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HOLY PHARMA!

HEALTHISM DISCOURSES IN A PHARMACEUTICAL ADVERTISING WEBSITE

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ABSTRACT

Modern changes in the public health philosophy and government legislation reflect a desire of health for all. The changes support a new healthism ideology that controls the experience and definition of health. Scholars parallel the function of healthism to that of a religion that meets the needs of a modern secular culture. This study examines a pharmaceutical advertising website, taking a social constructionist stance to investigate dominant representations of healthism and any parallels to the values and practices of Western religion. The website selected is published by a pharmaceutical marketing group that has been disseminating health and product information for 10 years. The installment of March-April 2009 was examined in its entirety. A critical discourse analytic approach drawing on Durkheim and Foucault was adopted to analyse texts, images, and videos. Particular attention was given to the similarities and differences of healthism and religion in terms, meanings, subject positioning and function. Results show healthism to parallel religion in its construction as information, instruction and ritual practice. The expert discourse within healthism promotes a morality that parallels and deviates from religious values with a turn toward the value of the self. This expert discourse informs healthism discourses, constructing a doctrine of unquestionable behaviours that legitimate ritualized health practices. When viewed as an integral entity, the form, content, and function of healthism in pharmaceutical advertising takes on the religious connectivity of values, beliefs and practices that underlies all social life. The website is an intense concentration of coercive and symbolic power to inform the institutionalized social system of healthism.

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Preface

The road to 'health' is paved with good intentions, and history is laden with health regimens conceptualized through the cultural the values of their time (Tulchinsky & Varavikova, 2009). Many of these regimens advocate altruistic intentions focused on safety and the promise of a 'good life' for those who adhere to specific practices (Crawford, 1980; Skrabanek, 1994). The most recent regimen is coined 'healthism' (Crawford, 1980, 2006). Upheld as the attainment of perfect 'health for all' (WHO, 1981), healthism is a powerful social practice inextricably bound to medicalisation and the intensity of consumerism driven by a neo-liberal agenda (Crawford, 1980; Greenhalgh & Wessely, 2004). Scholars parallel the function of healthism to that of a religion (Conrad, 2007; Schaler, 2002), positioning its practices as offering a new value system to meet the needs of a modern secular culture (Skrabanek, 1994).

Healthism has the potential to expand as a global ideology via a road paved by media advertising that promotes the attainment of health through the consumption of services and products (Crawford, 1980, 2006). The potential advancement of healthism is robust in New Zealand as one of only two countries in the OECD that allows direct-to-consumer advertising (DTCA) (Toop et al., 2003). However, national boundaries cannot contain advertising due to the global accessibility of the Internet (Murero & Rice, 2006; Richardson, 2005). The road to health is now an information superhighway.

CHAPTER 1

The Road to Health

"In the weak version of healthism, as encountered in Western democracies, the state goes beyond education and information on matters of health and uses propaganda and various forms of coercion to establish norms of a 'healthy lifestyle' for all."

(Skrabanek, 1994, p. 15)

Due to the influential World Health Organization (WHO) agenda of "health for all", modern changes in public health strategies and government legislation reflect an altruistic desire for social justice in the area of public health. Chapter 1 focuses on the 'good intentions' of public health strategies that take the form of coercive advertising strategies to influence individual behaviours. The public health strategies found legitimation through government backing and legislation with changes incorporating advertising strategies to convey health education messages. These interwoven changes support a healthism ideology that controls the experience and definition of health. Scholars compare this manner of regulation with religion, with the "right to health" mandated by authority as usurping other human rights in the areas of self-determination and freedom of choice over life issues. If healthism is functioning as a religion, then the "right to health" is also superseding religious freedoms. The chapter describes the processes contributing to a shift from altruistic intentions to government regulation and social control that obstructs individual freedoms.

Health for all

WHO is the leading voice of the global health agenda and defines health as '...complete, physical, mental, and social well-being and not merely the absence of disease or infirmity' (WHO, 1981). Altruistic in intention, the idealistic definition simultaneously expands the meaning of health to all areas of human life, positioning health as a "human right" and a means to end suffering on a global scale (Crawford, 1980). Consecutively, WHO mandates that the governments of all nations have the responsibility to set priorities, make cost-benefit decisions and allocate resources in the "health for all" campaign (WHO, 1981). The resultant combination contracted individual liberties through legislative efforts while expanding individual responsibility for health. The "right to health" on the road to "health for all" became a legitimate reason for governments to limit human rights (Crawford, 1980; Mann, 1997; Skrabanek, 1994).

Health: From 'right' to 'duty'

WHO's definition creates an agenda for health that is limitless in scope and an aspiring process, but the national health care systems are limited in economic resilience for health resources (Callahan, 2005; Conrad, 2005). The response from Western governments to an increased demand for health care was to shift responsibility for health onto the individual by supporting the practices of individualist health promotion (IHP) (Crawford, 1980; Lupton, 1995). The 1970s produced new social models as approaches to health from which two opposing models in health promotion practice were generated and are currently in use. The structuralist-collectivist health promotion approach (SCHP) focuses on community and environmental action programmes as well as employing legislative

means (laws) as methods of intervention. The IHP model focuses on health education targeted at the individual to promote behavioral changes in 'lifestyle' (Richmond, 1999). The government support of public health campaigns that focus on an individual's lifestyle generated present social practices of self-surveillance, self-control and individual responsibility for health. The "right to health" instigated by WHO became a "duty of health" for every individual and culturally viewed as a moral act of a 'good' citizen (Crawford, 2000, 2006; Galvin, 2002; Kamin, 2005).

'Healthy lifestyle' and public health strategies: Mandating values, limiting choices

IHP as a form of public health education employs strategic and coercive approaches that result in publicly normalizing 'healthy' individual lifestyles as a method of primary prevention (Crawford, 1980; Richmond & Germov, 1998). Public health services and scientific innovations had accomplished lowering morbidity and mortality through the introduction of vaccines, antibiotics, and improvements in the standards of food and sanitation. Therefore, public health endeavours in the 1970s turned away from hygiene and curative health care toward chronic disease and prevention. The long-term focus remained on reducing mortality and increasing longevity, but turned to concentrate on promoting health through educational strategies premised on the reduction of risk (Tulchinsky & Varavikova, 2009).

IHP programmes, as public health education strategies, implement one way models of communication using media strategies to expose individuals to health messages focused on risk reduction (Petersen & Lupton, 1996). The new public health agenda uses social

marketing strategies and techniques to educate the public on behavioural standards toward a 'social good'. The strategies use advertising campaigns that draw on commercial marketing techniques that engage scientific and political information. Individuals are now conceptualized as customers with their consolidated and conventional understandings of health used to plan and manage policy development (Tulchinsky & Varavikova, 2009). A strong pleasure principle operates as the main drive behind media advertising and the target audience. Consequently, the use of mainstream commercial advertising to advocate health created an overlap in public health and purely commercial agendas that turned the road to health into a coercive road to pleasure. The result is a concept of health as an item that can be acquired or sold, and is valued as a commercial commodity that can produce 'happiness' (Naidoo & Wills, 2000; Seale, 2002).

Promoting the belief that health can be acquired remains the centre of public health advertisements that pivot on the achievement of health through 'rational' choices and the individual's power to control health outcomes (Crawford, 2006; Stephens, 2008). By highlighting individual behaviours, including consumptions, primary prevention advocates health as an individual's responsibility (Smedley, 2006). Advertising mediums easily back the IHP programmes in their public health education agendas as they are positioned at the level of the individual. This operates to reinforce the priority of individual responsibility for health as the main value with the individual defined as the problem and focus for intervention (Seedhouse, 2004).

Mandating mainstream values, limiting unconventional choices

The IHP public health strategy prevention messages incorporate behavioural modification strategies that lack understanding of the dynamics between the media discourses, individuals, society, and the power of authority (Lupton, 1995; Petersen & Lupton, 1996). Drawing on the powerful position of epidemiological statistics and medically advised risks, illness and disease are positioned as 'bad' because they prevent productivity and thereby cause individuals to be an economic burden on society (Seedhouse, 2004). This position is a reflection of the mainstream middle class values centered around productivity and individual responsibility for health behaviour. Fundamentally, public health professionals do not show reflexivity regarding their personal investment in these dominant values. This oversight contributes to IHP media programmes with advertising mediums that reinforce mainstream values and thereby disparage viewpoints or lifestyles that diverge from the dominant value system. The programmes inadvertently reinforce media discourses of sensationalism, negative stereotypes and power divisions maintained by the dominant culture (Fowler, 1991; Seale, 2002). Prevention messages are criticized as unethical and biased for their unexamined assumptions and these mainstream representations of health issues (Guttman, 2000; Mann, 1997; Petersen & Lupton, 1996; Seedhouse, 2004).

Criticisms of IHP prevention messages are framed not only as unethical but insensitive in matters of sociocultural processes, cultural constructions of disease and their meaningful context. The concerns span the international health literature with a focus on these insensitivities as leading to discourses within advertisements that perpetuate cultural

stereotypes and discrimination which ultimately contributes to failure in preventive intervention (Nichter, 1996). The former AIDS education programmes present good examples of how dominant values of heterosexuality were constructed within the discourse. AIDS impacts heterosexuals as well as homosexuals, yet the discourses within the programme constructed homosexuals as a 'deviant' group, portraying those at risk of AIDS as homosexuals, prostitutes or drug needle users. The campaigns ignored the risk to women and functioned to stigmatize homosexuals as 'diseased' (Guttman, 2000; Petersen & Lupton, 1996; Welch-Cline & McKenzie, 1996). Ignorance of meaningful context led to consequences such as HIV-positive individuals being denied occupations, the right to marry and travel (Mann, 1997).

Another criticism of the new public health messages surrounds their reliance on statistics gained from epidemiology and medical evidence as a platform from which to present problems and solutions to health concerns. The messages use epidemiological statistics as a way of ordering and defining average events within populations with figures lying outside the average designated as 'deviants'. The messages operate to promote the definition and segregation of 'normal' and 'abnormal'. The messages also present assumptions that are congruent with epidemiology and medicine in their predisposition for matter over spirit, one truth for all, and individual functioning as separate from culture and society (Gordon, 1988; Petersen & Lupton, 1996). For example, research in New Zealand regarding health disparagements for native Maori found the epidemiological process of identifying and classifying those at risk to be an educational discourse that operates within physicians' racial discourses based on stereotype. This racial discourse

founded in epidemiology is used by physicians to explain health inequalities for native Maori rather than acknowledge the oppressed fundamental differences in their cultural values as a basis for those inequalities (McCreanor & Nairn, 2002).

Mainstream values drawn from the dominant culture are known to drive the prioritization process of public health messages and as Frankenberg highlighted these processes '…are surrounded by culturally defined moral problems in which power relations always have a central position' (Frankenberg, 1993, p. 236). Seedhouse (2004) positions the new public health approach as deriving from assumptions of the meaning of a 'good life' designated by the central position of the mainstream. He outlines these assumptions as: the unquestioned value of the medical perspective, the duty of the individual to not become sick, the irresponsibility of those who are ill, the untrustworthiness of the individual to maintain their health, the unquestioned ability of public health professionals to outline the 'good life', and that the current social environment is not in need of change.

The assumptions operate to eclipse broader social, economic and environmental aspects that influence health outcomes and return responsibility to the individual while maintaining the 'authority' of 'knowledgeable' professionals (Murray & Campbell, 2003; Wilkinson & Marmot, 2005). These assumptions are derived from the new public health philosophy that values collective responsibility and the contribution of the autonomous individual to that society with the assistance of health care professionals. The assumptions obscure the fact that the philosophy from which the new public health is drawn is a matter of opinion and not based on objectivity. The assumptions therefore

maintain a status quo that favours one form of political prejudice other another and in this instance specifically favours the opinion of the powerful mainstream. This type of prejudice is well acknowledged to promote inequity and limit life choices for those whose have different ideas of the values that comprise the 'good life' (Germov, 2005; Seedhouse, 2004).

The powers behind prevention: Practices and promises

"Public health represents the state as the agency responsible for guarding and ensuring the health of the populace" (Petersen & Lupton, 1996, p. 71). IHP programmes are advocated and accepted as changing individual behavioural patterns in a cost-effective manner. Yet, research focused on the effectiveness of IHP has found that it produces little change in long-term behaviour and is unsuccessful across differing motivational groups (Van Beurden, Montague, Christian, & Dunn, 1993). Governments fund the IHP model within public health despite the dismal results of its programmes because the focus on the individual obscures the control established by those in power to define health and ration access to health resources (Galvin, 2002; Hodgetts & Chamberlain, 2006a). In the public eye, the IHP programmes bring repute to the government through the guise of active concern for health and thereby generate public support (Lupton, 1995). However, IHP programmes focused on educational awareness are often supported by powerful interest groups such as pharmaceutical companies and various health professions who have a vested interest in profiting from individuals who are driven by the educational messages to seek professional products and services (Moynihan & Cassels, 2006).

The altruistic goal of primary prevention is behavioural change which is framed as an avenue to avoid illness in the population and thereby promote 'social good' (Skrabanek, 1994; WHO, 1981). However, the critical view positions public health as a technology of control to reduce health care costs for national governments (Gostin, 2007; Lupton, 1995). Models underlying primary prevention such as the Health Belief Model, Theory of Reasoned Action, and Protection Motivation Theory focus on individual rationality. The theories profess that beliefs and attitudes mediate behaviour and therefore the rational individual, through gaining knowledge and awareness in the form of education, will change behaviours according in an effort to achieve health (Lupton, 1995; Stephens, 2008). Therefore, health promotion itself can be seen to rely on principles of Western thought that value rationality, independence and self control as methods that contribute to well-being and social order. Public health discourses can thereby be seen to regulate and restrain the human body (Lupton, 1995).

The Western standpoint turned the focus of primary prevention toward educational practices that instruct individuals to identify and avoid risky behaviours as an avenue to secure 'good health' (Stephens, 2008; Tulchinsky & Varavikova, 2009) and help lower government health care resource costs (Gostin, 2007). Illness now carries the meaning of producing high socioeconomic costs in loss of productivity, in medical expenditures absorbed by national health care systems and private insurance companies. Furthermore, individuals who suffer from illness are viewed as a dependent drain on national budgets (Turner, 2005) and are viewed as 'bad' citizens (Kamin, 2005). The public health philosophy promotes the idea that illness is a failure in this rationality that results in the

consequence of poor individual choices, and the moral individual will avoid behaviours that might result in dependency. In this respect, public health discourses operate to categorize individuals according to their level of conformity with state health objectives (Lupton, 1995).

The practicing power of the medical sphere

Public health professionals legitimize IHP by advocating that their values are benevolent because they are aligned with the objectivity of the medical profession against illness and disease (Seedhouse, 2004). In turn, IHP is legitimated through government sponsorship and the power of medical knowledges to define health. The government takes advisement in the constitution of deviances and the ethics of preventative medicine from the objectivity of the medical profession. The core of social health matters therefore draws on the medical profession and its social standing as objective and benevolent in nature (Richmond & Germov, 1998). However, the assumptions behind the science of medicine are as much matters of opinion as those underlying the public health philosophy, and therefore not objective (Seedhouse, 2004). Further criticism argues that biomedicine itself proffers discrimination in its dominance over health issues and tendencies to medicalise social experiences. The power of the medical sphere is argued to contribute to forms of social control (Conrad, 2007; Conrad & Schneider, 1992; Crawford, 1980; Moynihan & Cassels, 2006).

Medical experts and the biomedical model hold the power to define the meaning of health and the avenues toward its attainment through their position as gatekeepers who diagnose

illness, recommend treatments, and refer patients to specialists. In Western societies, the biomedical approach of these experts is a conventional one, positioning illness and disease as biological malfunctions if the individual body. Their power, however, was claimed through scientific authority, in its ability to offer knowledge of 'truths' and statistical facts (Germov, 2005; Lyons & Chamberlain, 2006). However, scientific theory, methods and outcomes are also a facet of Western rationalized thought and values and therefore are not objective (Lupton, 1995).

Scientific theory and processes are based in a positivist theoretical perspective that values understandings and explanations of society based on an objectivist epistemology. This epistemological view positions truth and meaning as fixed objects that reside beyond the boundaries of human consciousness and experience. These 'truth objects' can therefore be discovered through human methodological endeavors that employ objectivity (Crotty, 1998). However, there are many epistemologies that vary from this position that, for instance, engage interpretive and symbolic standpoints (Crotty, 1998). Therefore biomedicine's foundation in science can be seen to prejudice one particular form of knowledge and human experience. Medical science is not "morally neutral" (Conrad & Schneider, 1992, p. 35).

Currently, the medical model continues to construct the reality of new phenomena and 'undesirable' social issues (Conrad, 1992, 2007; Conrad & Schneider, 1992) such as post-traumatic stress disorder (PTSD) and premenstrual syndrome (PMS) (Clarke, Shim, Mamo, Fosket, & Fishman, 2003). These 'diseases' and 'illness' have been socially

stigmatized with their terminologies incorporated into social discourses. These medical discourses are then 'normalized' as constructions of the body and disease, furthering the domination of the medical institution to define and expand the constitution of 'normal' individuals (Foucault, 1994). By establishing 'norms' around certain behaviours, the medical profession also establishes social expectations regarding 'abnormal' behaviours with individuals who do not or cannot adhere to 'norms' labeled as 'deviants'. Critics argue that the medical provision of social expectations regarding the status of 'normal' operates as a form of social control in the management of deviant behaviour. Social control guides societies onto narrow roads of conformity maintained by medical intervention and in some instances enforcement by legal regulations.

The negative status, label and social punishment (termed 'treatment') of homosexuals as sexual deviants that occurred in the first and second editions of the DSM is a good example of the ramifications of medical labeling. In this case, homosexuals were legally unable to join the armed forces and were dishonorably discharged due to the labeling of homosexuality as pathology. The example clarifies how medical labeling can result in the categorization of individuals as 'norms' and 'deviations' while this information is used to support political and legal standpoints with the medical profession solely holding the power to change these definitions (Conrad & Schneider, 1992).

Medical discourse has the power to define individual bodies and states of being, transforming a subjective embodied experience to one interpretable through objective language. As the medical practitioners hold the cause of disease within the individual,

and decipher the behaviours that contribute to health and illness, they claim the power to define 'normal' healthy behaviour from 'abnormal' unhealthy behaviour. In this moral atmosphere of health promotion, government legislation and medical domination, the medical profession dictates and controls the constitution of the ethical and responsible individual, with normalized behaviors becoming legislated state policies (Conrad, 1992, 2007).

Government intervention in the lives of individuals follows the public health approaches reliance on the medical standpoint as an 'ethics' of prevention (Galvin, 2002). Prevention approaches are increasingly comprehensive of lifestyle choices and vary with changes in cultural values or discoveries of 'new medical risks'. In epidemiological statistics, risk was initially used to indicate probability. However modern social discourse has turned the meaning of risk into one of *danger* with the risk discourse indicating the identification and surveillance of *potential deviances* as a practice toward prevention (Frankenberg, 1993; Petersen & Lupton, 1996). Western countries have been termed "risk societies" due to the awareness through mass media publications of prevention approaches and risk discourses (Beck, 1992, p. 49). WHO's directive of government's duty and responsibility to protect citizens' health became a platform for government intervention in the area of risk (Skrabanek, 1994).

Risks generally reflect common problems, yet are labeled and perceived as 'factual threats' in daily discourse (Petersen & Lupton, 1996) and are assigned medical terms such as high blood pressure and high cholesterol (Moynihan & Cassels, 2006). Daily

discourses surrounding prevention and risk have seen a crossover between the medical sphere and daily life termed *medicalisation*. Medicalisation uses medical knowledge as a power to define and categorize life events. The medical definition of common experiences, such as menopause and adult Attention Deficit Hyperactivity Disorder (ADHD), positions them in a medical framework, subjecting the individual to medical and therefore government intervention. The new public health and government platform of ethical responsibility can be seen to enhance processes of categorization thereby exchanging subjective individual experience for the directed control of the medical standpoint (Conrad, 2007; Moynihan & Cassels, 2006).

Directed control can also be seen in the government's ethical duty to protect the population from dangers to health by eliminating environmental hazards through practices of intervention. This duty is used as justification to intervene through legislation of a vast array of areas from the use of bicycle helmets (Skrabanek, 1994), the banning of trans-fats to prevent obesity (Gostin, 2007), and the subjugation of entire groups of people such as homosexuals who may be carrying 'disease' (Conrad, 2007; Mann, 1997). Government legislation as prevention mimics puritanical practices that avoid overindulgence in alcohol, tobacco, food and sex and are therefore indicative of mainstream values (Skrabanek, 1994). The ethical duty of prevention is used to justify taxation of 'unhealthy' goods such as tobacco and alcohol. On a grander scale, government intervention involves the surveillance of citizen's bodies through techniques such as 'health' screenings for breast cancer, hypertension and cholesterol (Mann, 1997; Skrabanek, 1994).

The road to health

The result of the new public health approach is the 'healthy citizen' who is an objectified reflexive subject in a culture that advocates and normalizes medical, government and self surveillance (Foucault, 1994). The individual is seen through the medical sphere as an object and product to be assessed and inventoried (Foucault, 1994). IHP promotes constant monitoring of the body and lifestyle choices as a normalized behaviour, with judgment for breaches in self-discipline enacted by the self and society (Conrad & Schneider, 1992; Foucault, 1994). The prevention of illness has become transposed with the prevention of judgment and punishment, states to be avoided by the individual through an ongoing search for knowledge about health and preventive forms of 'health care' (Crawford, 2006). The new meaning of health leaves no room for the random conditions that generate illness (Davison, Frankel, & Davey Smith, 1992). Now, disease lies within the non-adherent individual whose illness is socially viewed as fair recompense for mismanagement of the body and nonconformity (Galvin, 2002). The coercive advocacy of lifestyle advertises the promise of a 'good life' with specified meanings of longevity and absence of disease for those who follow the directed health practices (Crawford, 2000).

Crawford (2006) interprets the rule-setting actions, such as surveillance, and models of the 'good life' in the new public health as constructing ritualized practices based on assumptions regarding 'common sense' and the 'rational nature' of health processes. Rituals are directed forms of conduct and fixed actions that are repeated on a regular basis that are open to a cultural interpretation of morals. For example, frequent hand

washing is commonly considered an avenue to destroying germs and bacteria that can cause illness. However, symbolically it represents the purification of the body as a step toward cleanliness and the association of cleanliness with 'goodness'. Further, it demonstrates connectivity with the common rhetoric of 'cleanliness is next to godliness', which signifies a sacred postioning of the act of washing. As rituals, health practices are performed in everyday settings and informed by discourses that employ symbolic meaning and action (Crawford, 2000). Health now functions as:

> *"...a code for signifying persons, qualities, moral capacities and situations. Health reveals the 'truth' of a body that 'cannot lie'... In the body's health, we search for and find confirmation of a life well lived or lived poorly... Health points to the order of things and to their disorder, to transgressive 'dirt' and to purifying acts of restitution" (Crawford, 2000, p. 225).*

...paved with good intentions

A critical approach argues that the altruistic pursuit of 'health for all' instigated through the IHP advertising medium has created a coercive and legislative governmental strategy supported by the opinion of medical 'experts' and a commercially driven public health discourse (Crawford, 1980, 2000). The 'right to health' has been distorted into the enforcement of a 'health promotion' agenda that creates citizens dependent on experts to outline the boundaries of a standardized personal rationality in the manner of health practices now termed 'common sense' (Crawford, 2000). The promotion of an ethics,

morality and obligation toward 'good health' created a value system inherent in these social practices that contribute to a government sanctioned ideology – the promotion of a supreme value and legalized doctrine of physical health (Crawford, 1980, 2006; Skrabanek, 1994).

The legalized doctrine operates to elevate the 'right to health' over other individual rights. Disqualification from health insurance, disease screenings, surgeries, and career attainment is the new penalty for deviances in mandated health obligations such as age, drinking, smoking, sex and overeating (Butler, 1999; Lee, Lindquist, Segal, & Covinsky, 2006; Mann, 1997). The new punishment for 'health immorality' can be seen to extend beyond social stigmas to the termination of the right to health care for those suffering illness and the rationing of health care resources to those deemed 'worthy' based on a false 'medical objectivity' (Butler, 1999; Callahan, 2005). Critics argue that surveillance and control is rapidly becoming a avenue toward punishment wielded by the powerful who hold jurisdiction over the values of a 'worthy life' and who is deserving of health care resources (Cheek, 2008; Conrad & Schneider, 1992; Galvin, 2002; Skrabanek, 1994). In this respect, individuals' rights of self-determination over their bodies and lifestyles are rescinded.

Individuals are no longer trusted with the 'right to choose' a personal meaning of life, happiness and health. Instead they are required to practice the discipline of lifestyle technologies by engagement in a hypervigilant state to avoid potential deviances, and ultimately punishment or death (Crawford, 1980). The changing areas of health provide

pathways for government agencies and health promoters to intrude into any area of human life (Schaler, 2002; Skrabanek, 1994). The intrusion continuously usurps the autonomy of individuals by denying them their right to choose how their bodies are respected, and to make mistakes or unwise choices. In this manner, an individual's freedoms are restricted by the state in that the desire for health is positioned within the state and not the individual (Skrabanek, 1994).

The achievements of public health to reducing morbidity and mortality on a global scale are not contested (Tulchinsky & Varavikova, 2009). In question is the employment of public health approaches to legitimate the imposition of values and practices into individual lives by governmental powers (Sykes, Willig, & Marks, 2004). These changes, while well intended, reflect an altruistic desire for social justice in the area of public health through imposed mandates and the rationing of health care resources. While philanthropic in intention, the definition and character of altruism positions such philanthropy as detrimental to the individual while contributing to a 'greater good' defined by the powerful. Any ethical stand requires a position of values, and only from a position of values can health issues and its evidence be chosen by governmental powers (Seedhouse, 2004). Mann (1997, p. 9) states: "Public health, at least in its contemporary form, is struggling to define and articulate its core values. In this context, the usefulness of the language and structure of ethics as we know it today has been questioned". The altruistic intentions behind health promotion approaches fail to take into account that *promotion involves a choice of values* and therefore decisions made from those *values can never be value-free or objective in reasoning* (Seedhouse, 2004).

The imposed values within lifestylism reflect a *state ideology of healthism* by mandating conformity to 'expert' knowledges and by regulating the organization of society in health matters (Crawford, 1980). The government commitment to the ideological beliefs, values, and ritual practices of healthism imposes a meaningful relationship of human existence onto the individual experience. In so doing, the government positions health as a 'master value' which is inherent in the establishment of religious endeavours (Schaler, 2002). Scholars argue that a government dictatorship over an individual's moral value system when combined with legislative adherence to choices and rituals established by that value system is promoting a pseudo-religious doctrine (Schaler, 2002; Skrabanek, 1994; Sykes et al., 2004; Zinnbauer & Pargament, 2005).

The term *doctrine* refers to principles based on values and beliefs that shape the individual's view of and practices toward the achievement of a 'good life'. In this respect, religion and its doctrines is viewed as holding *good intentions* towards their adherents in their concern for the betterment of the human condition, particularly in the endeavour to relieve human suffering and offer solutions to the problems of life (Pargament, 1997). Religion is also viewed as an ideological system, comprised of beliefs, meanings and values that function to meet the needs of social groups (Furseth & Repstad, 2006). On a sociological level, religion is viewed as a process of regulation with rules or principles derived from a myth (Beckford & Richardson, 2007) that operates to inform the types of information, instruction and ritualized practices inherent to the religion (Cowan, 2007). Beyond this point, however, definitions of religion vary.

Within psychological realms, definitions are comprised of two traditional types: the substantive tradition which holds that the sacred along with transcendent forces are the essentials of religion; and the functional tradition which holds that symbolic forms and ritual practices operate toward endowing meaning and significance in life. These two definitions operate together to encompass the elements of religion as both sacred and functional process toward understanding and regulating the experience of the human condition, especially in approaches to life and death. From this grander scale, religion can be seen to support people on the road of life offering pathways of meaning for emotions, thoughts, behaviours and relationships (Pargament, 1997).

In line with this pattern of the substantive and the functional, Durkheim theorizes that all religions hold the same consistencies with beliefs (values) categorizing the sacred from the profane and that ritual action is a function toward meeting the needs of society. Durkheim projected that religion in modern society would be rational and hold sacred social values of *reason* and *justice* (Durkheim, 1995). Contemporary scholars parallel the function of healthism to that of a religion (Conrad, 2007; Schaler, 2002), positioning its practices as offering a new value system to meet the needs of a modern secular culture (Skrabanek, 1994). If so, healthism must combine the sacred and the functional, the rational and the transcendent in structures of belief and regulatory practices that brings meaningful experience to the human condition.

If healthism is functioning as a religion, then governmental regulations and health care rationing may be inappropriate and viewed as a violation of human rights in the area of

religious freedom. In this respect, government support of public health approaches and legislative mandates supporting healthism are potentially operating as a platform for religious discrimination against those who do not adhere to the tenants of healthism. Chapter two takes a closer look at the systems that sustain the healthism ideology and how it functions to meet the needs of specific social groups in modern culture.

CHAPTER 2

The Secular Trinity: Healthism, Medicalisation and Consumerism

"If death is to be the final stop, perhaps the inevitable can be indefinitely postponed... Since disease may lead to death, disease itself must be prevented by propitiatory rituals."

(Skrabanek, 1994, p. 17)

Lifestylism provides the theoretical underpinnings to healthism. Healthism is a modern moralizing ideology that moves beyond unhealthy behaviour as the cause of disease to the intense focus of individuals and governments on health issues (Skrabanek, 1994). When defining healthism, Crawford (1980) states that healthism cannot be understood without understanding its unity with medicalisation and consumerism. This chapter focuses on how this trinity of healthism, medicalisation and consumerism integrally functions and describes the effects of healthism as a neo-liberal practice. First, discourses of healthism and its generation as a moral imperative for the healthy identity are explored. The chapter then moves to how healthism is inseparably connected to the process of medicalisation that expands health needs beyond the arena of the public heath system and into commercial systems. This expansion creates propitiatory rituals backed by medical consumerism and a neo-liberal agenda. Next, the connection of the neo-liberal agenda to support consumer choice and interest is discussed. Finally, the chapter explores how the role of media functions within the trinity to support health as a 'commodity'. The discussion at this point draws on Couldry's (2003) framing of media as a ritual that

relegates social order and takes a look at the modern issues of direct-to-consumer advertising and the Internet as roads to consuming health.

Healthism: Reconciling interests

Healthism has been described as a moralizing ideology that incorporates a singular fixation with personal health and fundamentally changes the concept of health. In general, ideologies are based on the practice of power supported by the validation of particular beliefs that inform social values, norms and goals. Specific to the area of health, the powers of health advocates, governments, the medical profession and media have contributed to validating the idea that health is a continuous process, consumable commodity and ultimate goal for everyone (Crawford, 1980). In this manner, the healthism ideology can be viewed as an overarching system of beliefs that reconciles government supported IHP imperatives toward social solidarity in health norms with neo-liberal support of the individual in the private right to choice and the commercial right to provision of health resources. The IHP and neo-liberal agendas overlap in their focus on the individual, reinforcing the concept of health as an individual responsibility and individual provision.

Healthism: The ultimate value and moral imperative

The health discourses in the IHP media have contributed to the shift in the concept of health as normalized behaviours toward surveillance, self-control and perfection as indicators of 'good health'. Health-related practices are driven by discourse and

supported by underlying beliefs such the achievement of perfect health being within the 'rational' individual's control. 'Good health' socially signaled an individual's worth by indicating their ability to rationally adhere to healthism values (Crawford, 1980, 2006). 'Good health' thereby became a moral imperative of 'right conduct' and reflection of an individual's determination toward this 'duty'. Stemming from this moral system, Crawford (1980, 2006) argues that healthism is an ultimate value that has reached sacred status in its unquestionable assumption that perfect health is an achievable living standard for all. The meaning of health is no longer regarded as an ease that comes with the freedom from pain and suffering of disease, it is now socially constructed as a sign of moral worth that socially signifies deserving and undeserving identities (Lupton, 1995; Petersen & Lupton, 1996).

Crawford positions actions toward health, such as exercising, as "social practices" as they carry "connotative meanings" (Crawford, 2006, p. 401). For example, a person who exercises might judge themselves and be judged by others as a 'good person' for adhering to a socially normalized 'healthy' behaviour. The social importance of health practices has also been described as representing "the social and cultural legitimacy of the body, both to self and others…' (Williams, 1998, p. 444). In a culture that places supreme value on health, 'doing health' is a major discursive topic and a process for defining the self through the success, failure or ongoing endeavors of various health related actions (Crawford, 1980, 2006).

Public health discourses have supported the definition of the self through comparing the characteristics of the self with social constructions of health norms steeped in moral values. The healthism discourses within IHP focus on the body and the regulation of the self and operate through imperative statements (Petersen & Lupton, 1996). Research has monitored the effects of healthism discourses from various standpoints. One effect has been to change the meaning of health as equal to a 'good life', reflected by longevity and permanent youth (Crawford, 2006; Skrabanek, 1994). Another effect is the desire for and pursuit of an all-encompassing 'perfection' that can be described as an end state to the battle for securing health in order to achieve 'success' and 'worthiness'. However, morality has its basis in the differentiation of 'good' and 'bad', and research shows the 'doing' of health to also generate 'bad' or 'unhealthy' effects.

'Doing health'

The healthism discourse frames health as a pursuit of perfection shown to stimulate an individual's preoccupation in what seems a limitless array of everyday life areas (Crawford, 1980). This framing has resulted in a vast amount of practices for the surveillance and controlled management of the body and everyday life such as: body weight (Malkin, Wornian, & Christler, 1999), food (Coveney, 2006), skin (Detweiler, Bedell, Salovey, Pronin, & Rothman, 1999), 'optimal' aging (Aldwin & Gilner, 2003), sex and reproduction (Miller & Green, 2001), emotions (Bendelow, 2009), relationships (Pulkkinen, Kapiro, & Rose, 2006), career (Zunker, 2008), stress (Brennfleck, 2002) and pets (Laue & Tucker, 2006; Wilson & Turner, 1998). Studies show that avenues to *feeling good* about oneself, having a sense of *self -worth* or living a *depression-free life*

lead to *painful practices* such as cosmetic surgeries (Blum, 2003) and rigorous gym routines (Smits & Otto, 2009). Practices such as rhinoplasty, breast augmentation, and sun bed tans have become naturalized as common practices and part of everyday experience toward perfection and youth (Cheek, 2008). These practices are positioned as 'healthy' options to 'correct' negative personal characteristics (Cheek, 2008; Crawford, 1980; Gattuso, Fullagar, & Young, 2005).

'Doing health' means following the latest medical advances and professional advice which are constantly being redefined with each new 'discovery' of health concerns, interventions and associative practices. Research surrounding these shifting definitions of health show the constant preoccupation with health and surveillance of health issues to generate feelings of anxiety and powerlessness (Evans, Davies, & Wright, 2003; Lupton, 1995; Shoebridge, O'Ferrall, Howat, & Mitchell, 2003; Sykes et al., 2004). The shifting of definitions promotes an atmosphere in which perfect health is unlikely to ever be achieved. The limitless range of the health concept perpetuates a state of anxiety in 'never doing enough' to affirm its acquisition (Kamin, 2005; Markula, 2001; Roy, 2009).

Individual responsibility discourse is shown to disempower rather than empower individuals. The discourse strengthens feelings of powerlessness within the shifting array of advocated health practices that are beyond the individual's ability to manage (Evans et al., 2003; Lupton, 1995; Shoebridge et al., 2003; Sykes et al., 2004). This position of responsibility without power is reflected in an individual's ability to participate in health strategies, and their inability to predict new health concerns or control health outcomes

(Robertson & Minkler, 1994). Responsibility without the ability to participate in power structures is well recognized as an unhealthy position (Petersen & Lupton, 1996).

Striving for perfect health has further consequences, however, for those who do not or cannot adhere to its practices. Healthism discourses have generated intolerance and victim blaming by changing the concept of illness and the sick role (Petersen & Lupton, 1996). Initially, the sick role allowed exemption of those so positioned from participating in social tasks and responsibilities. However, discourses of personal control over health outcomes have changed the social expectations and connotations of illness and the sick role to one of moral and rational failure of the individual (Galvin, 2002). The sick role is now seen as adopted largely by those 'morally reprehensible' individuals who have failed in their responsibility to avoid risks and now reap the punishment they 'deserve' (Crawford, 2006; Crossley, 2003). The moral phenomenon of the healthy person as 'good' and the sick person as 'bad' promotes a culture of discrimination with those suffering illness positioned as 'inferior' (Conrad & Schneider, 1992; Crawford, 2006; Crossley, 2003; Galvin, 2002).

The secular trinity: Inciting propitiatory rituals

This section focuses on the effects of healthism, medicalisation, and consumerism as a trinity vitalized by media content and its influence on consumers (See Figure 1). Particular attention is given to how neo-liberalism works in the area of medical consumerism, and the commodification of health and health care. The ability of the

media to deem which issues are important, structure their meanings and create reality (Couldry, 2003) in combination with the scientific credibility of the medical profession presents a formidable system of power (Seale, 2002). This power is well recognized by the pharmaceutical industry in its use of health discourses in advertising campaigns to piggyback its agenda onto an expanding market (Conrad, 2007) that has global potential due to Internet accessibility (Richardson, 2005).

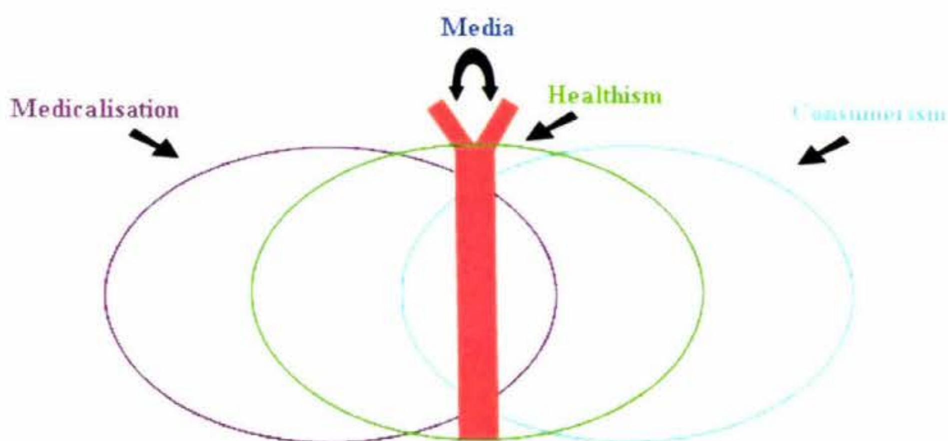


Figure 1. The secular trinity of healthism, medicalisation and consumerism

Reconciling health and consumption

The dominant healthism discourses surrounding surveillance and controlled management construct a moral value of a person through their ability to avoid risk and illness. The individual has responsibility over the 'legitimacy' of their body by keeping it free of illness, disease and imperfection. The 'morally right identity' is aligned with the healthy individual who practices individual responsibility by adhering to this discourse. In this interest of balancing the practice of responsibility with the socially normalized

imperatives of IHP, the 'moral' individual turns to practices that enhance the attainment of resources that will support and sustain their ability to pursue health. In this respect, the meaning of health overarches the meanings, practices and values of consumption.

The healthy identity established by the new public health discourses encourages individuals to consume resources deemed 'healthy' as a means by which the individual can attain a 'healthy identity'. The framing of health as an aspect of everyday life by the new public health discourses expands the consumption of resources into an array of medical and professional arenas. The framing thereby functions to align health with a neo-liberal agenda through the practice of individualized consumptive freedoms and commodification of health care resources (Petersen & Lupton, 1996).

Inciting propitiatory rituals

Medicalisation framed health issues as spawning from deficiencies in everyday life activities. The effect commodified health care by broadening the concept of health care beyond the traditional heath care system or government initiatives. The 'modern' meaning of health positions the everyday activities of lifestyle as *consumptive activities* with health resources as scarce yet tangible objects to be acquired. This positioning opened health and health care to economic development by commercial and professional interests in order to present consumable products and resources. Health became a 'consumable resource', an 'achievement', and a social symbol of economic status. Spending money on health resources became a way to *value* the self, alleviate moral judgment associated with illness, and postpone the finality of death.

At work was a neo-liberal agenda, the invocation of defendable individual rights and a pull away from state intervention that transformed *care and monitoring* in the area of health into an individual choice. Governance in neo-liberalism occurs through autonomous subjects and their 'empowered' participation to make choices to spend money on resources of their choice (Petersen & Lupton, 1996). Research shows the reflexive subject to actively engage in the pursuit of health resources in the form of information, products and technologies through media sources and the Internet (Richardson, 2005). These sources operate to enhance personal surveillance and management of expert knowledges and their mandates function as ritual acts that are propitiatory in nature (Crawford, 2000; Foucault, 1994).

Medical neo-liberalism frames medical procedures and advances in technologies as an individual's right to access. Medical knowledge about health and illness, technological 'breakthroughs', enhancements and pharmaceutical solutions took a new positioning as consumable commodities. Medical services were no longer about alleviating pain and suffering, but became associated with social status toward total 'well-being'. As medicalisation continued to define the meaningful features of complete well-being, marketing strategies offered propitiatory rituals through the consumption of pharmaceutical or surgical procedures (Conrad, 2007; Moynihan & Cassels, 2006).

Medical consumerism driven by neo-liberalism is strongest in the middle class of the United States where a culture of healthism has risen as a result of household surplus

funds and advertising, making increased spending on proactive health screening, risk medication, and unnecessary surgeries commonplace (Fox & Ward, 2008; Greenhalgh & Wessely, 2004). However, studies show the healthism culture is spreading with 'at risk' medications and unnecessary surgeries becoming routine in affluent nations (Angell, 2000; Heath, 2006; Henderson & Petersen, 2002). For example, in Norway, 75% of the adult population qualities for blood pressure medication (Heath, 2006) while cosmetic rhinoplasty among Iranian women is used to secure economically beneficial marital unions (Henderson & Petersen, 2002). Medicalisation has set a very narrow standard for what is socially considered 'normal' and thereby broadened the areas of perceived medical 'need' (Frank, 2002).

The positioning of health as a commodity perpetuated health care resources to become focused on the 'rich well' with an increasing demand in resources leading to global increase in price and inequity in health care access (Koivusalo, 2003; Moynihan & Cassels, 2006). The increase is pushing global health care consumption beyond the limitations of resources and costs (Angell, 2004; Savage, Campbell, Patman, & Nunnelley, 2000). Furthermore, the escalation of medical consumerism is creating a perversion of public health priorities where billions are spent on pharmaceuticals for the 'needy healthy' while the 'sick poor' continue to suffer and die of treatable diseases (Angell, 2000; Koivusalo, 2003; Moynihan & Cassels, 2006; Skrabanek, 1994). The boom in medical consumerism has risen pharmaceutical industries to global superpowers (Moynihan & Cassels, 2006) and much of the increase is attributed to healthism discourses in media, particularly pharmaceutical advertising combined with increasing

access of information on the Internet (Conrad, 2007; Crawford, 1980, 2006; Greenhalgh & Wessely, 2004).

Media: Expanding health to a global market

The role of media in health is one of connectivity between consumers, the government, commerce and society in general. Media is a well-acknowledged pathway to disseminating health information as evidenced in the new public health approaches strategies that were reliant on advertising to convey education messages. The dissemination of health messages has expanded through various media forms such as lifestyle magazines and newspaper and television journalism (Bunton, 1997). Media is currently regarded by social theorists as a network of generative meaning that reflects and shapes the modern world (Thompson, 1995). The combination of media and the credibility of science that supports the medical field presents a formidable centralization of power from which to effect and control society (Beck, 1992). However, research into the effects of media on society has made little progress in substantiating outcomes using the media-effects model (Couldry, 2004; Gauntlett, 1998). Drawing from a sociological theory of practice, a new framing behind the understanding of media is being posited as an "ordering of other practices in the social world" (Couldry, 2004, p. 115) that occurs through the normalizing and categorical power of discourse (Couldry, 2003).

The media-effects model is a popular approach to analyzing the impact of media on audiences and individuals as a form of social control. The model draws from social cognitive theory in an effort to explain and predict the direct effects of media on

judgment and behaviour (Roskos-Ewoldsen, Roskos-Ewoldsen, & Dillman Carpentier, 2009). Extensive research on the effects of pharmaceutical and health advertising have risen from this model with results suggesting that media plays a negative role in the perceptions, judgments and behaviours surrounding health, often promoting stereotypes, insecurities, and damaging unrealistic representations (see Seale, 2002, for a more elaborated argument on this issue). However, the findings from media-effects studies are unsuccessful in revealing any direct and predictable effects on the audience and individuals. Generally, this is due to the inability of the research to eliminate alternative explanations and variables. The research also suffers from the effects of unnatural settings, categorical weaknesses and lack of understanding into the meaningful content of media (Gauntlett, 1998).

A new theory concerning the role of media in society discounts the media-effects model and its focus on proving *how* audiences or individuals are *'enticed to do things'*. Instead, Couldry (2003) uses the term *media rituals* to denote the turn toward the practice of media to "form part of other practices" (Couldry, 2004, p. 126). Media is set within this paradigm to be a social practice that brings people together in the performance of actions indicated therein. From this viewpoint, media is theorized to "have a privileged role in anchoring other types of practice because of the privileged circulation of media representations …" (Couldry, 2004, p. 127). Media representations are often aligned as revealing social realities, and as a ritualized practice media research in this vein can be viewed as having the ability to expose wider patterns of meaning being enacted by individuals and wider society. Rituals are reproductive and highly repetitive acts that can

be exposed through media discourse. Media, in this context, is the ritual that connects the *experience of normality* through ritual actions and thereby carries a categorical and *symbolic connection with a 'social centre'*. These patterns *within media* can be seen to give *order* to the social world and allow researchers to understand how media impacts the dissemination of social power (Couldry, 2003).

The role of media and its impact on health consumers continues to be contested, in part from inadequate research resulting from the use of the media-effects model. For instance, much of the debate over direct-to-consumer advertising (DTCA) exists because of incongruent results of the effects of drug advertising. The following section explicates the intricacies and controversies of neo-liberalism in the area of health and advertising.

DTCA: The neo-liberal discourse of consumer empowerment

New Zealand and the United States are the only countries within the OECD that allow DTCA. DTCA constitutes any promotion of prescription drugs by a pharmaceutical company to the lay population using media. In countries that ban DTCA, no information regarding prescription drugs may be presented through advertising in print or electronic format, however DTCA is widely available through Internet sources (Finlayson & Mullner, 2005; Gurau, 2005). In the past decade, DTCA has become commonplace in both countries, and New Zealand's Ministry of Health has recommended tightening guidelines, however little action has been taken (Toop et al., 2003).

Strong debate exists over DTCA. The main neo-liberal discourse frames DTCA as a tool of empowerment and promotes early intervention for consumers who suffer from underdiagnosis and undertreatment of diseases and symptoms. Patients are no longer 'victims' or passive agents in their own health but learn to be 'active' consumers who are well informed by DTCA campaigns and educationally empowered to request medications. The main argument against DTCA focuses on the increase in prescriptions for DTCA products and the substantial increase in patients' request and insistence to their physicians for advertised drugs. As the advertising minimizes risks yet primes patients in symptomologies, doctors experience pressure and hesitancy in prescribing the drug which leads to negative doctor-patient relationships (Finlayson & Mullner, 2005; Toop et al., 2003). The argument furthers the question of whether the pharmaceutical interest is for health and education or for profit as rising costs linked to what may be an overutilization of drugs threatens health care resources worldwide (Angell, 2000; Finlayson & Mullner, 2005; Toop et al., 2003).

Previous research

Much of the previous research surrounding DTCA uses a social-cognitive approach that shows DTCA to influence consumers by using social learning components. Social Learning Theory (SLT) holds that learning occurs through reinforcement. The learning process creates individual beliefs that outcomes are either a result of individual action or the result of external forces (Rotter, 1990). Health outcomes are improved by the individual developing the belief in personal control over health (Bender, 1995; Consoli & Bruckert, 2004). This premise is used widely in health education programmes by

emphasizing patient responsibility for personal health (Bodenheimer, 2005). In addition, the New Zealand Ministry of Educations health education programme adopts this premise as part of the curriculum by encouraging students to take responsibility for their own health and well-being, and encouraging reflection on individual beliefs (Ministry of Education, 1999, 2009).

The principles of SLT include learning through reward and punishment, learning by observation of others (vicarious learning), and the individual's modeling of other's behaviour (Bandura, 1986; Rotter, 1990). Key components of these principals are found heavily in DTCA in the form of direct and vicarious motivators that operate as the forces behind observationally learned behaviour. For example, DTCA plays upon social rewards by advocating material benefits and pleasant social/familial interactions for the product user. DTCA makes use of vicarious learning through consumer observation and experience of the behavioural patterns of other people (models) who advocate benefits closely aligned with the values of healthism: freedom, normality and medical rewards with product use (Young & Welch-Cline, 2005).

In a limited manner, exposure to marketing communications is shown to influence consumer behaviour (Janiszewski, 1993). DTCA provides patients with behavioural information to "request prescriptions and with arguments to present to the family physician" (Bell, Kravitz, & Wilkes, 2000, p. 330). A persuasion or inducement platform argues that DTCA influences consumers' perceived behavioral control, a component of behavioural intention (what the consumer intends to do), by providing information that

increases the perception of their abilities to perform the action of 'requesting prescription drugs' (Naik & Desselle, 2007; O'Keefe, 2002). From this mainstream cognitive-behavioral perspective, DTCA can be seen to influence consumer behaviour by influencing intentions. However, research into intention formation is fraught with confounds in constructs and variables (Armitage & Conner, 2001).

There is some evidence that DTCA impacts consumer behaviours (Finlayson & Mullner, 2005), but no evidence it improves health outcomes (Gilbody, Wilson, & Watt, 2005). However, the report acknowledges rising concerns in the areas of health and the doctor-patient relationship (Ministry of Health, 2001). The NZMOH recommendation was to continue DTCA with firm regulations, and to allow continuance of industry self-regulation. A driving argument for this recommendation stated that there was *limited empirical evidence to show that DTCA directly harms or benefits consumers*. Media-effects studies have failed to produce the results required to clarity whether DTCA benefits or harms consumers (Gauntlett, 1998).

Searching for definitive answers through empirical evidence will fail to account for the dominant discourses of DTCA promoted by media, the pharmaceutical industry and advertising interests. Aligned with public health education and the ethics of prevention, the framing of DTCA as empowerment to activate consumer autonomy is made from a position of governance. "Personal autonomy…is not antithetical to political power, but rather is part of its exercise since power operates most effectively when subjects actively participate in the process of governance" (Petersen & Lupton, 1996, p. 11). The

imperative of self-management instigated by the healthism ideology is framed in dominant DTCA discourse as looking after which products or knowledge to acquire and consume (Applbaum, 2006); to be autonomous in specific sanctioned ways (Moynihan & Cassels, 2006; Petersen & Lupton, 1996). Studies involving discourse analysis of DTCA have the potential to provide substantiation of the influence of DTCA on shaping public opinion, behaviour and framing the construction of health, illness and treatment.

DTCA 'intentions'...

A critical approach argues that pharmaceutical companies promote disease and their products through DTCA in order to expand drug sales (Mintzes, 2006; Moynihan & Cassels, 2006). Evidence is mounting of the negative impact of DTCA in turning healthy people into patients by heightening perceived symptoms in populations (Moynihan & Cassels, 2006; Woloshin & Schwartz, 2006). DTCA is also argued to promote the financial drain of health care systems through the use of expensive name brand drugs consumed to combat the ever-widening categories of disease and the insatiable needs of the consumer which has resulted from medicalisation and consumerism (Almase, Stafford, Kravitz, & Mansfield, 2006; Angell, 2000, 2004; Moynihan & Cassels, 2006). The combination has bred a new term: the 'pharmaceuticalization of daily life' (Fox & Ward, 2008)

The governments have encountered much difficulty ensuring DTCA is more beneficial than harmful, and advertisements are often in direct violation of government regulations which has led to a demand for tighter regulations or a ban on DTCA (Mintzes, 2006;

Toop & Richards, 2003). However, global accessibility of the Internet has rendered ineffective the national laws that govern DTCA. Left unchecked, the dominant discourses of DTCA bring a message to a worldwide market of consumers to be willing and active patients.

The Internet: The superhighway to health

The Internet is an information superhighway that can provide an even faster conduit for disseminating a healthism ideology. Studies show mass media discourses on the Internet function to shape accounts of health and medication in the same manner as other advertising mediums (Richardson, 2005). The format of websites actively engages multiple consumer interests by incorporating various perspectives of health related information combined with Internet access to pharmacy products to facilitate interactive consumer participation (Murero & Rice, 2006). Consumer attention is drawn to websites that match the individual's needs. Interactive participation takes the form of self-help, self-diagnosis and online purchasing of health products (Murero & Rice, 2006; Seale, 2003), a modern ritualized form of agency in healthism's moral imperative of individual responsibility (Couldry, 2003).

The global superhighway registers over 12.5 million health searches everyday (Murero & Rice, 2006). It is the most universal avenue for acquiring health information, with one in three searches focused on health related material (Richardson, 2005). How to obtain health information on the Internet is now taught in textbooks that include sections and assignments on locating information on disease and evaluating the validity of Web

sources (Schneider & Evans, 2009). The Internet offers various types and sources of health information with its accessibility to professional and lay advice perhaps its greatest attraction to users (Murero & Rice, 2006).

Superficially rich in 'choice', an individual can engage in cyberspace social networks, or 'alternative' Web pages for support in non-medicalised health knowledge. Individuals suspicious of media discourses influenced by professional or commercial opinion are shown to value Internet access as an opportunity to interact with the likeminded. Unfortunately, research into unofficial websites, online groups and various chat rooms shows the dominant and discriminatory medical discourses of prevention, risk and individual responsibility to prevail (Richardson, 2005).

For those who value professionally endorsed information, the value of the Internet is in the individual's ability to access professional attention regardless their standing on insurance, appointment or global location. E-health (using the Web for commercial health purposes) and the e-pharmacy (online pharmacy) trends make accessibility to online doctor's appointments, pharmacist's advice and medications a reality. The instant access to health care recommendations and pharmaceuticals quickly became recognized as profitable for e-commerce (Murero & Rice, 2006).

Many drug companies or commercial organisations now produce websites that serve as 'health portals' to accessing health care products and services (Murero & Rice, 2006). By providing extensive health content information and proclaiming to operate in the public

interest, the websites build direct commercial relationships between drug companies' products and consumers' need (Conrad & Leiter, 2008; Richardson, 2005). The websites offer direct access to e-pharmacies where products and prescription drugs are available via online purchase or order for pick-up (Murero & Rice, 2006). The practice of online medical product and service consumption is presented as a public expectation by business-to-consumer advocates, especially in offering access, empowerment and self-help for the disabled, impaired or those without medical insurance (Carrard et al., 2005; Surdilovic & Zhang, 2005). However regulatory agencies are concerned with the implications it poses to the ease of regulated drugs to be shipped across borders. Following the same ineffective trends as the ban on DTCA, national regulatory bodies find the boundlessness of Internet advertising fuels the international flow of illegal pharmaceuticals. Although only some countries allow online pharmacies, the national regulations, standards of quality, and illegal sale to those without a prescription is little hindrance to online shoppers (Murero & Rice, 2006). The Internet has become an effective conduit to supply the increases in 'need' caused by DTCA and media messages.

The interactive gratification of health

Internet media is found to have the same effects as mass media on individuals and populations (Richardson, 2005). Internet gratifications research focuses on the function of Internet media for specific audiences. Specific research in the area of gratification of 'needs' in the information seeking process targets how individuals use Internet media to satisfy their needs (Murero & Rice, 2006). The most common needs identified are

entertainment and knowledge seeking through surveillance of various websites (Papacharissi & Rubin, 2000).

Consumers' attention to Internet websites is based on cues that draw consumer attention. The cues are aligned with the fulfillment of their needs in the moment (Murero & Rice, 2006). The functional categories of knowledge seeking and surveillance are in areas of medical news, services, drugs, disease, lifestyle, and online discussion groups. The health beliefs and individual orientation toward specific information guides consumers in their search and acceptability of website information (Dutta-Bergman, 2003). For example, medical news websites may be more trusted than personal blogs for information on the H1N1 virus. The evaluation of quality of information varies with the needs of the consumer, however whether the information is from medical, alternative or personal blogs, the Internet is commonly regarded as the most credible source of health information (Adams, de Bont, & Berg, 2005; Self, 2009).

Regardless of type of health information sought, the role of the Internet in addressing the 'need' of knowledge gathering and surveillance is to provide an avenue for self-help to enhance power and control over health issues (Broom, 2009) which Crawford presents as another form of individual responsibility (Crawford, 1980). The individual nature of searching for information contrasts with the interactive dimension of internet interaction. In the 'social space' of the Internet, the ritualized performance of the connection between people with similar needs occurs through the medium of websites by the 'clicking' of hypertext to acquire 'live' information such as chat rooms, video, updated news or blogs

and animated (JavaScript) advertisements (Couldry, 2003). The interactivity provides a form of ritualized management similar to that which operates to connect social groups, generating "sensations of togetherness" (Nichols, 1994, p. 56) experienced by the user in a socio-cultural atmosphere that prizes individual agency.

However, "sensations of togetherness" cannot take the place of the individual risk entailed in employing Internet health care resources. Although providing alternative and orthodox views on an equal standing, there are few regulations over online health content, and therefore unknown sources may publish medical information that lacks validity (Ernst, 2002). The risk of encountering false information and suffering harm through its application runs high, especially in e-pharmacy or e-health consult situations that provide prescriptions based on unreliable questionnaires (Murero & Rice, 2006).

The spread of false information, user risks and the pharmaceutical agenda is of particular concern as it exposes information seekers to potential harm (Ernst, 2002; Murero & Rice, 2006; Richardson, 2005), but it is only the beginning of the road. Critics argue that ritual internet practices make media an agent of social control for those who have the power to create images, video and generate information because the categories and forms presented contain the discursive functions through which society fixes meanings (Couldry, 2003). A good example is the perceived superiority of Western medicine that has fixed medical knowledge as expert, and its power has begun to shape the understanding and practices of health worldwide (Whyte, van der Geest, & Hardon, 2002). The Internet has been used for many years to deliver Western style health care

and medical libraries to populations where indigenous medical traditions already exist (Ernst, 2002). Global exposure to Western health information via the Internet has the potential to expand the practices of health consumption and the healthism ideology. As an aspect of globalization, the information superhighway holds the power to collectively alter the human experience of health.

CHAPTER 3

The Current Project: A Pharmaceutical Advertising Website

The US Food and Drug Administration, health psychologists, and public health officials advocate research into pharmaceutical advertising and its impact on understandings of health (Glinert, 2005; Hodgetts & Chamberlain, 2006b; Toop & Richards, 2003). In New Zealand, the convergence of health interests, DTCA, pharmaceutical advertising and the Internet has manifested an interesting phenomenon of pharmaceutical advertising websites. Of particular interest is a prominent New Zealand pharmaceutical website named Family Health Diary (FHD) which combines consumer education with the advertising of medicines (Norris et al., 2005). The potential for examining the promotion of a healthism ideology is especially robust in the discourses operating within this medium. The present study analyses the construction of health(ism) in this website to determine the extent to which it is informed by healthism discourse (Crawford, 1980, 2006), whether that discourse parallels the moral values or practices of religion, and what function online pharmaceutical advertising serves.

The objective of the study is the examination of the website advertising material for dominant representations of healthism and any parallels to the values and practices of Western religion. Focus is given to the healthism discourse, including its ascribed interconnection with medicalisation and medical consumerism discourses. How does a pharmaceutically-based website such as FHD construct health and does that construction

function to perpetuate the social practices of healthism? Does healthism parallel the discursive function and practices of religion and thereby promote a pseudo-religious doctrine as scholars advocate (Schaler, 2002; Skrabanek, 1994; Sykes et al., 2004; Zinnbauer & Pargament, 2005)? If so, what are the similarities and differences in the constructions and social practices as revealed in the discursive mediums?

Due attention in this study is dedicated to the constructions of health, illness, lifestyle, risk, cure, well-being, morality, attitudes, behaviours, choices, emotions, responsibility, agency and presence or lack of alternatives presented for the individual. Also under investigation are critical issues surrounding power, knowledge, gender, management, expertise, commonalities, discursive resources and their function. Within this Internet source, attention is dedicated to these representations in text, image and video.

Project design

Crawford defines the healthism ideology as "...a socially and culturally constructed way of seeing, interpreting, and evaluating... the physical and social world and relation of self to those worlds..." (Crawford, 1980, p. 367). Ideologies are based on the practice of power supported by the validation of particular ideas and beliefs (Crawford, 1980). As such, social constructionism provides an ideal critical platform to reveal the power structures driving these relationships in the healthism ideology (Nightingale & Cromby, 1999; Parker, 1992). Internet studies employing discourse analysis are uncommon, yet

the power of social constructionist analysis to inform the public is well recognized and endorsed (Seale, 2003).

Employing critical social constructionism illuminates power structures that legitimate knowledge. Knowledge is viewed critically, as a production and synthesis of history and culture. Unconcerned with truth, social constructionism investigates the systems of values that empower particular beliefs, knowledges, and groups. In an effort to explain processes that give rise to particular knowledges, critical social construction allows analysis of concepts such as individual responsibility, self-value or morality toward the exposure of structures behind the social processes that create such beliefs (Nightingale & Cromby, 1999).

The approach contends that questions concerning social and contextual processes and their emergent relationships can be discovered through discursive analysis. As humans are engaged in conversation, reading, or listening to language, constructionism deems language a social process through which meaning is actively generated and actions toward a social purpose are fulfilled. The structure of language thereby operates as an expression of social processes in context (Nightingale & Cromby, 1999). Examination of patterns of talk and text can reveal dominant discourses and thereby expose the nature of power relationships operating in discursive events (Gergen, 1999; Nightingale & Cromby, 1999). Exposing *how* beliefs and practices are legitimated through language reveals how meanings can be created to achieve the goals of the powerful.

A critical discourse analytic approach was adopted to analyse texts, images, and videos from the pharmaceutical advertising website 'Family Health Diary' which focuses on health issues. Particular attention was given to the similarities and differences of healthism and religion in terms, meanings, subject positioning and function. Reference was also made to psychological and sociological standpoints of religion. Particular reference was made to Durkheim who emphasized the cultural basis of religious phenomena featuring symbolic and ritual aspects (Durkheim, 1995), and whose theories are accepted in social psychology, linguistics and anthropology. Couldry's (2003) paradigm of media as ritual and social practice with its basis in social constructionism and alliances with Durkheimian theory was implemented as the media approach and was influential in opening up questions and reflexivity of orientation during the process.

Data and collection

FHD is a globally accessible Internet website published by the pharmaceutical marketing group 'Brandworld' within New Zealand (Norris et al., 2005). The data medium http://www.familyhealthdiary.co.nz was identified through repeated exposure to FHD TV advertisements and the free newsletters that grace participating pharmacy check-out shelves nationwide. The website was selected because the pharmaceutical marketing group has been disseminating health and product information for over 10 years. Although FHD advertising material is available from these many sources, the website was also chosen because it was found to contain current and backdated newsletters along with all

current advertising media available to the public from this pharmaceutical organization through one online source.

FHD undergoes updates on a bi-monthly basis. The bi-monthly installment of the March-April 2009 issue was selected as it occurred at the stage of data gathering. The website's html documents were downloaded using the free software HTTrack Website Copier (Rosche, 2002) that enables websites to be saved in their entirety, including text, images, and videos. The software allows an accurate, comprehensive and interactive offline collection of the material to be available as it appeared on the live website. The material was also hard copy printed in its entirety which resulted in 231 hardcopy pages that enabled analysis of static images and texts. Although Internet-based information is a relatively new source for research, Internet materials are considered documents that present data on institutions whose contents are readily available for discursive analysis (Sixsmith, 2002).

Data analysis

The analysis of the website comprised five stages that built on psychosocial knowledge of religion and health. Using an inductive method to move beyond the known, an interconnected framework of assumptions and categories was developed to inform an overall view of the phenomenon (Morse, 2002). The first stage of analysis was engagement with the virtual website and an exploration of its themes, categories and accomplishments. websites have an agenda that defines the communication and what the

authors intend to accomplish through the communicative mediums (Pollach, 2005). Therefore, this stage involved getting a feel for the overall picture and worth of the website as it would be encountered by an Internet surfer. Repetition and dominant views were easily identified as aligning with previous knowledge of health related topics.

The second stage was an analysis of hardcopy text and static images of the large medium. Specific discursive constructions were sought and identified along with subject positions drawing on Foucauldian and Critical Discourse Analysis (CDA). CDA allowed for specific focus on understanding the regulative, purposeful and symbolic nature of the discourse as a collective cultural phenomena and Durkheim was referred to as a guide in this area. Drawing on CDA also allowed deeper discernment during the analysis through use of linguistic insights of social meanings in areas such as grammar and syntax. In this manner, CDA is capable of revealing the ideology behind constructions and their impact on power-knowledge relations and significant social structures such as health and religion (Barker & Galasinski, 2001). In many instances, engagement with CDA followed aspects indicated by Fairclough (Fairclough, 1992, 2001).

Text

Gathering and identifying discursive themes and positionings in the second stage consisted of logging those identified into a notebook and noting the occurrence by hardcopy page number. Each advertisement of the website consisted of many discourses, but an overall patterning of major discourses emerged. For example, a strong theme of *morality* occurred consistently throughout the advertisements, but adopted different

meanings according to its positioning within different discourses in each particular advertisement. This stage also consisted of focusing on the variable positions of the Internet surfer offered by the text, and therein identifying the intended position of the authors. During this stage it became apparent that the message of the text at times contrasted with the messages of the static images which spawned an intense investigation of the relationship between text and image.

Static Images

The third stage was a thorough examination of the images and their meaningful relationship with each other and the text. Palpably apparent was an overrepresentation of Caucasian female images. This induced a frequency count of all images based on gender, age and ethnicity. Iconic images such as popular celebrities were also identified. From that point, the features of the images were analyzed according to photographic quality, physical positioning, interactive qualities, and gaze to denote the purpose and significance of the image in its social construction. "Images reflect, represent and reveal a community's values, norms, culture…" (Cross, 2006, p. 185) and these aspects were considered using a discursive approach to the images and guided by previous studies of this caliber (Lassen, Strunck, & Vestergaard, 2006).

Video

The fourth stage involved intense engagement with video content. Each video on the website was watched in its entirety using *RealPlayer version 11 Downloader and Recording Manager* for Windows, which has a time index counter. The time index

counter was convenient for allowing note making of themes and categories in talk and image. Repetition within the video format was easily identified and when compared with textual format, the two mediums were found to mirror one another in discursive content and sequence. This finding led to a closer investigation of the overall intention and message of the website, including its title and structure, by taking a step back from text, image, and other discursive elements. Stepping back from the material allowed a broader picture to emerge.

Taking a step back

The fifth stage involved gaining a new perspective of the material. This was accomplished by taking a step back from the close analysis to gain a view of the overall collective function. This involved allowing the structure of the content to reveal how these discursive forms, messages and themes fit together. What was the higher purpose and message intended by the website? What were the authors building? A tree-diagram enabled the mapping and exposure of a newly termed *meta-structural formation* that constitutes a unified concept of health and highlights the communication of this message as a movement toward social solidarity in individual conceptualizations of health.

Synopsis of findings

Chapter 4 describes the key findings from the FHD website. After thorough interaction with the virtual content of the website and actual hardcopy text, the intensely repetitive nature of the form and of the content became readily apparent. The format of texts, static images, and videos repeated each other in structural nature and the discursive resources

used to create those structures. Therefore, at that point, an overview of the function of the website took place revealing the FHD website as establishing the dominant views of medicalisation, perpetuating discourses of individual responsibility and providing an avenue to the instant gratification of needs through consumerism.

Upon returning to the discursive resources, the repetitive discourses are found to function together to:

a) Inform and prescribe the beliefs and actions that comprise a new morality with repetition strongly operating as a form of ritualized practice;
b) Construct a meta-structural formation that functions as a unified concept of health Through an additive paratactic relationship between paragraphs;
c) Position the individual as one of a believer who belongs to a congregation that believes in the morality and ritualized practices of healthism;
d) The believer is subject to the unquestionable texts written by experts.

The findings chapter presents the sequential process revealed in the data: information, instruction and ritualized practice. These are shown to operate to form the process of social solidarity through integration and regulation that administers religious systems and social life (Beckford & Richardson, 2007).

CHAPTER 4

Healthism: Constructing Social Order

Chapter 4 presents findings that position healthism as paralleling the core tenets of religion in their shared construction as information, instruction, and ritual practice. Underlying the construction are discourses that reveal the morality, beliefs, and behaviours presented as sanctioned actions that contribute to the practice of any institutionalized system. The website media is shown to present discourses of health in concentrated and repetitive forms that normalize the healthism ideology and promotes social solidarity.

At the outset, this chapter contains an overview of the scope, content and function of the website. The chapter then moves to explore healthism's expert discourse which is shown to promote a morality that parallels and deviates from the traditional Western 'middle class' religious values while drawing on a symbolic dichotomy of the sacred and profane. Psychosocially, the discourses can therefore be seen to follow both substantive and functional traditions. However, a highlighted difference is healthism's turn toward the value of the self and a faith positioned in scientific 'rationality'. Next, the chapter moves to take a closer look at the secular trinity which reveals these integral discourses to construct an overall concept of health that solidifies human experience. The chapter concludes by showing the expert discourse to have a second function in the construction

of a doctrine of unquestionable behaviours through sanctified secular texts that legitimate ritualized health practices.

Overview: Scope, content and function of the website

Attractive yet professional in appearance, the website is a colourful blend of informative text, images, and videos operating within an interactive area that combines several presentation styles. The Web pages are packed with over-the-counter and DTCA pharmaceutical advertisements listing current health issues, statistics, advised behaviours and treatment options in a style that reflects the altruistic and 'educational' qualities of health promotion campaigns. However, the information presented also strongly consists of 'social marketing' strategies that supply modern health care resources, goods and expert health advice as commercial merchandise (Naidoo & Wills, 2000). Many product images and text titles are directly linked to online pharmacies where they can be immediately purchased. The website has an 'edutainment' flavour in its celebrity endorsed, aesthetically pleasing and interactively fun design that mixes animated JavaScript ads, real-time Flash player video infomercials, expert blogs, membership benefits and prize draws.

The FHD website is built in *frames* which carry constantly accessible menu bars that position health categories on the left and top of the view screen with changes in selected information presented in the centre. The left frame consists of menu categories presented in images or scroll-over bars and the top frame consists of the logo image, animated

advertisement and menu categories presented in plain text. Some categories reoccur on the menu bars of both frames. The main central frame contains graphics, images, photographs, animations, video with audio playback, and text-based messages with similar overlap occurring.

Varying the format of information through the use of images, audio and video, and text in order to communicate the same information is a tactic developed by health message designers. The tactic targets and attracts the differing cognitive abilities of the audience. Where consumer audiences with lower cognitive processing skills may be attracted to the television-like quality of the automatic audio and video advertisement playback, the text-based message may attract those with higher education (Bernhardt & Cameron, 2003).

Enabling instant gratification of health needs

Categories compartmentalize information, enabling individuals' perceived ability to locate sought information. Categorical, textual, video and image information occurring within categories is extensive and repetitive. The scope includes information positioned with advertising on lifestyle, fitness and environmental health issues, as well as minor ailments such as nappy rash and major diseases such as cancer (See Figure 2). "Your Health A to Z" outlines 82 health concerns with recommendations for prevention and treatment. The category "FHD Magazine" spotlights many "A to Z" issues that come into seasonal focus with a gateway to the online pharmacy Pharmacy Direct for instant product purchase. Much of the content of these two categories present images of illness sufferers alongside recommended products for these illnesses and links to associated

product video-infomercials contained in the "FHD TV" category. The "About Us" category projects an expert online identity by proclaiming all content to be written by medically and pharmaceutically licensed individuals. The "Healthy Living" category offers blogs (frequently updated personal commentary with Web links) of these expert writers, while the category "NZ Support Groups Directory" offers contact details for lay-person support and networking groups.

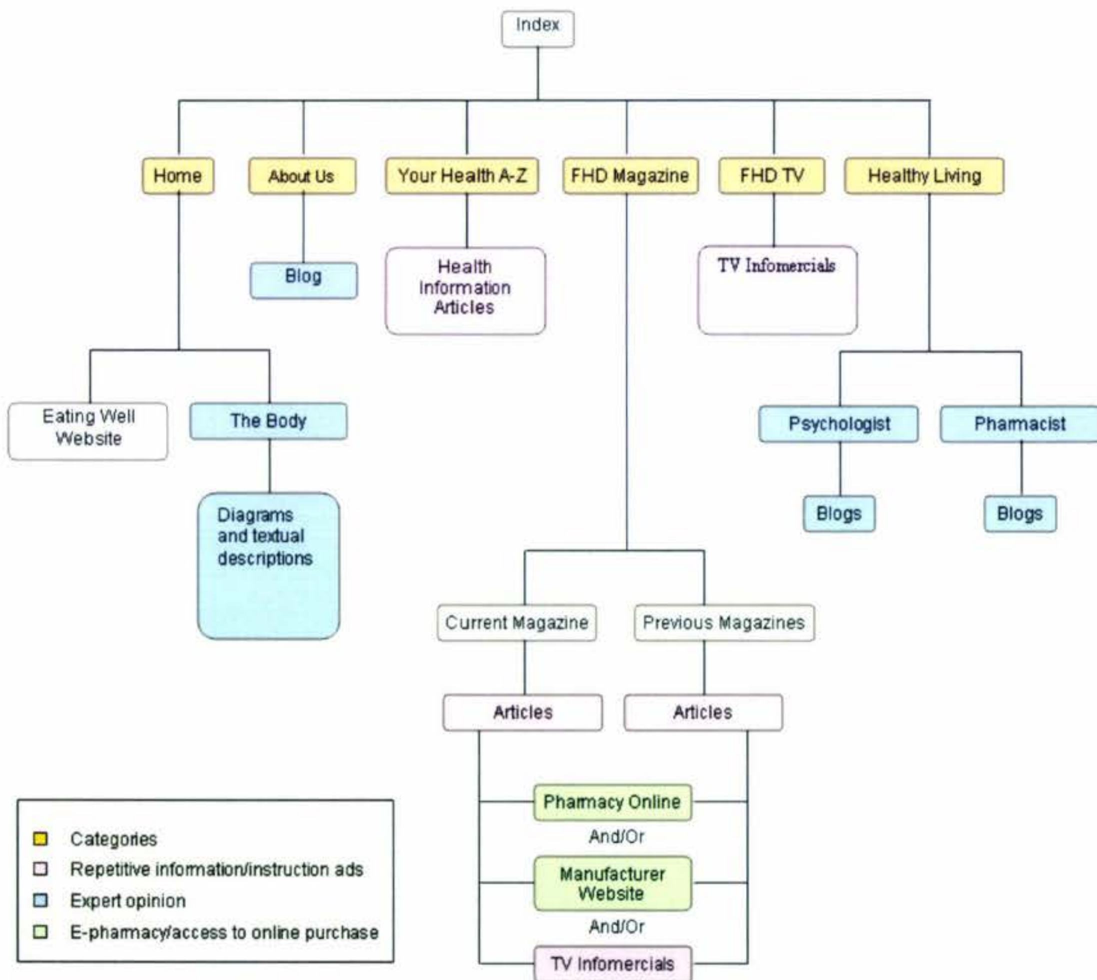


Figure 2. Overview of FHD website construction.

Figure 2 can hardly do justice to the vast amount of material housed within the website. Producing 190 Megabytes of information, the amount appears adequate to address the various health information requirements of the average Internet surfer. The website unobtrusively acknowledges and projects itself as an extensive storehouse of health data by incorporating a website search engine at the top of every inside frame, no matter the surfer's location within the website. The general connotation of a search engine is that anything related to the subject matter of the website that interests the individual can be immediately found and that health 'problems' can instantly be 'solved' here. The search engine thereby symbolizes the instant gratification of needs offered by the website.

Establishing the legitimacy of the dominant

Although owned by a pharmaceutical marketing group which is a commercial organization, the website presents itself as operating in the public interest. The "About Us" section presents the website as a "health information network that aims to keep you informed on health conditions and current issues, as well as offer practical solutions" that are "reliable" and "up-to-date." Nowhere in the website's text is there a reference to pricing. Previous research shows that the "About Us" sections of corporate websites are used as communicative strategies to project a source 'cue' to audiences that enhances the perception of the quality of information presented (Pollach, 2005). To an internet savvy audience, the 'story' behind the website enhances the source's credibility (Greer, 2003). With the rise in public skepticism in media content (Richardson, 2005), promoting an altruistic message of operating in the public interest by presenting health care information

is a strategy that enhances the website's credibility of information and trustworthiness of source.

The "About Us" page also draws on credibility of experts to enhance trustworthiness by presenting the information as written and reviewed by pharmacists and medical professionals. Seeing your doctor is advised as the course of action in case of illness, which legitimizes a biomedical positioning of information and practice. The page presents contradictions in content by communicating trustworthy sources yet positions responsibility for use of the content of the website to the individual who is advised to see a GP as: "*Only your GP* can advise you on the course of action that is best for you." The text mimics that of the disclaimer that appears at the bottom of every page that states the information is not a substitute for a GP's opinion, and any information presented that results in self-diagnosis should be met with medical advice. The combination reinforces the legitimacy of the authors through deference to the existing hierarchy of power over health issues and the interpersonal function of the text which relies on the assumption that the authors *have the right to give orders* to the audience.

The establishment of a hierarchy constructs and legitimizes with the user an underlying structure of segregation between rulers and ruled, between those who command and those who obey, and those who guide and those who follow. Through common use of the second person pronoun "you", both the individual and the masses are addressed concurrently, at once establishing a personal and impersonal relationship with the audience. The conflict is extended by textual referral to expert medical opinion and

proclamation of a philanthropic agenda. The messages simultaneously communicate an *intention to help*, a directive to *help oneself*, and a directive over the *way in which help should be enacted* by instructing users to seek help from third-party professionals. The website thereby represents power without responsibility by presenting itself as a "guide to health problems", which constructs itself as an authority in actions that produce healthy lives yet takes no responsibility for outcomes of those who act upon the information.

The website appears to comprehensively target a wide audience and increase health areas in its lists of personal categories for "men's health", "women's health", "child health', "senior health", and "general health". The website extends health concerns to "pet health" by positioning them as members of "family". Furthermore, the website incorporates all health related information identified by previous research that functions as a cue to information seekers outlined by Dutta-Bergman (2004): medical news, services, pharmaceuticals, disease-specific information, lifestyle, and identifying discussion groups. Therefore the website appears to cater to multiple audiences through its messages. However, the "Login" and "New Members" links that permanently appear in the left side frame promote a relationship of 'elites' and 'masses', positioning FHD members as a defined group with characteristics that set them apart from other groups.

Pictures of people on the website effectively clarify the relationship of difference for this group and establish group identity (Brewer & Kramer, 1985) by portraying an unequivocal amount of adult Caucasian female pictures compared with any other pictures of people (See Table 1). Further establishment of group identity can be seen in the

endorsement of products made by the use of various women's resources such as women's magazines ("Voted 'Best Sunscreen' by New Zealand Women's Weekly readers.").

Table 1 (*N = 209*)

Picture Frequencies by Relative Age and/or Ethnicity.

Relative age and/or ethnicity	***n***
Adult Caucasian Female	122
Adult Caucasian Male	29
Elderly Caucasian	20
Child Caucasian	29
Maori/Pacific Islander	5
Asian	2
Other ethnicity	2

The female pictures portray the women in what can be described as middle class environments and attire. Further, the website uses the Caucasian New Zealand celebrity Jude Dobson as the smiling front-face representative on every magazine and many TV advertisements to symbolize the healthy female (See Figure 3). The use of celebrities to cue target audiences, symbolize health (the product) and build trust is a well known advertising strategy (Seale, 2002).

Figure 3. Celebrity Jude Dobson representing the middle class female as target audience.

Functional positioning: A relationship in the public interest?

The form and content of online discourse has implications for the social construction of healthism. Health is constructed as a broad system of urgent requirements that can be instantly mollified by the individual through online resources. This is evidence in the provision of information on health needs and instant pathways to their gratification (See foldout Figure 4). Although the website is presented as 'operating in the public interest' in health matters, as many websites do (Richardson, 2005), the target audience is clearly middle class Caucasian females. Previous studies on media discourses in health have revealed women to hold responsibility for individual and family health (Lyons, 2000), and therefore it is not surprising to find the main content targets their attention. However, what is missing from the website are the common public forums or interactive areas for personal exchange between 'consumers' or 'the public' such as chatrooms, feedback discussion boards and lay person blogs. In this respect, the website's communicative function takes the form of a dictatorship with an unspoken commercial agenda. As an overview, what is communicated between and within categories is a repetition of information in form and content from authoritative sources that is believed to address health issues.

The following section reveals more fully the beliefs that support this system to be mandated by authority as an individual responsibility. The section also highlights the beginnings of religion in its ideological form; a system of behaviours based on moral beliefs and directed by authority (Durkheim, 1995).

'Diary' is restriced access item. Discourse of 'priveleged information. 'Family' postions everyone as belonging and engenders trust in social group.

Implies benefits may be missed by non-membership. Promotes elitism.

'Free' items entice exploration.

A-Z is dictionary format that contains 'value-free facts'. Dictionary is sacred in its 'unquestionable' authority.

Individual categorization of health issues.

Promotes 'interactive' communication.

'Free items entice exploration. The term 'newsletter' promotes FHD as a 'special interest group'.

A 'report' is a scientific heading. Engenders 'truth, 'trust' and 'expert' positioning.

Advocates personal responsibility for site use.

Public health agenda alongside commercial ads.

Ads masked as education.

Responsibility discourse invoked Global citizen responsible for non-human entities.

Ads masked as education.

Constructs associations with conditions.

Fear mongering. Medicalisation offers hope.

Imperative for individual responsibility.

Personal and intimate positioning.

Pan-value conglomerate heading. All living can be healthy.

Site search engine implies any health problem can instantly be 'solved' here.

Celebrity expert title. Expert stands in front of 'common person' denoting power and authority.

Health products are 'prizes', highly desirable posessions for 'winners'.

Suffering must be relieved/managed.

Cartesian/biomedical view of body.

Act of eating sanctioned foods leads to health.

Figure 4. Website index page with researcher commentary.

Healthism in the garden of good and evil

Moving into the detail of the pharmaceutical advertising, the findings establish systems of information and instruction that inform health practices. The doctrine created within pharmaceutical advertising operates to guide health practices and draws on moral views based on the values held by authority and supported by 'educational' strategies of the new public health. The informational and instructional discourses are drawn from the further establishment of the website authors as authoritative sources through the use of text, image and video. These discourses create rules and regulate beliefs based on moral values of 'good and evil'. The indication from this section is the founding of a social solidarity based on morality.

The genesis of doctrine: Advertising as education

Within the website, pharmaceutical product advertising is presented in a similar format to public health messages. The format thereby serves to generate the healthism doctrine within the advertising. Public health messages use educational formats laden with behavioural modification instructions. These educational formats are apparent in the pharmaceutical advertising in the form of experiential and biomedical information and instruction presented for various ailments. The result is overlap between messages that are based in government funded public health services and those based in a pharmaceutical and therefore commercial agenda. A prime example is the government advertisement for its free "Human Papillomavirus immunization programme" for school girls appearing alongside "Voltaren" advertisements for "muscle and joint pain" and

"Maxalt Melt" for managing "migraines". All provide experiential and biomedical terms for the reasoning behind the causes of the illness such as "pain" or "embarrassment", "viruses" or "swelling", along with expert medical backing that refers to "doctors" or other "health care professionals", listed treatments such as the "RICER method" or "immunization", and outcomes such as "joy", "protection" and "relief". The overlap produces uncertainty as to the authority behind the message as being philanthropic or capitalistic.

Further, the educational style of public health advertisements in the effort of behavioural modification is usurped by pharmaceutical advertising. The definition of causes of illness ("too much sugar in the blood"), terminologies ("hormone insulin"), symptoms ("blurred vision"), risks ("contaminated"), and the behaviours of prevention ("pre-natal health checks") and treatment ("injection") are commonplace in the pharmaceutical advertisements. *Good behaviour* is marked as conformity to the behavioural mandates advocated by experts that repeatedly appear as "prevention", "treatment" with pills, "treatment" with surgeries, medical "testing", and seeking "medical advice" and "diagnosis". *Bad behaviour* is that which is against expert mandates and is marked by negatively labeled activity such as 'poor' ("*poor*-dietary patterns"), inactivity ("*sedentary* lifestyle") or food intake expertly regarded as 'bad' ("fast food"). The advertising begins to generate a doctrine cultivated by a morality that clearly designates good and evil behaviour selected by authority.

Thy will be done: The 'expert' discourse

Sources of health advice throughout text, image and video portray doctors, pharmacists, and celebrities as the expert knowledge behind good and evil behaviours. Text occurs regularly indicating the individual to "ask your pharmacist", "ask your GP" or "ask your health care professional" which establishes these professionals as the credible experts. Texts also display the names of celebrities, doctors, health care professionals and *health care professionals as celebrities*, in many cases with credentials listed alongside names. Credentials symbolize the knowledge and authority given these representatives from the institutionalized systems of science and medicine.

Further symbols of authority are shown in the content of images and videos of these representatives. The representatives often wear the uniform of their profession, white smocks or shirts, lab coats and nametags as outward displays that indicate their affiliation with science and professionalism that accords their status above the common person. 'Celebrity professionals' and uniformed professionals stand in front of the common person in the videos. The positioning and posture indicates a commanding and controlling status. The modality of the images of health advisors is one of domination with their image positioned in a full-face view in the front of the screen. The relationship promoted with the consumer is of a personal yet demanding nature, and therefore authority in the social relationship. The views hold engaging, penetrative and confident gazes signifying their 'rightness' (See Figure 5).

Celebrity Pharmacist Celebrity Psychologist Video Celebrity Expert Video Celebrity Pharmacist Expert

Figure 5. Static and video celebrity expert positioning.

In video, the common person is positioned behind the expert, indicating submission, and either as committing a wrongdoing and suffering for it or following the 'good' behavioural information and instruction given by the expert. The interplay never shows the expert as engaging in any indicated behaviour, contraindicated behaviour or suffering. The interaction in the images thereby offers clear authoritative standards, directing the common persons' behavioural effort such as how to apply nappy rash cream exemplified in the *Video Celebrity Expert* image.

The celebrity and professional experts dictating the meaningful behaviours of health take the form of idolized representations in that they are *elevated* above the common individual in word and deed. The idolatry, when combined with their representation of morality, contributes to the images adopting a deified position. In this sacred position, the images operate as powerful expressions that promote and endorse the beliefs and behavioural practices. As deified experts and self-professed "guides" *their will must be done*.

"Healthy Living": Constructing social order through morality

At the core of morality is the distinction between good and evil which Durkheim posits to represent a symbolic division between the sacred and the profane that functions to guide what is valued and not valued in society, thereby creating a form of *order*. The "Healthy Living" section presents an overview to the connected moral system of doctrine (principles as rules or laws) surrounding the social function of the healthism ideology. The dense nature of the blog reflects the scope of the doctrine that guide discourses throughout the website material. Following this section, a detailed analysis of website discourses is presented.

The "Healthy Living" section is written by a famous psychologist in New Zealand, and therefore is from a celebrity and professional expert platform. The moral discourse frames health practices as rational choices between good and evil with the rational individual modifying their behaviour in accordance with the positive and negative guidelines: "start by being positive!", "Every time you wander down the *slippery slope* of negativity, *banish* that thought and replace it with a positive one." The text parallels Christian or Catholic qualities in the avoidance of *backsliding* and *banishment* of evil. Stipulated behaviours include dietary intake ("alcohol-free days"), exercise ("the positive effects of exercise"), speech ("speak words of hope"), thinking ("staying in a positive mind-space") and emotional states ("harmony and joy"). The word positive functions throughout the website in this manner ("positive aging", "look for the positive").

Stipulated areas expand to include acceptance or rejection of good and evil in life situations such as conversation topics ("put gossip and intrigue and nastiness aside") and relationships ("surround yourself with people who contribute to good things in your world"). The phrase "good things" operates to centralize the *directed pursuits of health as good*, reflecting the overall supreme value of health as *good*. Stipulations of good and bad occur throughout the website and are most readily seen in blatant usage of the word "good" ("good sleeper", "good cholesterol", "Whatever your excuses for dodging exercise, they're no longer good enough"), "should" ("cues for feeding should be observed") and "don't" ("Don't use sleep props"). The expansion of areas of morality reflects the expansion of health into all areas of life.

Good and evil outcomes are framed as resulting from conformist or aberrant behaviour, or attitudes with the individual positioned as responsible for either outcome *by choice*. Individuals are directed to disclose only those things that are sanctioned as *valuable* "some secrets that are worth sharing"; and to segregate themselves from those who do not follow the sanctioned health values "sometimes tough decisions will need to be made, as you jettison people who weigh you down or *who are part of any negative processes*, insecurities or anxiety." Individuals who are "depressed", "lonely", or "de-motivated" are suffering those *unvalued* states because they do not adhere to the "key" of "positivity" or know the "secret worth sharing" indicated by the health regime. Aberrant behaviour is thereby inferred as resulting in both ill health and risk of being ostracized by others, with connotations that span the website as something to be *avoided* ("Avoid constipation", "Avoid foods which may increase anxiety"), or "secrets worth sharing" that enable health

goals ("what's the secret to long-term, healthy weight loss?"). The dichotomy perpetuates the belief that conformist behaviour results in good health and acceptance by others.

Unvalued experiences in this system are framed as "burdening someone else", while the principles advocated are "secrets of *success*", "secrets of *life*" (longevity) and "secrets of *youth*." Using the word "secrets" to designate what is "worth sharing" operates to cover the dark side of life and deny that suffering, anxiety and depression are usually temporary states that exist alongside happiness and joy. Keeping "secrets" deemed negative obfuscates the reality that anyone can become ill at any time for any reason even if they are conforming to stipulated health practices. Within the system this represents a large scale denial of the randomness of illness. People who suffer are positioned as not choosing to make an effort to engage in the 'proper behaviours' and therefore are deserving of suffering. From a Foucauldian standpoint, the power behind the expert stance to health reduces nonadherents or those suffering illness to *silence*. The voice of resistance against the 'secrets' of health will not be heard.

"Healthy Living" frames the things of worth as success, longevity, and youth which are *attainable through correct choices* and evident in phrases such as "choose healthy options", "holistic health is only a decision away!" and "the secrets that we so desire to discover may be more attainable than we ever realized!" Extending throughout the website they are exemplified in phrases using the word "choose" ("choose from healthy fats"). Choice has a connotative meaning that there is freedom to choose. However, the blaring contradiction is that the meaning and value of health is dictated by those in

authority; therefore "Healthy Living" must be about obedience to the proper behaviours that are dictated by authority. In order to avoid the context of a life without choice as equaling a life of slavery, the individual is positioned as having the *right to choose*. The assumption is the individual will choose from a platform of rationality and common desire to live a long life, enjoy success and eternal youth because these values are positioned as "all pieces of information that anyone would value." In an effort to avoid the suffering, pain, segregation and death that is advocated to follow unsanctioned choices, the 'right choice' seems a rational one. Individual choices must also be in line with the "higher will", a close referent of 'God's will'. The connotation of "higher" is that which is in authority or above the common person. The "higher" person has outlined carefully what to do and it is the 'common' individual's responsibility to choose to adhere.

Lack of adherence is framed as occurring not by choice but is a matter of low self-esteem that keeps the individual from achieving health: "low self esteem which manifests as inability to believe in one's self, which often leads to low motivation and no great hopes or desires to achieve." Achievement of the health goals is indicated as a rational desire and hope. Therefore, lack of adherence is a matter that can be changed by the health authorities by supporting individuals in a rationality that adheres to health tenets of good and evil such as "banishing negativity", "surround yourself with positivity", and "exercising". The message is that nonachievers are unbelievers who can and need to be converted to the rationality of achievement in health. This 'rational choice' is indicated as an individual responsibility through these directive phrases.

Principle beliefs of the healthism morality

The indication from the "Healthy Lifestyle" section is of a social solidarity based on morality. The moral system produces the *promise* of the rewards of success, life and youth *given to the adherent by the authority*. Abidance to the laws that govern the moral system constitutes a contract, an agreement of obligations under certain terms. The contract can be described as a *covenant* of success in health and its outcomes of longevity and eternal youth for those who agree or make the commitment to health stipulations. The social agreement behind the morality of healthism constructs a social order that promotes individualism wherein the following assumptions or principle beliefs are structured:

1) A healthy life is a wanted benefit to all;
2) Health in all aspects of life is attainable by all;
3) Authority knows what health is and how to accomplish it, therefore:
4) Authority has the right to dictate good and evil in aspects of health;
5) The individual is responsible for following health rules;
6) The individual via responsibility for rationality is capable of controlling health and therefore is deserving of outcomes (justice);
7) Adherence of belief and practice creates the indicated result (the covenant);
8) Faith that #7 will occur.

Becoming apparent in the assumptions is the formation of a doctrine of rules – a system of beliefs, principals and opinions informed by a morality. An analysis of the moral tenets

of good and evil reveals the foundations of beliefs (negativity is evil) informing practices (banish negativity). Of vital interest is the belief that rationality begets control over health issues, justice in health outcomes and faith in this covenant. Morality is based on core values (Furseth & Repstad, 2006) with authority directing the clear standards (Geyer & Baumeister, 2005), and the next section delves deeper into this belief system by providing a discourse analysis of values maintained by those standards.

Healthism discourses: Internal, external and transcendent values in the garden

The major discourses within the website reflect the core values of healthism that operate to inform its moral belief system. The values occur on internal, external and transcendent levels and reflect morality's dichotomy of good and evil based on the sacred and profane. The discourses construct the ability of the individual to view their behaviour in this meaningful context and to view themselves in dichotomous subject positionings that support or deny their achievement of health. The interwoven discourses reveal the motivation for pursuing health as fixed on a value of the self with the value of scientific rationality contributing to the construction of solidarity among believers. Ultimately, the discourses are shown to contribute to and reinforce self-control efforts through faith in the covenant between authority and the individual. Essentially, the section reveals self-control as an individual responsibility that functions to regulate thought and action which brings the function of the discourses into a closer alignment with religious functions of regulating conduct through indications of the sacred and profane (Beckford & Richardson, 2007; Cowan, 2007; Durkheim, 1995).

Internal level

Health is positioned subjectively within the individual with internal deficiencies impacting the individual's health. The individual's internal *sense of self* is regulated and controlled by external discourses that operate to equate the individual's *sense of self-control* as a meaningful voluntary effort.

Health as supreme value discourse

Health as supreme value discourse frames all contexts of the individual's life as viewed through their impact on individual health. The individual's internal concept of health is thereby expanded to areas perhaps previously unconsidered such as: "menstrual health", "healthy eating", "mind health", "pet health", "pregnancy health", "digestive health", "oral health", "joint health", "home health", "family health", and "travel health". For example, the context of traveling is now viewed through the array of health "difficulties ranging from motion sickness to jet lag through to contracting a serious infectious disease." Life contexts become realigned to be viewed through health itself as comprised of the values and moral beliefs focused on prevention and treatment of potential illness with the individual positioned as responsible for hypervigilance ("watch your food") and knowledge seeking in these contexts ("find out which areas, if any, are safe to travel in"). The individual is thereby positioned as deficient in vigilance and knowledge if experiencing poor health. The individual is also exposed to a life of *health in all contexts* that promotes hypervigilance to avoid deficiency. The supreme value of health contributes to looking for and finding health 'everywhere' and in turn to health being

present in all things. The nature of health as simultaneously present everywhere signifies omnipresent qualities that are usually reserved for descriptions of 'God'.

Health as a supreme value adopts a concrete nature on the website through the display of health products as prizes ("Be in to WIN one of five Orthaheel packs", "Click here to enter", "Become a member and be in to win great prizes!"). Offering health products as prizes constructs products as desired possessions awarded to those who achieve victory. Health products are thereby positioned as things worth striving for by the individual and the individual positioned as victorious or superior in achievement as a 'winner' of the product. Accordingly, individuals without health products are positioned as 'losers' or deficient. The supreme value of health functions in this context to link achievements in health with consumption of health products. Prizing health products internally enforces in consumers that health has supreme value as a consumptive object.

Self-control and embedded management and surveillance discourses

Self-control is framed as a matter of individual responsibility that operates through an internal management system ("Just calm down!"). Texts that advocate "managing body pain" and "it's how we manage stress that has important implications for our health" reveal management as a tool of self control for which the individual is responsible ("you can help yourself cope better"). External forces, such as workplace stress, are constructed as deficiencies in the internal management system ("Problem is...the stress hormones are not used up in a burst of physical activity and you're left with a feeling of stress or tension"). Consequently, stress and other impingements on a healthy life are

implied as incorrect management. To support the management system, the text prompts the individual to engage in surveillance techniques in which the individual matches thought ("stop the mind chattering"), behaviour ("check the kilojoule content of the food you eat"), attitude ("keep positive to boost your immune system") and emotions ("be happy and laugh a lot") with those directed as moral by the expert ("a healthy lifestyle is all about *good* habits").

Surveillance includes gaining knowledge and vigilance of self and surroundings in order to inform the management system on the things to be managed. *Deficiencies in surveillance* are posed as contributors to *loss of self-control* ("it's not the drinking, its *how* we're drinking', and about 25% of New Zealanders are *'binge'* drinking every week"). Surveillance areas are presented as lists of actions ("drink 'named' brand bottled water with an intact seal"), conditions ("someone in your family has had melanoma") and/or symptoms ("excessive sexual appetite"). The underlying assumptions behind surveillance and self-management advocacy are that *control is possible* and that *external forces can be withstood* using self-control "because life is what you make it". Discourses of surveillance and management as self-control are apparent in virtually every full-page advertisement and the repetitive nature operates to establish the *systemic processes and values as good and normal.*

The discourse elucidates the disciplinary power behind the process of self-surveillance as a form of ongoing self-examination and self-correction aligned with Foucault's *panopticism* (Foucault, 1995). The authoritarian gaze via the Internet website medium

constitutes powerful yet unverifiable watchers or invisible observers through the expert discourse. The subject position of the moral individual is revealed as a subjectivity in which they are subordinate to an invisible power, and engage in objectifying the self through self-examination and self-judgment. According to the authoritative standards of the institution, this is a 'good and normal' avenue toward the goal of self-control. Contrastively implied is the subject position of the immoral individual, as a subjectivity in which nonengagement in objectification and surveillance processes produces a 'bad self' as designating an individual who lacks the goal of self-control.

The internal level discourses operate through enculturation of the Internet surfer to control the body by positioning the individual as a subject to the doctrine presented. From the authoritative stance the discourse can be seen as coercive in its position of power over the individuals' own internal boundaries of self and mechanisms behind thoughts and actions. Important behavioural patterns for the individual and society are informed in the customs advocated and can be largely viewed as foundations in the establishment of a regulatory institution.

Worthiness and justice discourses

Surveillance processes rely on the individual's self-judgment, or amount of adherence to advocated standards of "healthy living" as an avenue to lowering the occurrences of illness such as in the advertisement for exercise, "Increasingly it's revealing itself as the panacea for all ills, with its payoffs escalating in virtue." Moral worth or *worthiness* is framed as adherence to conformity or engagement in the indicated standards: "Kiwi's are

taking notice of their health and *feeling good* about it". Adherence entails self-sacrifice of desires for a greater good and adherence requires self-control which combined socially function to denote a virtuous (worthy) individual. Changing the self toward better health is constructed as an admired, commendable challenge and therefore constitutes a worthy act because it has positive outcomes "By continuing to challenge yourself physically, mentally, and socially, life can stay good". Worthiness can also be gained through restitution for nonadherence:

> *"Deep-fried foods, alcohol, tobacco smoke, pesticides and air pollutants all have the potential to create more free radicals than our bodies can naturally deal with. So in this modern life, nearly everybody needs to consume more antioxidants to counteract free radical damage. When you follow the Ministry of Health's advice to eat plenty of fruits and vegetables, you're* ***compensating*** *for the effects of environmental and lifestyle toxins."*

The strength of an individual's worth is measured according to their responsible conformation to the moral tenets, and therefore the subject position of the individual becomes one who is *deserving of the positive or negative outcome*. Worthiness is recognizable and measured socially and individually in qualities of the individual's beauty ("love ourselves, wrinkles and all!"), longevity ("...the ever-increasing benefits of aging"), perfection ("keeping your body in tip top condition"), and happiness ("energizing your mind so that your life is full of contentment"). There is also a large focus on the ability to be productive, well recognized as a middle class value ("regular

exercise helps improve functional ability", "produce the best possible outcome for our daily functioning").

The product of the process is the self-correcting individual ("find ways to go about your day without stressing your joints"), a routine that drives and is driven by the core value of *justice and the fairness of life*. The text constructs the concept of justice through portraying cause and effect scenarios such as "if you continue to learn and challenge yourself, your brain is more likely to stay in good shape". Justice implies there is fairness in who gets sick and who stays well, which can be seen as a great comfort to people as it provides the illusion and establishment of a universal 'law' that there is regulation and order in events. Justice follows the assumptions of the principle beliefs behind morality (refer to the previously discussed social agreement behind the morality of healthism). Specifically number six, *the individual via responsibility for rationality is capable of controlling health and therefore is deserving of outcomes;* and number seven, *adherence of belief and practice creates the indicated result.* This is best shown in the advertisement for "Aging Positively" wherein Okinawa residents are portrayed as a "miracle" because they enjoy a "history of aging slowly and delaying, or sometimes escaping, the usual age related diseases" which is revealed as accomplished through 'proper' food and exercise regimens ("The people of Okinawa eat healthy food… grains, legumes, fish and vegetables", "Okinawans have a low risk of …cancer, possibly due to their intake, …and high level of physical activity"). The value of justice is in its motivational quality. The individual is motivated to adhere *in order to avoid* being judged as unworthy or *in order*

to receive a 'long life' which further defines the individual's subject positioning and sense of self as *deserving of life or death*.

Ego-strength as value of self discourse

Self-worth (often termed self-esteem) is framed as an achievement of conformist behaviour (self-control) fuelled by ego-strength (willpower). Phrases such as "you're worth it!" endorse the exercise regimes, products or services listed, advocating expending effort in its pursuit. The energy expended by conforming to the mandated rational choices drains the internal resource of ego-strength which also results in diminished self-worth. For example, "resist[ing] temptation" requires ego-strength to perform self-control over nonconformist desires. The phrases "meeting deadlines", "managing families" and "set some goals for YOU" reveals the tension between outer demands of health and the demands of the self as separate from the outer world. Achieving health mandates enhances self-worth by enhancing moral worthiness, but can *deplete the value of the self* through rejection of the individual's own desires ("everyone has needs that are unique to them").

Depletion in the value of the self is constructed as leading to an entire breakdown of this self-control system: "stress is almost synonymous with life today and can have serious implications for us if we do not give ourselves adequate time and space to *recharge and rejuvenate*. You may become lethargic, attention span can be affected..." Loss of self-control is depicted as a result of lack of focus on the self. Regular attention to the self reduces a person's vulnerability to being depleted of ego-strength and therefore self-

control can be enhanced by adhering to mandates of 'recharging' or 'rejuvenating' the self. For those who do not value the self (the unbelievers) then the imperative is to adhere to the standards for the value of others ("minimize the impact of migraine on your family"). Ultimately, the unhealthy person is positioned as being unhealthy from a lack of value in the self and the strength this requires to abide to the self-control systems *including those systems such as 'rejuvenation' that operate to regulate the value of the self*. Therefore the value of the self is revealed as the core value underlying self-worth, worthiness and the totality of the self-control system *as a part of and supporting health as the supreme value*.

External level

Biomedical and scientific discursive resources define health and health goals from an external position in relation to the individual. From powerful positions of authority, they operate as main sources of health directives. These sources also interact to create a medicalisation discourse that frames daily life experiences from an external position. Consumerism is revealed as an external resource used in the process of illness identification and cure which is often presented as "prevention and treatment" and therefore aligns itself with power by usurping biomedical and scientific directives.

Biomedical, scientific and medicalisation discourses

As experts, medical and scientific knowledges inform and instruct the individual in ways to improve health and thereby function as creators of the health context. These two discourses also interact to form the medicalisation discourse which functions to

assimilate 'other' experiences and interpretations of health into the biomedical and scientific framework. Biomedical discourse frames an individual's health as positive or negative through the identification and categorization of symptoms, diagnoses and cure. The scientific discourse frames the nature of health as 'cause and effect'. As medicine draws from a scientific basis, both framing processes parallel one another as a scientific rationality with positive connotations. Human rationality in health follows the accord of scientific rationality in this framing of science as *'good reasoning'* wherein information, instruction and practice is the structure of *good self management*. This *morality of scientific reason* constructs the information, instruction and practice regime as *the moral individual's rational course to health*.

Biomedical discourse is evidenced by the defining, listing and categorizing of health as symptoms, diseases and cures. The individual's health experience is constructed as separate and diverse parts with those parts positioned as being acted upon negatively by external forces that require external expertise to cure. This is evidenced in the full-page advertisements that are titled by a combination of disease, body part and disorder, such as "Cancer", "Autoimmune disorders", and "Ears: Ear disorders" which splits in a Cartesian manner the individual's attention to parts of the body indicating their functioning as separate. The website's Cartesian stance is clearly indicated in the section title "The Body: A part by part description." In constructing the body as separate parts, the framework perpetuates attention and vigilance to each part.

Medical lists and definitions provide the framework for the individual to assess body experiences as positive or negative by comparison of symptomologies in order to identify whether they are deficient or being acted upon. The advertisements provide medical definitions of diseases ("Crohn's disease – this is an inflammatory bowel disease affecting any part of the digestive system") and lists of negative states ("abdominal pain, diarrhea") or forces upon the body ("Wetness from urine"). The advertisements also provide directives in imperative tense as expertise, a listing of commandments per se, from external experts directed at the individual should such an assessment result in perceived congruence: "recognize the symptoms, obtain a diagnosis, seek the right treatment, change nappies frequently, eat little and often."

Definitions of causes of illnesses often rely on scientific technologies that have identified internal agents ("infection, virus") and external agents ("chemical") as "foreign" or separate from the body and impacting the body. The implication is that negative symptoms are suffered as a deficiency of the individual with cures phrased as working to "fight" or "resist" such agents. Assessing risk of such agents and the ability to protect oneself is also constructed from the external source of science and reliant on scientific measures such as statistics ("25% of all cancers") and methods ("testing"). Science is therefore implied as giving individuals the ability to fight and resist with individuals *suffering effect* due to their own *deficiency*. Deficiency implies responsibility yet simultaneously denotes fault. The individual is thereby positioned as inadequate to resolve the health issue, which implies that the rectification of the issue through external resources is required.

Using terminologies of scientific technologies evidences the interaction of science and biomedicine in constructing understandings of health. The understanding promoted is that the health process works through external forces and knowledges. This is seen in the construction of cures. Cures are framed as biomedical or scientific interventions that are external to the body and individual. Medicines ("cough syrup"), treatments conducted by experts ("quitline for quitters") and technologies ("radiation") are sourced externally from the individual and located within medical and scientific resources. Alternative belief systems are also included which ensures that the beliefs of all audiences are targeted. This operates to shift alternative beliefs into a medical or scientific connotation. This is accomplished by framing alternative beliefs to medicines such as "natural products" as operating in the same scientific and biological manner as external agents in "fighting the cancers cells" or "destroying toxins" despite many alternative medicines' claim to working on spiritual levels or producing self-healing. Reconstructing alternative health choices functions to integrate diverse beliefs systems about health and treatments into biomedical and scientific connotations. The connotation of medical intervention, medicines and technologies are as positive external sources that act upon the individual to improve health processes with the individual *dependent on the external* to construct the illness and the cure.

Medicalisation is evidenced as drawing on scientific and biomedical constructions to assimilate 'other' experiences and interpretations as medical in nature. In topics such as "positive aging" and "general wellness", for example, being well or healthy is now

dependent on and the outcome of a scientific and medical recipe "this is the recipe for a healthy lifestyle… healthy nutrition [with] low GI foods, exercise helps keep your cholesterol in check, sleep well [which] boosts your immune system, be happy and laugh a lot." Aging that is 'positive' for the elderly includes directives such as "use it or lose it" playing on the fear behind the finality of losing to death if the individual does not abide by the directives to "maintain bone density" through exercise, staying strong to prolong independent living through "weight training", and staying efficient by doing "cardio workouts." In these examples, medicalisation is demonstrated as forming a type of control over the thoughts and actions for those experiencing life conditions, and not necessarily suffering illness.

The texts make apparent the function of medicalisation as a form of control over the meanings and beliefs surrounding life events. What science and medicine identifies as 'positive' it also designates the dichotomous opposite as 'negative' and thereby positions these states as events to be avoided (illness, agedness, dependent living, weakness, inefficiency). Medicalisation also controls the connotative understandings of everyday life. A good example is "health is a recipe" which denotes health as a set of ingredients that give a certain result. Life events are the ingredients with medicalisation assimilating the beliefs and meanings behind the perception of life events as operating toward health outcomes. Laughter is now a method of "boosting the immune system" and "playing a musical instrument" is now a method of keeping your "brain in good shape". Individuals who do not 'believe' in medicine or science are coopted through these constructions into a *cause and effect style of perception* between body function or life experience and

outcome. In the end, the text reflects the ability of medicalisation to covertly create more believers in science, and thereby implement an unacknowledged process of conversion to scientific rationality.

Scientific processes of cause and effect are framed as good and trustworthy facts regarding life events. Phrases such as "Results from ongoing studies show", and "ongoing research…offers hope" position scientific processes as truthful certainties that are vital to continue and virtuous in nature. Harmful effects of health directives occur only as fine print to some medications while lists of symptoms and causes remain unquestioned directives in their presentation ("5-step prevention & treatment"). In their authority as creators of the health context and harbingers of cure, medicine and science are subjectively positioned as morally benevolent experts in their provision of beneficial information and instruction to the individual. The cause and effect rationality of science becomes the rationality behind the perception of human life in its representation of the human experience as "causes" and symptomatic effects, or as informative *measures* ("recent memory loss and repetitive conversations"), instructional *methods* ("using your brain regularly by doing crosswords") and *procedures* for curative outcomes ("pharmaceutical solutions include oral drugs that cause the blood vessels in the penis to relax… normal sexual activity is needed"). The discourses position scientific processes as 'good truths' while normalizing their rational construction of *ways of science as ways of health as ways of life*.

The 'goodness' of *ways of science* drawn from scientific rationality are also seen as operating to concretize the human experience. This is evident in the listing of self-management techniques appearing as "Steps" within the texts. Listings of 1, 2, 3, type processes are based on scientific rationalities of production leading to outcome and signify methods of *scientific procedure*. This morality of scientific reason creates an information and instruction regime as the individual's rational course to health. This is a circular rationality, feeding itself and evidenced in the texts' displays of the individual management discourse: "Step 5 -Manage your disease, Step 4 – Make appropriate lifestyle changes…adapt your lifestyle to *cope* with the symptoms…a high fibre diet low in processed ingredients…will help, recognize when your remission period is over, *symptoms should act as a warning* and help you *manage your disease* more effectively." The individual is then led back to "Step 1 – Recognize the *symptoms*." These management regimes, from their formative basis in rational science, usurp the positive connotation of scientific reason. The individual management of health issues thereby is reinforced from external experts as a positive (moral) method of self-control and is *reliant on the established positive connotation of scientific rationality*.

Internal and external: The positioning of the individual

Defining health from external expert sources and its prescriptions of self-management regimens positions the *individual as submissive* to the health regime. The individual is constructed as responsible for self-management (self-control) with the only power to control residing in the conformity or nonconformity to the prescribed management regime. The individual does not create the management structure, and has no power over

health information and instruction. *The healthy individual is thereby positioned as a follower* in the matters and processes of their own health, and can be described as a disciple, a believer who is adherent in the external teachings of another.

Consumerism discourse

Consumerism discourse frames an individual's health needs as being satisfied through the consumption of external products or services. The commodities adopt sacred or profane connotations with the individual positioned as moral through their ability to responsibly consume 'proper' commodities. The body is constructed as a profane object, inherently flawed in every part and these profane parts can be made sacred through the acquisition of health products or services. In text, consumerism discourse is apparent in the use of the term "buy" occurring with the "Pharmacy Direct" link, but indicated only within the bulk of the advertisement in the imperative mood that appears as instructional expert directives. In video, consumerism discourse is verbally hidden but visually apparent in images of products. The directive signifies the position of health as a commodity and consumption as a means of acquiring health. Most importantly, the directive signifies the *end of the pursuit of health* – the achievement of the desired goal through directives that are aligned with medical and scientific discourses to indicate 'ethical acts' of consumption for various parts.

Consumerism discourse is widely evidenced as external products and services in the texts by its frequent positioning with in the "Treatment" or "Prevention and Treatment" section of the advertisements. The health issue is prominent at the top of the page with the

"Prevention and Treatment" section positioned at the right top corner alongside the health issue title and appears again textually in richer definition at the end of the advertisement. Indications for "prevention" in this context denote preventing the health crisis, framing prevention as a need and consumption of risk assessments ("risk assessments for heart disease"), testing ("monitor blood cholesterol") and food or lifestyle items as its alleviation ("berries may help prevent dementia", "consider a vitamin supplement"). In this manner, prevention as medical consumerism with its alliances in scientific terminologies is revealed to extend to medicalised areas of food and 'natural' food supplements as ethical consumptive health objects.

Treatment is the application of remedies to a patient such as medical or surgical care and therefore denotes external sources from which health can be acquired. The "Treatment" section generally focuses on medical consumerism and advises "drug therapy", "operations" or "alternative therapies" and lists particular brands or general categories of drugs as relevant medicines ("Lamasil", "Steroids") or particular types of therapies ("Hypnotherapy", "aromatherapy") or particular operations ("Angioplasty", "laparascopic surgery"). The section also lists various experts to consult such as a "podiatrist", "GP", "psychologist" or "pharmacist" in the imperative mood by conveying the old adage "if in doubt check it out!" and more modern versions of "seek help" and "seek professional advice".

Indicated in the visual layout of text and textual structure is the directive to use external sources such as medicines, surgical procedures and/or treatments, advice and knowledge

from professionals. Direct consumption terms such as "buy" are unseen in the body of the text but occur in the visual advertisement for "Pharmacy Direct" the online pharmacy. Consumption terms are largely hidden in text yet indicated by the placement of directives which creates an imperative mood toward satisfying the health need "Treat injuries promptly… ask your pharmacist for advice on medicines". These directives are substantiated by the appearance of images of the product at the bottom of the advertisement and/or under the "Prevention and Treatment" directives.

Although the prices are not listed on the website, that the items or services have to be paid for is contextually understood and reinforced by the appearance of the online pharmacy hyperlink image and text such as "Lamasil Once is available at your pharmacy" (See Figure 6). When clicked, the image takes the Internet surfer directly to the product on the pharmacy website which contains the pricing list and online shopping cart, making immediate purchase available and thereby completing *the hidden imperative to buy*.

Figure 6. Lamisil advertisement in connection with Pharmacy Direct link as appears on website.

Cleverly, by placing the term "buy" only with the online pharmacy image, the end result of consumption appears to be the agenda of Pharmacy Direct and not part of the website agenda. This functions to maintain the utopian appeal of the website to the masses. External sources are reinforced as the answer to health needs with attention deflected from the fact that consumption is dependent on the purchasing power of the masses.

The term "treatment" is verbally spoken by the authority figure in video advertisements with experts such as "physiotherapist[s]" and celebrities using directive language to indicate consumption of products, advice or knowledge such as "see a health professional" or "double your chances of quitting with the Nicorette ActiveStop Programme". Although the experts verbally refer to "treatment" by professionals or "choosing" the correct product, *they do not directly verbalize the terms buy or purchase*. However, the images at the end of the video are of pharmacists counting tablets or capsules, of the products and names of products ("Cancer Society Sunscreen"), and often contain the text "at pharmacies, supermarkets and department stores". The imperative to buy is therefore more adeptly hidden in the video medium but external sources positioned as solving health problems still prevail.

The consumerism discourse presents a symbolic logic in the dichotomy between the sacred and the profane. The symbolism is represented in the advocacy by idolized experts of *certain product choices*, along with *specific types of people* to ask for advice and knowledge. From their exalted status, the choices they present and mandates they speak operate to consecrate consumptive objects by setting them apart, once again creating a

division between the morally *valued good* and *unvalued evil*. Consumptive health objects are thereby constructed as having sacred and profane connotations and therefore take on religious significance. In line with the 'hidden' directives to consume sacred health objects, the images that accompany the directives contain hidden meaning. Sacred objects are shown in flattering, colourful arrangements and under appealing lighting and are in sharp contrast to dull, colourless, slanted images of profane objects (See Figure 7). The images present this separation which plays off the dichotomous connotations of beauty and ugliness, right and wrong, that exist as variations behind good and evil and ultimately operate to elevate the sacred objects above the profane. Therefore sacred consumptive objects such as medicines, products, services and food can be seen to function as reflecting the moral values and ultimate consumerist goals within the healthism culture.

Figure 7. The dichotomy through image of sacred and profane consumptive objects within the website.

The division of sacred and profane consumptive objects defines the individual as moral or immoral through their 'responsible choice' to consume 'properly'. 'Proper' consumption is categorically determined by body part and its associated sacred object that operates to bring health to the ailing part. This is particularly evident in the "Your Health A-Z" category that divides the body and potential ailments into 82 separate pages and on the "FHD magazine" which presents body parts as needing "care" or "health" ("joint care", "nail care", "oral health", "foot care", "skin care" "breast health"). The division of the body into ailing parts signifies each body part as potentially or inherently *flawed and therefore profane*. Each body part is thereby positioned as dependent on the individual to procure sacred consumptive objects to achieve the sacred status of health for each part.

The consumerism discourse covertly positions the spending of money as the 'rational' means by which to move the position of flawed body parts from the profane to the sacred. On a grand sale, health in certain parts may be attained, but health itself is never fully retained, as it is not tangible. The intangibility is apparent in the fluxing focus of health categories, and consumptive products and services within the "FHD magazine" back-issues. The profane categories shift with each season, scientific or medical discovery. For example, November-December 2007 and November-December 2008 contain only four overlapping categories out of the 15 presented, indicating different profane areas and consumptive resources. This reflects Foucault's position of Western rationality as an arbitrary exercise (Foucault, 1995) and one more rightly positioned as a religious endeavour.

The subject position available to the individual is that of the flawed and therefore profane body. This positions individuals in a persistent moral dichotomy of the sacred and profane wherein spending money in the pursuit of health becomes a sacred act. The changing *nature* of health makes its attainment intangible, but the goals of health can be positioned as attainable because of the tangibility involved in the consumption of sacred *objects*. Therefore, *health is merely symbolized through consumptive acts of sacred objects*. The symbolic meaning of health appears to be *the continuous act of consuming the sacred*.

As a continuous act of spending toward the achievement of desired health goals, the act of purchasing reflects the large scale ritualization of health practices. Ritualized practice is the final piece to the instruction, information and practice systems behind religious institutions and has religious symbology. The following section elucidates religious symbology, significant yet invisible religious themes that reconstruct transcendence potentially internalized by the unaware consumer. The chapter then moves to illustrate how this transcendent reconstruction is at the centre of a repetitive meta-structure and a systemic part of the ritual of health(ism) practices.

Transcendent level

Transcendent forces are seated within the substantive tradition as an essential of religion (Furseth & Repstad, 2006). Although religions can operate as ideologies, they are also distinctively different in that they are centred around and driven towards a transcendental level. Transcendence is to move beyond the physical world and common thought toward

the promise of salvation from death through a higher power (often termed the *divine*), which operate as intangible and therefore separate from everyday life. This movement also incorporates future events as transcending the present experience and therefore transcendence is often at interplay with its opposite, immanence, which signifies the here and now. Transcendent experiences are often communicated by individuals, systems and institutions and thereby become part of a social solidarity of experience (Luckmann, 1990).

The transcendent level can be seen within the discourses to bridge the internal level subjective experience of health to an external level quasi-objective reality. In this case the quasi-objective reality is based on the 'rationality' of science. The thematic transcendent discourses are cloaked in religious rhetoric of salvation through the transformation of fear into hope, faith, and the 'good life'. The ultimate transcendence of the health discourse therefore appears to be between death and life with the discourses operating to postpone the inevitable future. Life and death carries with it the underlying symbolic dichotomy of order versus disorder.

Transforming fear to hope as transcendence

A transformative construction of health appears at the transcendent level operating through the incitement of fear in health matters to the generation of hope by scientific and medical 'discoveries' to resolve such fearful matters. Within the material, a linear method of the construction begins with fear stimulating discourses such as those used in disease mongering (Mintzes, 2006). Fear discourses often order the individual through

use of the imperative to engage in a negative fantasy about ill health in the present or future ("Imagine opening your eyes and looking at a world that is blurred and distorted", "Imagine never knowing when your bladder is going to let you down in public…"). Fear discourses also provide disease prevalence rates consisting of somewhat vague scientific or medical statistics and percentages that are often difficult for the layperson to comprehend and tell signs of knowing the future ("The rate of infertility in New Zealand is steadily increasing each year and one in six of all couples trying to conceive *will experience* infertility problems…"). Fear discourses are mainly comprised of the risk discourse which contextually serves to create a symbolic state of imminent or 'ever-present' death.

Fear discourses are closely followed by discourses of hope involving "research", "discoveries", and new "treatment" which oftentimes blatantly use the word "hope" ("Fortunately, ongoing research into the cause and treatment of some eye conditions offers hope of a major breakthrough for saving failing eyesight", "Stem cell research offers hope to paraplegics, among many other people", "Science and technology has advanced so much recently that illnesses and ailments once thought to be untreatable are now on the brink of the long-awaited "miracle" cure."). Illness is thereby constructed as a hopeless state filled with connotations of unpleasantness and grave uncertainty, a state of imminent death. Of note is the word "ailment" which holds connotations of disorder. The 'fortune' of science connotatively creates an air of luck and advantage that provides a bridge from hopelessness because of the interventions of "miracle" cures, and "saving" from human health failures offered by science and medicine. This construction offers a

transformation for the individual from a hopeless, disadvantaged state of imminent death to a hopeful one of *escape* and therefore *'salvation'* through the offerings of scientific and medical treatment products and services which connotatively *hold the power to transform death to life*. Connotatively, this salvation is to a 'good life', whether constructed as "longevity", "productivity", "happiness" or freedom from suffering.

The individual is subjectively positioned as helpless without the transformative power of science and medicine. The individual is also positioned as *in need of salvation,* with science and medicine positioned as the *saviours who offer miracles*. Foretelling the future, offering transformation from suffering and salvation through miracles are usually subjective positions held by the *divine* and such statements traditionally originate within the realm of religion. Science and medicine is thereby no longer populated by experts but by individuals bearing godly attributes that allow individuals to transcend the suffering of worldly *disorder and death* in the present to a heavenly state of *order and life* in the hoped-for future. The movement is from the profane world to a sacred state. In this manner, salvation within the transformative construction of health is shown to reconstruct a wish-fulfilling religious rhetoric of transcendence from death to life for the consumers of the sacred products and services offered by the divine power of these individuals.

Faith in science as transcendence

Transcendence requires a leap of faith to bridge the conceptual framing from the imminent present to the hoped-for intangible future; "When religion speaks of hope it speaks of faith in the transcendent" (Cox, 2002, p. 168). Faith indicates strong belief and

trust in a power or powers that control individuals' futures. Having faith means one is assured that the hoped-for and expected will happen, no matter how intangible. Faith enables the individual "to achieve a state of mind and resultant lifestyle that is grounded in the extra ordinary without having to see it in order to believe it will occur" (Cox, 2002, p. 170). Faith therefore must be employed to achieve transcendence from fear to hope and is consequently inherent in the transformation discourse. From a psychological perspective it can be argued that faith is required to soothe the cognitive dissonance between the present and the hoped-for experience (Cox, 2002).

Belief in future "miracle" cures is a belief beyond the present reality to a future reality. The imminent subjective reality of present illness is *bridged through faith* to a transcendent quasi-objective reality of future health based in science (it cannot be 'objective' because it is based in the future and therefore cannot be presently experienced or observed). Further evidence of this process can be seen in the material which professes that products and services are "known to work" or "shown to work", which encourages trust and truth of present observances to hold for future situations. This is a trust in the intangible, a by-product of faith (Christiano, 2007). *If* a product or service works now *then* it will work in the future is the reasoning employed. As shown in findings above, this is based in scientific logic as 'good reasoning' and therefore the text engenders faith in logic as 'good reasoning' in order to transcend the present experience to the future situations. The transcendent level thereby employs the principle beliefs behind morality (again refer to the previously discussed social agreement behind the morality of healthism). Specifically, assumption number seven and eight, which state that

belief and practice will create the indicated result and *faith that this will occur*. The transcendent level thereby invokes *faith in logical reasoning behind this covenant*.

Faith in future outcomes means faith in scientific analysis – this is faith in science as 'ultimate truth' that offers transcendence from present worldly ills. Faith, inherent in the transformation discourse, therefore can be seen to function in maintaining the moral order between the profane and the sacred which is an order based on the scientific tenets of 'logic' and 'common sense'. However, because scientific reasoning is now revealed to be based on moral order it carries an *imagined rationality* because it is based on the internal symbolic logic of the moral discourse. Therefore, faith in 'good reasoning' is shown to be faith in a nonrational processes wrapped in the symbolic rationality behind the dichotomy of good and evil.

Faith is also a sequence of committed actions guided by beliefs with an envisioned outcome (paradise on earth, freedom from suffering, happiness, longevity). Previously discussed were the texts' directives to the Internet surfer, through the use of the imperative, to engage in actions based on potential future outcomes. This directive can in the present context be viewed as directing individuals to participate in the practice of faith and it is therefore posited that engaging with the material operates to generate faith.

Summary

Identified from within the Web analysis, the moral system and its doctrine parallels religion in the regulation of thought and action on an internal and external scale

(Beckford & Richardson, 2007; Cowan, 2007). Discourses surrounding health form a meaningful morality based on the work of management (self-control) driven by the underlying value of the self in a connotative atmosphere of 'positivity' or 'goodness' behind scientific rationality. Further, faith is revealed to work within the discourses at a transcendent level. Faith is commonly regarded as a virtue deemed to separate ideology from religion (ideology, 2009). The act of engaging with the material can be seen to generate faith and the advocated practices. Therefore, in this area healthism can be viewed to generate an alliance closer with religious rather than ideological processes.

The revealed information and instruction processes in the healthism ideology are a requirement of religious structures and well recognized in establishing social order. A further requirement in this combination is ritualized practice (Cowan, 2007). The following section reveals the ritualized nature of the practices of healthism occurring on the website which regulates the health concept and ultimately can be seen to operate as a method of social control in its overarching framework for human experiences.

The secular trinity

In this section, the focus moves beyond the public health model's use of behavioural modification and moral guidelines to question its stance as one of education and educational devices. Paratactic syntax within educational devices is revealed to support the movement from prescription to practice. Furthermore, the meticulous alliance of repetitive format in text and video reveals 'doing health' as not only about practical rules

but also about symbolic ritualized practice as outlined by Crawford (2000). On a grander scale, the section reveals healthism discourses as providing an overarching framework, newly termed as a *meta-structural formation*, which illuminates a conceptual understanding of health comprised of the secular trinity's combination of healthism, medicalisation and consumerism. The meta-structural formation reveals the power of pharmaceutical discourses to determine the individual's conceptual experience of health.

Healthism missionaries: Repetitive preaching and ritual practice

Advocates of the new public health approaches describe their endeavour as "a modern version of missionary work widely done to spread concepts of religion..." (Tulchinsky & Varavikova, 2009, p. 457). Pharmaceutical advertising has adopted this missionary stance. This is evidenced in the excessive use of additive paratactic syntax within the texts. Additive paratactic syntax occurs as lists and repetition of lists. Lists are often used as educational tools that enhance the memorization of material (Intons-Peterson, 1993) but in this instance are revealed as supporting ritual practice. The contrastive paratactic syntax that occurs is a grammatical regime used to contrast power relations and justify the position of power. Therefore, the contrastive paratactic syntax highlights the function of the grammar as *justificatory rather than educational*. In this manner, the educational platform behind the new public health approach (Lupton, 1995; Tulchinsky & Varavikova, 2009) can be described as one of repetitive *preaching rather than teaching* to support an unquestionable position of power.

Additive paratactic syntax: Prescribing higher structures of meaning

Additive paratactic syntax builds relations between clauses, sentences and paragraphs in order to gradually build meanings of concepts without the use of conjunctions. The syntax is well evidenced in the repetitive use of lists on the website. Lists occur on pages focused on particular topics and are set apart from the text as bulleted or numbered sentences and clauses. Generally, these lists dominate each page, and through their separation from other text bring attention to the subtopics. For example the one-page topic of "pregnancy health" contains three bulleted and one numerical list (See Figure 8).

Figure 8. Bulleted or numerical lists within the advertising.

Most pages also include a numerical list such as the one above as part of the "5-Step Prevention and Treatment" for each health issue (See Figure 9). The general function of lists is to bring attention to the material to enhance the memorization of contents, and therefore they serve as external memory aids. Memory aids are strategies for improving memory and are regarded as educational tools (Vvidis, 2002), and in this instance the educative stance behind the new public health approaches appears substantiated. However, a different story emerges at the structural levels including syntax and grammar.

Figure 9. Health issue and accompanied numerical list.

Within these lists are the telltale signs of paratactic syntax. The signs are revealed by the lack of conjunctions to *link* clauses and sentences together. The result is that one clause or sentence has no meaningful purpose, or makes no sense in constructing the meaning of the issue without the layering provided by the others. For example, "Steps 1-5" are all "Prevention & Treatment" elements that structure and support the meaning of "Pregnancy Health". The steps hold a relationship to each other that creates the *higher structure of meaning* – "Pregnancy Health". This additive paratactic structure symbolizes a closed-endedness to the range of options available in the *linked* construction of meaning for each issue. Notice, there is no *and* or *or* linking the meanings. The clauses and sentences thereby cumulatively build a meaningful story of "Pregnancy Health" that closes the range of thoughts, ideas or experiences that could potentially build a meaning of the higher structure. Therefore, the lists can be described as taking on a true missionary style that *preaches rather than teaches* by using a *closed and therefore unquestionable prescriptive form* to construct the meaning of the higher structures of each health issue. The text is no longer descriptive of the health issue but evidences its prescriptive position, which *signifies a positional movement to leadership and the power inherent therein.*

Contrastive paratactic syntax: Justification, prescription and ritual practice

The lists also reveal a contrastive paratactical relation between clauses and sentences that is apparent by the use of words such as "limit", "avoid" and "stop". This form of syntax operates as a contrastive element to the prescribed meanings by devaluing alternative meanings. Contrastive elements operate to justify the position of the powerful with the

devalued functioning as a contrast that functions to enhance the positively positioned characteristics. The outcome is a reinforcement of the justified position and in this case, *signifies the justification of the position of the powerful to prescribe.*

From a rational cognitive standpoint, lists are well recognized as external memory aids that assist the individual's adjustment from prescription to action (Intons-Peterson, 1993). Within these lists, the contrastive paratactical relation operates to prescribe behaviours and negate alternative behaviours from the justified position of power. The lists are thereby transitioned from a description of practical rules to a prescription of orders. The prescription is cumulative in meaning and facilitates meaningful performative practices toward the higher structure which is denoted by the health term. The lists serve to disguise the content as education; however the advertisements' underlying discursive elements essentially reveal regulated prescriptions that facilitate ritual actions ("ED treatments", "stop smoking and drinking", "check your blood pressure", "medication"). The texts therefore construct ritualized practices as symbolic and material as described by Crawford (2000) in their constitution as a series of prescribed and meaningful procedures or acts.

Repetition is a core component of ritual actions (Crawford, 2000), and the repetitive nature and closed structure enhances the evidence of the texts as symbolic ritual practices in which the thoughts and experiences that comprise each health issue are mandated and regulated by the powerful. Furthermore, their repetitive occurrences form a regular structural reoccurrence in the creation of and performance toward higher structures

similar to Couldry's proposed hierarchy of practices (Couldry, 2004). The following section reveals a *meta-structural formation* that mandates and regulates the very concept of health.

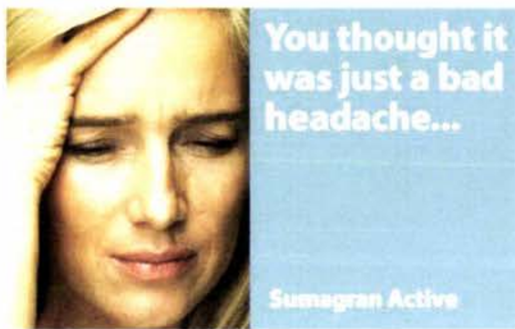
Holy Pharma: The secular trinity revisited

On a grander scale than the listed construction of each health issue, the discourses within the advertisements provide an overarching structure of the concept of health when the additive paratactic relationship between paragraphs is viewed. This structure is comprised of the secular trinity which appears in a standardized, repetitive and linearly ordered form. The overarching structure is best termed a *meta-structural formation* to denote the health concept itself as comprised of a paratactical relationship of hierarchical units. Each unit has a meaningful discursive structure that when added and viewed together are revealed to function as one entity.

The first unit always occurs at the beginning of the advertisement as the healthism discourse. This discourse introduces the *uncertain experience of health and symbolically represents disorder* ("Why do some people sleep like a freight train, while others sleep like a peaceful baby?", "If you suffer from sever recurrent headaches, usually localised to one side of the head, you could be a migraine sufferer."). The second unit stretches through middle of the advertisement as the medicalisation, medical or scientific discourse. This discourse defines the health experience with certainty and *through the certainty of definition symbolically offers order* ("Sleep apnea is a frequently undiagnosed cause of much ill health.", "COMMON MIGRAINE TRIGGERS."). The

third unit occurs at the end of the advertisement as the consumerism discourse. This discourse introduces *ritualized consumptive practices as solutions and symbolizes the acquisition of order* ("Just one tablet can bring headache relief...", "Surgery for snorers"). The internal symbolic logic or 'rationality' to the advertisements is to transition the profane position of disorder to the sacred position of order (See Figures 10, 11, 12).

The constant repetition of the secular trinity in this formation reveals the discourses of the secular trinity to be operating as *units of meaningful stories* of health, medicine and consumption with the internal symbolic logic constructing a larger meaning. The meaning is a movement from disorder to order, profane to sacred, through ritualized practices denoted by consumerism's occurrence at the end of the advertisement and the imperative tone of its discourse. The movement illuminates the stories as together comprising a *mythology about the nature of health* that operates to resolve the uncertainty of the human experience of health. The beliefs and practices of health are thereby revealed to be entrenched in a *myth of health* rather than rationality that functions to explain the relationship between the human experience of life and death and a higher power.



A migraine involves throbbing or pulsating pain, or pain that worsens with physical activity.

Additional symptoms often include sensitivity to light, sounds and smells, nausea and vomiting.

Sufferers often need to lie down and sleep in a dark, quiet place, all of which means time out from family, friends and work.

Although migraine is a very common illness, the underlying cause is still unclear.

Migraine is thought to be due to a widening of blood vessels around the brain. This stimulates sensory nerves, resulting in pain and inflammation.

A drop in the brain chemical 'serotonin' is known to play a large role in dilating the blood vessels, which is why migraine treatments need to address serotonin levels and not just pain symptoms.

Migraines affect three times more adult women than men, with fluctuations in oestrogen being a common trigger. Other common triggers include:

- Food, such as chocolate, cheese, red wine, coffee, tea and skipping meals
- The menstrual cycle and oral contraceptives
- Sleep fluctuations
- Stress
- Heavy exercise
- Temperature changes, bright lights, fragrances and odours

A migraine is more than just a 'bad headache'. Everyday pain relief may help reduce the symptoms, but only specialised treatment can stop a migraine as it's beginning.

Sumagran Active contains two tablets of sumatriptan 50mg which is part of a class of drugs know as triptans.

Triptans are designed to stop a migraine in its tracks, by acting like serotonin in the brain, thereby relieving the pain and related symptoms of migraine including the four main migraine symptoms – headache, sensitivity to light and sound, and nausea.

Triptans have previously only been available on prescription for migraines, but new Sumagran Active is available as a pharmacist only medicine – that's great news for migraine sufferers.

Just one tablet can bring headache relief in around 80% of migraine sufferers, and it does it fast. Headache relief can start in 30 minutes, and complete relief can take just two hours.

That could mean the difference between hours spent in bed, or getting on with daily life.

Sumagran Active is a pharmacist only medicine conveniently available from your local pharmacy, meaning you can now get help the moment you feel a migraine coming on.

Ask your pharmacist if Sumagran Active is right for you

Sumagran Active is a Pharmacist Only Medicine used for the acute treatment of migraine attacks, and the associated symptoms of nausea and sensitivity to light and sound. Contains sumatriptan 50mg. Medicines have benefits and some may have risks. Possible side-effects are tingling; dizziness; drowsiness; flushing; fatigue; feelings of weakness or pain; sensations of heaviness, heat pressure or tightness. DO NOT TAKE SUMAGRAN ACTIVE IF you have any of the following: heart, liver, kidney or vascular problems, or history of seizures or strokes. Do not take SUMAGRAN ACTIVE if you are taking other medicines used for the treatment of migraine, or treatment of depression (MAOI). Your pharmacist's advice is required. Always read the label carefully and use strictly as directed. Incorrect use can be harmful. If symptoms persist or you have side-effects, see your health professional. Pacific Pharmaceuticals Ltd, Auckland.
TAPS NA2376

Healthism discourse.

IHP 'educational' style discourse.

Biomedical and scientific discourse.

Consumerism discourse.
Imperatives of consumption and non-consumption.
Constructs prevention and treatment as consumptive practices.

Figure 10. Meta-structural formation in migraine advertisement.

Hair loss

Baldness is the topic of many a supposedly funny joke. But if you're the one who has watched your formerly luxuriant crowning glory slowly disappear you'll know that there is nothing at all funny about hair loss. While the vast majoity of people you notice with a thinning or bald head are male, women also suffer from the stress of hair loss.

On a healthy head, the usual cycle of hair growth lasts somewhere between two and six years, with hairs growing about one centimetre a month during this time. At any given time about 90% of your head hairs are growing, while the other 10% are in a resting phase. After about two to three months the resting hair will shed itself and in its place grows new hair. It is normal to lose about 100 hairs a day but sometimes this shedding is faster than usual, leading to thinning hair and baldness.

Healthism discourse.
IHP 'educational' style discourse.

WHAT CAUSES HAIR LOSS?

There are several different forms of hair loss, each with a different cause. Sometimes hormonal issues such as an under or overactive thyroid gland can cause hair loss. Male and female hormonal imbalance such as an imbalance of androgens and oestrogen, can also stimulate hair loss. After pregnancy it's not uncommon for the huge hormonal shifts to cause rapid hair loss, which usually self-corrects within a few months. Fungal infections of the scalp and hair abuse in the form of over-colouring, teasing and drying can also lead to abnormal hair loss. Sometimes hair loss may be a sign of a serious underlying condition such as kidney or liver disease or the autoimmune disease lupus erythematosis. In women of reproductive age, excessive hair loss can sometimes be caused by Polycystic Ovarian Syndrome (PCOS).

Male Pattern Baldness (or androgenetic alopecia) is by far the most common form of baldness in men. This genetic form of hair loss usually begins with a receding hair line before the age of 40 and then proceeds to baldness on top of the head. There is a female equivalent called female pattern baldness which usually causes hair loss all over the head.

Medicalisation discourse.

The second most common form of alopecia is Telogen Effluvium (TE) which causes a change in the number of hair follicles in the resting phase leading to excessive hair loss. This form of hair loss is poorly understood and can affect both men and women, and is most frequently seen after physical or emotional trauma or after childbirth. There is some suggestion that deficiency of iron, zinc, B6 and B12 may contribute to TE.

The next most common form of hair loss is Alopecia Areata. This occurs in people who are apparently healthy and have no skin disorders. This is thought to be an autoimmune condition in which the body attacks and destroys its own hair follicles and suppresses hair growth. This condition usually starts as one small round patch of hair loss, which may then become multiple areas of hair loss usually on the scalp. In rare instances, the condition can involve the whole of the scalp and all skin-bearing surfaces.

PREVENTION AND TREATMENT

Step 1: Visit your GP
You may need an examination and tests to ensure you don't have an underlying medical condition causing your hair loss. Iron deficiency anaemia, thyroid imbalance and autoimmune disorders can all lead to hair loss as can liver and kidney problems. Fungal infection needs to be excluded. Some cancers can also cause hair loss (as can the chemotherapeutic drugs used to treat them). Also check that your hair loss is not related to pharmaceutical drugs you are using such as acne medications, diet pills and some medications used for bipolar disorder.

Step 2: Stop sabotaging the health of your head
If you are a smoker, stop, as smokers lose their hair faster and go grey more quickly than non-smokers. If you have permed and coloured hair, your hair loss may be a direct result of chemical damage on your scalp.

Step 3: Optimise your diet
Hair loss may be associated with insulin resistance and metabolic syndrome. High insulin levels caused by insulin resistance resulting from an excessive dietary intake of high glycaemic carbohydrates (sugars, refined grains and processed foods) increases testosterone levels and can stimulate hair loss. Reduce omega-6 fats in your diet (polyunsaturated cooking oils) in favour of increasing omega-3 fats such as fish oil, flax oil, avocado, rice bran oil and nuts and seeds.

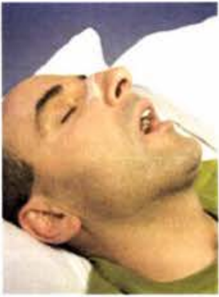
Step 4: Pharmaceutical help for hair loss
Depending on the cause of your hair loss, there may be pharmaceutical help for your condition. If you have a scalp infection, treatment will prevent further hair loss. In women, hormonal imbalances may be addressed by some types of the oral contraceptive pill; steroid injections are also sometimes helpful. Rogaine is a commonly used non-prescription product which can be safely used by both men and women. Propecia is an oral medication suitable only for men, and available on prescription. The best results for men probably come from using both drugs in combination. With either product it may take as long as six months to see an improvement.

Step 5: Hair implants
Hair implants may help cover bald areas and wigs are also widely used, in particular after chemotherapy.

In about 50% of cases of alopecia areata, the hair will grow back spontaneously without any specific treatment and the final outcome is good for the majority of people.

Consumerism discourse.
Imperatives of consumption
and non-consumption.
Constructs prevention and treatment
as consumptive practices.

Figure 11. Meta-structural formation in hair loss advertisement.



Snoring

Healthism discourse.
IHP 'educational' style discourse.

Medicalisation discourse.

Consumerism discourse.
Imperatives of consumption
and non-consumption.
Constructs prevention and treatment
as consumptive practices.

Figure 12. Meta-structural formation in snoring advertisement.

Evidenced by repetition of the structural format of advertisements, the stories operate to regulate thought and experience toward this myth of health as an achievable movement from disorder to order through consumptive acts. This mythology of the meaning of health is the core formation revealed by the meta-structure, which exists as the entity or concept or account of health itself. The myth is constructed by the website's use of the secular trinity, which functions to position the pharmaceutical creators of the website as the creators and purveyors of the myth of health, and connotatively the *divine creators and source of sacred order*, symbolically represented within the material as their ability to offer transcendence from death to life.

The video advertisements contain further evidence of this myth with the sequential images of video revealing the units of the secular trinity in the same linear formation, symbolizing disorder to order. The video models in real time how 'doing the pharmacy' is a ritual practice in itself, following the same structure and enabling movement to the sacred through the provision of the sacred consumptive objects (See Figure 13).

Furthermore, the pharmacy is positioned as worthy of respect because of its association with the sacredness of order and usurped power of the public health, medical and scientific discourses. This combination with this association of the sacred reinforces the symbolic meaning of pharmaceuticals and the pharmacy to that of a *holy position* and place. Unknown to the Internet surfer, the pharmaceutical group behind the website is the purveyor of the myth and ultimately creator of its self-serving holy stance.

Disorder
Symbolically: Death

Time index: 0:04

Offer of order
Symbolically: Transcendence/Salvation

Time index: 0:25

Acquisition of order
Symbolically: Life

Time index: 0:39

Video total time index: 0:41

Figure 13. The symbolic meta-structural formation of the health concept as revealed in video.

Meta-structural formation: Symbolism and solidarity in the concept of health

The pharmaceutical advertisements have usurped the revered social power of public health, scientific and medical discourses. Therefore, the secular trinity can be seen as a hierarchical body of stories that constructs a mythology of the powerful – *a making sense of health through a 'common sense' myth* that regulates the concept of health into the rationalized view of order and consequently 'life' through the meta-structural concept of

health as a sequentially ordered concept held together by symbolic meanings that influence a variety of health practices. As a revered power, the pharmaceutical discourses construct and govern the individual's conceptual experience of health as movement from the profane to the sacred. The secular trinity can thereby be seen to operate toward the sacrilization of this pharmaceutical advertising medium.

Durkheim (1995) posits that the communication of a repetitive structure that holds symbolic meaning operates to strengthen social solidarity, a core function of religious endeavours. In this manner, the ritual practices have the power to affect reality. In this case, the meta-structural formation represents the concept of health as a complex structure of information constructed by the discourses. The structure can be viewed as operating to promote such solidarity including the symbolic positioning of the pharmacy with its practices and contents as holy. The next section exposes another illustration of how the website functions to promote social solidarity.

Family discourse as the healthy congregation

On the surface, the use of the word "family" in the FHD title and logo (See Figure 14) depicts the website as endeavouring to support the individual's family, yet as a textual vehicle of communication the word "family" takes on several meanings and connotations. In the aspect of individual religiosity, the modern day family still represents "...the most important religious vehicle of socialization" (Furseth & Repstad, 2006, p. 117). As a function of order in the social sphere, the family socializes members into modeled roles

in which the individual adheres in order to seek acceptance from other members (Furseth & Repstad, 2006). The website can be viewed as operating to socialize individuals in the frameworks of a healthism culture by the modeling of beliefs and behaviours visible in text, image and video.

Figure 14. The Family Health Diary logo.

"Family" is also commonly used to denote a primary social group or organization not unlike that seen in religious organizations (Furseth & Repstad, 2006). The connotation of "family" promotes a group feeling through shared values (Fontanille, 2006) and what Nichols (1994, p. 56) expressed as "*sensations of togetherness*" that bind common beliefs and interests into a community. The all-encompassing nature of health creates a space wherein *everyone has health* and *therefore everyone can belong* to this online community of "family health". However, a deeper analysis reveals there are divisions to this belonging.

Textual references of nationalism combined with the first person plural pronouns "we", "us" and "our" create a division between those who do and do not belong. The references also operate to perpetuate the idea of health as a common cause with references to "family" promoting a coherent unity among readers and authors as well as inferring a separation from *others*. All *can* belong, but *there are those who cannot* belong: "*Kiwi's*

love to go to the beach", "*New Zealand* has among the highest rate of skin cancer *in the world*", "due to *our* climate", "many of *us* have fair skin", "Whenever *we* encounter stress *our* body undergoes rapid change..." The use of nationalistic references and first person plural pronouns in the context of "family" promotes connectedness while masking the existing hierarchy behind the text. Simultaneously, a sensation of equality is promoted with those who participate in the common cause of health while a sensation of segregation from others is also promoted. The *others* in this dichotomy are those who do not engage in this cause.

The segregation can be clearly seen in the pictures that denote belonging and segregation. Despite the connotation of "family" as an intimate space of protection in which everyone belongs and the indications of *togetherness* that it holds, most pictures of people who suffer illness are alone. Contrastively, pictures of 'healthy' people (ads focused on "wellness", "promotion" or "prevention") are commonly shown as happily interacting with other healthy people (See Figure 15). The symbolic message is one of isolation and segregation of illness and acceptance of wellness. The pictures further function to normalize and typify ostracizing or avoiding those who are unwell which promotes the solidarity of the adherents to the moral foundation. At the level of practice, the pictures represent outcomes for those who adhere or deviate from the common cause of health. Health practices are thereby advocated as methods to prevent isolation and promote belonging. One can belong to the family or the nation through good health, and does not belong if suffering illness.

Figure 15. Images of illness sufferers contrasted with healthy individuals.

Most religions regard the family as the foundational component of society (Furseth & Repstad, 2006). Religions depict adherents as a family or congregation with the members as children and authority represented by the *rules that regulate* the religious beliefs and practices. The congregation supports the individual in obeying the rules and judges their abidance (Collins, 2007; Demerath & Farnsley, 2007). Although the existence of 'online communities' is hotly debated due to lack of actual contact (Richardson, 2005), there is no stipulation of actual contact behind the meaning of congregation (Demerath & Farnsley, 2007). Congregations dually function to mediate between the individual and religious beliefs as well as the individual and society. Although the individuals who visit the website are exposed to rules yet have *neither virtual nor actual contact* with one another, *the act of contact is secondary to the functional act of interacting with the influential information.* In a congregation, the function of the organization is to provide a point of contact that influences the individual's behaviour (Demerath & Farnsley, 2007).

Congregations encourage a common identity (Demerath & Farnsley, 2007; Pargament, 1997). In the Western middle classes where Protestantism and Catholicism are widespread (Wallis & Bruce, 1992), families depict "formal organizational structures with ties to a larger religious identity" (Demerath & Farnsley, 2007, p. 193). A congregation consists of members with common ethnic, racial and SES status. In this context, the functional focus of the website on middle class females and Caucasian ethnicity appears a fundamental building block of a congregation. To *have religion* is to identify with the common interests within a congregation (Furseth & Repstad, 2006) with congregational space used to learn and teach (Demerath & Farnsley, 2007). The website operates on these levels, providing information on personal interests and *sensations of education*. (As revealed in the previous section, prescription is cleverly masked as education.)

No matter what cue draws the consumer, they are exposed to a sensation of togetherness and belonging. The rules that regulate beliefs and actions are portrayed in an environment that professes to be one of learning and teaching from an authoritative yet personal content. The website's connotative use of "family" can represent a healthy congregation and enhance the website's function as a mediating avenue toward *uniting* individual beliefs (thoughts) and practices in society.

Unquestionable information as sacralization: The secular texts

Thus far the findings establish the website material as drawing on rules that regulate beliefs and actions operating to construct a new morality and social order based on healthism discourses and the greater structuring of the health concept. Also established is the functional level, the information, instruction and ritual action as received from sources that are external to the individual. "The 'external' source of the most explicit statements of religious rules usually lies in texts widely regarded as sacred" (Beckford & Richardson, 2007, p. 400). The website draws on secular texts that have been made sacred to establish legitimacy and power for its rules through the use of four prominent reference points: the categories "Your Health A-Z" and "Family Health Diary Reports", an interactive textual and imaged account of the body in the section titled "The Body: A part by part description," and the influential term "Diary" that appears in the website's title (See Figure 16).

Figure 16. Images of prominent reference points on the website.

While the healthism discourses draw on science based facts to establish legitimacy throughout the texts, three of these four influential reference points operate to position the information as from scientific or professional experts. "Your Health A-Z" represents a

dictionary-style guide to health issues in its alphabetical presentation. Dictionaries provide a prescriptive account of preferred word meanings in an effort to *establish commonality* in a culture. Dictionaries can only be changed by lexicographers who operate as *expert* consultants who have the *authority to change meanings* to keep them current. The website describes "Your Health A-Z" as an "updated guide" written by "professionals". The title "Reports" refers to *expert* documents that describe in detail the findings of authorized groups or individuals. In conjunction with the pen-and-paper image that represents this category, the inference is to a scientific or medical report written by such authorities. "The Body" section offers an encyclopedia-style description and Cartesian division of body parts that functions to teach "how your body works" from a biomedical standpoint that incorporates subsections on "DNA", "Medicines" and "Conception to Birth". An encyclopedia is an exhaustive book of facts that is used as a reference. The authors draw on the meaning of encyclopedia as *authoritative facts*, and its instructive and educational function to establish credibility for this section.

The inability of the common person to change or interfere with the 'facts' of the knowledge presented signifies the elevation of these secular texts to sacred status. Sacralization occurs when "...the secular becomes sacred or other new forms of the sacred emerge, whether in matters of personal faith, institutional practice or political power" (Demerath, 2007, p. 66). Therefore, as secular texts, dictionaries, reports and encyclopedias are sacralized in their untouchable and unquestionable nature within the website.

The diary: My own 'personal' religion

Turning now to the final prominent area, the term "Diary" refers to more personalized yet restricted material. Blogs, Facebook, and MySpace are examples of known areas where the Internet expands public discourses to restricted or private material (Richardson, 2005). In this context, "Diary" also simultaneously provides an enticement to the Internet surfer to read such *restricted* material. As restricted material, it can also be viewed as a sacred document that is controlled by the authority of the author and consequently unchangeable by another individual. The term "Diary" occurs within the title and logo, and therefore the entire content of the website is positioned as containing sacred information that cannot by changed by anyone except the author.

At this point the personal aspect of "Diary" comes into position as providing facts that reflect the *value of a personal perspective as opposed to the 'value-free' facts of science.* The cold, harsh, and sterile connotation of scientific or medical endeavours is balanced through the intimate and personal connotative meaning of "Diary". The overall communicative endeavour of the website thereby takes on a sacred, authoritative and yet personal nature, which mimics aspects of religious communicative endeavours (Furseth & Repstad, 2006).

Emergence of the sacred

Durkheim shifts from religion to broader cultural processes that operate to sacralize what was once secular, positioning religion as only one area from which the sacred can emerge (Durkheim, 1995). The new sacred is viewed as arising from within specific social

contexts that were before deemed secular (Demerath, 2007). In these prominent areas of the website, the social context of science rising to replace God (Beck, 1992) is revealed. The authority of science produces and administers a sacralized institution with the replacement of religious beliefs by positivistic, scientific and 'value-free facts' from a textual source of information that maintains sacred positioning.

The regulation of rules represented by dictionary references are integrated into health rituals and supported by the educational context of the encyclopedia that represents information from a belief in biomedical processes. As doctors draw biomedical information from scientific method, Foucault's positioning of doctors as the new 'priests' who inform the sacred texts is evidenced in this context (Foucault, 1994). These areas function similarly to the content of religious rules which are based on belief systems and known to be normalized through various sacred texts written by those in power and practiced by adherents (Demerath, 2007).

The sacred pursuit of health

Durkheim (1995) argues that society perpetually offers categories of the sacred and profane through communication and symbol which operate to strengthen social solidarity and thereby promote social order. Emphasized within this study is this religious categorical foundation which appears to underlie the cultural phenomena of healthism. CDA illuminated the processes at work in the modern secular world of the Internet, highlighting how representations and discourses within the website address higher issues

of life and death as revealed in the meta-structural formation. Also revealed is the individual's positioning as an adherent to the higher powers of the pharmaceutical companies. Psychologists position religious processes as gratifying human needs for knowledge with the search for the sacred as offering meaning and importance represented by the highest values in life (Pargament, 1997). Represented within the website material, the pursuit of health as the highest value appears to parallel the search for God as a means of fulfillment of these individual and social needs.

CHAPTER 5

Healthism: The Invisible Religion?

"Healthism is a powerful ideology, since, in secular societies, it fills the vacuum left by religion. ...The righteous will be saved and the wicked shall die."

(Skrabanek, 1994, p. 17)

The findings suggest that the discourses of healthism go beyond that of a moralizing ideology to parallel religion in its sociological construction as regulation derived from a constructed myth that informs information, instruction and ritual practice. Constructions of the sacred, transcendent and meaningful ritual practices within substantive and functional traditions are also evidenced. Healthism's expert discourse is shown to promote a morality that closely parallels religious values with a variation shown in the promotion of the value of the self.

The variation is reflective of cultural changes that denote modern society's turn to neo-capitalism wherein the acquisition of money and tangible objects no longer denotes the *sin of greed* but is morally situated as *positive action in the interests of the self.* Historically, religion operated to restrain individual motives, especially in areas that would do harm to others, promoted selflessness for the greater 'collective good' of society and brought meaning to life, death and the hereafter (Geyer & Baumeister, 2005).

On the surface, the findings would suggest a conflict between traditional and modern moral standards.

A modern secular culture can be described as one that has turned from a base of religious values and morality. Baumeister and Exline (1999) theorize that societies rely on sources of value as moral foundations for social conduct and that as cultures evolve certain values drop away and others rise to take their place. From this stance, the rise of the value of the self inherent within the discourses can be viewed as functioning to fill the need for a new value source within a secular society. The discourses also evidence, however, an alignment with traditional moral standards in the value of the self as *a practice in not harming others or society* by consuming health resources because one has contracted an illness through moral transgressions. In this context, the value of the self can be seen to function to meet the needs of a society that is focused on the life and death issue of health care rationing. Healthism discourses, as a substitute for religious discourse, may therefore be operating to meet the needs of society by bringing consensus on moral issues which in turn promotes a type of social solidarity.

The findings show that perhaps a social solidarity is being constructed in the meaning of health via the integral functioning of the secular trinity. Overall, the meta-structural formation conceptually reveals the form, content, and function of healthism in pharmaceutical advertising to take on a religious connectivity of values, beliefs and practices that Durkheim (1995) posits to underlie all of social life. This meta-structure

can be viewed as a preliminary finding in Couldry's (2004) theory of media practice and ritual as producing a "hierarchy of practices" indicative of symbolic social order.

As psychologists, we cannot assume that the technologies of health and the economics of health resources combined with the 'effects' of media drive social and cultural changes in the conception, experience and practice of health. A deeper system of symbolic meaning for our modern society is present within these discourses. The pharmaceutical advertising group may use religious rhetoric in the messages to legitimate neo-liberal interests, but what appears to be employed at a deeper level are the productive forces and relations that are inherent in social structures as symbolic representations of the valued sacred and profane. If so, then resting upon this symbolism are the public health approaches, policies and legalized government initiatives that impact the daily lives of individuals. Perhaps religion is not a consensual part of our modern secular culture but exists unobserved in the health mandates and other *invisible social forms of meaning* (Luckmann, 1990) within our society. In any case, the sacred and profane are worth investigating further to consider whether healthism and other socially 'invisible' presentations of holy, sacralized and sacred forces remain unobserved in their implications for life and death.

Limitations and Future Research

This research has reinforced previous findings into the subject positionings and discourses of health constructed by media. These specific areas include the imposition of

a morality behind health practices (Galvin, 2002), individual's positioned as deficient and dependent (Lyons & Griffin, 2003), individual responsibility for health (Galvin, 2002; Lupton, McCarthy, & Chapman, 1995; Murray, Pullman, & Rodgers, 2003), and the expert positioning of the medical and scientific (Howson, 1998; Marshall & Woollett, 1997). However, the Web-based medium selected for this research was limited to one pharmaceutical advertising group and its website materials. Further analysis is therefore advised in advertising material within Internet mediums, magazines, TV and other health-related and sources. The research should also examine similarities and differences within those discourses in relation to the target audience as the FHD website was clearly targeted at middle class Caucasian women.

Substantial Internet research on changes to the health concept could take place on the edge of this sweeping technology, where the expansion of the Internet intersects with new populations previously unexposed to pharmaceutical advertising content. Of particular interest in this area would be its continuity in the area of subjectivity and practices, including adaptation to the meta-structure due to local ritual health practices and religious positionings. Extensive research is needed in the area of the Internet as a communication device and its influence on the character and experience of health.

Additional discourse analytic research in the form of interviews or focus groups could be advantageous in revealing the individual's personal and social experience with the beliefs and practices presented to them through advertising material. Especially useful would be an investigation into the possible reproduction of the meta-structural formation of the

concept of health and the existence of the health myth as a meaningful representation of health and illness within the general populace. Furthermore, future studies with a strong focus on symbols, morals, values and meanings underlying healthism on individual, social, cultural and political levels can help define and expose its similarities and differences with religious functions. The employment of a critical discursive approach in this area can increase awareness surrounding the issue of freedom in the area of human rights versus the right to health, allowing the voices of those who cannot or will not adhere to health as a 'supreme value' to be heard.

Conclusion

Exemplified within this research are healthism discourses in pharmaceutical advertising with their parallels and variations to religious discourses and endeavours. Much of this alliance is found within constructions of morality and its symbolic cultural underpinnings. Little mainstream research has been accomplished in the area of morality or its social function, perhaps because such studies bring to light the moral underpinnings of scientific rationality on which psychology as a field has gained its social credibility. Without a critical and reflexive stance, health psychology cannot reveal the dominative forces behind social organization, its possible restrictions on personal freedom, and a pursuit of order that if left unchecked has prejudicial implications in educative, policy and legal spheres for those dominated.

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