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The neoliberal subject, reality TV and free association: A Freudian audience study of *Embarrassing Bodies*

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Abstract:

This article presents particular themes from an audience study with viewers of the British reality show *Embarrassing Bodies* (Channel 4). A methodology based on the Freudian technique of free association was used to research viewers' narratives about the programme. I focus on two participants who spoke about the show in terms that make use of internalised neoliberal discourses about the limits to entitlement to public healthcare as well as self-responsibility for staying healthy. They also discussed aspects which contradicted those themes. The narratives were of an ambiguous nature and shifting views were outlined in the course of each interview. I theorise such shifting with Sigmund Freud's concept of 'negation' whereby an idea is rejected in order to avoid further engagement with it. Rather than accusing the viewers of lying or having false consciousness, psychoanalysis opens up nuanced ways of interpreting the data. It helps us to understand how individuals are (un)consciously positioned in contemporary austerity and crisis discourses around healthcare. Given the ambivalent interview narratives, I conclude that the current economic climate in the UK has resulted in the formation of subjectivities who struggle to make sense of it as they simultaneously resist and embrace it.

Keywords: Reality TV Audiences, Free Association, Psychoanalysis, Negation, NHS

Introduction

Scholars have shown that viewers often feel ambivalent about reality shows and articulate a critical distance towards the content they consume, yet may be strongly attached to certain formats at the same time (Hill, 2005, 2007; Skeggs and Wood, 2012; Sender, 2012; Whitehouse-Hart, 2014). Such feelings of ambivalence are often articulated in relation to

the shaming or ridiculing of participants that takes place on reality television for entertainment or *schadenfreude* moments on the part of audiences (Sender, 2012). This article builds on such arguments and discusses results from an audience study with viewers of the British show *Embarrassing Bodies* (Channel 4, 2007-2015) by drawing on psychoanalytic frameworks and methodology. Some scholars within television studies (Ang, 1991; Silverstone, 1994; Ellis, 2000; Hill, 2007; Kavka, 2009; Whitehouse-Hart, 2014) have drawn on psychoanalytic theories in their works. Media and communication studies more generally make some references to psychoanalysis (e.g. Radway, 1984; Walkerdine, 1986; Hills, 2002; Dahlgren, 2013; Carpentier, 2014) but there is scope to develop and use psychoanalysis, particularly when it comes to empirical audience research as a theoretical and methodological framework. Before outlining such a framework in this article, I contextualise *Embarrassing Bodies* regarding its location within neoliberal, British culture in times of austerity.

Embarrassing Bodies was a medical reality show. It features scenes of consultation between patients and doctors and subsequent medical treatment. It shows a range of ages and ethnicities as well as very common and rare medical conditions. Mostly, patients are granted treatment by private medical professionals that is paid for by Channel 4. The programme often shows narratives of patients who implicitly express that they were not helped or received the wrong kind of treatment in the past on the National Health Service (NHS) – the public British health system financed by the government and the taxpayer – and articulate that *Embarrassing Bodies* is their last hope.

Ouellette and Hay argue that as part of neoliberalism many public services, such as healthcare, or job schemes, have been contracted to private companies in the western world. Reality television shows tap into that development and serve functions the welfare state once held to a fuller extent: e.g. training people for new jobs, helping with educational problems, advocating a fitness programme, administering medical treatment (Ouellette and Hay, 2008). Questions around austerity and the provision and affordability of healthcare are particularly pertinent with regards to *Embarrassing Bodies*. As part of wider austerity politics, there were and are continuing actions and plans by British governments to privatise sections of the NHS in times of budget cuts and a public healthcare system on the brink of financial collapse (Baggott, 2004; Davis, Lister and Wrigley, 2015). Rather than investing in the NHS, privatisation is communicated as a better option by politicians. The current crisis of an underfunded NHS is linked to the 2008 global financial crisis that led to austerity measures in the UK (Roberts, Marshall and Charlesworth, 2012). From 2010 onwards, UK governments have introduced a spending freeze that has resulted in cutbacks to services by hospital trusts in order to save money (Tallis, 2013; Davis, Lister and Wrigley, 2015; Hamad, 2016). In her overview of past and current British medical television programmes, Hannah Hamad has argued that there has been an increase of documentary and reality formats over the past 15 years that portray nurses and doctors on British television. This increase is also related to public discussions about the future of the NHS.

In the UK, the 2013 implementation of the Health and Social Care Act of 2012 has brought about a situation in which the future of the NHS has never been more precarious. Compounded by the attacks on the medical and nursing professions that followed in the wake of the Stafford Hospital scandal, the stakes for doctors, nurses and other healthcare workers in how the media shapes public consciousness of their professions, their identities and the value of their labour have never been higher (Hamad, 2016, 146).

As a media text, *Embarrassing Bodies* features perhaps uneasily in such a climate. Given that it provides private treatment in the majority of cases shown. What does this 'public consciousness' look like? How is it infused by unconscious elements? Based on the background outlined above, a research question of how audiences responded to and made sense of *Embarrassing Bodies* was chosen by me. *Embarrassing Bodies* represents a media text that is situated within wider NHS crisis discourse in popular culture (Hamad, 2016). I was interested in if the NHS and its so-called 'crisis' would emerge in the interviews with viewers. As noted, there is some contrast between the current situation of public healthcare in Britain and how healthcare provision is portrayed on *Embarrassing Bodies*. As most reality television, the show suggests that any ailment can be treated and patients are immediately seen by expert doctors. However, the study was not only about the themes discussed in this article. I was also interested in hearing about people's views on *Embarrassing Bodies* more generally and how the show may relate to feelings about their own bodies. The data presented complex and affective ways of engaging with the programme. An important theme which is not discussed in this article related to how highly the participants spoke of the doctors. They spoke of the doctors in ideal terms and all expressed that they would like to have such doctors as their GPs. All participants also shared experiences about their own bodies and how similar they felt at times to the patients on the programme. They had experienced chronic illness, trauma, as well as 'embarrassing' bodily conditions. I interpret such narratives as desires for being similarly helped and contained by the *Embarrassing Bodies* doctors (Johanssen, 2018). This ultimately remained a fantasy because my research participants had never met the doctors and would not go on the programme.

In that sense, the data is 'messier' than what the discussion of specific themes in this article may suggest and it is important to keep this in mind.

As many other reality programmes, *Embarrassing Bodies* consists of elements that relate to ridicule and sensationalist exposure of their bodies in order to make for an engaging reality show (Johanssen, 2017). The following sequence illustrates such performative dynamics:

Dr. Dawn: Trina, come on in, take a seat. How can I help you?

Trina: I'm here today to talk about my belly, erm, just from scarring, I've got deep scars.

Dr. Dawn: So scarring, did you have an operation or an injury to your tummy?

Trina: Yeah, I had surgery done. I had part of my bowel removed, erm, from colitis.

Dr. Dawn: What were the symptoms that you were experiencing?

Trina: Erm, just, erm, being able to control, erm, toilet, having accidents, daily, erm.

Dr. Dawn: Oh my word, so you were actually leaking faeces, were you?

Trina: Basically.

Dr. Dawn: And was there a lot of blood and so on?

Trina: Yeah (S5, E4, 26/03/2012: 10.05-10.26).

In the above sequence, Trina is seen as being uncomfortable about her body. Dr. Dawn reacts by asking questions that reinforce embarrassment in her: Trina is apprehensive in her answers as the number of 'erms' indicate. Towards the end of the sequence, the doctor replies with a performed shocked reaction by grimacing and raising her voice: 'Oh my word, so you were actually leaking faeces, were you?' to which Trina merely utters a 'basically'. These graphic questions create powerful imagery through speech acts and dialogue. Particularly words like 'faeces' or 'blood' are emphasised in a performative manner by Dr. Dawn. From a content-oriented perspective, such a scene could be analysed through Kristeva's notion of the abject (1982) which suggests an affective repulsion and existential fear of e.g. seeing a body that leaks faeces.

However, while the programme could be criticised for such a sensationalist coverage and can be positioned as a media text within neoliberalism, audiences may still consume it for a number of reasons beyond sensationalism. Previous research on similar programmes may suggest that it might be consumed for reasons of voyeurism, escapism or *schadenfreude* alone (e.g. Deery, 2004; Hall, 2006; Baruh, 2010). However, *Embarrassing Bodies* offers particular narratives of healing and cure of all kinds of bodies. Bodies are welcomed on the programme and are treated. The programme offers the message that all bodies can be treated and cured. This may be of value to audiences. It may add to (un)conscious feelings of ease about their own bodily problems, as many interviewees in the study articulated. At the same time, and this was very present in the data, audiences are also shocked and sometimes disgusted by the graphicness of the programme. Many interviewees articulated a morbid fascination with seeing bodies on the show. They were shocked and fascinated at the same time. Interviewees were keen to stress that they empathised with such bodies but were not quite the same. From a psychoanalytic perspective, such layers of data reveal contradictory and yet connected motives. Viewers are at once drawn to and repelled by the text. Skeggs and Wood (2012) note that viewers may feel ambivalent about reality television because they may recognise themselves in certain scenes and think about themselves. Such responses 'reveal the moments where our respondents are virtually subject to judgment: the programme positions them "as if" they are the television participants.' (Skeggs and Wood, 2012, 150) As a result, viewers may move in and out of moments of compassion and empathy within the viewing process.

Skeggs and Wood theorise this movement as a very conscious process of recognition that leads to misrecognition and differentiation through narratives that, in their project, were mostly related to cultural and class distinctions (Skeggs and Wood, 2012). In drawing on psychoanalysis, I suggest that there may be an unconscious dimension of such ambivalent¹ responses which was partly rendered conscious through particular narratives in the interviews. This is one of the key methodological innovations that a psychoanalytic approach to audience research can offer.

Free Association as Methodology

I was interested in (among other questions) what audiences thought of the show’s patients and their interactions with the doctors, such as the one reproduced above. In order to find out more about such issues, a psychoanalytic methodology was chosen. I posed general questions about the participants’ thoughts on the doctors and patients in order to generate detailed narratives from participants. As noted, I was also interested in questions that went beyond issues touched on in this article (such as participants’ own views of their bodies) and there is no space to discuss them in much detail. I thus present particular themes in relation to the NHS, public healthcare and austerity in this article. A more comprehensive account of other themes which were present in the data is discussed in (Johanssen, 2018). A total of ten in-depth interviews were conducted with viewers of the show in the course of 2014. They were recruited through Twitter by searching for tweets on *Embarrassing Bodies* and then informing them about my research project. All interviews took place in cafés. Eight were held in London and two in Cambridge.² The interviewees’ demographic information is as follows:

Interview #	Gender	Age	Ethnicity	Occupation
01	Female	32	White - Other	Postgraduate Student
02	Female	54	White - British	Journalist
03	Female	29	White - British	Facilities Manager
04	Transgender	21	White - British	Undergraduate Student
05	Female	47	White - British	Nurse Practitioner
06	Female	Not disclosed	White – Other	Undergraduate Student
07	Male	53	White - British	Civil Servant
08	Female	26	White - British	Undergraduate Student
09	Male	52	White - British	Chef
10	Male	25	White - British	Freelance Journalist

It needs to be pointed out that the sample was not balanced in terms of the ethnicity and gender of the participants and this constitutes a limitation of the study.

Sigmund Freud maintained that psychoanalysis is a method (Devereux, 1967; Freud, 1978), as well as a theory. Free association is one of the key principles of psychoanalysis. In

encouraging his patients to freely associate and speak of anything that came into their mind, Freud argued that unconscious ideas, fantasies and memories could be rendered conscious. In thinking and speaking about them, a transition from something unknown to something known may occur. In that sense, free associations are never totally free. A flow of utterances is enabled through them that is not entirely subject to conscious control and self-censorship. Repressed, forgotten, or negated fragments can thus come to the surface (Freud, 1978).

To be sure, a psychoanalytically informed research method does not aim to uncover a 'real' self, or gain access to someone's true desires. As I demonstrate in the following pages, free association may lead to rich(er) data and narrative accounts that can be characterised by ambivalence, contradiction, affective responses and complex utterances. Freudian psychoanalysis in particular has been criticised in the past for its universalism, ahistoricity and anachronistic views. Critics have argued that Freud was largely ignorant to the specific (bourgeois) conditions of his own practice that did not take account of issues such as ethnicity or class belonging. His foregrounding of the *Oedipus complex* (an unconscious desire of the young boy for his mother that is eventually abandoned as he becomes more aware of social forces around him) and female hysteria in his early works has been labelled as sexist and constructed (Mitchell, 1974). It is important to bear in mind that aspects of Freud's ideas were problematic, but this does not render some fundamental paradigms of psychoanalytic thought obsolete. I did not replicate psychoanalysis as a form of therapy or a therapeutic method. I did not psychoanalyse my participants or infer information from them that was not grounded in the data. The interview method is thus only informed by psychoanalytic ideas and is still rooted in qualitative research methods. The emerging field of psychosocial studies, which broadly speaking combines psychoanalytic concepts and methods with ideas from the social sciences, has been partly responsible for a revival of psychoanalytic frameworks in social research. Wendy Hollway and Tony Jefferson's work (2012) is particularly noteworthy here. They have adapted the notion of free association for social research. In drawing on free association, an interview is not structured according to a formalist, conscious logic but according to an unconscious one: 'the associations follow pathways defined by emotional motivations, rather than rational intentions' (Hollway and Jefferson, 2012, 34). In addressing the subject in a more complex way, one may open up ways of responding in a less restricted and conscious way than in traditional interviews that involve a question-answer dynamic. Before each interview began, I asked the participant to freely associate and speak about anything that would come into their minds during the interview. I explained that I would ask them general questions about *Embarrassing Bodies* and that they could share anything they wished to share in response. In order to generate narratives about the doctors and patients on the show, I specifically asked participants the following question (among others): 'What do you think of the people who go on the programme?'

When it comes to interpreting qualitative data from a psychoanalytic perspective, I was particularly interested in sections of the transcripts that may point to the unconscious

and a movement whereby something unconscious is rendered conscious through thinking and speaking during an interview. Bereswill et al. (2010) suggest that there are moments in interviews that point to unconscious processes being made conscious. They are 'often signalled [sic] by gaps, inconsistencies, unusual or disjointed language, narrative leaps and abrupt changes of subject' (Bereswill et al., 2010, 239).

Psychoanalysis points to such moments in the data. Interpretation is also primarily structured by an associative reading of the data by the researcher as a first step in order to feel what the data may evoke in him / her. Following Hollway and Jefferson (2012), I read each interview transcript many times in order to get a sense of the interview as a whole and what words and images I associated as a result. As a secondary step, I then came up with general themes that summarised narratives that were shared or stood out across the interviews. The reader might ask at this stage: Why psychoanalysis now? What can the discipline and specifically the notion of free association contribute to media audience research? Psychoanalysis consists of a particular theory of the human subject that can potentially add a level of complexity to television studies and media studies more generally. It can shift our attention to contradictions, incoherencies, ambiguities and resistances both within media texts as well as in the responses to them by audiences. Such an angle places an emphasis on relational dynamics between interviewer and interviewee. Particular narratives may emerge and are hindered from emerging because of the rapport between interviewer and interviewee and how unconscious dynamics and processes also contribute to the atmosphere of the interview. It is helpful to acknowledge not only that what we say contributes to rapport but also what we do not say and merely think. I return to this point when discussing some of the data. Secondly, in being attentive to the associative dynamics of each interview and how they were brought about through free association, the focus shifts beyond rationality and consciousness. Some commentators have remarked in the past that there is an implicit and sometimes explicit theory of the human subject in media and communication studies that is characterised by rationality, coherence and conscious agency (Hill, 2007; Dahlgren, 2013; Whitehouse-Hart, 2014). In contrast to other epistemologies commonly held in the field of media and communication research, a 'psychodynamic mode places emphasis on the irrational self, subjective rather than objective experiences and contradictory responses, all of which are part of viewing practices' (Hill, 2007, 85). I explore examples of such narratives that came about as a result of free association in the next sections.

Social Change, Neoliberalism and Discursive Shifting

There were a number of narratives in the data set that can be summarised under themes of neoliberalism³, social change, privatisation and healthcare. I did not specifically probe or ask about such themes but they came about through free associative narratives in response to open questions that were verbalised by a number of participants. For instance, amongst the sample was a woman who worked in the public medical sector as a nurse practitioner. She

stressed that the workload for her and her colleagues had increased ever since *Embarrassing Bodies* was first broadcast:

I: Can you remember when you saw it for the first time?

*I5: Vaguely, yeah, I mean, I can remember just thinking, oh, my first thoughts were 'Oh my god!' which I think a lot of people thought, you know, why would these people to be too embarrassed to see their GP or their nurse and yet they're happy to go on television and disclose it to the public? [...] I've seen, several people who've said "Oh I've seen on *Embarrassing Bodies*, so I thought I'd want to come" [...] I kind of think well actually it is beneficial because at first I think a lot of us felt "Oh that's it, we've got all coming cos' they've seen it on *Embarrassing Bodies* and they're gonna think they've got it and we're gonna be overwhelmed with patients who are now obsessed with illness". But I don't think you can blame just *Embarrassing Bodies* for that, I think it's a general change in society, a lot of the media is, we've got *Embarrassing Bodies*, we've got *House*, there's lots and lots of programmes isn't there? People do watch and take note. Whereas my parents wouldn't have watched medical programmes. So I think there's that shift in the public's awareness of things [...] (Interview 5, lines 108-128)*

In the last 15-20 years, medical programmes on television have increased across different genres (Hamad, 2016). This fact has had effects on the medical system itself because the numbers of patients may have increased as a result. Even though the informant implicitly mentioned an initial disapproval of *Embarrassing Bodies* because it meant a higher workload and longer shifts without rising wages for her, she also spoke of incidents that she regarded as beneficial. The fact that the patients on *Embarrassing Bodies* are mostly transferred to private specialists that are paid for by Channel 4 is of further importance here. There is a split between the public and the private healthcare system and people's awareness and understanding of the two. Whereas private medicine may offer any procedure to patients as long as they can pay for it, there are limits to the provision of healthcare in public health systems, such as in the NHS.

The participant did not relate those limits to the NHS cutbacks that have hit the service since 2010, but to *Embarrassing Bodies* itself. She explained a potential rise in patients she saw by referring to the television show, rather than cutbacks and staff redundancies that may have also played a part in the increase of patients for her. The participant mentioned later on that many patients would come to her with a sense of entitlement for any procedure because they had seen it on *Embarrassing Bodies*: 'they've seen it on TV and they think "Oh that's all I have to do, go and see my doctor and say this that and the other and I'll get it" [...]' (Interview 5, lines 148-49). In many cases, demands for a certain procedure might not be granted because the NHS does not provide all treatments, unlike the private medicine sector. *Embarrassing Bodies* essentially provided care and

solutions for any case presented on the programme. The programme presented a solution for everything and may therefore have led audiences to believe they are entitled to the same. At one point in our interview, the participant underscored this further:

I: And you talked about that they always get private care or specialists on the programme. Can you say a little more on that?

I5: For instance, somebody with a verruca, it's not life threatening, it's not really gonna damage them, it would go anyway but the parents insist that they want it removed that they don't like it and that shouldn't be NHS that should be private. Yes, you can have it removed but you would have to pay for it! Just like you buy a new car, you want to have pimped-up wheels that's fine but you have to pay extra for it. You know, I kinda see there is a duty but back to *Embarrassing Bodies* they don't, either they're not always open and honest with the fact that you wouldn't be able to get some on the NHS, this is private and again that comes back to then people's expectations cos' they'll then come to us and say 'I saw on *Embarrassing Bodies* that I can have laser treatment for x, y or z.' Yeah you can but not on the NHS (Interview 5, lines 344-360).

Drawing a parallel between a pimped-up car and a body in possible need of medical procedures certainly makes for a vivid image. The nurse practitioner's example is particularly noteworthy because there was a famous case involving a verruca on *Embarrassing Bodies*. Charlotte, who was seen for a painful verruca, underwent a blood test and it was revealed that the girl had a lack in CD4 cells and needed chemotherapy. She also needed a bone marrow transplant so that her immune system could be restored. In this case, a verruca was the sign of a weak immune system and had revealed a life threatening condition. Channel 4 produced a special episode focussing solely on Charlotte's case. It is unclear if the nurse practitioner was aware of the case but the sweeping dismissal of a verruca being a real medical problem was striking.

This quote shows the neoliberal discourse and vocabulary that the participant had internalised and reproduced unconsciously. The neoliberal language of self-responsibility and self-help that is – amongst others – advocated by the NHS itself as well as reality television was reproduced here. As noted by many scholars, reality television is often about a focus on the self. The individual is represented as being responsible for their own problems and is given advice by experts but, ultimately, has to overcome them themselves (Walkerdine, 2003; McCarthy, 2007; Couldry, 2010). While reality television bears some resemblance to the classic fairy tale (Bratich, 2007) and programmes often show successful solutions and happy endings, this cannot always be achieved in reality. According to the above participant, reality television may therefore create a false impression in some individuals as they equate what is shown on programmes like *Embarrassing Bodies* with the same treatment that the NHS would offer. The NHS cannot continue to 'provide healthcare

to all for free' because 'it's not a bottomless pit' (Interview 5, lines 358-359), the nurse practitioner remarked with a slightly raised voice. The way these sentences were uttered was very affirming, passionate and affective. She probably felt in such ways because she worked in the medical sector and budget cuts in the NHS resulted in tougher working conditions for her (Davis, Lister and Wrigley 2015). According to the participant, *Embarrassing Bodies* thus suggested to viewers what treatments were possible, while in reality the NHS could not provide all of them. '[W]hy have you not got a true reflection of what you got out there, so patients can, cos' that could be a massive stepping stone for us [medical practitioners]' (Interview 5, lines 211-212), she had commented on the programme at an earlier point during the interview.

Immediately following the narratives about entitlement to healthcare, the nurse practitioner suddenly paused for a moment and remarked 'It gets difficult ethically, doesn't it?' (Interview 5, line 363). This suggests that a form of conscious self-censorship set in. Apparently the participant realised what she had said in a free associative manner and felt the need to moderate her expressions. Her sudden question can be regarded as a discursive shifting away from her previous narratives. Freud argued that free associations are less governed by consciousness and the subject may realise what they said after an utterance and moderate or hedge their own narratives in a deferred manner in order to conform to social and interpersonal expectations. The narratives by the participant suggest that she had deeply internalised neoliberal ideology about entitlement to healthcare. In the UK context, politicians in favour of a privatisation of the NHS have advocated that healthcare should be provided in a basic form but procedures that surpass such a basic model should be privatised and paid for by patients (Maynard, 2010; Stevens, 2014). It is not clear at this point in time which treatments should be free of charge and which should be paid for. Many services that once belonged to the NHS have already been sold off to profit-oriented, private companies (Stevens, 2014). In neoliberalism, healthcare has become commodified and the above participant expressed similar sentiments. She related entitlement to specific medical procedures to shopping for car components but then halted and reflected on and questioned her own narratives that had come about through free association.

There is an additional element to her narratives which can be discussed at this stage. The nurse practitioner not only faced a higher workload, as she said, because of the programme. There also was a sense of anger at and envy of the doctors on the show. Early in the interview, the participant told me that she had briefly worked in the same hospital as one of the doctors when they were both younger. The following passage both expresses a sense of admiration for the doctors as well as a sense of envy and anger:

I think, professionally, they're obviously very experienced. I like the fact that they all allegedly work in the field, I don't know how much work they actually do on the shop floor. I know that Pixie used to do an awful lot of private GP work erm which is very different what I do and my colleagues do. I mean we're lucky, I think some of the inner city, I worked in [inner city district] for a while,

some of those inner city practices are just, I don't think that those doctors of the programme would have a clue really how to, I don't know, I could be wrong and they're a little bit too polished now, they've gone a bit kinda media, haven't they? They're not as normal. Do you know what I mean? They're kind of a bit polished now into presenters, as opposed to experts on the television. That's how I see them now, they look you know, yeah, it's gotta be right, the makeup's gotta be right, they're presenting the programme, it's gotta be that as I say presenter type quality as before, they just seemed to be doctor's talking about what they did but that's been a progression as the series progressed and I think their popularity has increased and they are kind of falling into that role of celebrities now (Interview 5, lines 180-194).

The nurse practitioner not only faced intensified working conditions as a result of *Embarrassing Bodies*, she had also witnessed the transformation of the doctors from 'normal' people to 'celebrities'. When she was younger, she had 'been to a few parties' (Interview 5, line 68) with one of the doctors and the doctor had gone on to become a successful TV personality and she had remained 'only' a nurse practitioner who felt she was not accurately portrayed by *Embarrassing Bodies*. She, unlike the doctors on the programme, knew how to treat all kinds of cases in an inner city practice, whereas they would not have a clue, as she said. '[T]hey just seem to have their egos grow a little bit too much I think and I would like to see a nurse on the programme because they don't represent, you know, like I say, I see the same kind of things that they would and a lot of nurse practitioners do' (Interview 5, lines 201-204). There may have been a sense of injustice and disappointment felt by the interviewee, but it may have been painful for her to discuss such feelings. This was defended against by saying that the doctors had become clueless and had also contributed to a sense of entitlement for audiences which was disproportionate and led to intensified working conditions for her. If this really was the case might be subject to debate. However, the nurse practitioner then sought to tone down her narratives a little and shifted her view by thinking about the ethics of private healthcare. We can see from such narratives how paying attention both methodologically and analytically to shifting narratives opens up ways of discussing audiences' multi-layered ways of engaging with media content. Psychoanalysis is particularly useful here, as I go on to discuss in the next sections.

Ambivalent Bodies

A similar affective, shifting mode of expression from another interviewee was experienced by me. In general, the interviewee, a facilities manager at a large company, had spoken of the *Embarrassing Bodies* patients in very compassionate terms. 'I think they're very brave for going on a national programme and displaying intimate details about themselves' (Interview 3, lines 259-260), she remarked. She talked of her 'respect' and 'compassion' (Interview 3, lines 263-264) for the patients. 'You're more empathising with those people,

thinking it must be awful to have that condition' (Interview 3, lines 347-348), she added. The overall tone of the interview was one of warmth, compassion and empathy until suddenly a different kind of narrative emerged. The participant wondered what living with some medical problems was like for the participants on medical reality shows, when she abruptly remarked:

You know thinking what life must be like to be, to have that impact on your body and how sometimes that's a choice as well! How can you choose to allow yourself to become quite so big? Some people don't mind if they're a certain size but when you get so big that you can't even wipe your own bum after going to the loo that's something else! I don't think we really learn much from those problems but its perhaps more of a shock factor, to people or if you're thinking that you're getting a bit big and you wanna lose a bit of weight that might inspire you, thinking "You know what, I don't wanna end up like that, so I've got a choice to do something about it" (Interview 3, lines 391-400).

To her, *Embarrassing Bodies* was also about being reminded to stay in shape and stay healthy. These utterances suddenly erupted and were voiced in an accusatory tone. The participant had similarly internalised the language of the neoliberal market that is about staying committed to the healthy, slim body as a project (Bordo, 1993; Heyes, 2007). From a psychoanalytic perspective, her sentences suggest an unconscious fear of losing control, of suddenly being out of shape herself. One always has 'the choice to do something about it'. The participant experienced some of the patients' bodies as shocking and evoked a vivid image of someone not being able to 'wipe their own bum'. Coupled with this experience could be an unconscious fear of losing control of her own body. *Embarrassing Bodies* shows that patients are always healed and that bodies can be brought back into shape. For the participant, this message of the show resulted in a reaction of telling herself and me that she herself could always act to prevent her body from losing shape. A psychoanalytic angle suggests that she consciously combatted an unconscious fear of becoming fat by verbalising and stressing agency. By talking about 'some people' she deflected that fear into an accusation of others. In that way, she turned an individual fear into a social problem that implicitly made use of well-established discourses that refer to the social problem of obesity and are communicated by the NHS and discussed in the media (Inthorn and Boyce, 2010). This turnaround made it more of a social theme. The narrative shifted at this point in the interview from one about compassion and respect towards one more characterised by a dismissive tone. As the interview went on, the interviewee, similarly to the nurse practitioner, associated more freely and let her utterances flow without consciously reflecting too much on how her narratives may have been perceived by me. There may be a further layer to this discussion when considering some biographical information the participant had spoken about during the interview. A former partner of hers had had a life-threatening condition which was cured by the NHS. She had also been the carer for a family

member since she was young. Those people who were really in need of medical treatment, as opposed to others who, in her view, had simply ‘allowed’ themselves to become obese may have influenced her opinion of the programme. She may have also had a fear of becoming an ‘embarrassing’ body herself one day. She emphasised during the interview that staying healthy and in shape was very important to her and that she had had experience of modelling when she was younger.

[Y]ou can imagine the pressure on me to look a certain way when you were there erm so I didn’t feel very happy with my body for a while then because I was a little pressured to being very thin and just you know survive on three pieces of fruit a day or something ridiculous (Interview 3, lines 428-430).

A few minutes later, she remarked:

I feel erm thankful that I don’t have some of the, sorry, I don’t have any of the issues that the people have who go on there but in terms of body image I guess it makes you appreciate what you have, erm, but they show a varying range of body types and different kinds of people as well so I guess they’re not exclusive to anybody and it means it reaches for more people who might be able to relate to it more because you might be erm that short, thin girl or that overweight middle aged man or you might be a number of things, you might be that person with that skin disorder or anything like that so in relation to myself I would say it makes me appreciate what I’ve got (Interview 3, lines 480-488).

Seen in relation to the narratives that blamed other people for being obese, the narratives of the interviewee’s experience of her own body while she was a model seem to touch on similar aspects around controlling the body and a fear of losing control. While the excessive control of the body that comes with modelling was difficult for the participant, as she remarked, she nonetheless still seemed to expect other bodies to stay in shape. While she had perhaps arrived at a different image of her own body ever since she had stopped modelling, she was still keen to differentiate herself from those obese bodies in light of an unconscious fear of losing control of her body (again) as she might have done when having to ‘eat three pieces of fruit a day’ during modelling. While she did not feel happy about her body when modelling, possibly because of others telling her to be extremely thin, she nonetheless maintained a sense of control over her body since she had stopped modelling through staying in shape and healthy as well as through discursively separating herself from some of the patients on *Embarrassing Bodies*.

Like the above participant, all interviewees were quick to point out that they were in no way near as severely impaired as patients on *Embarrassing Bodies*. For instance, one interviewee said:

Yeah, fine I am pretty happy and healthy you know and haven't really got any hang ups, erm, yeah. I think shows like this do make you appreciate, you know everyone is like critical of themselves but shows like this they put a perspective in people, people go through a lot worse, like scary stuff [...] (I10, 323-326).

A young woman remarked:

Erm, I'm very lucky, I don't, I think stretch marks are the one, like when people come on and they say "I have really bad stretch marks" and you get to see their body and I feel better because I know I'm not the only one, erm, I, I also don't like the weight I am, I'd like to lose weight so when chubby people come on like "Yeah, you go," I feel better but, erm, I tend to be, I'm quite lucky to be honest, I think compared to people who go on it. It makes me feel normal like the small mistakes I have, it's not the end of the world (I6, 250-255).

One female said:

Erm on the whole, I'd say fairly okay, I mean, I suppose I have like some irrational problems like I've got a bit of a belly on me (I8, 437-439).

With these utterances we can see a distancing from the patients. Interviewees seemed to be glad that they were relatively healthy and had nothing to complain about. I interpreted the utterances that were about the interviewees' bodies in relation to the bodies on *Embarrassing Bodies* as creating a distance between them. This function of a comparison between one's own body and the bodies on *Embarrassing Bodies* was highly important to the interviewees. Seeing other imperfect bodies made the participants feel at ease about their own bodies. This was strengthened for the facilities manager by actively dismissing some of the patients and calling them 'something else', as discussed earlier. One interviewee said:

Yeah it helps to just put things in perspective, just to say, you know, god yeah, I felt shit when I got up this morning but hey at least I am not like that girl with the nasty skin disease, terrible skin disease that has to bathe in a bath full of wax and then rub cream all over herself because if she doesn't, her skin will just crack and she'll be in agony. So yeah I felt a little bit stiff when I got up this morning, oh dear, so it does help you put things into perspective (I2, 665-670).

Interviewees may have felt a sense of relief in seeing imperfect and suffering bodies as they said but they could also differentiate themselves from these. In that sense, by stressing that they were different from the suffering bodies on the show, the interviewees articulated a desire for a sense of mastery over our bodies that of course we all wish for. We want our

bodies to be healthy, clean and proper. There was thus a complex sense-making at stake here that shows the ambivalent response to the patients on the programme. They are valued and dismissed at the same time.

Theorising Discursive Shifting as Negation

The two discussions of the nurse practitioner and the facilities manager show how subjects can shift in their narratives during interviews. Rather than labelling such discursive shifts as completely rational and conscious, I argue that they came about through the utilisation of the method and a specific attention to them in the process of data analysis. As the interviews progressed, the interviewees exercised less self-censorship. The narratives also show that *Embarrassing Bodies* is a product of neoliberal times and is partly spoken about and responded to by unconsciously drawing on the language of neoliberalism. Both participants made use of neoliberal vocabulary and talked about the patients and limits to entitlement to specific healthcare procedures as well as the shock value of seeing obese patients on television. I suggest that such vocabulary was reproduced more associatively and was not exclusively shaped by conscious thought and reflection. The narratives emerged dynamically in the interviews without specific questions that aimed to trigger them.

How can we think of the analysis on a more abstract level? What happened during the discursive shifts and narratives about the patients that I have discussed? I suggest that in the narratives I presented, a psychodynamic phenomenon was at play that we can explore through Freud's idea of 'negation' (Freud, 1989). Negation functioned in two ways: as a form of turning away from neoliberal discourses about healthcare (Interview 5) and as a defence against a fear of similarity with the patients (Interview 2). In contrast to repression, Freud conceptualised negation as a discursive denial of a fact or phenomenon by a subject. If a subject strongly disagreed with, or shifted away from a notion, there can also be times where these disagreements are consciously used to mask an *actual agreement* with them.

According to Freud (1989), negation is often used in order to reject an unpleasant idea in front of another person. In that way, a subject distances themselves from an idea and is therefore able to disown it. In that way, unpleasant implications that may come with a thought are left behind. In the psychoanalytic session, negation refers to 'a situation of interpretative conflict. The patient first produces the interpretation, which he imputes to the psychoanalyst, claiming that it is false.' (Schneider, 2005, 1122) Negation thus often involves a judgment about certain phenomena. A similar process occurred during the interviews. The participants reflected on the treatment of participants and subsequently discursively rejected any sense of similarity with them. In negating their fears about their own bodies, they negated such fears by stressing how different they were from the patients. The facilities manager (Interview 2) may have had a fear of becoming obese, or of developing similar ailments to a patient and therefore strongly voiced an objection to such subjects. There may have thus been a personal-biographical element in her viewing and thoughts on the programme. The nurse practitioner, who questioned and to some degree

negated her own narratives about the limits to public healthcare entitlement, asked the question 'It gets difficult ethically, doesn't it?' as a negation, in order to mask her actual agreement with neoliberal NHS reforms that are regarded as unpopular by many. She may have also feared that I could have judged her in a certain way and she therefore negated her own narratives.

As with the facilities manager, there may have been a strong personal element for the nurse practitioner in her engagement with the programme. Not only had the programme resulted in tougher working conditions for her (as she said), but a doctor she *knew* had become a celebrity and in turn contributed to a misrepresentation of the nursing profession. This may have been disappointing for her. Nonetheless, the interviewee remained deeply attached to and fascinated by the programme. The programme, or perhaps reflecting about it in the interview, acted as a mechanism for her that allowed her to put the blame on it rather than on the government for a harder working life. In that way, she was able to sustain a healthy relationship with the NHS and her job. In following the neoliberal language that justified the NHS practice of only providing treatment for certain ailments, the interviewee was able to construct herself as a good and loyal worker in relation to myself in the interview who instead put the blame on a television programme. This act may have been more tolerable to her than if she had openly criticised austerity politics. Her question 'it gets difficult ethically, doesn't it?' suggests that she agreed with neoliberal policies which had made her own working life harder and did not want to discuss those further in the interview. I suggest that this contradiction needed to be resolved somehow discursively by her in the interview. In blaming the 'clueless' *Embarrassing Bodies* doctors for increasing the number of patients she saw on a daily basis, she was able to negate neoliberal policies which she had defended earlier. This interpretive conflict – an objective worsening of her working conditions thanks to budget cuts in the NHS and the agreement with such policies – was handled by her through negating it by focussing on how the programme was to blame for her situation. Putting the blame solely on the programme, enabled the interviewee to continue to defend neoliberal austerity politics while she may have been in a more conflicted position beneath the surface. I do not know the full extent of such a conflicted position and cannot make any more interpretations at this point.

The concept of 'negation' is not used by me in order to expose participants as liars. It helps to consider the discursive complexities at play in the interviews. The ways the participants talked about the patients and the programme more generally were very passionate and affective. They resorted to such a passionate forms of arguing because of the interview dynamics and my status as a researcher. Annette Hill has noted that 'we cannot avoid involvement in the ethics of reality programming' (Hill, 2005, 133). In her discussion of medical reality programmes, she argues that viewers respond in a compassionate and ethical manner to serious and often dramatic cases they see (Hill, 2005, 131-133). While this was also the case in my study, I would argue that the interviewees were struggling with the involvement in the ethics of the show. Problematic ethical questions were negotiated or avoided in the interview extracts through negation. These

narratives were thus of a defensive nature. One would possibly not want to admit to being an accomplice in a show that is ethically problematic on certain levels. The fact that I asked them questions about their consumption of a reality show may have been influential in bringing about their narratives about the patients. I was perceived as a figure with authority and expertise and the participants (unconsciously) felt the need to frame their engagement with the show in particular ways. This was echoed in another major theme in the data which was about education. Most interviewees stressed early in each interview that they watched *Embarrassing Bodies* in order to educate themselves about medicine. As interviews progressed and participants associated more freely, other, messier themes came to the surface. This does not mean that the programme was not used for educational purposes, but there were other motives present at the same time.

Conclusion

In this article, I presented results from an audience study with viewers of *Embarrassing Bodies*. Rather than offering only a content-orientated (ideology) critique of reality television, I was interested in if and how audiences would respond to a programme that explicitly features private healthcare provision and makes (implicit) references to public healthcare and its failures. I positioned the programme as being embedded in a climate of austerity and a financially weakened NHS. I also argued that the programme contradicts such a climate by showing the sheer endless possibilities of private healthcare.

I discussed two themes from the dataset that all had to do with negation, or discursive shifting: limits to the entitlement to public healthcare, and accusing some of the patients of being responsible for their own problems.

In adapting free association as a methodology, complex narratives emerged that were partly of a conscious nature and partly of an emergent process that rendered something conscious through the acts of thinking and associating freely. Such data may not have been produced if I had drawn on more 'traditional' audience research methods, like ethnography, qualitative interviews, or discourse analytical frameworks. A potential strength of psychoanalysis is that it consists of methodological aspects as well as theoretical concepts that can be drawn on when researching subjectivities. In that sense, it offers a holistic angle on a research topic by which data can be gathered and interpreted through a particular epistemological system which specifically includes a focus on participant's biographies and how they might relate to media use. Psychoanalysis is the only paradigm which specifically makes space for the (un)conscious dynamics of subjectivities and how they articulate themselves in and are shaped by intersubjective dynamics (for example a research interview). Two points can be reflected upon at this stage: did free association always work and is it a useful concept for qualitative audience research? In some interviews, free association did not work as well and interviewees were confused as to – as they put it – what I wanted to hear. It can be concluded that some individuals were more able or willing to freely associate than others. In that sense free association as a methodology is highly dependent on the research participants, the state of mind of the researcher and the rapport

and atmosphere during the interview. Additionally, I did not completely rely on free association because some, general, open questions were used to encourage associative narratives. I feel it would have been helpful, had I met interviewees a second or third time, to follow up on some of my interpretations and to establish more rapport. My use of the question 'What do you think of the people who go on the programme?' deserves critical commentary. It may have resulted in more defensive narratives because it is an evaluative question. The question should have been framed in an open manner e.g. 'Can you tell me something about the patients on the programme?'

There are some limits to the method, then, and its usability depends on the wording of the questions, on time and resources available to researchers, as well as their ability to establish rapport with research participants. Finally, using psychoanalytic ideas without being a psychoanalyst can be critiqued by some. One has to be very careful and nuanced in interpretations of data so as not to sound pathologising or all-knowing. However, psychoanalytic ideas may inform audience research without the need for clinical training because they add a level of complexity to notions of subjectivity and interview dynamics.

In returning to the data by way of concluding, neoliberal ideology has been internalised and is unconsciously and possibly unknowingly used by subjects living in neoliberal societies. We may therefore see how economic and social frameworks shape our psyches. It is reality television in particular that advocates a neoliberal ethos (Couldry, 2010) and the interviewees in this study expressed narratives about a particular programme that mirror such discourses. However, as I showed, their narratives were ambiguous in nature. They did not simply mimic or imitate neoliberal ideology through utterances, but expressed contradictory narratives. I suggest that such contradictions point to some of the psychosocial effects of austerity politics of the post-2008 recession in the UK, how they are represented in popular culture and made sense of by audiences. The associative utterances by the participants point to their process-like, (un)conscious positioning in neoliberal culture and ideology. Participants are part of the very framework they sought to negate. By consuming *Embarrassing Bodies* and advocating neoliberal healthcare (Interview 5), self-responsibility for staying slim (Interview 2) and stressing agency and rationality *vis-à-vis* the patient's bodies, subjects reproduced neoliberalism and maintain its functionality. Consuming neoliberal, commercial programmes guarantees their continuation. However, there were also moments in the data that I discussed that pointed to more conflicted narratives: the questioning of privatised healthcare (Interview 5), or the compassionate tone with which the facilities manager also spoke of the patients (Interview 2). One can therefore conclude that contemporary subjectivities struggle to comprehend and find their place in austerity politics that on the one hand are internalised and discursively reproduced as a matter of personal survival but also discursively shifted away from in a more communal spirit. As I worked with a very small sample, it is difficult to argue that such narratives present a wider sentiment of the UK population, but they may nevertheless point to a cultural conjuncture that we all find ourselves in. While psychoanalysis holds that all human beings are fundamentally ambivalent in nature and are often torn between contradictory

feelings, fantasies and practices, some individuals in the sample (who I referred to in this article) were perhaps more ambivalent than others. All interviewees spoke about the *Embarrassing Bodies* doctors and patients in very compassionate terms, but some interviewees presented stronger shifts than others. I argue that this has something to do with their subjective investment in the consumption of *Embarrassing Bodies* and its relationship to their biographies. Some interviewees, the nurse practitioner is a case in point here, were more affected by the programme than others, because it related to their biographies more. Specific lived experiences (e.g. of working in the NHS and consuming a reality show about it at the same time) resulted in more ambivalent accounts of the programme. In total, seven interviewees spoke of their own bodily experiences in relation to healthcare and often referred to similar experiences to the *Embarrassing Bodies* patients but, crucially, not the same kind of ‘perfect’, private medical care that the programme provides (Johanssen, 2018).

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Notes:

¹ Bleuler (1952) originally defined the term 'ambivalence' as an experience, or thought that is simultaneously cathected with (attributed with) unpleasant and pleasant feelings. I draw on this definition in the article.

² The project was based at the University of East London and received formal approval from the University Research Ethics Committee.

³ For the purpose of this article, neoliberalism is defined, following Gilbert, as an economic framework that 'encourage[s] particular types of entrepreneurial competitive and commercial behaviour in its citizens, ultimately arguing for the management of populations with the aim of cultivating the type of individualistic, competitive, acquisitive and entrepreneurial behaviour which the liberal tradition has historically assumed to be the natural condition of civilised humanity, undistorted by government intervention' (Gilbert, 2013, 9).