kings College London (referenced through captions and end credits). The gender distribution within the psychotherapeutic team reflects the finding identified in Chapter 5, showing that construction of psychotherapeutic expertise in factual

psychotherapy programming, particularly in non-institutional factual psychotherapy programming, is constructed along gendered lines, with programmes featuring greater numbers of male psychotherapists. One of the (male) psychotherapists - Paul Salkovskis - is singled out, referred to throughout the programme as 'the professor' (he is captioned as Professor of Clinical Psychology, Kings College London, with a PhD thrown in for good measure), and described in voice-over as a 'leading agoraphobia expert', an 'anxiety expert', and a 'leading psychiatrist', even though this final description is factually inaccurate. The professor is presented as the programme's main psychotherapeutic expert, with overall responsibility for the design of the psychotherapeutic treatment. Salkovskis has had previous experience of appearing in factual psychotherapy programming, including *The Test*, *Obsessions Run My Life*, and *The House of Obsessive Compulsives*; his popularity with programme-makers suggests another feature which is typical of non-institutional programmes, which is a preference for recognisable psychotherapeutic 'personas'. This will be returned to later in this chapter. The other three psychotherapists are not identified through graphical captions (although they are listed in the end credits) and are referred to simply as 'therapists', or by name. Apart from the use of the title 'professor', no professional titles are used within the programme. During the second episode, the psychotherapists are referred to by their first names. This lack of emphasis on the psychotherapists' professional credentials is unusual in the non-institutional setting but is likely to be related to the way that the psychotherapeutic relationship is constructed within the programme, with each volunteer appearing to have continuous access to their own personal psychotherapist.

The emphasis on the informal nature of the psychotherapeutic relationships in *House of Agoraphobics* is reinforced by the informality of the psychotherapists' appearances, which conform to the findings presented in Chapter 5. The professor's outfits comprise dark trousers, plain shirts in mid or dark colours (dark blue, dark red) paired with 'loud' patterned or coloured ties, signifying a dress style which is simultaneously conformist and non-conformist. He usually carries a pen and notepad in his shirt pocket and wears a bulky anorak rather than a tailored jacket. The impression created is of a man who does not care too much about how he looks; one sequence shows him lying on the pavement during an activity-based behaviour experiment. The other male psychotherapists reflect, in different ways, the dress codes available to them; ranging from those who wear conventional suits but undercut their formality with open-

necked shirts and lack of tie, to those who do not wear suits, and dress with even less adherence to institutional dress codes, in a style that could be described as casual. The programme's only female psychotherapist wears the predictable dark, casual but stylish clothing, accessorised with distinctive jewellery.

The programme voice-over describes the psychotherapeutic treatment that features in *House of Agoraphobics* as 'unique', 'pioneering', 'new', 'ground-breaking', and 'intensive'. At no point in the programme is the psychotherapeutic modality named. The programme's opening sequence - a dramatic montage of actuality footage depicting volunteers in the throes of panic attacks in the presence of their psychotherapists - signals the kind of psychotherapeutic actuality that is going to feature in the programme. While talk-based psychotherapy does feature in *House of Agoraphobics*, it is frequently limited to the role of preamble or lead-in to sequences of activity-based psychotherapeutic treatment. For example, the programme's first talk-based psychotherapy sessions - used to prepare the volunteers for their journey to the rented house - are reported by the voice-over as lasting at least ninety minutes and are edited down to extracts of thirty-four and fifty-four seconds duration. One of these sessions is reduced to its closing remarks and used as a preamble to the volunteer's departure from his home:

[The session is drawing to a close. The psychotherapist closes his notebook.]

Volunteer: So, em, can I have a couple of minutes by myself...?

Psychotherapist: Sure.

Volunteer: ...to mull it over, please.

Psychotherapist: Course you can. Absolutely fine.

[The volunteer leaves the room.]

Psychotherapist: [to camera, framed as close-up, speaking quietly, looking stressed] It's very difficult. For [the volunteer], not for me. Really, really tough thing to do because it's, as I said, it's a leap of faith. [Big sigh.] And it's tough.

[Exterior shot of the building. The volunteer has returned.]

Psychotherapist: We need your em...

Volunteer: ...decision.

Psychotherapist: Well, this is probably the part when where you have to decide whether or not you make a leap of faith. So, are you going to do it?

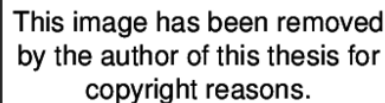
Volunteer: [standing up] Come on.

Psychotherapist: OK. Let's go.

The extensive use of activity-based psychotherapy set in exterior and public settings in *House of Agoraphobics* has implications for the programme's construction of expertise. In actuality sequences set in public or exterior settings, psychotherapists are shown to be able to use their expertise in inventive ways, to think on their feet, and to do unpredictable things where therapeutically appropriate. For example, in a sequence from the first episode, featuring an activity-based behaviour experiment, the psychotherapist is depicted taking the volunteer into the surrounding area to make him 'face his fear of strangers head-on'. The sequence begins with talk-based actuality that establishes the volunteer's intense self-consciousness (the effect of being filmed in a public place is not considered). The psychotherapist suggests doing something designed to attract even more attention:

[The psychotherapist suddenly lies down on the pavement.]

Psychotherapist: [indistinct] Lie down! [the volunteer joins him] (see Figure 30).



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Figure 30 *House of Agoraphobics* (Channel 4, 2006)

Psychotherapist: Look up at the ceiling. Can you see the ceiling?

Volunteer: Aw, Jesus.

Psychotherapist: What's that?

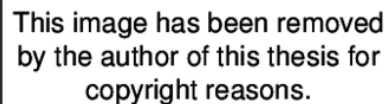
Volunteer: It's a bit open. My anxiety raised right to a point there and then it sort of subsided.

Psychotherapist: That's good, that's what I want to happen. And then did anything bad happen?

Volunteer: No but, em, I'm on the floor!

Psychotherapist: Yeah. So sit up, have a look. Sit up. [The camera pulls back to capture the movement.] So here we are. Sitting on the street. Let's see, let's have a look and see if people think we're idiots.

[The camera moves behind them and tilts up to capture the road in front. A van passes.] (see Figure 31).



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Figure 31 *House of Agoraphobics* (Channel 4, 2006)

Psychotherapist: Wave.

[They wave at the van.]

Volunteer: [indistinct]

Psychotherapist: Fuck 'em, because basically do these people prevent you from reclaiming your world?

[The camera is now in front, filming down on them.]

Volunteer: Definitely not

Psychotherapist: How are you feeling?

Volunteer: [laughing]: You're a nutter.

[They get up and start walking. The camera captures the movement and follows them, side on.]

Psychotherapist: That's what I said, that's what I said. And is it OK to be a nutter?

Volunteer: Yes.

Psychotherapist: Because I think you're about worried about being a nutter really, aren't you?

Volunteer: Yes.

[The psychotherapist jumps up in the air and whoops. They laugh. They cross the road, now filmed from behind. The wide shot captures the approach of an elderly lady pulling a shopping trolley on the opposite pavement.]

Psychotherapist: Come on, now your turn.

[The elderly lady stops abruptly as the volunteer opens his arms and cheers.]

While the use of exterior and public settings enables constructions of psychotherapeutic expertise that emphasises the psychotherapist's capacity for effectively managing unpredictable situations, it can simultaneously undermine psychotherapeutic expertise by opening up readings which suggest that the disintegration of the psychotherapeutic process is the result of poorly-thought-through or poorly-executed psychotherapeutic practice. There are sequences featuring activity-based behaviour experiments in the first episode of *House of Agoraphobics* which are constructed as being unsuccessful, such as the bridge crossing experiment that one volunteer refuses to complete, and which shows the psychotherapist compromising 'for today only. For today, a one day only offer' as he accompanies the volunteer across the bridge. What in the institutional setting would be framed in terms of the vagaries of the psychotherapeutic process, or the unpreparedness of the volunteer, in the non-institutional setting leads to readings which potentially undermine psychotherapeutic expertise. The psychotherapeutic actuality in *House of Agoraphobics* which advances a more critical reading of psychotherapeutic expertise comes in the sequences of psychotherapeutic actuality filmed in Tokyo, sequences which are pre-empted in the statement by the programme's lead psychotherapist, positioned at the end of the first episode and repeated in the second episode, where he says, 'we tried bringing people to Tokyo and it's probably not working'.

The potential failure of the psychotherapeutic process is an idea which is exploited through a series of sequences in which volunteers refuse to participate in tasks, threaten to withdraw from the programme and go home, and argue with their psychotherapist. The professor appears to acknowledge this in an interview extract in which he says, 'For various reasons, with this particular group of people, it looks like this particular strategy is of limited value'. This idea culminates in a sequence filmed erratically on a Tokyo street, in which one of the volunteers asks her psychotherapist, 'if everyone else can let me down, why are you so different? What makes you so different from every Tom, Dick, Harry? Nothing'. The implication is that we have come a long way from the security of the institutional consulting room.

The potential undermining of psychotherapeutic expertise within *House of Agoraphobics* sets up expectations about how both psychotherapeutic process and programme will end. In the first episode's pre-title sequence, the voice-over asks if this 'pioneering treatment will cure them of their agoraphobia forever'. The volunteers have personal goals: one wants to be able to take her daughter to school; one wants to live with her husband; the other wants to move out of his parent's flat. The programme must now answer these questions. The narrative trajectory, which culminated in the trip to Japan, has led to the suggestion that the 'experiment' may have failed. The programme constructs its ending gradually, through various stages that reverse the suggestion that the 'experiment' has failed. It begins by showing that the conflict between volunteer and psychotherapist is resolved; followed by a behaviour experiment on public transport that all three volunteers complete; followed by a sequence in a temple, filmed to evoke its meditative ambience, with soothing piano music, images of birds, and 'cleansing' rain. A shot of a plane coming into land is accompanied by an out-of-vision interview extract from the professor:

I believe that in the long-term each of them will benefit quite a lot from this. They're setting off in a different direction, which is not entirely about agoraphobia. It's about them as people, and that's really important.

The programme ending is signified by a caption stating *Three months later*. The first part deals with the volunteer who was the subject of the programme's most conflictive actuality. Her closing sequence is illustrated with actuality of her and her daughter in a swing park, reinforced by a voice-over update that her daughter is now 'going to school regularly'. From the psychotherapeutic perspective, the voice-over reports that she is 'still improving'; in an interview, she says, 'The anxiety and fear will be there for a while, you know, and it's every day's a new challenge I have to face and push myself to do'. The second part deals with the volunteer who appeared to make the most progress during the programme; for example, he was the sole volunteer to complete the Tokyo shopping task. However, in his update, over a shot of the exterior of his father's flat, the voice-over reports that, 'things have been more difficult. Just days after returning home he stopped going out again'. The sequence concludes with an interview extract from his father, who says, 'I'm disappointed. I thought he'd be up and out and ready to move.'

The final part deals with the outcomes for the volunteer who was depicted as most resistant to the activity-based behaviour experiments. This uses actuality of her travelling in a car on a motorway and moving into her new home with her husband. The voice-over describes her progress as ‘astonishing’. *House of Agoraphobics* constructs its ending in a way which maximises the differential outcomes. It sandwiches the poorest outcome between the two that have made progress and keeps the best till last.

House of Agoraphobics attracted interest in the lead up to, during, and following its broadcast, with national and local newspapers carrying previews and reviews. The combination of the programme’s popular factual scheduling profile and its title, which has been described by reviewers as evocative of a ‘Big Brother-style house’ (Pauley, 2006, p. 9), ‘a low-budget horror movie’ (Robinson & O’Neil, 2006, p. 75), and a ‘sadistic game show’ (Merge, 2006, p. 39), are likely to have been contributory factors. Responses to the programme were mixed. One reviewer remarked that ‘there’s no excuse for programme-makers who think (mental illness) can be turned into entertainment’ (Baylis, 2006, p. 53); another commented that the programme featured situations that ‘aren’t supposed to be funny, but you just can’t help laughing’ (Wollaston, 2006, p. 31). Others responded positively, with one concluding that the programme did not ‘rely on cheap laughs or cruelty for its appeal. What could be a subject of ridicule is treated sensitively’ (McManus, 2007, p. 33), and another claiming that the programme ‘breaks new ground in the depiction of mental health’ (Wild, 2006, p. 768). These mixed and sometimes contradictory responses to *House of Agoraphobics* may ultimately be a reflection of a tension within the programme between its positioning both as a public service documentary - Channel 4 named *House of Agoraphobics* as an example of its commitment towards diversity, through its depiction of disability (Lygo, 2007) - and as an example of innovative programming. Despite references to *Big Brother* in the programme reviews (Baylis, 2006; Pauley, 2006; Whitelaw, 2006), a number of reviewers categorised *House of Agoraphobics* as a documentary (Bradley, 2006; Dempster, 2006; McManus, 2007; Whitelaw, 2006). However, these mixed responses suggest there was uncertainty about how to react to the programme, summed up in the review below:

If House of Agoraphobics were pure documentary, and the cameras were simply filming what would have occurred regardless, if reality TV had not changed the

way the masses watch television, would such a stunt have been even thinkable? (McManus, 2007, p.33).

There was a significant response to the programme on online forums. On the *uncommon knowledge* online forum - a self help psychology forum - a thread about the programme recorded forty-seven posts between 14 December and 24 December 2006. Most of the forum users appeared to have personal experience of agoraphobia. There was a general fascination with the programme, and some strong reactions to it, some were positive but the overall tone of the responses was negative. The thread which ran on *No More Panic forum* - an online community for people with anxiety disorders - recorded one hundred and seventy three posts between 20 December and 20 January 2007. Most forum users were self-reported agoraphobics. The programme's lead psychotherapist joined the thread on the 21 and 22 December 2006, and again on the 9 January 2007 to give advice. Overall reactions were positive. The thread's main themes included: 'triggering' - several forum users reported finding the programme 'triggering', i.e. it brought on a panic attack; the pavement sequence was mentioned positively several times - it appears to have been a stand-out sequence; the husband of one of the volunteers came in for a lot of very negative criticism; lots of comments expressing disappointment and sadness that things did not work out for the male volunteer - yet they seemed to understand why this had happened. A thread was posted on the Digital Spy forum - an entertainment forum - recording sixty-one posts between 19 December 2006 and 13 January 2007. Most forum users were self-reported agoraphobics. Reactions to the programme were mixed. The thread themes included: negative criticism of the husband of one of the volunteers; some users thought the psychotherapist was too rough with the volunteers; the programme ending attracted a lot of comments on this forum, the 'failure' of the male volunteer also attracted comment, but here it seemed to take people by surprise - things turned out differently to what people were expecting.

6.2 *The Panic Room* (BBC Three, 2007)

The premise of *The Panic Room* centres around a specialised treatment space called the 'panic room', which is used for the treatment of people with phobias. The programme was broadcast on BBC Three as a series of six one-hour episodes during April and May 2007, scheduled on Tuesdays at 9 p.m. This slot conforms to the findings presented in

Chapter 4, that show the most typical slot for factual psychotherapy programmes is Monday to Thursday at 9 p.m. The scheduling profile, in terms of the programmes which preceded *The Panic Room* in the 8 p.m. slot, was of a broadly popular factual nature, including *The Bull**** Detective* (an investigative series that sets out to ‘reveal the hype of the 21st century, expose it, confront those responsible and finally mock them for what they really are’ (BBC, 2017a), and *The Scam Squad* (an investigative series following trading standards officers as they confront rip-off merchants). All six episodes were followed by *EastEnders* in the 10 p.m. slot. There was some continuity within the scheduling with the inclusion of *Spendaholics Saved My Life* in the 7 p.m. slot, a format which revisits volunteers from the *Spendaholics* series.

The programme was made in-house by BBC Manchester, a regional production centre, for BBC Three, and has been cited, in the context of BBC Three’s 2007-2008 season, as part of a ‘launch of several new innovative series’ (BBC Press Office, 2006) to coincide with increased availability of BBC Three following the launch of BBC iPlayer. The series was also cited as being part of BBC Worldwide’s ‘push for its fast growing formats business’ (Schreiber, 2007). Chapter 4 has already identified the launch of BBC Three in 2003 as a significant factor in the emergence of non-institutional factual psychotherapy programming. The findings from my quantitative analysis of the research sample showed that BBC Three was one of the most influential factors behind the broadcasting ‘spike’ in non-institutional factual psychotherapy programming between 2005 and 2009. The reason is two-fold: first, as a new channel, BBC Three created demand for new programming; second, the channel showed a marked preference for commissioning series, particularly formatted series, of which there are three in the research sample (*The Panic Room*, *Freaky Eaters* and *Spendaholics*). My findings show that BBC Three’s broadcasting of non-institutional factual psychotherapy programming was particularly high in 2005 and 2007, the latter being the broadcast year of *The Panic Room*.

BBC Three’s remit was to commission ‘innovative British content and talent, providing a broad mix of programmes aimed primarily at younger audiences’ (BBC, 2007a, p. 26); specifically to attract viewers in the 16-34 age group. In 2008, it reported that ‘nearly one in four 16-34-year-olds now watch the channel’ and that the channel had developed a ‘strong reputation for original comedy’ (BBC, 2008, p. 24), including *The Mighty Boosh* - which ran from 2004 to 2007 - and *Gavin and Stacey* - which ran from

2007 to 2010. 2007 was also a time of significant change at BBC Three, with a new controller arriving in May 2007, just after the *The Panic Room* was broadcast. I would suggest that *The Panic Room* belongs to the outgoing regime. Although described as a ‘factual entertainment series’ (BBC, 2017b), the programme lacks the more ‘entertainment’ character of *Spendaholics* and *Freaky Eaters*. Despite being heavily promoted online (BBC, 2007b), *The Panic Room* achieved the lowest viewing figures of the three case study programmes. For example, the sixth episode attained an audience of just 117,000 viewers (Probert, 2007). However, this figure looks less alarming when compared to those for *Gavin and Stacey*, BBC Three’s flagship comedy programme: 527,000 viewers (Cohen, 2007). Given the positioning of BBC Three in 2007, its relative inaccessibility, it is unsurprising that *The Panic Room* lacked the impact of other non-institutional factual psychotherapy programmes.

The title of *The Panic Room* does not immediately signal that it is a programme about mental health and psychotherapeutic treatment. If anything, it references the 2002 feature film *Panic Room*, where a ‘woman and her diabetic daughter take refuge in their newly-purchased house’s safe room, when three men break-in, searching for a missing fortune’ (IMDb, 2002). However, the pre-title sequence quickly establishes the programme’s psychotherapeutic project when the opening voice-over link announces that ‘In Britain, two and half million lives are ruined by phobias’. The voice-over is read by Lee Boardman, an experienced narrator and ex-Coronation Street actor. His serious, melodramatic delivery establishes the seriousness of the psychotherapeutic project but is also necessary to counteract the programme’s bombastic soundtrack comprising layers of music and sound effects.

The title sequence includes the Latin names for phobias, such as ailurophobia and ranidaphobia, and uses them in voice-over links. However, unlike *House of Agoraphobics*, *The Panic Room* does not provide a definition of a phobia, suggesting that this was not thought necessary by the programme-maker. Each episode features two phobias: cats and frogs, fish and snakes, buttons and cockroaches, spiders and lifts, birds and vomit, and wasps and spiders. Like *House of Agoraphobics*, the programme constructs phobia as a mental health problem that is simultaneously normal and extreme. Its representation as a relatively commonplace, and by implication ‘normal’, mental health problem, is established through voice-over links claiming that ‘around ten per cent of us suffer with debilitating phobias’, that ‘phobias blight the lives of millions of people in Britain’, and

that two and a half million people in Britain are ‘tortured’ and ‘trapped by crippling phobias’. The volunteers are represented as ‘ordinary’ people who are also ‘severe phobics’, with a life-limiting mental health problem. For example, in the second episode, a volunteer who has a snake phobia describes her fear of everyday objects that look like snakes, including electric cables, tinsel, vacuum cleaner hoses, and scarves.

The Panic Room features twelve volunteers, with two volunteers in each episode. There is evidence that the production team found the volunteers through recruitment advertisements placed online, using specialist, psychotherapeutically-orientated websites such as: *CounsellingResource.com*, a ‘peer-reviewed mental health information you can trust...(and) one of the web’s leading resources for counselling, psychotherapy, psychology and general mental health’ (Counselling Resource, 2006); *No More Panic*, a website and online community that ‘provides information for sufferers and carers of people with Panic, Anxiety, Phobias and Obsessive Compulsive Disorders (OCD)’ (No More Panic, 2006); and generalist sites, such as *Casting Call Pro*, a jobs and audition resource for professional actors (Casting Call Pro, 2006); and local newspapers (e.g. Whitby Gazette, 2007). Nine of the programme’s volunteers are female - with one from a minority ethnic background - and three are male. This means that some episodes - the first, third and fifth - feature only female volunteers. However, the representation of diversity is managed through the careful placement of the three male volunteers and one minority ethnic female volunteer in the first, second, fourth and sixth episodes. The stand-out issue with *The Panic Room* is the poor mapping between the ages of its volunteers and the channel’s purported target audience of 16 to 34 years, with the volunteers at the upper end of this range, or older.

The Panic Room uses elaborate pre-title and title sequences to introduce its main psychotherapeutic setting. It seems likely that the programme title was chosen to exploit associations with the feature film of the same name; the voice-over emphasises that the Panic Room, like its cinematic counterpart, is a ‘safe environment’. However, just as *House of Agoraphobics* constructs representations of exterior and public locations as unpredictable and chaotic spaces, *The Panic Room* constructs its central psychotherapeutic settings as spaces associated with confinement and danger. As the promotional material points out, ‘Anything could lie behind the doors of The Panic Room - whether it is just pictures of the phobic object or the re-creation of a real world

worst nightmare' (BBC, 2007b). This obviously has echoes of another fictional counterpart: Orwell's *1984* and 'Room 101'.

Unlike the exterior and public spaces which feature in *House of Agoraphobics*, the Panic Room is a completely artificial environment. The nature of the space means that presence of production personnel is less transparent; for example, there will be studio-based staff, including camera operators, and a gallery for production staff, including the studio director and vision-mixer, in close proximity. The programme's promotional material describes the Panic Room as a purpose-built studio set which uses '360-degree projected images, plus custom-designed infrastructure and state-of-the-art light and sound techniques' (BBC, 2007b). I would add to this the use of post-production audio-visual techniques, sound effects and music which enhance the vision-mixed studio output in terms of pacing.

The construction of the Panic Room setting as a space associated with the themes of confinement and danger begins with representations of its exterior setting: a mid-nineteenth century canalside mill building, exploiting a visual contrast between old industry and new technology (see Figure 32). This building also houses the flat where the volunteers live during their treatment. The voice-over states that, 'As normal life goes on around them', illustrated with shots of busy, city-centre streets, 'this will be a world away, confined within the walls of the Panic Room building'.

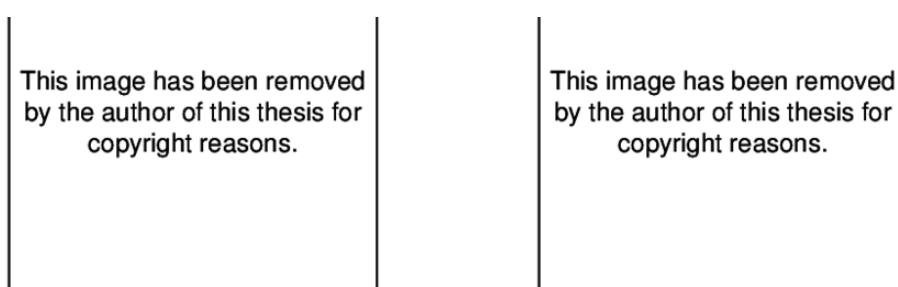


Figure 32 *The Panic Room* (BBC Three, 2007)

The theme of confinement is developed further when volunteers use an elevator to reach the Panic Room, that 'descends to the basement'. They are met by their psychotherapist, who waits in an empty reception area, reminiscent of the depopulated waiting-rooms which characterise constructions of private sector psychotherapeutic settings. They walk along a curved white windowless corridor to the Panic Room entrance (see Figure 33).

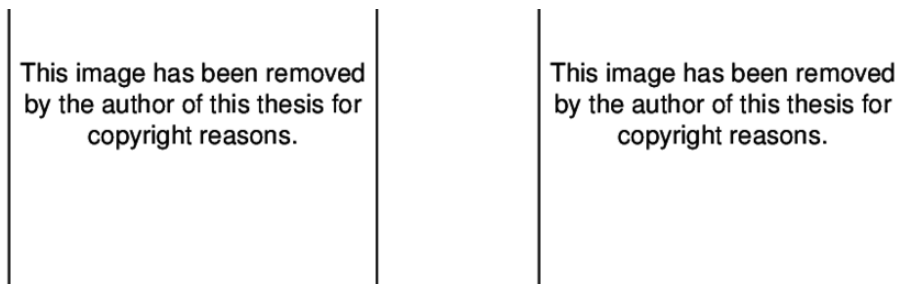


Figure 33 *The Panic Room* (BBC Three, 2007)

When the volunteer enters the Panic Room, a ‘guillotine’ door lowers, ‘ensur(ing) that they are alone, cut off from the outside world’. First impressions of the Panic Room - at this stage, a nebulous black space, illuminated by spotlights embedded in the studio floor - suggest a gameshow set, an observation shared by some reviewers (James, Kinnes, & Dempster, 2007, p. 60), or ‘Dr Who’s Tardis’ (Starkey, 2007, p. 21) by others. The volunteer follows an illuminated walkway leading to a small circle of white floor lights designated as the volunteer’s ‘secure spot’ (see Figure 34) to which, the voice-over explains, volunteers can retreat if they want it to stop. The theme of confinement is joined by the theme of danger.

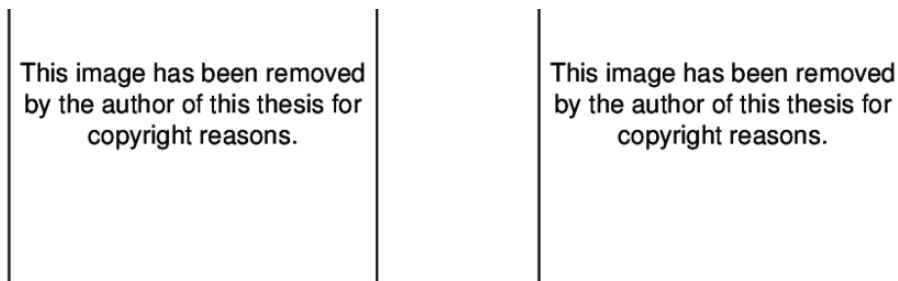


Figure 34 *The Panic Room* (BBC Three, 2007)

The psychotherapist remains outside, watching and communicating with the volunteer through a large mounted monitor, and controlling events inside the Panic Room. As the Panic Room ‘activates’, a variety of techniques are used to expose the volunteers to their feared object; large projected words float towards the volunteer; enlarged images of the phobic object; moving images (see Figure 35, overleaf). These images are often multiplied through the Panic Room’s ‘mirrored walls’ which are ‘technically-manipulated to surround the phobia with their fear’. However, it is likely that the volunteer’s experience of the Panic Room is different to that of the viewer, as the Panic

Room environment is further enhanced with the addition of post-production techniques such as rapid editing, percussive music, and audio-visual effects. It is likely that the volunteers would be more aware of the back-stage flimsiness of the artificial set than would be the television audience.

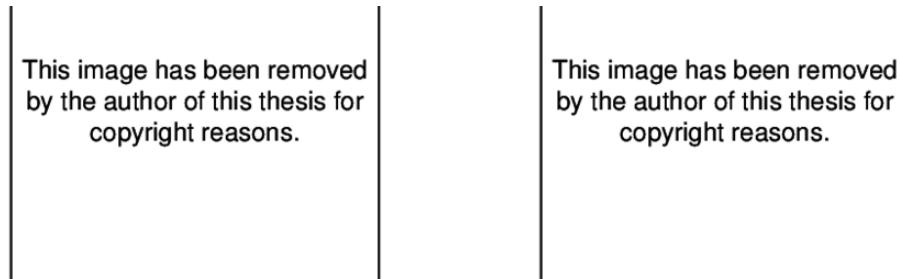


Figure 35 *The Panic Room* (BBC Three, 2007)

Each volunteer visits the Panic Room three times. The introductory sequences are edited tightly so that the first visit to the Panic Room can happen as soon as possible. This establishes fast-paced, dramatic action right from the start. On their second visit, physical objects associated with the phobia are introduced into the Panic Room set, such as a carousel decorated with toy cats which gradually become more realistic-looking and ultimately leads to a cage of live kittens. There are reconstructed locations, featuring actors playing roles, such as a country pub as a problematic setting for a volunteer with a wasp phobia.

However, it is in the sequences that feature the volunteers' final visit to the Panic Room which take the themes of confinement and danger to their most explicit articulation. In their 'final Panic Room', volunteers are exposed to the worst the Panic Room can deliver. This involves direct exposure to the phobic object - snakes, cockroaches, buttons, cats, fish, vomit, spiders, lifts, birds, frogs - with the help of either an animal handler or the psychotherapist. For example, in one episode, a volunteer stands under a button shower (see Figure 36, left) or handles live wasps (see Figure 36, right).

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Figure 36 *The Panic Room* (BBC Three, 2007)

The filming of these sequences at times visually references the mise-en-scène of Room 101 in Michael Radford's film adaptation of George Orwell's 1984 (see Figure 37):

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Figure 37 *The Panic Room* (BBC Three, 2007) / 1984 (Radford, 1984)

The use of danger in the construction of psychotherapeutic setting carries through into the construction of the programme's consulting rooms, also created artificially as sets. Both their general mise-en-scène and 'studio' style camerawork (slow, smooth crabs, i.e. lateral tracks) signify they are sets rather than actual physical spaces. In terms of their general layout, the consulting rooms are depicted in a recognisable way: two chairs facing each other but positioned at a slightly oblique angle to enable filming. They are decorated with props: a low table with a box of tissues; framed art on the walls; desks covered with the psychotherapist's laptop and documents. Both sets are dressed in what might be called a contemporary style, with differences presumably intended to signify their ownership by female and male psychotherapists: the use of fabric-covered plump armchairs, wood and neutral furnishings, a 'warm' ambience in the female psychotherapist's consulting room; the use of black, angular armchairs, metallic and glass furnishing, and a 'cooler' ambience in the male psychotherapist's set. These fictionalised consulting rooms are in marked contrast to their institutional counterparts. What most differentiates the spaces is the activity with which they become associated.

The female psychotherapist's consulting room continues the anxiety-provoking exposure work that began in the Panic Room; her sessions involved the continued use of phobic objects, dramatically produced from a box at the side of her armchair (see Figure 38, left). In contrast, the male psychotherapist's consulting room is associated with the practice of clinical hypnotherapy, visualised through sequences of soft focus shots, slow moving tracks and zooms, big close-ups and long dissolves or focus pulls which build elaborate sequences that construct the effect of clinical hypnotherapy (see Figure 38, right).

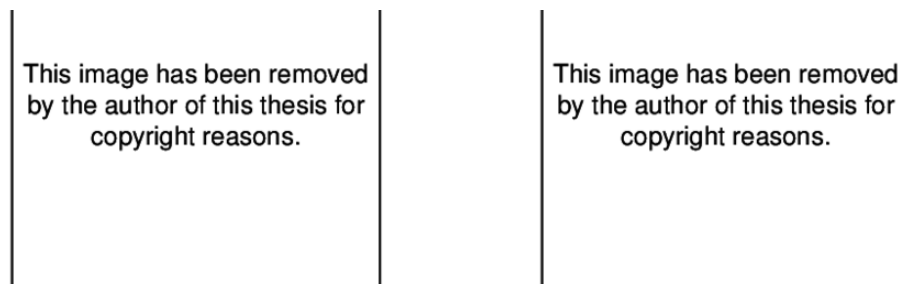


Figure 38 *The Panic Room* (BBC Three, 2007)

This visual difference between the two consulting rooms is extended through to the construction of the psychotherapists themselves. While they are both described in the voice-over as 'specialist' and 'expert' psychologists with professional expertise in treating phobias, and the psychotherapeutic project is presented as the result of their combined expertise, they are characterised in strikingly different ways.

The female psychotherapist - Dr Lucy Atcheson - is introduced in the first episode as 'a Harley Street psychologist', a reference that presumably is intended to infer a certain level of expertise; in fact, it signifies only that she works within the private sector. After her initial introduction, she is referred to as 'Dr Lucy', a name that is simultaneously formal and informal; unusual within the research sample, where psychotherapists are generally referred to by either their formal title or their first name. There is, perhaps, a similar ambiguity in *House of Agoraphobics*, which vacillated between calling the programme's lead psychotherapist 'the professor' or 'Paul', but in this instance, the two terms were not used simultaneously.

Dr Lucy is described in the voice-over as having a 'rigorous and disciplined approach'; her approach is 'sympathetic but firm'; she 'believes that phobia treatment calls for a methodical and determined approach'; she states that 'you have to be tough

on the phobia because the phobia has controlled that person for up to twenty years'. She uses the firm, assertive manner characteristic of psychotherapists working with activity-based psychotherapeutic practice, as described in Chapter 5. In two sequences of psychotherapeutic actuality, taken from the first and fifth episodes, she encounters volunteers who react strongly in her exposure experiments. In the first, the volunteer who is asked to handle a plastic box containing a frog becomes so distressed that she leaves the room. The camera holds on a shot of the empty consulting room, its two empty chairs, and a voice-over link stating that 'abandoning therapy now could have a devastating effect on [the volunteer]. It's down to Dr Lucy to complete the session before she will even consider putting [the volunteer] in the Panic Room'. In the fifth episode, when the volunteer is asked to look at a stuffed bird in a cage, she runs to the side of the room, crying uncontrollably. In both instances, Dr Lucy is depicted as avoiding reassuring behaviours and uses firm instruction to get the volunteer back to the chair so the session can continue. As we are repeatedly told throughout the series, Dr Lucy 'gets results'.

Her dress style might be described as a cross between 'bohemian' and 'gothic': fitted jackets; low-cut, corset-type tops; flouncy skirts in textured fabrics, such as velvet and satin; fancy shoes or boots; bold statement necklaces and rings; ostentatiously manicured nails, sometimes painted black; long curled hair, sometimes straightened; a lot of make-up (see Figure 39). Overall, a highly-groomed look that would look out of place in an institutional factual psychotherapy programme, based on my analysis of dress codes in Chapter 5, and even some non-institutional programmes, such as *House of Agoraphobics*.

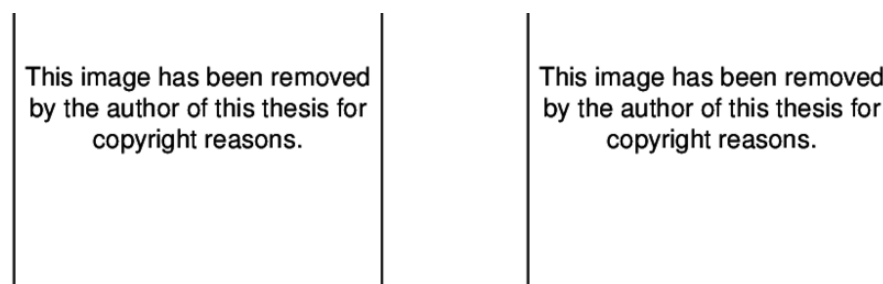


Figure 39 *The Panic Room* (BBC Three, 2007)

What emerges from this construction of the female psychotherapist, I would suggest, is a persona called 'Dr Lucy', who is distinct from Dr Lucy Atcheson who works in

Harley Street. This is not to say that Dr Lucy is unique - there is at least one female psychotherapist within the research sample, from the institutionally-based *OCD Ward*, who could be described in similar terms where her manner is concerned. What is unusual, and may be a consequence of appearing in a formatted series, is the emergence of a distinct persona, implying a performance as a psychotherapist. This is something that will be explored further in the next case study of *The Hoarder Next Door*. It is notable that Dr Lucy dresses very differently when she is 'off-duty', as illustrated in the first episode when she accompanies a volunteer to a nature reserve, dressed in a military-style khaki coat, long black scarf, rolled-up jeans, and pink Wellington boots.

In contrast, the male psychotherapist - Felix Economakis - is constructed in ways which emphasise his comparative ordinariness. He dresses in one of the conventional uniforms available to the male psychotherapist, as identified in Chapter 5: dark trousers and shirts in different colours - pink, black, grey - always open-necked and without a tie; a chunky silver watch and silver wedding band. In the exterior sequence, he wears a dark woollen overcoat and striped scarf. There is a level of grooming that is atypical of psychotherapists working in the institutional setting, but more common in private institutions and the private sector. He is referred to throughout the series as simply 'Felix'; the lack of a 'Dr' is simply down to his educational profile (he does not have a Psych. D.), and while the programme continually emphasises the equal roles of both 'psychologists' in designing and delivering the Panic Room treatment, Felix's lack of a 'Dr' title is salient. Combined with his use of 'an array of alternative techniques, including clinical hypnotherapy', the construction of Felix as psychotherapist lacks the hard edge of Dr Lucy and the cognitive behavioural therapy she practices with such gusto. In his defence, perhaps, he states that his approach is all about 'the allocation of very precise scientific interventions', and the voice-over reports that he is 'quick and effective when it comes to conquering phobias', and gets 'long-lasting results'. These sequences, filmed in his consulting room, with their distinctive visual treatment which is at odds with the programme's predominantly frantic pace, establish Felix as the binary opposite of Dr Lucy.

These findings necessitate a review of *House of Agoraphobics* and the way it constructed the character of its lead psychotherapist, Paul Salkovskis. This psychotherapist has appeared in a number of factual psychotherapy programmes, both institutional and non-institutional, and his 'persona', if it may be called that, has been

remarkably consistent. He looks the same, he appears to behave the same, and is depicted as working with volunteers in more or less the same kind of way: he is consistently and convincingly 'himself'. In contrast, the psychotherapist we will meet in *The Hoarder Next Door* - Stelios Kiosses - combines the distinctively visual persona of a Dr Lucy type character, and the alternative therapy approach of Felix, neither of which are found in the institutional setting. I would suggest this explains why both psychotherapists are the most distinctive across the whole research sample.

One of the problems with ending an episode in a formatted series is that the programme ending is as 'formatted' as any other aspect of the programme. Each episode of *The Panic Room* ends in a similar way, with a sequence which features the two psychotherapists, carrying their volunteer dossiers, as they exit the Panic Room via the elevator. The voice-over makes a concluding statement, such as, 'Dr Lucy and Felix have freed two phobics from a life controlled by fear. This week's cases are closed'. They get into the elevator and its doors close; or, 'For Felix and Dr Lucy, treating such severe phobics is never easy. But this week's case files are closed'; or, 'Entrenched phobias are notoriously difficult to beat but this time at least Felix and Dr Lucy's work is done'. Unlike *House of Agoraphobics*, which accommodated, and may even have benefitted from, a range of psychotherapeutic outcomes, the outcomes presented in *The Panic Room* are universally positive. This is unsurprising, given the way that its psychotherapeutic treatment is constructed as something that cannot fail. The voice-over continually emphasises the 'ground-breaking techniques', the 'brand new phobia treatment' that 'pushes the boundaries of traditional therapy'. The voice-over reports that 'the psychologists have combined their expert knowledge to develop a new weapon in the war against extreme phobias'. They approach the psychotherapeutic project like a military campaign, creating dossiers on each volunteer. When the volunteers meet the psychotherapists for the first time, in the waiting area outside the elevator, the voice-over explains that their 'limited initial contact...concentrates the attention on the treatment'. This is a no-nonsense, results-driven approach. This is reinforced by the continual voice-over links about the high levels of success enjoyed by the two psychotherapists. Felix even claims that 'you can literally change someone's life in a handful of sessions. The expectation, from the outset, is that these volunteers will be cured, or significantly improved.

This does create problems for the programme narrative. The sense of jeopardy that was constructed so effectively in *House of Agoraphobics* through the use of behaviour experiments in public and exterior settings is developed here through the extensive use of unpleasant exposure exercises which, I suspect, distract the viewer from the inevitability of a positive outcome. However, the programme does feature some sequences which show volunteers withdrawing temporarily from treatment, or confessing among themselves that they are having second thoughts, or are ‘finding the pressure of the Panic Room too much’. The most dramatic of the two final Panic Room sessions at the end of each episode, is always presented last. For example, in the second episode, the fish phobic negotiates his final panic room session successfully; his session is shown first. The volunteer with the snake phobia goes second, and is depicted as struggling with her final task which is to allow a snake handler to drape the tail of a python around her shoulders, a task she is initially unable to complete. Dr Lucy asks her ‘Do you want to beat the phobia? Do you want to be free of this?’ The volunteer responds with ‘I don’t know if I can’ but after some forceful persuasion from Dr Lucy is able to complete the task, which is timed for ten seconds on a giant projected clock. The end credit sequence includes interview extracts with the volunteers. Such universally positive constructions of the psychotherapeutic process are difficult to sustain, but they have to be sustained in a formatted series. This is an example of how the programme genre is a factor that is influencing the construction of the psychotherapeutic process. The same could be said of *House of Agoraphobics* which, as a documentary, should present a more authentic account of the psychotherapeutic process. One reviewer commenting on *The Panic Room*, voiced his scepticism, ‘since we do not see them back in their own lives, you are left slightly wondering how well it worked’ (James et al., 2007, p. 60)

Unlike *House of Agoraphobics*, *The Panic Room* did not attract a great deal of attention, but this is likely to have been influenced by its being broadcast on a digital channel in the mid-2000s. There does seem to have been some confusion about the kind of programme *The Panic Room* is. To some, it was just a ‘series’ or a ‘show’ (Starkey, 2007; Williams, 2007); to others, a ‘reality show’ (Wright, 2007) or ‘a semi-gameshow format (applied to) to a serious documentary’ (James et al., 2007). On the whole, reviews were negative. One reviewer described the Panic Room as ‘a cross between The Crystal Maze and the prisoner recreational facilities on Guantanamo Bay’ (O’Doherty,

2007, p. 8); another commented that ‘No doubt it’s all meant with the greatest purity of intention, but if nobody involved with this ever thought there might be something entertaining about watching someone be menaced by images of kittens, then that has undoubtedly been a serious oversight’ (Wright, 2007, p. 77). There were very limited responses to the programme on online forums. Threads featured on two mental health forums - Phobics-Awareness.org and the uncommon knowledge forum - but with little usable content, apart from a warning about an image of a spider on the programme’s website.

6.3 *The Hoarder Next Door* (Channel 4, 2012-2013)

The premise of *The Hoarder Next Door* (Channel 4, 2012-2013) centres around the claim that there is a ‘growing number of extreme hoarders...whose lives are being torn apart by their condition’ (Channel 4, 2012). The programme features volunteers who undergo psychotherapeutic treatment delivered by a psychotherapist with specialist hoarding experience.

There have been three series of *The Hoarder Next Door*, but only two are included in the research sample (the third series was broadcast in 2014, after the end of my research timeline). The research sample includes a total of nine episodes. Unusually for a formatted series, the classification of the programme changed with the broadcast of the second series, from non-institutional to institutional factual psychotherapy programme, because of changes within the programme format. Specifically, the introduction of a psychotherapeutically-orientated institution (The Priory Hospital) in place of the psychotherapist’s private consulting room.

The case study focuses on the first series of four episodes broadcast on Channel 4 during April and May 2012, scheduled on Thursdays at 9 p.m. Additionally, there was a one-off Christmas special in December 2012, scheduled on Friday at 9 p.m. The remaining four episodes were broadcast during April and May 2013, scheduled on Monday at 9 p.m. With the exception of the Christmas Special, which was scheduled on a Friday evening (my content analysis showed that factual psychotherapy programmes are rarely broadcast on Fridays, or weekend slots - this is one of the exceptions), the scheduling profile of *The Hoarder Next Door* conforms to the findings presented in Chapter 4, which show the typical scheduling for factual psychotherapy programmes is during Monday to Thursday, at 9 p.m.. During the broadcast of the first series, *The Hoarder Next Door* was preceded at 8 p.m. by *Phil Spencer: Secret Agent* (a factual format

about a property expert specialist who helps people sell unsellable houses) and followed at 10 p.m. by *8 out of 10 Cats* (a UK comedy panel game). This scheduling broadly conforms to the popular factual scheduling profiles already established in the previous two case studies.

The Hoarder Next Door was produced for Channel 4 by Twenty Twenty, an independent production company that is part of the Shed Media Group. Twenty Twenty makes factual television for UK television broadcasters, including ‘documentary, reality, entertainment and children’s’ (Twenty Twenty, 2017a). Programmes made by Twenty Twenty and broadcast during 2012 and 2013 include *The Choir: A Year with the Military Wives* and *First Dates*. The programme is categorised by Channel 4 as factual entertainment (Channel 4, 2013a) but as a documentary by the production company who made it (Twenty Twenty, 2017b). Confusion or disagreement about the categorisation of factual television programmes is also evident in the previous two case studied programmes, reflecting a lack of a consensus over how programmes are classified. This ambiguity extends into the academic study of factual television, with a variety of terms in common usage which can all be applied to the case study programmes to varying degrees, including *popular factual* (Biressi & Nunn, 2005; Hill, 2007), and *popular factual entertainment* (Arthurs, 2010; Corner, 2002).

Of the three case studied programmes, *The Hoarder Next Door* deserves the adjective *popular* most, achieving the biggest viewing audiences and comparatively large audiences for a factual psychotherapy programme. The first episode of *The Hoarder Next Door* achieved viewing figures of 2.73 million, ‘more than a million above slot average’ (Broadcast, 2012b). The series as a whole averaged 2.29 million viewers per episode, more than 600 thousand viewers above Channel 4’s slot average of 1.66 million (Broadcast, 2012a).

The popularity of *The Hoarder Next Door* is partly explained by its membership of a discrete and highly recognisable sub-category of programming: the hoarder programme. The first UK factual television programme specifically about hoarding disorder as a mental health problem was *World of Compulsive Hoarders*, shot partly in the US and featuring ‘America’s most famous hoarder’. There have been other notable programmes that feature hoarding but with little or no overt focus on its mental health angle, such as *Life of Grime* (BBC One, 2004), which featured hoarder Edmund Trebus, and *Obsessive Compulsive Hoarder* (Channel 4, 2011) which featured Richard Wallace, who was in

conflict with his local village as it prepared for the *Britain in Bloom* competition. The popularity of the programme led to an update *Obsessive Compulsive Hoarder: The Big Clear Out* (Channel 4, 2012). These programmes have also contributed to the construction of the ‘hoarder’ persona; some hoarders who have appeared in television programmes have become minor celebrities. The emergence of the non-institutional factual psychotherapy programmes about hoarding, from 2011 onwards can be partly attributed to the popularity of *Obsessive Compulsive Hoarder*. As one reviewer remarked, ‘Hoarding Disorder is rapidly overtaking Tourette’s syndrome as TV’s favourite form of mental illness’ (Simon & McIver, 2012, p. 45), another remarked ‘Blimey, it’s a fashionable subject right now, hoarding’ (Deanie, 2012, p. 45), and several reviewers made references to other hoarding programmes being broadcast around the same time. For example,

Just as Channel 4’s de-clutter series, *Get Your House in Order*, ended, their new one, *The Hoarder Next Door*, began, quickly followed by BBC1’s *Britain’s Biggest Hoarders*. Same shows, different titles. Thoroughly watchable rubbish on so many levels. Right now, it appears that the sexiest, most TV-friendly mental shortcoming is “hoarding”. (Dent, 2012, p. 10).

The subject matter of *The Hoarder Next Door* signals its content but does not make explicit its psychotherapeutic project. The strong entertainment focus of many hoarding programmes obscures their mental health angle. The treatment of hoarding disorder in television programmes - often referred to as ‘interventions’ - involves the input of psychotherapists and other hoarding-associated professionals such as ‘de-clutterers’. This pushes hoarding programmes into the space between factual psychotherapy programme and lifestyle programme. Like many Channel 4 programmes, *The Hoarder Next Door* falls somewhere between being a programme about a serious subject with a public service remit, and a programme that sets out to entertain.

Like *House of Agoraphobics* and *The Panic Room*, *The Hoarder Next Door* quickly establishes its psychotherapeutic project when the opening voice-over states that, ‘Hoarding disorder, as it’s called, is difficult to treat’. The voice-over is narrated by Olivia Coleman, the actress best known at the time for her comedy performances in

programmes such as *Peep Show* (Channel 4, 2003-2015) and *Rev* (BBC Two, 2010-2014). She has a distinctive voice and gives a jaunty delivery.

Like *House of Agoraphobics* and *The Panic Room*, *The Hoarder Next Door* constructs hoarding as a mental health problem using the mutually-contradictory themes of normality and extremity. The voice-over reports ‘there is an estimated 1.2 million hoarders in the UK’, that ‘all across Britain, ordinary people are keeping a shocking secret and their numbers are growing’, and that ‘over a million people now live in mountains of clutter’. The programme includes interview extracts from the programme’s psychotherapist, who asserts that hoarders ‘are not freaks. It isn’t a choice’, adding that, ‘There’s a little hoarder in all of us. When it’s out of hand, that’s what makes it different’. He states that, ‘It can happen to anybody’. At the same time, the programmes present the visual evidence of just how severe hoarding can become. One of the programme’s volunteers is described by the psychotherapist as ‘one of the most extreme cases we’ve had. If he hadn’t come for any treatment the probability is that he would’ve sooner or later killed himself in the house’.

The Hoarder Next Door features nineteen volunteers, of whom thirteen are female, and six are male, with no volunteers from minority ethnic backgrounds. Compared with other formatted factual entertainment series in the research sample - *Freaky Eaters* and *Spendaholics* - its lack of demographic diversity is unusual. However, there is a similar imbalance in *The Panic Room*, signalling that the recruitment of volunteers for non-institutional factual psychotherapy programmes can be problematic. Unusually, *The Hoarder Next Door* has production credits for the specific role of casting, suggesting difficulty in recruiting volunteers - hoarders are reputed to be secretive and reclusive - or perhaps that the programme-makers were looking for specific kinds of volunteer who would not normally be found using the usual methods, i.e. online recruitment adverts.

Nonetheless, like *House of Agoraphobics* and *The Panic Room*, *The Hoarder Next Door* also adopted this method, placing adverts on a range of forums including *Declutter Divas*, a professional declutterers’ organisation (Declutter Divas, 2013), Channel 4’s own recruitment site (Channel 4, 2013b), casting organisations such as *To Be Seen* (To Be Seen, n.d.), specialist hoarding forums, such as *Children of Hoarders* (Children of Hoarders, 2013), and mental health forums such as *No More Panic* (No More Panic, 2012). Considering the kinds of online sites used, and the use of casting production staff, suggests that the programme-makers were in fact looking for volunteers of a

particular kind - ones that would perform well on-camera, evident in the first (male) volunteer in the series, described by one reviewer as a ‘desperately unhappy cross-dresser from Liverpool whose hoarding began after his partner died of cancer’ (Chater, 2012 , para. 1). and the inclusion of an ex-Coronation Street actress. The emphasis is on finding ‘characters’ and ‘eccentrics’ that fit with the persona of ‘the hoarder’, already established in earlier programmes.

Like *House of Agoraphobics* and *The Panic Room*, *The Hoarder Next Door* constructs psychotherapeutic settings in distinctive ways. The programme uses two settings for the delivery of its psychotherapeutic treatment: the volunteer’s home, and the psychotherapist’s private consulting room. In the former - the volunteer’s home - it is possible to see constructions of psychotherapeutic setting similar to those used in *House of Agoraphobic* and *The Panic Room*, where psychotherapeutic settings are constructed as spaces that are inherently unpredictable, chaotic and even dangerous. In *The Hoarder Next Door*, this is articulated through the use of the domestic space gone wrong, as a visual representation of chaos and, for the volunteer and anyone else who enters the space, of potential danger from infection or injury. In *The Hoarder Next Door* the domestic space is constructed around the idea, expressed in the voice-over, that, ‘all across Britain, ordinary people are keeping a shocking secret’. In sequences which show the arrival of the psychotherapist to meet the various volunteers, locations are filmed in ways which, from the outside at least, suggest nothing untoward; these houses look like any other, they look ‘normal’ (see Figure 40). Most are terraced or semi-detached, and are always situated in residential areas, allowing for the realisation to form in the viewer’s mind that something similar might be close to them. The range of different environments depicted suggests that hoarding disorder affects people from different socio-economic backgrounds

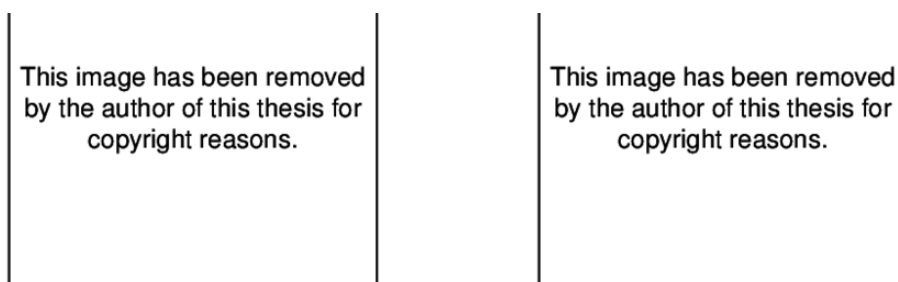


Figure 40 *The Hoarder Next Door* (Channel 4, 2012)

The homes of compulsive hoarders are depicted as no-go areas. All have their own front door, on which the programme's psychotherapist will eventually knock. One volunteer reveals that 'no one's actually been in the house for two years'; in another, it is revealed that, 'Stelios will be the first stranger they have opened their doors to in over five years'. In this respect, the interiors of the volunteer's homes in *The Hoarder Next Door* - in particular their 'hoard' - assume a greater symbolic importance than the volunteer's homes that feature in other factual psychotherapy programmes. The volunteer hoarder's home, like the Gothic house in *House of Agoraphobics*, and the hi-tech *Panic Room*, is an entity in its own right but, unlike any other settings used in non-institutional factual psychotherapy programmes, this setting must be transformed. In fact, the volunteer hoarder's home must change as much, if not more, than the volunteer. Unlike the public settings in *House of Agoraphobics*, volunteers' homes can be transformed, indeed the programmes insist that they *must* be changed if progress is to be made. However, unlike *How Clean Is Your House?* (Channel 4, 2003-2009), which concluded with a sequence depicting the presenters' return to the volunteer's home, and their occasional discovery that they have reverted to type, such sequences are absent from *The Hoarder Next Door*.

As stated previously, it is likely that properties have been selected because of their location in residential areas, so that sequences enabling visual comparisons are easily constructed. The idea is elaborated through the sequence which depicts the arrival of the psychotherapist at an otherwise ordinary, or typical, property. Arrival sequences are always filmed in the same way: the psychotherapist arrives at the property and knocks on the front door (see Figure 41, left), and is filmed squeezing through the front door from an inside perspective (see Figure 41, right).

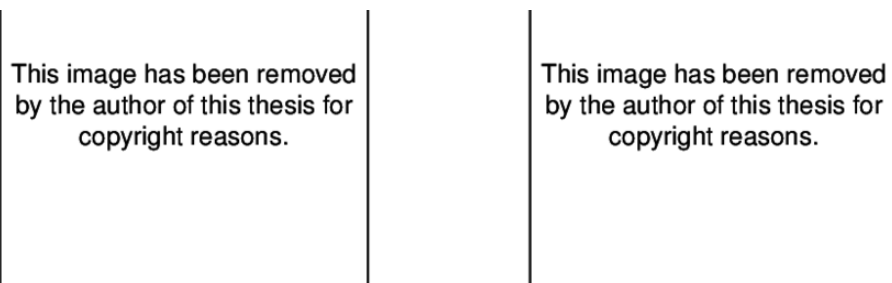


Figure 41 *The Hoarder Next Door* (Channel 4, 2012)

After his arrival at the volunteer's house, the psychotherapist is given a guided tour of the house by the volunteer. The 'guided tour' is a distinctive element of factual

psychotherapy programmes about hoarding. However, they are not always used in conjunction with the arrival of a psychotherapist. For example, in *Britain's Biggest Hoarders*, the programme presenter takes the tour, and it is common for footage of the volunteer's home to have already featured extensively by the time the psychotherapist arrives. However, in *The Hoarder Next Door*, the guided tour is always conducted with the psychotherapist, accompanied by the camera operator, leading to some awkward filming moments in the confined and hoarded spaces. For example, in the opening episode of the first series, volunteer and psychotherapist are filmed from behind, standing in the doorway of a room, facing a wall of hoarded materials that reaches above their heads, over which a cat scrambles (see Figure 42, left). The psychotherapist asks, 'Which room is this?' The volunteer replies, 'It is, was once, the dining room'. The psychotherapist's reactions during the guided tour are a bridge to the viewer, and communicate physical and sensory reactions to the hoard - something the volunteers appear to be immune to. On more than one occasion, the psychotherapist covers his nose with a flamboyant handkerchief (see Figure 42, right). The voice-over states that he 'may have years of experience in treating hoarders but that doesn't stop him being overwhelmed by the stench in the kitchen'; he is shown taking out his yellow handkerchief to cover his nose, 'it's really bad in here'.

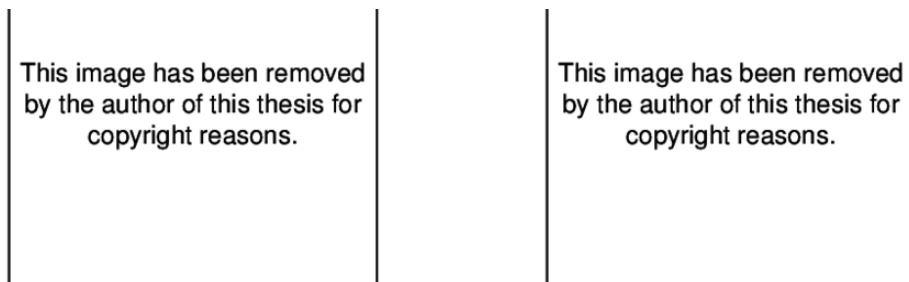


Figure 42 *The Hoarder Next Door* (Channel 4, 2012)

The guided tour concludes with the programme's first sequence of psychotherapeutic actuality, which takes place in the volunteer's home, against a backdrop of hoarded materials. These usually feature the volunteer looking perfectly comfortable, and the immaculately-groomed psychotherapist looking distinctly out of place (see Figure 43).

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Figure 43 *The Hoarder Next Door* (Channel 4, 2012)

The second setting for the delivery of psychotherapeutic treatment is the psychotherapist's private consulting room - an existing location situated in a modern, anonymous, non-descript building; there is no official signage, just a 'please ring for attention' sign on the glass door. Its reception area is light and airy, decorated with a pink orchid and colourful landscape paintings. Its uncluttered waiting room is furnished with three large sofas and magazines. As is typical of constructions of interior public areas in the private setting, the volunteer is alone; the reception and waiting room have the by now familiar unpeopled look of the private psychotherapeutic setting, and to the waiting area in *The Panic Room*.

The consulting room itself is decorated in an overtly and explicitly 'masculine' style: old-fashioned wood panelling, an oxblood leather sofa, a box of man-sized tissues on the table, a standard lamp with brass fittings, and a framed certificate and framed art on the walls (see Figure 44). It draws extensively on stereotypical ideas of the consulting room setting, evoking something of the psychoanalytic tradition and cinematic representations of the consulting room. The contrast with the building's exterior, reception and waiting room is visually striking, as if this consulting room was like those featured in *The Panic Room*, and had been purpose built for the programme.

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Figure 44 *The Hoarder Next Door* (Channel 4, 2012)

The construction of the consulting room setting is in complete harmony with the psychotherapist himself - Stelios Kiosses - who appears across all series of *The Hoarder Next Door* and is synonymous with the programme. He is described in the voice-over as a 'psychotherapist' who has been 'treating hoarders for the last fifteen years'. The programme includes no reference to psychotherapeutically-orientated institutions. The voice-over reports that the psychotherapist 'believes he can help anyone in just six weeks'. There is no explicit statement of the treatment modality used; the voice-over describes the psychotherapist's approach as 'unusual'. In an interview, the psychotherapist describes his approach as 'a little bit different and more innovative. We combine modern science with ancient wisdom'. In this respect, he is similar to Felix in *The Panic Room*, who also favours alternative therapies. Like Felix, he too is referred to throughout the programme as simply 'Stelios'. Informality is common in non-institutional factual psychotherapy programming, and this is also true for *House of Agoraphobics*, even though this does use the 'the professor' reference. However, it is Stelios' likeness to the Dr Lucy persona where greatest similarity is found.

In terms of dress codes and physical appearance, the psychotherapist is unique across the research sample in terms of how he dresses. Episodes include a sequence in which he gets ready in front of a mirror, before embarking on his latest project. He dresses in expensive-looking suits, shirt and flamboyant tie, cufflinks, coloured handkerchief in jacket pocket (which he occasionally uses when the stench gets too much), a chunky watch, and silver wedding band. The highly-groomed look is very unusual for a psychotherapist, particularly a male one. His dress code is in complete contrast to the chaotic spaces he visits. It is interesting to compare him to 'the professor' from *House of Agoraphobics*, who lies on pavements and does not look particularly out of place in the hoarding programme's he has worked on. The physical appearance and dress code used in the construction of the psychotherapist in *The Hoarder Next Door* was commented on in many reviews. For example, he was described as 'sharp suited' (Metro, 2012, p. 53) and 'snappy-dressing' (Butler, 2012, p. 17), as 'burnished and marvellous in an ankle length camel coat' (Dent, 2012, p. 10) (see Figure 45, overleaf). However, many other comments were negative to the point of ridicule.

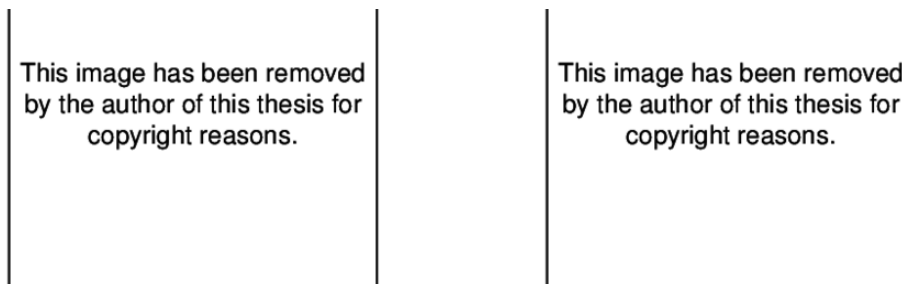


Figure 45 *The Hoarder Next Door* (Channel 4, 2012)

A transformation of the psychotherapist's look was already underway by the broadcast of the Christmas special in December 2012, and was fully-realised in the second series. The look is smart - suits, polished shoes - but undercut with a lack of tie, reminiscent of the male psychotherapists in institutional factual psychotherapy settings. (see Figure 46). This suggests that a degree of personal control and, perhaps, awareness led to a transformation of the 'Stelios' persona, and this kind of self promotion is much more common amongst psychotherapists in the non-institutional realm.

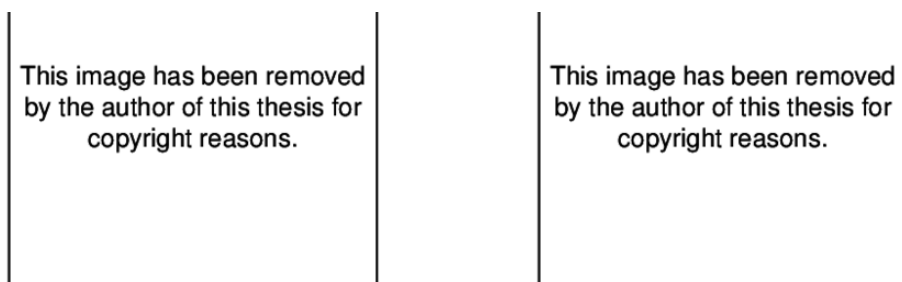


Figure 46 *The Hoarder Next Door* (Channel 4, 2013)

The construction of expertise is different in *The Hoarder Next Door*. There is no reliance on cognitive behavioural therapy with its exhortations. This is old-school talk-based therapy, with some alternative therapies thrown in for good measure - tai chi, art therapy, hypnosis. The first sequence of psychotherapeutic actuality, filmed among the volunteer's hoard, plays the same role in each episode - the psychotherapist is depicted as getting to the root cause of the hoarding. While this psychotherapeutic practice is depicted in *House of Agoraphobics* and *The Panic Room*, the emphasis in those programmes' construction of expertise is less on the cause of the mental health problem and more on its cure. The construction of psychotherapeutic expertise in *The Hoarder Next Door* is based on the idea that the cause must be rooted out.

These sequences are constructed to show the psychotherapist putting his expert psychotherapeutic skills to work. For example, in the first episode, when he learns that the volunteer's partner died nine years previously, he persistently questions the volunteer, while the camera holds on the volunteer's face, capturing every nuance of his facial expressions. When the psychotherapist directly suggests that the volunteer's partner's death is the probable cause of the hoarding, the camera crash zooms into the volunteer's face. He asks the volunteer why there isn't a single photograph of his dead partner in the house. Finally, the volunteer begins to cry. In *House of Agoraphobics* and *The Panic Room*, tears and distress are not treated as something to be assuaged; rather, they are presented as a necessary by-product of change. In *The Hoarder Next Door*, they are presented as a signifier of the necessary 'realisation' if change is to happen. Similarly, in the second episode, the psychotherapist identifies the death of a close one as a likely cause of the hoarding. The volunteer denies this, but she looks upset, her eyes welling up with tears. The voice-over reports that 'Despite [the volunteer's] denials, Stelios believes that she's used the hoard to bury the painful memory of her husband's death'. In another episode, within moments of the commencement of a consulting room session, the volunteer is crying because a link has been made between her hoarding and the wish to have another baby, and the fact that that her mum died six years previously. In another consulting room session, the voice-over states that 'Stelios believes that the cause of [the volunteer's] trauma was the death of her husband...sixteen years ago.' Stelios launches in with 'OK, let's talk about what was going through your mind when [your husband] died and you being left alone with [your son]. What were you thinking? What was going through your mind at the time?'. One of the reviewers remarked that,

Stelios uses a combination of conventional and alternative therapies, but I couldn't really tell you what they are because the editors of this programme have binned most of the footage...Stelios's methods remain very much a mystery. (Quigley, 2012, p. 1).

Perhaps this programme is not about 'showing' the psychotherapy after all, unlike the other two programmes in this chapter. As another reviewer has remarked, the therapy was 'opaque, except in its denouement' (Crace, 2013, p. 21).

One of the problems facing non-institutional factual psychotherapy programmes about hoarding is that unless the house is cleared, it is impossible to gauge the level of change. Hoarding programmes all involve some sort of de-cluttering intervention, whether it is the warehouse exercise used in *My Hoarder Mum and Me* and *Britain's Biggest Hoarders*, or the sending in of professional declutterers paid for by the production company. The involvement of the declutterers enable the volunteer's home to be completely transformed, as a visual representation of their cleared out mental state. This enables the use of a sequence in which Stelios returns for a second, and final, visit to the volunteer's home, 'to see if the therapy has been a success.' He is depicted driving to, or walking to, the volunteer's house, on occasion appearing tentative, nervous even about what he might find - an obvious conceit, given that it is highly unlikely that this information is not already known to the production team. The sequence follows the structure of the first visit, with a knock on the front door; the guided tour is repeated. The voice-over reminds us what things looked like 'six weeks ago', using a 'before and after device' more typical of home makeover programmes. Because of the impact of the house clearance, it is difficult to challenge the construction that the psychotherapeutic intervention has been successful. However, as reviewer remarked, 'it's a bit early to say whether it's permanent but somehow the programme cut too many false notes; everything was just a bit too pat, too smooth, conveniently dovetailing into TV's perfect ending' (Crace, 2013, p. 21).

As it has been discussed previously, *The Hoarder Next Door* is a highly visible programme. Unsurprisingly, there was considerable commentary on the programme when it was first broadcast in 2012. This was due in part to the general popularity of programmes about hoarding; it was partly due to the scheduling on a weekday 9 p.m. slot; and it was partly down to the decision to start the series with a volunteer who conformed to the eccentric hoarder persona. The programme attracted a lot of interest from journalists. Many reviewers commented on the rise of interest in hoarding. 'Despite the occasional spasms of humour and absurdity, the programme is horribly sad to watch' (Chater, 2012, para. 1). One reviewer described it as an 'affecting series' (Hogan, 2012, p. 57), another as a 'fascinating and moving reality series' (Ipswich Advertiser, 2013, p. 30).

Reactions to the programme on online forums were untypical for a factual psychotherapy programme. The main activity was on the Digital Spy forum, on a thread

which started on 3 May 2012 and accrued one hundred and seventy four posts by 25 May, covering the broadcast of Series One, and another twenty-eight posts made between 21 December and 22 December 2012 following the broadcast of the Christmas special. The forum users do not identify as hoarders, but promote the idea that there is a bit of hoarder in everyone. There were many negative comments about the physical appearance of the psychotherapist, but positive comments about his insightfulness and astuteness when working with the volunteers. His makeover in the Christmas special is immediately spotted and approved of. The main theme within the thread was about whether or not hoarding is a mental health problem. There were numerous posts about the filth and chaos of the hoarder's homes. One particular volunteer attracted significant levels of negative comment. *The Hoarder Next Door* featured in threads on a number of random online forums, including NissanSportz.com, organissimo jazz forums, Pet Forums Community, RailUK forum and Very Good Plus forum. The posts were of limited value to this study.

This chapter has presented the final set of research findings in the form of case studies of non-institutional factual psychotherapy programmes. The programmes selected for case study analysis have not previously been subject to serious academic study and were selected because they exemplify, in different ways, the new form of factual psychotherapy programming referred to within this study as non-institutional factual psychotherapy programming. The primary purpose of the case studies was to examine how non-institutional factual psychotherapy programmes construct setting, in the absence of the institutional space. I would suggest that while the departure from the institutional setting removes many of the constraints associated with making factual psychotherapy programmes, the absence of the institutional setting, and the legitimacy and authenticity it confers, leaves a space which must be filled. These three programmes, in different ways, have negotiated the absence of the psychotherapeutically-orientated institutional setting, through the use of public and exterior settings, the construction of a sinister artificial space, and the use of the hoarder's home. All three settings engage with the unpredictable, the chaotic, and the dangerous as an alternative experience to the ambience of the psychotherapeutic institution.

Chapter 7: Conclusions

This study has extended the research into UK factual television by investigating a group of programmes that have not previously been studied. A mixed-method research design was used to situate the programmes within their broader cultural, professional and industrial contexts. My broad subject area was constructions of the psychotherapeutic process in UK factual television programmes broadcast between 1999 to 2013, and the study's main research aim was to describe, analyse and explain these constructions in terms of their cultural, professional and industrial contexts. The study's specific research question was to explain how constructions of the psychotherapeutic process changed when programme-makers began to make programmes about psychotherapeutic treatments in non-institutional settings; in other words, without the direct involvement of psychotherapeutic hospitals, units, and clinics.

Throughout this study, I have argued that the departure of the programme-maker from the institutional setting, that began during the early to mid 2000s, was the key development behind the emergence of non-institutional factual psychotherapy programming. This development occurred at a moment in time when a number of other trends and developments were coalescing, such as: the emergence of new hybridised forms of factual television in the search for innovative programming, and the ongoing preoccupation in factual television with the inner subjective life; the shift away from programming about 'serious' mental health problems, such as schizophrenia and psychosis, and the emergence of a new and marked preference among programme-makers for mental health problems that can be pitched as both 'ordinary' and 'normal' while still fulfilling the requirement of 'otherness'; the emergence of cognitive behavioural therapy as the psychotherapeutic modality of our time. My research is contextualised in terms of legislative, industrial, technological and professional developments in UK television and psychotherapy. This study argues that it is the combination of these factors which led to the psychotherapeutic process becoming more amenable and more attractive to programme-makers.

In order to explain why there were changes in how representations of the psychotherapeutic process are constructed in programmes made in the non-institutional setting, a comparison with how they were constructed in institutional settings is required. As neither has been the subject of academic research, both research tasks

became central to this study. The departure from the institutional setting has remained the single most important prerequisite for the emergence of non-institutional factual psychotherapy programming. Without this development, this new form of factual psychotherapy programme is unlikely to have emerged. It would be inconceivable in the institutional setting - and although institutional psychotherapy can use settings outside of the institutional setting, these are not exploited and developed as programme content in the way that they are in the non-institutional setting. Everything else follows from this key development. During the process of producing this study, the implications of the break with the institutional were found to be more extensive than I had imagined, impacting on constructions of expertise and psychotherapeutic outcome. This aspect of the study is examined in detail in the case studies - the idea that while the departure from the institutional setting is freeing in some respects, allowing programme-makers and psychotherapists to operate without the constraints associated with working in the institutional setting, it also has a negative side. The institutional setting accords factual psychotherapy programmes with greater authenticity and validity, and access to powerful actuality. Its removal leaves a significant gap. The case study programmes show, in different ways, how programme-makers have addressed this absence.

My methodological approach was shaped by the decision to place at the heart of the study a sample of UK factual television programmes drawn from a fourteen year period and to analyse this sample using a mixed-method approach. As the research process draws to a close, and I reflect on this decision, I am satisfied that the approach I have taken within this study, in particular, the integration of production analysis, narrative analysis and textual analysis methodologies used in Chapter 5, has produced the kind of findings, in terms of richness and depth, that I had hoped for. However, it is inevitable that any research design will have areas of tension. The following evaluation of my methodological approach draws upon the experience of using such an approach, beginning with some fresh insights into the use of such an approach, before moving on to the identification of its limitations.

When I embarked on this research in January 2008, the phenomenon I had decided to research was emerging and still evolving at a time when the UK television industry was in the throes of significant change. At the time, it was impossible to say with any certainty how non-institutional factual psychotherapy programming would develop in the longer term. This presented a challenge in terms of setting temporal

parameters for the gathering of my primary data. Had I been a full-time doctoral student, it is likely that I would have curtailed my primary research in 2010. While this would have enabled me to capture the first ‘spike’ of non-institutional factual psychotherapy programming between 2005 and 2009, I would have missed the second smaller ‘spike’ in 2012, and lost the opportunity to identify how things might develop in the foreseeable future. In this respect, my status as a part-time doctoral student was fortuitous; the opportunity to extend my primary research phase has led to a more complete understanding of the phenomenon I set out to study.

The process of defining the study’s key terms of *psychotherapy*, *psychotherapist*, and *psychotherapeutic process* was more complicated than originally anticipated. Defining these terms was obviously essential to the study, not only because these are terms that have different meanings in different contexts, but also because they were to be instrumental to the process of establishing the eligibility criteria for the research sample. The aim was, therefore, to produce definitions that would sustain across the whole research process, and enable, rather than restrict, the research process. The research process was completed without any modification to the original definitions and, for the most part, they have been effective in terms of facilitating the research process and providing necessary limits on what could have turned into an ever-expanding programme sample. However, they resulted in the rejection of a small number of programmes that would have been useful for inclusion in the sample, such as non-institutional factual psychotherapy programmes involving the participation of psychotherapists who were not UK-based, or highly-trained psychotherapeutic professionals who did not meet the definition of *psychotherapist* as defined within this study.

The decision to devise a new term to represent the programmes in the research sample grew out of a lack of satisfaction with the available terminology. This task would not have been necessary if the literature had offered an existing, established terminology that represented effectively the sampled programmes. As I have explained elsewhere, I considered a number of terms drawn from the literature, and rejected them for different reasons. The name eventually selected - *factual psychotherapy programming* - with the use of *institutional* and *non-institutional* as prefixes, while admittedly cumbersome, have the advantage of not being associated with other kinds of

programme. It is hoped that the terms are effective in terms of signifying what they are meant to signify.

The distinction between the *institutional* and *non-institutional* forms of the factual psychotherapy programme was fundamental to my research, and enabled me to generate quantitative data to support my hypothesis. However, a small number of programmes did not fit neatly into either the institutional or non-institutional category; specifically, programmes that featured psychotherapeutic actuality filmed in *both* institutional and non-institutional settings. I considered devising alternative categories but found that there were always programmes which defied perfect categorisation. In the end, I stuck with my original categories which mapped most effectively to my hypothesis. In the case of those programmes that could have been categorised as either institutional or non-institutional, I devised an approach that used the explicit involvement of a psychotherapeutically-orientated institution as the defining characteristic, for the purposes of my quantitative content analysis. However, sequences of psychotherapeutic actuality from those programmes that were filmed in non-institutional settings would still be available for use in the qualitative programme analysis.

Insights and reflections of this kind have accompanied me throughout the research process. For the most part, my research design and methodology have served me well and enabled a smooth analysis and, I believe, the production of rich primary data. I do not regard these as limitations, in the sense that they are a natural by-product of the research process and have not had a significant impact on my results. However, I am also aware that there have been aspects of my research process that may have had an impact on my findings. These will be considered in the next section.

7.1 Limitations

One potential limitation of my study relates to the use of television programmes as its main primary data set, and to the variability in the availability of contextual materials associated with the sampled programmes. While it was my intention to treat the sampled programmes in equal terms, this was not always possible because the available data was not always equal. Ideally, comparable levels of the same kinds of primary data would be available for each sampled programme, including unlimited access to the programme itself, and availability of a range of associated contextualising materials, including broadcaster promotional materials, newspaper reviews, scheduling information, viewing statistics, programme-maker interviews, and programme

production information. While a degree of variability in these materials is to be expected and, indeed, accommodated within the research process, there were occasions when the limited availability of contextualising materials impacted negatively on how some programmes were used within the study. For example, it was almost impossible to collate data for the daytime series *The Test*, broadcast on ITV in 2003 and 2004, of which four episodes have been included in the research sample. As this was one of the earliest sampled programmes to signal the emergence of non-institutional factual psychotherapy programming, this was a setback. The broadcast date of the programme was clearly a factor in this case, but this was not always a problem. The oldest programme in the sample - *Talking Cure* - had an abundance of contextual materials, primarily because the decision to allow programme-makers into the Tavistock Clinic to film was perceived at the time, within the psychotherapeutic community, to have been a controversial decision. On the other hand, the more recent the programme's broadcast date, the more likely it was that there would be a superfluity of contextual materials, particularly where programmes attracted a lot of pre-broadcast publicity, as in the cases of *Bedlam: Anxiety*, *The House of Obsessive Compulsives*, and *Britain's Biggest Hoarders*. However, one potentially problematic consequence of a superfluity of contextual materials was because those programmes could assume a greater position within the study, something that had to be guarded against but at times felt unavoidable. To overcome this limitation, one solution was to only work with programmes that had sufficient associated materials, provided this did not lead to an overreliance on particular programmes.

A second area of potential limitation relates to the challenges of working with a subject involving ethical concerns over and above what would typically arise when researching factual television programmes. From the outset of the research process, I have been aware that working with factual television programmes that feature individuals with mental health problems necessitates additional considerations relating to the way that programmes as primary data are used within a research study such as this, particularly in the context of work that will end up in the public domain. An awareness of ethical concerns has been integrated into the research process in a number of ways. For example, it has informed the practice of avoiding, where practicable, the use of volunteers' names, or to references to biographical details that could lead to their identification. While this may seem unnecessary, given that individuals have appeared

voluntarily on television, it is essential to prevent ongoing discussions and commentary about those volunteers which might lead to undesired attention, particularly in the case of programmes that were broadcast many years ago. It also influenced the design and execution of my research participant information sheet and Research Questionnaire (see Appendices D & E), which were informed by an awareness of research ethics. It was essential, for example, that my own research did not breach any existing broadcaster-led compliance arrangements. For this reason, it was decided that my research questionnaire responses would be used anonymously within the study, and that full copies of the research questionnaire would be removed from any online digital copies. Concerns with research ethics have also affected how materials from online mental health forums have been used. It was noted, during the research process, that the use of materials from publicly-accessible online forums is becoming increasingly commonplace in academic research; this is unsurprising, given the potentially rich source of primary data. While there are existing restrictions placed on the use of such materials, as determined by the terms and conditions of individual forums, it was appropriate, within the context of this study, to treat the materials available on such mental health forums with the same circumspection. While materials published on online forums give the appearance of being in the public domain and, therefore, a freely-available resource for use in academic research, they are not. It has also been noted that individuals posting on online forums may do so under an assumption of privacy, particularly in cases where users divulge highly personal information which could lead to their identity being revealed. While these constraints have limited how I have used the available primary data, including the programmes, the research questionnaires, and material drawn from online forums, all three sources of primary data have been used within this study.

7.2 The Findings

My main research findings were presented in three stages - content analysis, programme analysis, case studies - with each stage becoming more specific in its scope. It began with an overview of the research sample, progressed to a comparative analysis of institutional and non-institutional factual psychotherapy programming, and concluded with case studies which enabled a more detailed analysis of the phenomenon at the heart of this study: the non-institutional factual psychotherapy programme. The research findings support my initial hypothesis that the non-institutional factual psychotherapy programme, as defined within this study, emerged in the early/mid-2000s; they also

showed that this new factual psychotherapy form peaked in 2007 and declined after 2009, with a small resurgence in 2012. The programme analysis identified a number of key differences between institutional and non-institutional factual psychotherapy programming, in terms of the construction of setting, expertise and ending/outcome. The findings demonstrate that the departure from the institutional setting had significant implications for the construction of setting, expertise, and endings/outcomes, as the ownership of the psychotherapeutic project passed from psychotherapeutic institutions to television professionals. The findings identify new areas of tension resulting from the departure from the institutional setting, chiefly the need to compensate for the loss of credibility and integrity resulting from the departure from the psychotherapeutic institution, and difficulties surrounding programmes endings and the completion of the psychotherapeutic process.

This study identified a number of factors that contributed to the emergence of non-institutional factual psychotherapy programming. One, that developments within popular factual television, specifically the emergence of reality television, led to the developments in popular factual television which foregrounded life experiments and transformational narratives, extending to the reinvention of existing programme forms. If there was an impetus to make programmes of this kind involving psychotherapeutic actuality, it could not take place within the institutional psychotherapeutic setting because of institutional constraints. Two, the privileged position accorded to the expert, that came as part of these developments in factual television, opened up a new space for psychotherapists to occupy. While psychotherapists have always been involved with factual television, their level of engagement in non-institutional factual psychotherapy programming was unprecedented, and brought to the television screen representations of the psychotherapeutic process which both complemented and contradicted those produced within their institutionally-based counterparts. The third factor is the launch of BBC Three, a new UK terrestrial channel requiring comparatively inexpensive UK-originated programming to fill its schedules. My findings show that the demand for multi-episode formatted series in particular, which typified the output of BBC Three during the research timeline, was a key factor in the demand for non-institutional factual psychotherapy programming. The fourth contributory factor relates to changes in technology and television production practice, that led to changes in how factual television programmes were made. My research identified developments that have led

to the gradual erosion and displacement of the traditional programme-making role of producer/director, which has implications for programming that involves the participation of ‘vulnerable’ contributors. They also identify a greater sense of personal responsibility by programme-makers towards those contributors on television-managed psychotherapeutic projects. The fifth factor is the rise of cognitive behavioural therapy which became the dominant psychotherapeutic modality of our time, and the primary application for the treatment of anxiety disorders. The high visibility of this modality in the sampled programmes - both institutional and non-institutional - partly reflects its privileged position within the psychotherapeutic domain. However, the primary reason for its prevalence in the sampled programmes, it is suggested, is because of the opportunities this modality provides for activity-based psychotherapeutic actuality, and for its promise to deliver a psychotherapeutic process that leads to quick and effective results. The final contributory factor was the official re-designation, in 2013, of hoarding disorder as a discrete mental health disorder. The ongoing lobbying for this change by research psychotherapists during the research timeline led to a change in how hoarding was represented in factual television programming from hoarding as human eccentricity to hoarding as a recognised mental health problem. It is suggested that these developments were contributory factors in the emergence of those non-institutional factual psychotherapy programmes which featured the psychotherapeutic treatment of volunteers who hoard.

7.3 Contribution to the Field

The research conducted within this study is situated within television studies, positioned between a number of related research fields which were identified in Chapter 2. Having now completed the research, this section presents an evaluation of the ways that this study has contributed to that literature.

The first area I considered was the literature on therapeutic culture. While this study does not make a direct contribution to this literature, it suggests that there is a value to bringing the research focus to factual television which represents the psychotherapeutic in its most overt and explicit ways. This would complement the work that has already been done on quasi-psychotherapeutic programming, or on factual programming in general, which explores the operation of therapeutic culture in its most diffuse articulation.

My research into existing examples of psychotherapy on television led me to identify an area of new research into what I have called ‘television-managed psychotherapy projects’, a term I have used to describe programmes in which psychotherapeutic treatment, in its various configurations, is delivered by psychotherapists to volunteers for the purposes of a television programme. This research would focus on the particular tensions associated with the production of television-managed psychotherapy projects.

The findings of this study make a contribution to the literature on the construction of expertise in factual television. Its analysis of how expertise is constructed in both institutional and non-institutional settings, and the identification of the key differences supported with primary data, complements existing work on expertise. In particular, this study makes a unique contribution to work on representations of psychotherapeutic experts in factual television, an area which is currently overshadowed by research on fictional representations. I would also suggest that there is space within the literature on how factual television programmes construct representations of mental health problems that could accommodate my findings on constructions of anxiety disorders and hoarding disorder as mental health problems that are both ‘normal’ and ‘severe’.

This study extends the literature on ‘therapy talk’ through its examination of how television constructs the psychotherapeutic encounter in programmes which feature ‘real’ psychotherapy. The programme analysis identifies the techniques and practices favoured in television constructions of expert psychotherapeutic practice, both in talk-based and activity-based psychotherapeutic practice. It observes, in the sampled programmes, a gradual displacement of ‘talk’ for ‘activity’ in constructions of psychotherapeutic practice, questioning the ongoing relevance of the practice of self-disclosure in factual psychotherapy programming.

To the literature on reality television, this study joins other work, identified in this study, which examines the reconfiguration of an existing programme form to accommodate the key characteristics of reality television. My analysis demonstrates that non-institutional factual psychotherapy programming makes liberal use of such techniques and devices while still operating, in many instances, as programmes recognised as documentaries. However, this study has concluded that the foregrounding of transformative narratives in the psychotherapy context produced particular tensions

within the programme texts which can undermine the successful execution of these programmes.

If I was to summarise the main contributions I have made within this research, I would choose the following: first, presenting an extensive study of a sample of programmes that have not been studied before, framed by its industrial and cultural contexts; second, a contribution to work on the representations of psychotherapists in factual television; third, the synthesis of a new field of study, that I am provisionally naming *television- managed psychotherapy projects* which can build on the research conducted in this study; fourth, an effective mixed-method research design that facilitates the close study of media products.

It is hoped that this study will be useful to other researchers working in the same field. This study has produced a detailed analysis of a programme sample that is now open to other kinds of research and analysis. It has generated new terminologies that may be taken up by future researchers, and developed an effective research strategy which has led to the production of rich primary data. At the conclusion of my research, I remain frustratingly aware that the complete story of factual psychotherapy programming, in both its institutional and non-institutional forms, is yet to be told. What has been examined in this study is just part of that story. The subject offers the possibility of research which could extend into the past, or focus on future developments. In the meantime, UK television broadcasters continue to commission programmes about mental health and the psychotherapeutic process which merit the scrutiny of academic researchers.

Bibliography

- Alasuutari, P. (1995). *Researching culture: Qualitative method and cultural studies*. London: Sage.
- Anthony, B. (2010). Sectioned: Filming inside a mental health unit [Web log post]. *BBC tv blog*. Retrieved from <http://www.bbc.co.uk/blogs/tv/2010/05/sectioned.shtml>. Accessed 20/03/2017
- Anxiety 2 Calm. (2006). Agoraphobics - Wanted for TV Therapy Show. *Anxiety 2 Calm*. Retrieved from <http://www.anxiety2calm.com/blogger/2006/03/agoraphobics-wanted-for-tv-therapy.html>. Accessed 20/12/2012.
- Apperley, A., Jacobs, S., & Jones, M. (2014). Introduction: Therapeutic Culture. *Culture Unbound: Journal of Current Cultural Research*, 6(4), 725-729.
- Archer, R. L. (1987). Commentary: Self-Disclosure, A Very Useful Behaviour. In V.J. Derlega & J.H. Berg (Eds.), *Self-Disclosure: Theory, Research, and Therapy*. 329-341. London: Plenum.
- Arthurs, J. (2010). Contemporary British television. In C.S.M Higgins & J. Storey (Eds.), *The Cambridge Companion to Modern British Culture*. 171-188. Cambridge: Cambridge University Press.
- Association of Internet Researchers. (2002). *Ethical decision-making and Internet research*. Retrieved from <http://aoir.org/reports/ethics.pdf>. Accessed 14/07/2014.
- Atkinson, P., & Coffey, A. (2004). Analysing Documentary Realities. In D. Silverman, (Ed.), *Qualitative Research*. (2nd ed.). 56-75. London: Sage Publications Ltd.
- Aubry, T., & Travis, T. (2015). What is "therapeutic culture" and why do we need to "rethink" it? In T. Aubry & T. Travis (Eds.), *Rethinking Therapeutic Culture*. 1-23. Chicago: The University of Chicago Press.
- Aveline, M. (2002). The Training and Supervision of Individual Therapists. In W. Dryden (Ed.), *Handbook of Individual Therapy* (4th ed.). 434-466. London: Sage.
- Bainbridge, C. (2011). From 'the Freud squad' to 'the good Freud guide': A genealogy of media images of psychoanalysis and reflections on their role in the public imagination. *Free Associations*(62), 31-58.
- Baxter, L. A. (1987). Self-Disclosure and Relationship Disengagement. In V.J. Derlega & J.H. Berg (Eds.), *Self-Disclosure: Theory, Research, and Therapy*. 155-172. London: Plenum.
- Baylis, M. (2006, 21 December). Dickens of a way to end; TV Express - Matt Baylis on last night's TV. *The Express*.

- BBC. (2007a). *BBC Annual Report and Accounts 2006/2007*. Retrieved from http://downloads.bbc.co.uk/annualreport/pdf/2006-07/bbcexec_eng_200607.pdf. Accessed 03/09/2016.
- BBC. (2007b). Into The Panic Room on BBC Three: three days, two phobias, one Panic Room – starts 10 April 2007 at 9pm on BBC Three. Retrieved from http://www.bbc.co.uk/pressoffice/pressreleases/stories/2007/03_march/20/panic.shtml. Accessed 28/01/2010.
- BBC. (2008). *BBC Annual Report and Accounts, 2007/2008*. Retrieved from http://downloads.bbc.co.uk/annualreport/pdf/2007-08/bbc_ara_2008_exec.pdf. Accessed 05/01/2017.
- BBC. (2017a). The Bulls*** Detective. Retrieved from <http://www.bbc.co.uk/programmes/b0072w0t>. Accessed 05/01/2017
- BBC. (2017b). The Panic Room. Retrieved from <http://www.bbc.co.uk/programmes/b0074h4t>. Accessed 05/12/2016
- BBC. (n.d.). *BBC Code of Practice*. Retrieved from http://downloads.bbc.co.uk/commissioning/site/code_of_practice.pdf. Accessed 22/3/2017.
- BBC Press Office. (2006). Julian Bellamy unveils Winter/Spring 2007 season on BBC Three. Retrieved from http://www.bbc.co.uk/pressoffice/pressreleases/stories/2006/12_december/14/bbcthree.shtml. Accessed 05/12/2016.
- Beck, D., Hellmueller, L. C., & Aeschbacher, N. (2012). Factual entertainment and reality TV. *Communication Research Trends*, 31(2), 4-27.
- Beck, U. (1992). *Risk society: Towards a new modernity*. London: Sage.
- Bellah, R., Madsen, R., Sullivan, W., Swidler, A., & Tipton, S. M. (1996). *Habits of the Heart: Individualism and Commitment in American Life*. Berkley: University of California Press.
- Bennett-Levy, J., Westbrook, D., Fennell, M., Cooper, M., Rouf, K., & Hackmann, A. (2004). Behavioural experiments: Historical and conceptual underpinnings. *Oxford guide to behavioural experiments in cognitive therapy*, 1-20.
- Bennett, J. (2011). Introduction - Television as digital media. In J. Bennett & N. Strange (Eds.), *Television as digital media*. 1-30. Durham and London: Duke University Press.
- Bertrand, I., & Hughes, W. (2005). *Media research methods: audiences, institutions, texts*. New York: Palgrave.
- Betts, H. (2005, 2 August). Facing compulsion with compassion. *The Times*.
- Bignell, J. (2013). *An Introduction to Television Studies* (3rd ed. ed.). London: Routledge.

- Bignell, J., & Orlebar, J. (2005). *The television handbook* (3rd. ed.). London and New York: Routledge.
- Biressi, A., & Nunn, H. (2005). *Reality TV. Realism and Revelation*. London: Wallflower Press.
- 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.
- Bonner, F. (2003). *Ordinary Television*. London: Sage.
- Bouhoutsos, J. C., Goodchilds, J. D., & Huddy, L. (1986). Media psychology: An empirical study of radio call-in psychology programs. *Professional Psychology: Research and Practice*, 17(5), 408-414.
- Bradley, M. (2006, 17 December). OTV: Tuesday 19 December: Screengrabs. *The Observer*.
- Bradshaw, P. (2002, 16 August). Lantana. *The Guardian*.
- Brannen, J. (2005). Mixing Methods: The Entry of Qualitative and Quantitative Approaches into the Research Process. *International Journal of Social Research Methodology*, 8(3), 173-184.
- Broadcast. (2004, 12 November). Feature: Documentaries - Shock tactics. *Broadcast*.
- Broadcast. (2005, 2 August 2005). 2.4m get The Bigger Picture. *Broadcast*.
- Broadcast. (2012a, 25 May). BBC2 nets more than BBC1 with fish market doc. *Broadcast*.
- Broadcast. (2012b, 4 May). C4 hoarder series collects 2.7m. *Broadcast*.
- Brunvatne, R., & Tolson, A. (2001). "It makes it okay to cry": two types of "therapy talk" in TV talk shows. In A. Tolson (Ed.), *Television Talk Shows: Discourse, Performance, Spectacle*. 139-154. New Jersey: Lawrence Erlbaum Associates.
- Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? *Qualitative research*, 6(1), 97-113.
- Busfield, J. (2012). Challenging claims that mental illness has been increasing and mental well-being declining. *Social Science & Medicine*, 75(3), 581-588.
- Butler, J. (2012, 11 May). Clutter? It's all in Tricia's mind; Last night's television. *Western Daily Press*.
- Cassidy, J. (2006). Getting camera happy. *BMJ*, 333(7581).
- Casting Call Pro. (2006). BBC Series, 'Panic Room' looking for people with Stage Fright. Retrieved from <http://www.castingcallpro.com/uk/forum/topic/25946/bbc-series-panic-room-looking-for-people-with-stage-fright>. Accessed 05/01/2017.

- Centre for Workforce Intelligence. (2014). *In-depth Review of the Psychiatrist Workforce - Technical Report* Retrieved from http://recipeforworkforceplanning.hee.nhs.uk/Portals/0/HEWM_LinksAndResources/Psychiatrist%20in-depth%20review_Main%20report%20-%20Nov%202014.pdf?ver=2016-04-18-111341-133. Accessed 04/12/2016
- Channel 4. (2012). The Hoarder Next Door [Press release]. Retrieved from <http://www.channel4.com/info/press/programme-information/the-hoarder-next-door>. Accessed 09/11/2016.
- Channel 4. (2013a). The Hoarder Next Door. Retrieved from <http://www.channel4.com/info/press/programme-information/the-hoarder-next-door-s2>. Accessed 16/11/2016.
- Channel 4. (2013b). Take Part: Hoarder Next Door. Retrieved from <http://www.channel4.com/programmes/take-part/articles/all/hoarder-next-door/325>. Accessed 03/11/2016.
- Channel 4. (2017). Bring Back... Retrieved from <http://www.channel4.com/programmes/bring-back/episode-guide/>. Accessed 02/11/2016.
- Charlton, D. (2013, November). Life Through A Lens. *Mental Health Today*. Retrieved from <https://www.mentalhealthtoday.co.uk/life-through-a-lens>. Accessed 05/11/2016.
- Chater, D. (2012, 28 April). Thursday's TV: The Hoarder Next Door, 1662 words. *The Times*.
- Chelune, C. J. (1987). A Neuropsychological Perspective on Interpersonal Communication. In V.J Derlega & J.H. Berg (Eds.), *Self-Disclosure: Theory, Research, and Therapy*. 9-14. London: Plenum.
- Children of Hoarders. (2013). *Children of Hoarders* [Website] Retrieved from http://childrenofhoarders.com/wordpress/?page_id=3668. Accessed 09/10/2016.
- Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, 47(11).
- Coates, D., & Winston, T. (1987). The Dilemma of Distress Disclosure. In V.J. Derlega & J.H. Berg (Eds.), *Self-Disclosure and Relationship Disengagement*. 229-251. London: Plenum.
- Cohen, D. (2007). BBC Three Winter/Spring 2008. Retrieved from http://www.bbc.co.uk/pressoffice/pressreleases/stories/2008/01_january/22/bbcthree.shtml. Accessed 03/01/2017.
- Communications Commission. (2004). *The Programme Code*. Retrieved from <https://www.iomcc.im/media/1006/broadcasting-programme-code.pdf>. Accessed 08/09/2016.

- Conlan, T. (2006, 21 December). TV Ratings: December 20. *The Guardian*.
- Corner, J. (1996). *The art of record. A critical introduction to documentary*. Manchester: Manchester University Press.
- Corner, J. (2002). Performing the Real. Documentary Diversions. *Television & New Media*, Vol. 3, 255-269.
- Corner, J. (2003). Television, documentary and the category of the aesthetic. *Screen*, 44(10), 92-100.
- Corner, J. (2008a). Form and Content in Documentary Study. In Creeber, G. (Ed.), *The Television Genre Book*. 124-125. London: BFI.
- Corner, J. (2009). Studying Documentary. In Creeber, G. (Ed.), *The Television Genre Book*. 123-124. London: BFI.
- Cornford, J., & Robins, K. (1992). Development strategies in the audiovisual industries: the case of North East England. *Regional Studies*, 26(5), 421-435.
- Counselling Resource. (2006). Panic Room: Overcome Your Phobias and Anxieties. Retrieved from <http://crclips.com/lib/2006/09/06/panic-room/>. Accessed 02/02/2017.
- Crace, J. (2013, 16 April). G2: Television: Last night's TV: Strange behaviour was everywhere on the schedules last night. *The Guardian*.
- Creeber, G. (2006). The Joy of Text?: Television and Textual Analysis. *Critical Studies in Television*, 1(1), 81-88.
- Creeber, G. (2008a). Genre Theory. In Creeber, G. (Ed.), *The Television Genre Book*. 1-3. London: BFI.
- Cross, S. (2004). Visualizing Madness: Mental Illness and Public Representation. *Television & New Media*, 5(3), 197-216.
- Cross, S. (2010). *Mediating madness: Mental distress and cultural representation*. Basingstoke: Palgrave Macmillan.
- Culture Media and Sport Committee. (2010). *Future for local and regional media. Fourth Report of Session 2009–10 Volume 1*. Retrieved from <https://www.publications.parliament.uk/pa/cm200910/cmselect/cmcmums/43/43i.pdf>. Accessed 12/01/2017.
- Dahlgren, P. (2005). Television, Public Spheres, and Civic Cultures. In J. Wasko (Ed.), *A Companion to Television*. 411-432. London: Blackwell.
- Davis, A. (2008). Investigating Cultural Producers. In M. Pickering (Ed.), *Research Methods for Cultural Studies*. 53-67. Edinburgh: Edinburgh University Press.

- Deanie, M. (2012, 3 May). What To Watch Tonight. *The Sun*.
- Declutter Divas. (2013). Your chance to take part in The Hoarder Next Door. Retrieved from <http://www.declutterdivas.co.uk/your-chance-to-take-part-in-the-hoarder-next-door/>. Accessed 21/12/2016.
- Deller, R. A. (2015). Religion as Makeover: Reality, Lifestyle and Spiritual Transformation. *International Journal of Cultural Studies*, 18(3), 291-303.
- Dempster, S. (2006, 19 December). G2: Television: Watch this. *The Guardian*.
- Dent, G. (2012, 12 May). Nigel is encouraged to tidy in a frock. It doesn't solve much, but we get to have a gawp; On Television: This week Grace watched... The Hoarder Next Door Channel 4. *The Independent*.
- Dominick, J., & Wimmer, R. (2003). Training the Next Generation of Media Researchers. *Mass Communication & Society*, 6(1), 3-9.
- Dosani, S. (2005). The House of Obsessive Compulsives. *BMJ*, 331(13/08/2005), 409.
- Dover, C., & Hill, A. (2007). Mapping genres: broadcaster and audience perceptions of makeover television. In D. Heller (Ed.), *Makeover television: realities remodelled*. 23-38. London, New York: IB Taurus.
- Dovey, J. (2000). *Freakshow: First Person Media and Factual Television*. London: Pluto Press.
- Doyle, G., & Paterson, R. (2008). Public policy and independent television production in the UK. *Journal of Media Business Studies*, 5(3), 17-33.
- Draper, D. (2007, 22/10/2007). The rise of therapy TV. *Broadcast*.
- Dryden, W. (1992). *The Dryden Interviews. Dialogues on the Psychotherapeutic Process*. London: Whurr Publishers.
- Dryden, W., & Feltham, C. (1992). Psychotherapy and its discontents: an introduction. In W. Dryden, and C. Feltham (Eds.), *Psychotherapy and its discontents*. 1-6. Buckingham: Open University Press.
- Edwards, R., & Nicoll, K. (2006). Expertise, competence and reflection in the rhetoric of professional development. *British Educational Research Journal*, 32(1).
- Ellenberger, H. F. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiatry*. New York: Basic Books.
- Ellis, J. C., & McLane, B. A. (2005). *A new history of documentary film*. New York London: Continuum.
- Elsaesser, T. (2001). Postmodernism as mourning work. *Screen*, 42(2), 193-201.

- English, P. (2005, 4 August). Is reality show the right place for mentally ill? The House of Obsessive Compulsives. *Daily Record*.
- Farber, B. (2006). *Self-Disclosure in Psychotherapy*. New York: The Guilford Press.
- Feasey, R. (2011). Mothers on the naughty step: Supernanny and reality parenting television. *Flow* 2011; 15.
- Felix, E. (2000). Creating radical change: Producer choice at the BBC. *Journal of Change Management*, 1(1), 5-21.
- Fitzpatrick, M. A. (1987). Marriage and Verbal Intimacy. In V. J. Derlega & J.H. Berg (Eds.), *Self-Disclosure: Theory, Research, and Therapy*. 131-151. London: Plenum.
- Flanagan, A. (2013). Filming at South London and Maudsley Hospital 31 October. Retrieved from <http://www.channel4.com/programmes/bedlam/articles/all/filming-at-south-london-and-maudsley-hospital/1089>. Accessed 09/10/2014.
- Ford, A. E. (2008). *The Effects of two-way mirrors, video cameras, and observation teams on clients' judgements of the therapeutic relationship*. Indiana University of Pennsylvania. [Unpublished Thesis]
- Freeview. (2009). Final Countdown to Freeview National Retune 30 September 2009 [Press release]. Retrieved from <https://www.freeview.co.uk/news-and-blog/press-releases/final-countdown-to-freeview-national-retune-30-september-2009.html#fkVJMdoPf724fcgl.97>. Accessed 17/12/2016.
- Furedi, F. (2004). *Therapy Culture*. London: Routledge.
- Gergen, K. (1990). Therapeutic professions and the diffusion of deficit. *The Journal of Mind and Behaviour*, 11, 3-4.
- Gibson, O. (2002, 28 October). Little fanfare for Freeview launch. *The Guardian*.
- Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age*. Cambridge: Polity Press.
- Giles, D. (2003). *Media Psychology*. New Jersey & London: Lawrence Erlbaum.
- Goffman, E. (1959). *The Presentation of Self in Everyday Life*. London: Penguin.
- Gossman, M., & Miller, J. H. (2012). 'The third person in the room': Recording the counselling interview for the purpose of counsellor training – barrier to relationship building or effective tool for professional development? *Counselling & Psychotherapy Research*, 12(1), 25-34.
- Goulden, R., Corker, E., Evans-Lacko, S., Rose, D. M., Thornicroft, G., & Henderson, G. (2011). Newspaper coverage of mental illness in the UK, 1992-2008. *BMC Public Health*, 11(1), 796.

- Green, L. (2010). *The internet: an introduction to new media*. Berg: Oxford.
- Haarman, L. (2001). Performing Talk. In A. Tolson (Ed.), *Television Talk Shows. Discourse, Performance, Spectacle*. 31-64. New Jersey: Lawrence Erlbaum Associates.
- Hall, S. (2013). Taking part in Channel 4's Bedlam - a review. [Web log]. Retrieved from <http://www.time-to-change.org.uk/blog/channel-4-bedlam-a-review>. Accessed 09/09/2016.
- Hamilton, J. (2013). Reality TV as Therapy. *Therapy Today*, 24(5), 14-17.
- Hansen, A. (1998). *Mass communication research methods*. New York: NYU Press.
- Harper, S. (2009). *Madness, Power and the Media*. Basingstoke: Palgrave Macmillan.
- Henderson, L. (2007). *Social Issues in Television Fiction*. Edinburgh: Edinburgh University Press.
- Herbert, J. D., & Forman, E. M. (2011). The evolution of cognitive behavior therapy. The Rise of Psychological Acceptance and Mindfulness. In J. D. Herbert & E.M. Forman (Eds.) *Acceptance and Mindfulness in Cognitive Behaviour Therapy*. 3-25. New Jersey: John Wiley & Sons.
- Hill, A. (2005). *Reality TV: Audiences and popular factual television*. London: Routledge.
- Hill, A. (2007). *Restyling Factual TV*. Routledge: London.
- Hill, A. (2008). Studying Reality TV. In G. Creeber (Ed.), *The Television Genre Book*. 136-138. London: BFI.
- Historic England. (2017). <https://historicengland.org.uk/listing/the-list/list-entry/1000395>. Accessed 12/01/2017.
- Hodges, I. C. (1998). *A problem aired : exploring radio therapeutic discourse and ethical self-formation*. University of London (Goldsmiths College). [Unpublished Thesis].
- Hogan, M. (2012, 28 April). What to watch; May 3 Thursday. *The Daily Telegraph*.
- Holmes, J., & Lindley, R. (1989). *The Values of Psychotherapy*. Oxford: Oxford University Press.
- Holmes, S. (2008). *Entertaining Television. The BBC and popular television culture in the 1950s*. Manchester: Manchester University Press.
- Holmes, S., & Jermyn, D. (2004). Understanding Reality TV. In S. Holmes & D. Jermyn, D. (Eds.), *Understanding Reality Television*. 1-32. Abingdon, Oxon.: Routledge.
- Hooker, C. (2010). Health scares: Professional priorities. *Health* 14(1), 3-21.
- Hooper, L. (2014, 19 June). Masterclass: How to come up with a killer title. *Broadcast*.

- Horwitz, A., & Wakefield, J. (2007). *The Loss of Sadness : How Psychiatry Transformed Normal Sorrow Into Depressive Disorder*. Oxford: Oxford University Press.
- Huskinson, L., & Waddell, T. (2014). Introduction. In L. Huskinson & T. Waddell (Eds.), *Eavesdropping: the psychotherapist in film and television*. 1-12. Hove: Routledge.
- IMDb. (2002). Panic Room. <http://www.imdb.com/title/tt0258000/>. Accessed 28/01/2017.
- International Television Expert Group. (2007-2010). *TV Market Data / EPG Penetration & Revenue Forecast (2008-2014)*. Retrieved from http://www.international-television.org/tv_market_data/epg-penetration-forecast-europe_2008-2014.html. Accessed 18/02/2017.
- Ipswich Advertiser. (2013, 20 February). The Hoarder Next Door: Helen, Jack and Yvonne. *Ipswich Advertiser*.
- James, M., Kinnes, S., & Dempster, S. (2007). Critics Choice. *The Sunday Times*.
- Jiwa, M. (2012). Doctors and the media. *The Australasian medical journal*, 5(11), 603.
- Jones, T. (2002). *Innovating at the Edge*. Oxford: Butterworth-Heinemann.
- Jourard, S. M. (1968). *Disclosing Man to Himself*. Princeton, NJ.: Van Nostrand Reinhold.
- Jourard, S. M. (1971). *The Transparent Self*. Princeton, NJ.: Van Nostrand Reinhold.
- Karasu, T. B. (1986). The specificity versus nonspecificity dilemma: Toward identifying therapeutic change agents. *The American Journal of Psychiatry*, 143(6), 687-695.
- Kilborn, R. (1998). Shaping the Real Democratization and Commodification in UK Factual Broadcasting. *European Journal of Communication*, 13(2), 201-218.
- Kilborn, R., & Izod, J. (1997). *Confronting Reality: An Introduction to Television Documentary*. Manchester: Manchester University Press.
- King, B. (2008). Stardom, celebrity and the para-confession. *Social Semiotics*, 18(2), 115-132.
- Lasch, C. (1979). *The Culture of Narcissism: American Life in an Age of Diminishing Expectation*. New York: Warner Books.
- Launer, J. (2005). Anna O and the 'talking cure'. *QJM*, 98(6), 465-466.
- Leason, K. (2005). In The Spotlight. *Community Care* (1587), 26-28.
- Levy, D. A., Emerson, E. P., & Brief, D. E. (1991). Radio Psychology Talk Show Hosts: Assessment of Counseling Style. *Journal of Community Psychology*, 19(2), 178-188.

- Liverpool Echo. (2006, 8 March). Do you suffer From Panic Disorder with Agoraphobia? *Liverpool Echo*. Retrieved from <http://www.liverpoolecho.co.uk/news/liverpool-news/you-suffer-panic-disorder-agoraphobia-3520630>. Accessed 07/01/2017.
- Livingstone, S., & Lunt, P. (1994). *Talk on Television: Audience Participation and Public Debate*. London: Routledge.
- London School of Economics. (2006). *The Depression Report. A new deal for depression and anxiety disorders*. Centre for Economic Performance special papers, CEPOP15. Centre for Economic Performance, London School of Economics and Political Science, London, UK. Retrieved from <http://eprints.lse.ac.uk/818/>. Accessed 09/10/2016.
- Lords Select Committee. (2009). *The British Film and Television Industries - Communications Committee*. Retrieved from <https://www.publications.parliament.uk/pa/ld200910/ldselect/ldcomuni/37/9052003.htm>. Accessed 26/02/2016.
- Lunt, P. (2008). Little Angels: The mediation of parenting. *Journal of Media & Cultural Studies*, 22(4), 537–546.
- Lury, K. (2005). *Interpreting television*. London, New York: Hodder Arnold.
- Lury, K. (2009). 'For crying out loud': The repression of the child's subjectivity in 'The House of Tiny Tearaways'. *Semiotica*, 173(1-4), 491-507.
- Lygo, K. (2007). *Channel 4 Annual Review of 2006*. Retrieved from [http://www.channel4.com/media/documents/corporate/programme-review/2006\(standard\).pdf](http://www.channel4.com/media/documents/corporate/programme-review/2006(standard).pdf). Accessed 12/12/2016
- Malloy, F. (2005). The death of film. Retrieved from <http://www.theage.com.au/news/livewire/the-death-of-film/2005/09/21/1126982069009.html>. Accessed 03/02/2017.
- Marks, M. (2000). Talking Cure: Programme 1. *British Journal of Psychotherapy*, 14(1), 75-77.
- Marzillier, J., & Hall, J. (2009). The challenge of the Layard initiative. *Psychologist*, 22(5), 396-399.
- Mataix-Cols, D., Frost, R. O., Pertusa, A., Clark, L. A., Saxena, S., Leckman, J. F., Wilhelm, S. (2010). Hoarding disorder: a new diagnosis for DSM-V? *Depression & Anxiety* (1091-4269), 27(6), 556-572.
- McKee, A. (2003). *Textual analysis: A beginner's guide*. London: Sage.
- McManus, B. (2007, 26 July). The reality of agoraphobia. *The Age*.
- Merge, A. (2006, 19 December). House of Agoraphobics. *London Evening Standard*.

- Metro. (2012, 4 May). Inside the Box: What Keith Watson watched last night. *Metro*.
- Miller, J., & Glassner, B. (2011). The 'inside' and the 'outside': Finding realities in interviews. In D. Silverman (Ed.) *Qualitative research*. (3rd ed.). 51-66. London: Sage Publications Ltd.
- Miller, T. (2002). *Television studies: The Basics*. London: Routledge.
- Milmo, D. (2001, 19 November). ITV agrees Sky distribution deal *The Guardian*. Retrieved from <https://www.theguardian.com/media/2001/nov/19/bskyb.itv>. Accessed 29/12/2016.
- Monkey Kingdom. (2015-2017). Honey I Suckle The Kids. Retrieved from <http://www.monkeykingdom.com/shows/honey-i-suckle-kids>. Accessed 12/11/2016.
- Monkey Kingdom. (2015-2017b). Transmission Impossible. Retrieved from <http://www.monkeykingdom.com/shows/transmission-impossible>. Accessed 12/11/2016.
- Moorey, S. (2002). Cognitive Therapy. In W. Dryden (Ed.), *Handbook of Individual Therapy* (4th ed.). London: Sage.
- Morison, L., Trigeorgis, C., and Joh, M. (2014). Are mental health services inherently feminised? *The Psychologist*, 27(6).
- Murdock, G. (1994). Money Talks : Broadcasting Finance and Public Culture. In S. Hood (Ed.), *Behind the Screens : The Structure of British Television in the Nineties*. London: 155-183. Lawrence and Wishart.
- Myers, G. (2001). "I'm out of it; you guys argue": making an issue of it on The Jerry Springer Show. In A. Tolson (Ed.), *Television Talk Shows: Discourse, performance, Spectacle*. 173-192. New Jersey: Lawrence Erlbaum Associates.
- Nabi, R. L. (2007). Determining dimensions of reality: A concept mapping of the reality TV landscape. *Journal of Broadcasting & Electronic Media*, 51(2), 371-390.
- No More Panic. (2006). Panic Room BBC programme. Retrieved from <http://www.nomorepanic.co.uk/showthread.php?t=13023>. Accessed 15/08/2016.
- No More Panic. (2012). If you are a hoarder and need help we're here. Retrieved from <http://www.nomorepanic.co.uk/showthread.php?t=118300>. Accessed 17/12/2016.
- Noonan, C. (2011). 'Big stuff in a beautiful way with interesting people': The spiritual discourse in UK religious television. *European Journal of Cultural Studies*, 14(6), 727-746.
- Nunn, H., & Biressi, A. (2010). 'A trust betrayed': celebrity and the work of emotion. *Celebrity Studies*, 1(1), 49-64.
- O'Doherty, P. (2007, 17 April). Fast-tracking phobias. *The Irish Times*

- Ofcom. (2005). *Review of television production sector*. Retrieved from https://www.ofcom.org.uk/data/assets/pdf_file/0023/51278/tpsr.pdf. Accessed 12/11/2016.
- Ofcom. (2008). *Ofcom review of public service television broadcasting. Phase 1 – Is television special?* Retrieved from https://www.ofcom.org.uk/data/assets/pdf_file/0023/25655/psb.pdf. Accessed 11/11/2016.
- Ofcom. (2013). *The Ofcom Broadcasting Code*. Retrieved from https://www.ofcom.org.uk/data/assets/pdf_file/0021/27633/broadcastingcode2013.pdf. Accessed 17/12/2015.
- Orbach, S. (2000). Commentary By An Object Relational Psychotherapist. *British Journal of Psychotherapy*, 17(2).
- Orchowski, L. M., Spickard, B. A., & McNamara, J. R. (2006). Cinema and the Valuing of Psychotherapy: Implications for Clinical Practice. *Professional Psychology - Research & Practice*, 37(5), 506-514.
- Orgad, S. (2009) How can researchers make sense of the issues involved in collecting and interpreting online and offline data? In A. Markham & N. Baym (Eds.) *Internet Inquiry: Conversations About Method*. 33-53. California: Sage.
- Ouellette, L., & Hay, J. (2008). *Better Living Through Reality TV: Television and Post-Welfare Citizenship*. London: Wiley-Blackwell.
- Palmer, G. (2008). Introduction - The Habit of Scrutiny. In G. Palmer (Ed.), *Exposing Lifestyle Television. The Big Reveal*. 1-14. Aldershot: Ashgate.
- Parker, I. (1996). Postmodernism and its discontents: Therapeutic discourse. *British Journal of Psychotherapy*, 12 (4), 447-460.
- Pauley, N. (2006, 5 May). I'll Spy On Big Bruv Lab Rats. *Daily Star*.
- Peck, J. (1995). TV Talk Shows as Therapeutic Discourse: The Ideological Labor of the Televised Talking Cure. *Communication Theory*, 5(1).
- Philo, G. (1999). Media and Mental Illness. In G. Philo (Ed.), *Message Received: Glasgow Media Group Research, 1993-1998*. 54-61. London: Longman.
- Philo G. (1996). The media and public belief. In G. Philo (Ed.), *Media and Mental Distress* 105-144. London: Longman.
- Pilgrim, D. (2002). The Cultural Context of British Psychotherapy. In W. Dryden (Ed.), *Handbook of Individual Therapy* (4th ed.). 1-15. London: Sage.
- Pollock, L. (2008, 23 April). Rise of a treatment that works. *The Guardian*.

- Prasad, B.D. (2008) Content analysis: a method in social science research. In: D.K. Lal Das & V. Bhaskaran (Eds.). *Research Methods for Social Work*. 173–193. New Delhi: Rawat Publications
- Price, M. E., & Raboy, M. (2003). *Public service broadcasting in transition: A documentary reader*. The Hague: Kluwer Law International.
- Probert, I. (2007). The Panic Room. Retrieved from <https://sites.google.com/site/ivanprobert/channel/BBC3/Panic-Room>. Accessed 12/02/2017.
- Quigley, M. (2012, 3 May). We Love TV; Pick of the Day. *The Mirror*.
- Raviv, A., Raviv, A., Yunowitz, R. (1989). Radio Psychology and Psychotherapy: Comparison of Client Attitudes and Expectations. *Professional Psychology: Research and Practice*, 20(2), 67-72.
- Reiff, P. (1966). *The Triumph of the Therapeutic: Uses of Faith After Freud*. London: Chatto and Windus.
- Richards, B. (2007). *Emotional Governance: Politics, media and terror*. Basingstoke: Palgrave Macmillan.
- Robinson, J., & O'Neil, P. (2006, 16 December. Television: Tuesday 19 December. *The Guardian*.
- Robson, C. (2011). *Real world research* (3rd ed.). Chichester: John Wiley & Sons.
- Rose, N. (1989). *Governing the Soul: Technologies of Human Subjectivity*. London: Routledge.
- Rose, N. (1998). *Inventing Our Selves: Psychology, Power and Personhood*. Cambridge: Cambridge University Press.
- Rose, N. (2001). Power in Therapy: Techne and Ethos. *Academy for the Psychoanalytic Arts*. Retrieved from <https://www.academyanalyticarts.org/rose-power-in-therapy>. Accessed 13/04/2015.
- Sadler, J. Z. (2005). *Values and psychiatric diagnosis*: Oxford: Oxford University Press.
- Safire, W. (1999, 28 November). On language: Bread 'n' Butter. *New York Times Magazine*, 46-48.
- Salkovskis, P.M. (2006). Channel 4's "House of Agoraphobics". Centre for Anxiety Disorders & Trauma. *South London and Maudsley NHS Foundation Trust*. [Public Information Sheet].
- Sandison, N. (2008, 10 April). BBC iPlayer proves a success with more than 42m programmes accessed. *Campaign*.

- Schreiber, D. (2007, 10 April). BBC Worldwide focuses on local production push. *Broadcast*.
- Schwartz, J. (2000). Clinical Commentary XXV11: BBC Programme - The Talking Cure. *British Journal of Psychotherapy*, 17(1).
- Sectioned. (2005). Can stigma be challenged by evoking stigmatising stereotypes? From the Maudsley to Bedlam. [Web log] Retrieved from <https://sectioneduk.wordpress.com/2013/10/02/can-stigma-be-challenged-by-evoking-negative-steretypes-bedlam/>. Accessed 24/11/2016.
- Select Committee on Communications. (2009). *Public service broadcasting: short-term crisis, long-term future?* Retrieved from <https://www.publications.parliament.uk/pa/ld200809/ldselect/ldcomuni/61/61.pdf> Accessed 09/12/2015.
- Shattuc, J. M. (1997). *The Talking Cure. TV Talk Shows and Women*. London: Routledge.
- Shattuc, J. M. (2008). The Confessional Talk Show. In G. Creeber (Ed.), *The Television Genre Book*. 167-170. London: British Film Institute.
- Simon, J., & McIver, B. (2012, 3 May). Record TV: A gran departure. *Daily Record*.
- Smith, P. (1999). The politics of UK television policy: The introduction of digital television. *International Journal of Communications Law and Policy* (3), 3-9.
- South London & Maudsley NHS Foundation Trust. (2013). Second Bedlam episode attracts record number of viewers [Press release]. Retrieved from <http://www.slam.nhs.uk/media/news/bedlam-attracts-record-number-of-viewers>. Accessed 12/08/2015.
- Spinelli, E. (1994). *Demystifying Therapy*. Ross-on-Wye: PCCS Books.
- Starkey, G. (2007, 10 April). Digital Choice. *The Times*.
- Stout, P. A., Villegas, J., & Jennings, N. A. (2004). Images of Mental Illness in the Media: Identifying Gaps in the Research. *Schizophrenia Bulletin*, 30(3), 543-561.
- Stricker, G. (1990). Self-Disclosure and Psychotherapy. In G. Stricker & M. Fisher (Eds.), *Self-Disclosure in the Therapeutic Relationship*. 277-290. London: Plenum.
- Stuart, H. (2006). Media Portrayal of Mental Illness and its Treatments: What Effect Does it Have on People with Mental Illness? *CNS Drugs*, 20(2), 99-106.
- Sutcliffe, T. (2005, 2 August). Last Night's TV: Don't leave the house. *The Independent*.
- The Guardian. (2005, 2 August). TV Ratings: August 2. *The Guardian*.
- The Guardian. (2005a, 8 August). TV Ratings: August 8. *The Guardian*.
- The Guardian. (2006, 20 December). TV Ratings: December 19. *The Guardian*.

- Thirkell, R. (2014). *CONFLICT. The Insiders' Guide to Storytelling in Factual/Reality TV & Film*. London: Methuen.
- Thornton, J. A., & Wahl, O. F. (1996). Impact of a Newspaper Articles on Attitudes Toward Mental Illness. *Journal of Community Psychology*, 24(1), 17-25.
- To Be Seen. (n.d.). Are You A Hoarder? Retrieved from <https://www.tobeseen.co.uk/jobs/Are-You-A-Hoarder?id=10487>. Accessed 12/02/2017.
- Tolson, A. (1991). Televised Chat and the Synthetic Personality. In P. Scannell (Ed.), *Broadcast talk*. 178-200. London: Sage.
- Turner, G. (2002). Television production and distribution. In T. Miller (Ed.), *Television studies* 46-50. London: British film Institute.
- Twenty Twenty. (2017a). About Twenty Twenty Television: What We Do. Retrieved from <https://www.twentytwenty.tv/whatwedo.aspx#>. Accessed 23/01/2017.
- Twenty Twenty. (2017b). The Hoarder Next Door - Series 1. Retrieved from https://www.twentytwenty.tv/program/the-hoarder-next-door-series-1_623.aspx. Accessed Accessed 23/01/2017.
- Ursell, G. (2000). Television production: issues of exploitation, commodification and subjectivity in UK television labour markets. *Media, Culture & Society*, 22(6), 805-825.
- Virtue, G. (2005, 7 August). When as good as it gets is not enough: review. *The Sunday herald*.
- Waddell, T. (2014). Shrink-wrapped television: simulated therapy, disclosure and the lure of 'plausible doubt'. In L. Huskinson & T. Waddell (Eds.) *Eavesdropping: The Psychotherapist in Film and Television*. 129-143. Hove New York: Routledge.
- Wahl, O. F. (1992). Mass Media Images of Mental Illness: A Review of the Literature. *Journal of Community Psychology*, 20(4), 343-352.
- Wahl, O. F. (2003). Depictions of mental illnesses in children's media. *Journal of Mental Health*, 12(3), 249.
- Wedding, D., & Niemiec, R. M. (2003). The clinical use of films in psychotherapy. *Journal of Clinical Psychology*, 59(2), 207-215.
- Whitby Gazette. (2007, 19 March). Would you like to be in Panic Room? *Whitby Gazette*.
- White, M. (1992). *Tele-Advising: Therapeutic Discourse in American Television*. Chapel Hill & London: University of North Carolina Press.

- Whitelaw, P. (2006, 20 December). Last Night's Review: All they really have to fear is fear itself. *The Scotsman*.
- Wild, J. (2006, December). Moving into the house to get out. *The Psychologist* 19(12), 168.
- Williams, T. (2007, 18 April). Man cured of 'life affecting' fish phobia. *Western Mail*. Retrieved from <http://www.walesonline.co.uk/news/wales-news/man-cured-life-affecting-fish-2259628>. Accessed 05/11/2016.
- Wilson, D. (2005, 13 August). Big Brother damages our health. *The Guardian*.
- Wollaston, S. (2006, 21 December). G2: Last night's TV: In the Bad Girls festive farewell, the Ghost of Christmas Yet to Come climbs out of a toilet. *The Guardian*.
- Wood, H. (2009). *Talking with television: Women, talk shows, and modern self-reflexivity*. Urbana and Chicago: University of Illinois Press.
- Woodrum, E. (1984). "Mainstreaming" content analysis in social science: Methodological advantages, obstacles, and solutions. *Social Science Research*, 13(1), 1-19.
- World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*: Geneva: World Health Organization.
- Wright, J. (2007, 7 April). The Guide: Radio Easter Monday: pick of the day. *The Guardian*.
- Wright, K. (2011). *The Rise of Therapeutic Society: Psychological Knowledge & the Contradictions of Cultural Change* Washington: New Academic Publishing.
- Wulff, D. P., St George, S.A., and Besthorn, F.H. (2011). Revisiting confidentiality: observations from family therapy practice. *Journal of Family Therapy*, 33(2), 199-214.
- Yates, C. (2011). Charismatic therapy culture and the seductions of emotional well-being. *Free Associations*(62), 59-84.
- Yeo, M., and Brook, A. (2003). The Moral Framework of Confidentiality and the Electronic Panopticon. In C. M. Koggel, Furlong, A., and Levin, C. (Ed.), *Confidential Relationships. Psychoanalytic, Ethical and Legal Contexts*. 84-112. New York: Rodopi.
- Yin, R. K. (2009). How to do better case studies. In L. Bickman & Rog, D.J. *The SAGE handbook of applied social research methods*. (2 edn.), 254-282.
- Yin, R. K. (2014). *Case study research: Design and methods*. Los Angeles London: Sage
- Zoellner, A. (2009). Professional Ideology and Program Conventions: Documentary Development in Independent British Television Production. *Mass Communication & Society*, 12(4), 503-536.

List of Programmes

A Home For Maisie (2011, 11 April), BBC Two, BBC Productions.

Addicted to Asda (2007, 18 June), FIVE, Landmark Films.

Bedlam: Anxiety (2013, 31 October), Channel 4. The Garden Productions.

Britain's Biggest Hoarders (2012, 8 May), BBC One, TwoFour Productions.

Britain's Biggest Hoarders (2013, 9/16/23 May), BBC One, TwoFour Productions.

Britain's Weirdest Phobias (2008, 30 December), ITV, Landmark Films.

Children Behaving Badly: Food Fights (2002, 15 August), Channel 4, Maverick TV.

Children Behaving Badly: Anxious (2002, 22 August), Channel 4, Maverick TV.

Extreme Phobias (2003, 17 September), Five, Landmark Films.

Fix My Fat Head (2009, 5 May), BBC One, Prospect Pictures.

Freaky Eaters (2007, 14/21/28 February & 7/14/21/22 March), BBC Three, betty Productions.

Freaky Eaters (2008, 13/20/27 February & 5/12/19/26 March & 2/4/ April), BBC Three, betty Productions.

Freaky Eaters (2009, 17/24 February & 3/10/17/24/31 March & 7 April), BBC Three, betty Productions.

Grendon (2000, 12 June), BBC Two, BBC Productions.

Growing Children: OCD (2012, 20 August), BBC Four, Pioneer Productions/Open University.

Help Me Help My Child: Anorexia (2006), Channel 4, Island World Communications.

Help Me Help My Child: OCD (2006, 4 December), Channel 4, Island World Communications.

Help Me Help My Child: Anorexia (2006, 4 December), Channel 4, Island World Communications.

House of Agoraphobics (2006, 19/20 December), Channel 4, Monkey Kingdom.

Hypochondriacs: I Told You I Was Ill (2007, 19 February), Channel 4, Century Films.

I Hate Mum (2010, 9 February), BBC One, ZKK.

I Want My Dad Back (2008, 27 October). Channel 4. Love Productions.

Inside My Head (2013, 7 August), BBC Three, The Comedy Unit.

Looks That Kill (2000, 7 March), BBC One, Films of Record.

My Child Won't Eat (2008, 16 June), ITV, Ricochet.

My Hoarder Mum and Me (2011, 16 August), BBC One, BBC Productions.

Obsessions Run My Life (2005, 2 January), Five, Landmark Films.

OCD Ward (2013, 28 October), ITV, Minnow Films.

Phobias (2000, 26 July), BBC One, BBC Science.

Sectioned (2010, 19 May), BBC Four, A Maverick Production.

Spendaholics (2005, 17/24/31 March & 4/11/18/25 April & 2/5/12 May), BBC Three, betty Productions.

Spendaholics (2007, 2/9/16/23/30 January & 6 February), BBC Three, betty Productions.

Spendaholics (2007, 19/26 July & 2/9/16/23 August), BBC Three, betty Productions.

Talking Cure (1999, 2/9/16/23 November & 7 December), BBC Two, BBC Productions.

BBC Productions.

The Hoarder Next Door (2012, 3/10/17/24 May), Channel 4, Twenty Twenty.

The Hoarder Next Door Christmas Special (2012, 21 December), Channel 4, Twenty Twenty.

The Hoarder Next Door (2013, 15/22/29 April & 6 May), Channel 4, Twenty Twenty.

The House of Obsessive Compulsives (2005, 1/8 August), Channel 4, Monkey Kingdom.

The Madness in Me (2005, 21 June), BBC One, BBC Productions.

The Man Who Loved the Number 12 (2005, 15 November), ITV, ITV Productions.

The Panic Room (2007, 10/17/24 April & 1/8/15 May), BBC Three, BBC Productions.

BBC Entertainment.

The Test: Agoraphobia & Flying (2003, 17/21 November), ITV, Meridien. Meridien.

The Test: Social Anxiety & Buttons (2004, 23 June & 6 August), ITV, Meridien. Meridien.

Too Ugly For Love (2006, 30 August), BBC Three, BBC Productions. BBC Productions.

World of Compulsive Hoarders (2007, 2 May), Channel 4, Zig Zag Productions.

APPENDICES

Appendix A: Research Ethics Approval Form

College Ethics Panel
Ethical Approval Form for Post-Graduate Researchers

Ethical approval must be obtained by all postgraduate research students (PGR) [prior](#) to starting research with human subjects, animals or human tissue.

A PGR is defined as anyone undertaking a Research rather than a Taught masters degree, and includes for example MSc by Research, MRes by Research, MPhil and PhD. The student must discuss the content of the form with their dissertation supervisor who will advise them about revisions. A final copy of the summary will then be agreed and the student and supervisor will 'sign it off'.

The signed Ethical Approval Form and application checklist must be forwarded to your College Support Office and also an electronic copy MUST be e-mailed to the contacts below at your College Support Office;

The forms are processed online therefore without the electronic version, the application cannot progress. Please note that the form must be signed by both the student and supervisor.

Please ensure that the electronic version of this form only contains your name and your supervisor's name on [this](#) page, where it has been requested.

All other references to you or anyone else involved in the project must be removed from the electronic version as the form has to be anonymised before the panel considers it.

Where you have removed your name, you can replace with a suitable marker such as [.....] Or [Xyz], [Yyz] and so on for other names you have removed too.

You should retain names and contact details on the hardcopies as these will be kept in a separate file for potential audit purposes.

Please refer to the 'Notes for Guidance' if there is doubt whether ethical approval is required

The form can be completed electronically; the sections can be expanded to the size required.

Name of Student: Lesley Blaker

Name of Supervisor: Andy Willis

School: Arts & Media

Course of study: PhD

Name of Research Council or other funding organisation: n/a

1a. Title of proposed research project

Current Title

From *Talking Cure* to *Bedlam*: Representations of Psychotherapy in British Factual Television 1999 to 2013

[Original Title: The role of psychological discourse in British factual television.]

1b. Is this Project Purely literature based?

NO

2. Project focus

How British factual television (particularly hybridised factual forms such as reality TV and lifestyle television) has utilised psychotherapeutic actuality as programme content.

3. Project objectives

To extend the research field of British factual television through the study of an under-represented programme category. To explore and extend the methodologies involved in the study of factual television programmes.

4. Research strategy

I will use a multi-method, triangulated approach, involving both quantitative and qualitative research methods, to identify, describe and analyse a sample of factual television programmes which use psychotherapeutic actuality as programme content.

My main primary data category is British factual television programmes which feature psychotherapeutic actuality.

This will be supplemented with the following data categories:

- Published industry-generated documentation and online materials related to the sampled programmes
- Online audience-generated materials associated with the sampled programmes
- Programme-maker accounts related to the production of the sampled programmes.

Data collection strategies:

- Database/library/archive research for sourcing television programmes
- Online/archive research for sourcing industry-based documentation
- Online research for sourcing audience-generated materials
- Interview and questionnaire methods for generating programme-maker accounts.

Recruitment of interviewees:

- Names of potential questionnaire respondents and interviewees have been generated from programme credits
- Online research will be used to generate contact details (e.g. company websites, personal websites, LinkedIn, BECTU, PACT).

Analysis of data:

Primary data will be analysed quantitatively (content analysis) and qualitatively (production analysis, genre analysis, narrative analysis and discourse/ideological analysis).

5. What is the rationale which led to this project?

The observation that psychotherapeutic actuality was being used differently in British factual television programmes following the emergence of reality TV. The observation that there is has been very little published research on this category of programme.

6. If you are going to work within a particular organisation do they have their own procedures for gaining ethical approval

NO

7. Are you going to approach individuals to be involved in your research?

YES

To supplement the key category of primary data within my research - British factual television programmes which use psychotherapeutic actuality as programme content - I will generate data from questionnaires and interviews with programme-makers who have been involved in making programmes in my research sample.

8. More specifically, how will you ensure you gain informed consent from anyone involved in the study?

Study participants will be given a Participant Information Leaflet (attached) which explains who I am, what my research is about, what would be involved and how confidentiality will be maintained.

Questionnaire respondents will be required to complete an informed consent form before completing the questionnaire. The questionnaire - which has been designed to generate generic, quantitative data - will be anonymised, the questions generalised and references to specific programmes avoided.

Interviewees will be required to complete an informed consent form before being interviewed. The interviews - which will be conducted to generate detailed, qualitative data - will be conducted in such a way as to ensure that desired levels of anonymity/confidentiality are met and maintained. Interviewees will select their preferred mode of identification (real name, initials or pseudonym) and choose how much detail about their professional background is to be included. A copy of the interview transcript will be sent to the interviewee for approval and/or amendment *but only if requested* (a time limit will be set for this task and a non-response will be taken to mean the interviewee does not wish to make amendments).

References to specific programmes and programme participants (psychotherapy volunteers or psychotherapists) will be scrutinised for potential breaches of pre-existing confidentiality arrangements made at the time of the programme's production. These will be anonymised or excised from transcripts/notes/extracts at the discretion of the Researcher.

I will not be approaching individuals who contribute to online forums, social networking sites, video-sharing sites and broadcaster-generated, programme-related message boards and blogs. However, I recognise that individuals who post online may, in some instances, be doing so with an expectation of privacy. My broad aim is to preserve the anonymity of individual posters who are referred to within my study. In order to achieve this outcome,

only online materials which are password-free will be used, published guidelines for how posted materials may be used will be observed, new 'handles' may be allocated to any poster who is referred to directly, personal and potentially sensitive material will be excluded and the use of exact-quoted materials will be minimised.

9. How are you going to address any Data Protection issues?

See notes for guidance which outline minimum standards for meeting Data Protection issues

I have completed the University of Salford's *Data Protection Induction* Blackboard module.

I have consulted online guidance provided by the University of Salford's *Research Data Management* Working Group concerning the creation of a Data Management Plan describing the data that my research will collate and generate, how it will be stored during my research period, how it will be archived at the end of my research and how access will be granted to it where appropriate.

Using this guidance, I have produced a Data Management Plan using the online tool at *DMPonline* (produced by the UK's Digital Curation Centre).

10. Are there any other ethical issues that need to be considered? For example - research on animals or research involving people under the age of 18.

No

--

11. (a) Does the project involve the use of ionising or other type of “radiation”

NO

(b) Is the use of radiation in this project over and above what would normally be expected (for example) in diagnostic imaging?

NO

(c) Does the project require the use of hazardous substances?

NO

(d) Does the project carry any risk of injury to the participants?

NO

(e) Does the project require participants to answer questions that may cause disquiet / or upset to them?

NO

If the answer to any of the questions 11(a)-(e) is YES, a risk assessment of the project is required and must be submitted with your application.

12. How many subjects will be recruited/involved in the study/research?

What is the rationale behind this number?

The number of individuals who will be directly involved in this research is proportionate to the number of programmes in the research sample. There are currently around forty-five programmes in the research sample. I anticipate making contact with upwards of thirty programme-makers with a request to complete my questionnaire.

In terms of the number of programme-makers who proceed to the interview stage, my aim is secure interviews with three to five programme-makers.

13. Please state which code of ethics has guided your approach (e.g. from Research Council, Professional Body etc).

Please note that in submitting this form you are confirming that you will comply with the requirements of this code. If not applicable please explain why.

Association of Internet Researchers (2012) Ethical Decision-Making and Internet Research. Recommendations from the AoIR Ethics Working Committee (Version 2.0)

Remember that informed consent from research participants is crucial, therefore all documentation must use language that is readily understood by the target audience.

Projects that involve NHS patients, patients' records or NHS staff, will require ethical approval by the appropriate NHS Research Ethics Committee. The University College Ethics Panel will require written confirmation that such approval has been granted. Where a project forms part of a larger, already approved, project, the approving REC should be informed about, and approve, the use of an additional co-researcher.

I certify that the above information is, to the best of my knowledge, accurate and correct. I understand the need to ensure I undertake my research in a manner that reflects good principles of ethical research practice.

Signed by Student _____

Print Name _____

Date _____

In signing this form I confirm that I have read this form and associated documentation.

***I have discussed and agreed the contents with the student on _____
(Please insert date of meeting with student)***

Signed by Supervisor _____

Print Name _____

Date _____

Research Centres Team
G.03 Joule House, Acton Square
The Crescent, Salford, M5 4WT
Tel: 0161 295 5876

22 July 2015

Lesley Blaker
University of Salford

Dear Lesley

Re: Ethical Approval Application – [REMOVED]

I am pleased to inform you that based on the information provided, the Research Ethics Panel have no objections on ethical grounds to your project.

Yours sincerely

[REMOVED]

On Behalf of the Research Ethics Panel

Appendix B: Research Sample Raw Data

1999	inst	TALKING CURE 1 indiv	2150	ep	BBC2	TUES	40'
1999	inst	TALKING CURE 2 fam	2150	ep	BBC2	TUES	40'
1999	inst	TALKING CURE 3 org	2150	ep	BBC2	TUES	40'
1999	inst	TALKING CURE 4 fam	2150	ep	BBC2	TUES	40'
1999	inst	TALKING CURE 6 couple	2150	ep	BBC2	TUES	40'
2000	inst	GRENDON	2130	single	BBC2	MON	50'
2000	inst	LOOKS THAT KILL	2200	single	BBC1	TUES	60'
2000	inst	PHOBIAS 3 feathers J PPS	2000	ep	BBC1	WEDS	40'
2002	inst	CHILDREN BEHAVING BADLY anxiety	2030	ep	C4	THURS	30'
2002	inst	CHILDREN BEHAVING BADLY food fights	2030	ep	C4	THURS	30'
2003	inst	EXTREME PHOBIAS	2100	single	Five	WEDS	60'
2003	inst	THE TEST 1/2 fear of flying W	1430	ep	ITV	FRI	30'
2003	inst	THE TEST 1/1 agoraphobia PPS	1430	ep	ITV	MON	30'
2004	non-inst	THE TEST 2/5 fear of buttons cbt PPS	1130	ep	ITV	FRI	30'
2004	inst	THE TEST 2/3 social anxiety E	1130	ep	ITV	FRI	30'
2005	inst	OBSSESSIONS RUN MY LIFE	2000	single	C5	SUN	60'
2005	inst	THE MAN WHO LOVED THE NUMBER 12	2000	single	ITV	TUES	60'
2005	inst	THE MADNESS IN ME	2235	single	BBC1	TUES	45'
2005	non-inst	SPENDAHOLICS 1/4 An	2100	ep	BBC3	MON	60'
2005	non-inst	SPENDAHOLICS 1/5 N	2100	ep	BBC3	MON	60'
2005	non-inst	SPENDAHOLICS 1/6 Al	2100	ep	BBC3	MON	60'
2005	non-inst	SPENDAHOLICS 1/7 D	2100	ep	BBC3	MON	60'
2005	non-inst	SPENDAHOLICS 1/8 Ad	2100	ep	BBC3	MON	60'
2005	non-inst	THE HOUSE OF OBSESSIVE COMPULSIVES 1	2100	ep	C4	MON	60'
2005	non-inst	THE HOUSE OF OBSESSIVE COMPULSIVES 2	2100	ep	C4	MON	60'
2005	non-inst	SPENDAHOLICS 1/1 C	2100	ep	BBC3	THURS	60'
2005	non-inst	SPENDAHOLICS 1/2 T	2100	ep	BBC3	THURS	60'
2005	non-inst	SPENDAHOLICS 1/3 R	2100	ep	BBC3	THURS	60'
2005	non-inst	SPENDAHOLICS 1/9 G	2100	ep	BBC3	THURS	60'
2005	non-inst	SPENDAHOLICS 1/9a Ah	2100	ep	BBC3	THURS	60'
2006	inst	TOO UGLY FOR LOVE	2100	single	BBC3	WEDS	60'
2006	inst	HELP ME HELP MY CHILD anorexia	2000	ep	C4	MON	60'
2006	inst	HELP ME HELP MY CHILD ocd	2000	ep	C4	MON	60'
2006	non-inst	HOUSE OF AGORAPHOBICS 1	2200	ep	C4	TUES	60'
2006	non-inst	HOUSE OF AGORAPHOBICS 2	2200	ep	C4	WEDS	60'
2007	non-inst	HYPOCHONDRIACS: I TOLD YOU I WAS ILL	2100	single	C4	MON	60'
2007	inst	ADDICTED TO ASDA	2100	single	C5	MON	60'
2007	non-inst	WORLD OF COMPULSIVE HOARDERS	2305	single	C4	WEDS	65'
2007	non-inst	SPENDAHOLICS 4/1 Ja	2000	ep	BBC3	TUES	60'
2007	non-inst	SPENDAHOLICS 4/2 Sa	2000	ep	BBC3	TUES	60'
2007	non-inst	SPENDAHOLICS 4/3 G	2000	ep	BBC3	TUES	60'
2007	non-inst	SPENDAHOLICS 4/4 P	2000	ep	BBC3	TUES	60'
2007	non-inst	SPENDAHOLICS 4/5 Re	2000	ep	BBC3	TUES	60'
2007	non-inst	SPENDAHOLICS 4/6 Jo	2000	ep	BBC3	TUES	60'
2007	non-inst	SPENDAHOLICS 5/1 St	2100	ep	BBC3	THURS	60'

2007	non-inst	SPENDAHOLICS 5/2 Ma	2100	ep	BBC3	THURS	60'
2007	non-inst	SPENDAHOLICS 5/3 Lo	2100	ep	BBC3	THURS	60'
2007	non-inst	SPENDAHOLICS 5/4 Ro	2100	ep	BBC3	THURS	60'
2007	non-inst	SPENDAHOLICS 5/5 Mi	2100	ep	BBC3	THURS	60'
2007	non-inst	SPENDAHOLICS 5/6 Sh	2100	ep	BBC3	THURS	60'
2007	non-inst	THE PANIC ROOM 1 cats & frogs	2100	ep	BBC3	TUES	60'
2007	non-inst	THE PANIC ROOM 2 fish & snakes	2100	ep	BBC3	TUES	60'
2007	non-inst	THE PANIC ROOM 3 buttons & cockroaches	2100	ep	BBC3	TUES	60'
2007	non-inst	THE PANIC ROOM 4 spiders & lifts	2100	ep	BBC3	TUES	60'
2007	non-inst	THE PANIC ROOM 5 birds & vomit	2100	ep	BBC3	TUES	60'
2007	non-inst	THE PANIC ROOM 6 wasps & spiders	2100	ep	BBC3	TUES	60'
2007	non-inst	FREAKY EATERS 1/1 crisps & pizza	2100	ep	BBC3	WEDS	60'
2007	non-inst	FREAKY EATERS 1/2 chips	2100	ep	BBC3	WEDS	60'
2007	non-inst	FREAKY EATERS 1/3 cheese	2100	ep	BBC3	WEDS	60'
2007	non-inst	FREAKY EATERS 1/4 spag hoops	2100	ep	BBC3	WEDS	60'
2007	non-inst	FREAKY EATERS 1/5 chocolate	2100	ep	BBC3	WEDS	60'
2007	non-inst	FREAKY EATERS 1/6 fried chicken	2100	ep	BBC3	WEDS	60'
2007	non-inst	FREAKY EATERS 1/7 junk food	2100	ep	BBC3	WEDS	60'
2008	non-inst	BRITAIN'S WEIRDEST PHOBIAS	2000	single	ITV	TUES	60'
2008	inst	MY CHILD WON'T EAT GH	2100	single	ITV	MON	60'
2008	non-inst	I WANT MY DAD BACK	2200	single	C4	MON	100'
2008	non-inst	FREAKY EATERS 2/1 sausages	2100	ep	BBC3	WEDS	60'
2008	non-inst	FREAKY EATERS 2/2 junk food	2100	ep	BBC3	WEDS	60'
2008	non-inst	FREAKY EATERS 2/3 meat	2100	ep	BBC3	WEDS	60'
2008	non-inst	FREAKY EATERS 2/4 bread	2100	ep	BBC3	WEDS	60'
2008	non-inst	FREAKY EATERS 2/5 meat & potatoes	2100	ep	BBC3	WEDS	60'
2008	non-inst	FREAKY EATERS 2/6 biscuits	2100	ep	BBC3	WEDS	60'
2008	non-inst	FREAKY EATERS 2/7 potatoes	2100	ep	BBC3	WEDS	60'
2008	non-inst	FREAKY EATERS 2/8 pasta	2100	ep	BBC3	WEDS	60'
2008	non-inst	FREAKY EATERS 2/9 cheese	2100	ep	BBC3	WEDS	60'
2009	non-inst	FIX MY FAT HEAD	2235	single	BBC1	TUES	50'
		FREAKY EATERS 3/1 bacon & burgers					
2009	non-inst	niquita	2000	ep	BBC3	TUES	60'
2009	non-inst	FREAKY EATERS 3/2 cheese	2000	ep	BBC3	TUES	60'
2009	non-inst	FREAKY EATERS 3/3 chips & beans	2000	ep	BBC3	TUES	60'
2009	non-inst	FREAKY EATERS 3/4 brown sauce	2000	ep	BBC3	TUES	60'
2009	non-inst	FREAKY EATERS 3/5 chips	2000	ep	BBC3	TUES	60'
2009	non-inst	FREAKY EATERS 3/6 diet cola	2000	ep	BBC3	TUES	60'
2009	non-inst	FREAKY EATERS 3/7 yorkshire puds	2000	ep	BBC3	TUES	60'
2009	non-inst	FREAKY EATERS 3/8 meat	2000	ep	BBC3	TUES	60'
2010	inst	SECTIONED	2100	single	BBC4	WEDS	60'
2010	inst	I HATE MUM	2235	single	BBC1	TUES	50'
2011	inst	A HOME FOR MAISIE	2100	single	BBC2	MON	60'
2011	non-inst	MY HOARDER MUM AND ME	2235	single	BBC1	TUES	50'
2012	non-inst	THE HOARDER NEXT DOOR xmas special	2100	single	C4	FRI	60'
2012	non-inst	BRITAIN'S BIGGEST HOARDERS orig	2100	single	BBC1	TUES	60'
2012	inst	GROWING CHILDREN: OCD	2100	ep	BBC4	MON	60'

2012	non-inst	THE HOARDER NEXT DOOR 1/1 n&j	2100	ep	C4	THURS	60'
2012	non-inst	THE HOARDER NEXT DOOR 1/2 t&p	2100	ep	C4	THURS	60'
2012	non-inst	THE HOARDER NEXT DOOR 1/3 y&h/j	2100	ep	C4	THURS	60'
2012	non-inst	THE HOARDER NEXT DOOR 1/4 t&j	2100	ep	C4	THURS	60'
2013	inst	INSIDE MY MIND (mental me)	2000	single	BBC3	WEDS	60'
2013	inst	OCD WARD	2100	single	ITV	MON	55'
2013	inst	THE HOARDER NEXT DOOR 2/1 a&j	2100	ep	C4	MON	60'
2013	inst	THE HOARDER NEXT DOOR 2/2 r&s	2100	ep	C4	MON	60'
2013	inst	THE HOARDER NEXT DOOR 2/3 t&l	2100	ep	C4	MON	60'
2013	inst	THE HOARDER NEXT DOOR 2/4 u&n	2100	ep	C4	MON	60'
2013	non-inst	BRITAIN'S BIGGEST HOARDERS 1 o&j	2100	ep	BBC1	THURS	60'
2013	non-inst	BRITAIN'S BIGGEST HOARDERS 3 w&l	2100	ep	BBC1	THURS	60'
2013	inst	BRITAIN'S BIGGEST HOARDERS 2 j&j	2100	ep	BBC1	THURS	60'
2013	inst	BEDLAM 1 anxiety	2100	ep	C4	THURS	60'

Appendix C: Gender Data

PROG	male psy	fem psy	male vol	fem vol	bame vol
A Home For Maisie	1	2	0	1	0
Addicted To Asda	1	0	0	1	0
Bedlam (Anxiety)	0	2	1	1	0
Britain's Biggest Hoarders	2	2	4	5	1
Britain's Weirdest Phobias	1	0	0	3	2
Children Behaving Badly (Anxious)	1	1	1	1	0
Children Behaving Badly (Food)	0	1	1	0	0
Extreme Phobias	1	1	1	1	0
Fix My Fat Head	0	1	0	1	0
Freaky Eaters	3	0	12	10	1
Grendon	1	0	5	0	0
Growing Children OCD	0	3	1	0	0
Help Me Help My Child (anorexia)	1	3	1	1	0
Help Me Help My Child (OCD)	1	1	2	0	0
House of Agoraphobics	3	1	1	2	1
Hypochondriacs	2	0	1	3	0
I Hate Mum	1	3	2	0	0
I Want My Dad Back	1	0	4	0	2
Inside My Mind (Anxiety)	0	1	1	0	0
Looks That Kill	1	0	0	1	0
My Child Won't Eat	0	1	2	1	0
My Hoarder Mum And Me	1	0	0	1	1
Obsessions Run My Life	1	0	0	2	0
OCD Ward	1	2	1	1	0
Phobias	1	0	0	1	0
Sectioned	4	1	3	0	1
Spendaholics	1	0	10	12	4
Talking Cure	2	5	4	2	0
The Hoarder Next Door	1	0	6	13	0
The House of Obsessive Compulsives	2	2	1	2	1
The Madness in Me	1	1	0	1	0
The Man Who Loved The Number 12	1	0	1	0	1
The Panic Room	1	1	3	9	1
The Test	4	0	0	4	0
Too Ugly For Love	2	0	1	2	0
World of Compulsive Hoarders	1	0	1	0	0
totals	45	35	71	82	16

Appendix D: Research Participant Information Sheet



RESEARCH PARTICIPANT INFORMATION SHEET

WHO AM I?

My name is Lesley Blaker. I am a former television professional who teaches at the University of Salford's MediaCityUK Campus. I am researching for my PhD within the university's Communication, Cultural and Media Studies Research Centre.

WHAT AM I RESEARCHING?

I am researching factual television programmes which feature psychotherapeutic actuality as a significant part of their content. My thesis title is: **An analysis of psychotherapy in UK factual television programming from *Talking Cure* (1999) to *Bedlam* (2013)**. My study has been approved by the University of Salford's Ethics Committee.

WHY AM I RESEARCHING THIS SUBJECT?

I have a long-standing interest in psychotherapy. There has been no significant academic research into this kind of programming. There was an increase in this kind of programming in the mid-2000s and I want to explore the reasons for this.

WHY AM I CONTACTING YOU?

I am approaching you because you were credited in a significant production role on one or more of the programmes in my research sample. The programmes I am interested in are UK-originated factual television programmes broadcast between 1999 and 2013 which feature psychotherapeutic actuality.

WHAT WOULD BE INVOLVED?

I would like you to complete a questionnaire which will enable me to explore the subject in more detail. Extracts from your responses will be anonymised and may be used within my thesis and any books, book chapters, journal articles and conference papers that emerge from my research. If you are interested in helping me further, I would like to interview you (and record the interview). If you agree to be interviewed, you will be able to determine how you are identified within the study and any associated

presentations and publications. The level of involvement is entirely up to you and you may, of course, withdraw from the study at any time.

Lesley Blaker / [REMOVED]

[REMOVED]

Appendix E: Research Questionnaire



Communication, Cultural and Media Studies Research Centre

Researcher: Lesley Blaker

Study Title: An analysis of psychotherapy in UK factual television programming from *Talking Cure* (1999) to *Bedlam* (2013).

How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?	
Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?	
With your particular programme(s), was the intention to reach a wide audience or a niche audience?	
What techniques did you use to find and select programme participants? Were these any different from your usual techniques?	
Was any psychological screening of the programme	

<p>participants required before filming began?</p>	
<p>What locations (e.g. consulting-room, studio set, public spaces) were used for the filming of the psychotherapy? What advantages and disadvantages did these present?</p>	
<p>Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?</p>	
<p>What production challenges did you face making a programme or series which featured psychotherapy? In your experience, how does filming psychotherapy differ from other kinds of actuality?</p>	
<p>Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?</p>	
<p>Would you be prepared to participate in a</p>	

<p>short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.</p>											
<table border="1"> <tr> <td> <p>Participant Consent Form - QUESTIONNAIRE</p> </td> <td> <p>Participant's Initials & Date</p> </td> </tr> <tr> <td> <p>I have read the Participant Information Sheet about the PhD study An analysis of psychotherapy in UK factual television programming from <i>Talking Cure (1999)</i> to <i>Bedlam (2013)</i>.</p> </td> <td></td> </tr> <tr> <td> <p>I have had the opportunity to ask questions about the study and have received satisfactory answers.</p> </td> <td></td> </tr> <tr> <td> <p>I agree that my responses to this questionnaire may be used anonymously within the thesis and any subsequent books, book chapters, journal articles and conference papers that arise from it.</p> </td> <td></td> </tr> <tr> <td colspan="2"> <p>Please return your completed questionnaire to [REMOVED]</p> <p><i>Thank you for helping with my research.</i></p> </td> </tr> </table>		<p>Participant Consent Form - QUESTIONNAIRE</p>	<p>Participant's Initials & Date</p>	<p>I have read the Participant Information Sheet about the PhD study An analysis of psychotherapy in UK factual television programming from <i>Talking Cure (1999)</i> to <i>Bedlam (2013)</i>.</p>		<p>I have had the opportunity to ask questions about the study and have received satisfactory answers.</p>		<p>I agree that my responses to this questionnaire may be used anonymously within the thesis and any subsequent books, book chapters, journal articles and conference papers that arise from it.</p>		<p>Please return your completed questionnaire to [REMOVED]</p> <p><i>Thank you for helping with my research.</i></p>	
<p>Participant Consent Form - QUESTIONNAIRE</p>	<p>Participant's Initials & Date</p>										
<p>I have read the Participant Information Sheet about the PhD study An analysis of psychotherapy in UK factual television programming from <i>Talking Cure (1999)</i> to <i>Bedlam (2013)</i>.</p>											
<p>I have had the opportunity to ask questions about the study and have received satisfactory answers.</p>											
<p>I agree that my responses to this questionnaire may be used anonymously within the thesis and any subsequent books, book chapters, journal articles and conference papers that arise from it.</p>											
<p>Please return your completed questionnaire to [REMOVED]</p> <p><i>Thank you for helping with my research.</i></p>											

Appendix RQ1: Research Questionnaire RQ1

<p>Q1 How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q2 Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q3 With your particular programme(s), was the intention to reach a wide audience or a niche audience?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q4 What techniques did you use to find and select programme participants? Were these any different from your usual techniques?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q5 Was any psychological screening of the programme participants required before filming began?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q6 What locations (e.g. consulting-room, studio set, public spaces) were used for the filming of the psychotherapy? What advantages and disadvantages did these present?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q7 Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q8 What production challenges did you face</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>

making a programme or series which featured psychotherapy? In your experience, how does filming psychotherapy differ from other kinds of actuality?	
Q9 Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
Would you be prepared to participate in a short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Participant Consent Form - QUESTIONNAIRE	
	Participant's Initials & Date
I have read the Participant Information Sheet about the PhD study An analysis of psychotherapy in UK factual television programming from <i>Talking Cure</i> (1999) to <i>Bedlam</i> (2013).	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
I have had the opportunity to ask questions about the study and have received satisfactory answers.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
I agree that my responses to this questionnaire may be used anonymously within the thesis and any subsequent books, book chapters, journal articles and conference papers that arise from it.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
<p align="center">Please return your completed questionnaire to [REMOVED]</p> <p align="center"><i>Thank you for helping with my research.</i></p>	

Appendix RQ2: Research Questionnaire RQ2

<p>Q1 How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q2 Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q3 With your particular programme(s), was the intention to reach a wide audience or a niche audience?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q4 What techniques did you use to find and select programme participants? Were these any different from your usual techniques?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q5 Was any psychological screening of the programme participants required before filming began?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q6 What locations (e.g. consulting-room, studio set, public spaces) were used for the filming of the psychotherapy? What advantages and disadvantages did these present?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q7 Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q8 What production challenges did you face making a programme or series which featured psychotherapy? In your</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>

experience, how does filming psychotherapy differ from other kinds of actuality?	
Q9 Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
Would you be prepared to participate in a short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Participant Consent Form - QUESTIONNAIRE	Participant's Initials & Date
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I have had the opportunity to ask questions about the study and have received satisfactory answers.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
I agree that my responses to this questionnaire may be used anonymously within the thesis and any subsequent books, book chapters, journal articles and conference papers that arise from it.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
<p>Please return your completed questionnaire to [REMOVED]</p> <p><i>Thank you for helping with my research.</i></p>	

Appendix RQ3: Research Questionnaire RQ3

<p>Q1 How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q2 Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q3 With your particular programme(s), was the intention to reach a wide audience or a niche audience?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q4 What techniques did you use to find and select programme participants? Were these any different from your usual techniques?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q5 Was any psychological screening of the programme participants required before filming began?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q6 What locations (e.g. consulting-room, studio set, public spaces) were used for the filming of the psychotherapy? What advantages and disadvantages did these present?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q7 Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q8 What production challenges did you face making a programme or series which featured psychotherapy? In your</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>

experience, how does filming psychotherapy differ from other kinds of actuality?	
Q9 Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
Would you be prepared to participate in a short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

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I have had the opportunity to ask questions about the study and have received satisfactory answers.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
I agree that my responses to this questionnaire may be used anonymously within the thesis and any subsequent books, book chapters, journal articles and conference papers that arise from it.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
<p>Please return your completed questionnaire to [REMOVED]</p> <p><i>Thank you for helping with my research.</i></p>	

Appendix RQ4: Research Questionnaire RQ4

<p>Q1 How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q2 Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q3 With your particular programme(s), was the intention to reach a wide audience or a niche audience?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q4 What techniques did you use to find and select programme participants? Were these any different from your usual techniques?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q5 Was any psychological screening of the programme participants required before filming began?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>

<p>Q6 What locations (e.g. consulting-room, studio set, public spaces) were used for the filming of the psychotherapy? What advantages and disadvantages did these present?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q7 Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q8 What production challenges did you face making a programme or series which featured psychotherapy? In your experience, how does filming psychotherapy differ from other kinds of actuality?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q9 Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Would you be prepared to participate in a short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>

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Please return your completed questionnaire to [REMOVED] <i>Thank you for helping with my research.</i>													

Appendix RQ5: Research Questionnaire RQ5

<p>Q1 How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q2 Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q3 With your particular programme(s), was the intention to reach a wide audience or a niche audience?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q4 What techniques did you use to find and select programme participants? Were these any different from your usual techniques?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q5 Was any psychological screening of the programme participants required before filming began?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q6 What locations (e.g. consulting-room, studio set, public spaces) were used</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>

for the filming of the psychotherapy? What advantages and disadvantages did these present?	
Q7 Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
Q8 What production challenges did you face making a programme or series which featured psychotherapy? In your experience, how does filming psychotherapy differ from other kinds of actuality?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
Q9 Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
Would you be prepared to participate in a short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Participant Consent Form - QUESTIONNAIRE	Participant's Initials & Date
I have read the Participant Information Sheet about the PhD study An analysis of psychotherapy in UK factual television programming from <i>Talking Cure</i> (1999) to <i>Bedlam</i> (2013).	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
I have had the opportunity to ask questions about the study and have received satisfactory answers.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
I agree that my responses to this questionnaire may be used anonymously within the thesis and any subsequent books, book chapters, journal articles and conference papers that arise from it.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
<p>Please return your completed questionnaire to [REMOVED]</p> <p><i>Thank you for helping with my research.</i></p>	

Appendix RQ6: Research Questionnaire RQ6

<p>Q1 How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q2 Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q3 With your particular programme(s), was the intention to reach a wide audience or a niche audience?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q4 What techniques did you use to find and select programme participants? Were these any different from your usual techniques?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q5 Was any psychological screening of the programme participants required before filming began?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q6 What locations (e.g. consulting-room, studio set, public spaces) were used for the filming of the psychotherapy? What advantages and disadvantages did these present?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q7 Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q8 What production challenges did you face making a programme or series which featured psychotherapy? In your</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>

experience, how does filming psychotherapy differ from other kinds of actuality?	
Q9 Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
Would you be prepared to participate in a short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Participant Consent Form – QUESTIONNAIRE	Participant's Initials & Date
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I have had the opportunity to ask questions about the study and have received satisfactory answers.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
I agree that my responses to this questionnaire may be used anonymously within the thesis and any subsequent books, book chapters, journal articles and conference papers that arise from it.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
PLEASE KEEP PRODUCTION NAME AND CONTRIBUTOR NAME CONFIDENTIAL. [REMOVED]	

Please return your completed questionnaire to [REMOVED]

Thank you for helping with my research.

Appendix RQ7: Research Questionnaire RQ7

<p>Q1 How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q2 Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q3 With your particular programme(s), was the intention to reach a wide audience or a niche audience?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q4 What techniques did you use to find and select programme participants? Were these any different from your usual techniques?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q5 Was any psychological screening of the programme participants required before filming began?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q6 What locations (e.g. consulting-room, studio set, public spaces) were used for the filming of the psychotherapy? What advantages and disadvantages did these present?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q7 Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>

<p>Q9 Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>										
<p>Would you be prepared to participate in a short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>										
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<p>Participant Consent Form - QUESTIONNAIRE</p>	<p>Participant's Initials & Date</p>										
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<p>Please return your completed questionnaire to [REMOVED]</p> <p><i>Thank you for helping with my research.</i></p>											

Appendix RQ8: Research Questionnaire RQ8

Q1 How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Q2 Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Q3 With your particular programme(s), was the intention to reach a wide audience or a niche audience?

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Q4 What techniques did you use to find and select programme participants? Were these any different from your usual techniques?

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Q5 Was any psychological screening of the programme participants required before filming began?

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Q6 What locations (e.g. consulting-room, studio set, public spaces) were used for the filming of the psychotherapy? What advantages and disadvantages did these present?

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Q7 Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Q8 What production challenges did you face making a programme or series which featured psychotherapy? In your experience, how does filming psychotherapy differ from other kinds of actuality?

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Q9 Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Q10 Would you be prepared to participate in a short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

Participant Consent Form - QUESTIONNAIRE

I have read the Participant Information Sheet about the PhD study **An analysis of psychotherapy in UK factual television programming from *Talking Cure* (1999) to *Bedlam* (2013).**

MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

I have had the opportunity to ask questions about the study and have received satisfactory answers.
MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.

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Please return your completed questionnaire to [REMOVED]

Thank you for helping with my research.

Appendix RQ9: Research Questionnaire RQ9

<p>Q1 How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q2 Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q3 With your particular programme(s), was the intention to reach a wide audience or a niche audience?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q4 What techniques did you use to find and select programme participants? Were these any different from your usual techniques?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q5 Was any psychological screening of the programme participants required before filming began?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q6 What locations (e.g. consulting-room, studio set, public spaces) were used for the filming of the psychotherapy? What</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>

advantages and disadvantages did these present?					
Q7 Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.				
Q8 What production challenges did you face making a programme or series which featured psychotherapy? In your experience, how does filming psychotherapy differ from other kinds of actuality?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.				
Q9 Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.				
Would you be prepared to participate in a short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.				
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(2013).		
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I agree that my responses to this questionnaire may be used anonymously within the thesis and any subsequent books, book chapters, journal articles and conference papers that arise from it.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.	
Please return your completed questionnaire to [REMOVED] <i>Thank you for helping with my research.</i>		

Appendix RQ10: Research Questionnaire RQ10

<p>Q1 How did the programme or series come about? Were you instrumental in developing the idea and getting the commission?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q2 Thinking about the programme(s) you were involved with, and others you may have seen, do you think psychotherapy is a good subject for factual television?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q3 With your particular programme(s), was the intention to reach a wide audience or a niche audience?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q4 What techniques did you use to find and select programme participants? Were these any different from your usual techniques?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q5 Was any psychological screening of the programme participants required before filming began?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q6 What locations (e.g. consulting-room, studio set, public spaces) were used for the filming of the psychotherapy? What advantages and disadvantages did these present?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q7 Roughly, how many psychotherapy sessions did you need to film in order to generate enough material for a single programme?</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>
<p>Q8 What production challenges did you face making a programme or series which featured psychotherapy? In your</p>	<p>MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.</p>

experience, how does filming psychotherapy differ from other kinds of actuality?	
Q9 Is there anything else you would like to say about your experience of programme-making which involves psychotherapy?	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
Would you be prepared to participate in a short recorded interview at your convenience in which we would discuss in more detail the points you have raised? If yes, please let me know your preferred contact details and availability.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
Participant Consent Form - QUESTIONNAIRE	Participant's Initials & Date
I have read the Participant Information Sheet about the PhD study An analysis of psychotherapy in UK factual television programming from <i>Talking Cure</i> (1999) to <i>Bedlam</i> (2013).	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
I have had the opportunity to ask questions about the study and have received satisfactory answers.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
I agree that my responses to this questionnaire may be used anonymously within the thesis and any subsequent books, book chapters, journal articles and conference papers that arise from it.	MATERIAL REMOVED BY THE AUTHOR OF THIS THESIS FOR RESEARCH ETHICS REASONS.
Please return your completed questionnaire to [REMOVED]	
<i>Thank you for helping with my research.</i>	