Driven to Anorexia:

The Medicalizing and Normalizing Discourses of Celebrity and Cultural Power in Media Mental Health Imagery.

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ABSTRACT

Previous research has suggested that the negative stereotype of mental health originates in the media (Signorielli, 1989; Hyler, Gabbard and Schneider, 1991; Wahl, 1995). Media embodies culture and celebrities; both of which construct how mental health is perceived within society (Draguns, 1980; Anderson, Berkowitz, Donnerstein, Huessmann, Johnson, Linz, Malamuth and Wartella, 2008). The present study aspires to raise consciousness of the presence of such discourses in media articles, specifically in relation to individuals with a medical diagnosis of anorexia (See Levine and Smolak, 1998). The analysis follows a Faircloughian (1995) framework of critical discourse analysis provided by Richardson (2007). The analysis presents mental health as a complex social phenomena through the emerging themes reflecting the cultural and celebrity discourses of normalization and medicalization. Additionally, discourses of femininity, negativity, control and exaggeration arose. These are commented on in detail in the discussion. Cultural perspective and celebrity endorsement of health has powerful implications for eliminating stigmatisation thus improving the lives of those with health issues. Ethics were in accordance with the BPS (2011) and the researcher's influence was reflexively considered within the analysis. The term 'individuals with mental health issues' replaces the term 'the mentally ill' as the researcher is keen to avoid identification through bodily experience of health.
Introduction

This is a descriptive qualitative study of power in relation to mental health representation, particularly anorexia and powers of culture and celebrity, within the media. The method of critical discourse analysis is based on Fairclough (1995) and extended to journalism by Richardson (2008). Newspaper articles were found by searching the online newspaper websites for articles incorporating celebrity and mental health. The topic of celebrity thinness endorsing anorexia was chosen as it had been reported differently by numerous newspapers. Multitudinous research demonstrates the negative media perception of mental health, however relatively little considers the origins of these representations or the role of endorsement of culture and celebrities. Celebrities and culture both shape journalism, and so must be important.

Research Questions

This proposed study strives to provide an answer to:

1. How is anorexia presented in the media?
2. How are the medicalizing and normalizing interconnections of culture and celebrity portrayed in the newspaper articles
3. What discourses of anorexia are presented within the portrayals of celebrity and culture
Literature Review

To what extent is normal behaviour depicted as abnormal? And what societal repercussions arise from labelling healthy behaviour as deviant? Authority and power in the media influence audiences in their construction of reality. Therefore the present study will unearth the power discourses of culture and celebrity in constructing the understanding of what constitutes ‘normal’ mental health and how these interplay with notions of medicalization and normalization.

Society places great importance on the distinction between normal and abnormal. Conventionally normality is defined as most prevalent behaviour (Durkheim, 1982), in mental health, normalcy is an ego-syntonic individual whose behaviours, emotions and impulses are balanced, yet individuals can be ego-syntonic and have atypical behaviour such as being highly intelligent. As a result of the controversies Lane (2007) theorised that: ‘we’ve narrowed healthy behaviour so dramatically that our quirks and eccentricities, the normal emotional range of adolescence and adulthood, have become problems we fear and expect drugs to fix.’ (p.8).

These behaviours are so prevalent that to regard them as diseases would render the term meaningless. If professionals can not define normality, how can abnormality be defined. It is unfair to prejudice against individuals differing from our own internal normality.

The phrase 'mental illness', which was introduced to avoid using the term disease, has not been adequately defined even by the DSM-IV (American Psychiatric Association, 1994), who states that no definition specifies precise boundaries for the concept of ‘mental disorder’. Thus the topic is so controversial that some challenge its entire existence;

'mental illness is a myth whose function is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations' (Szasz, 1974; p3).

The regulation of behaviours as 'mentally ill' justifies social control.

Mental health is inseparable from social contexts, generally attributed to behaviours which are not 'normal' in our culture (Insel and Wang, 2010). Society ideally desires perfection, imperfection is maladaptive. Perfectionism is misrepresented in the development of anorexia as being vanity induced, despite contradictory evidence (Garrett, 1998; Warin, 2005), as many anorexics do not crave thinness (O'Connor and Van Esterik, 2008). Similar results have been found cross-culturally (Khandelwal, Sharan and Saxena, 1995; Lee, Ho and Hsu, 1993; Katzman and Lee, 1997; Palmer, 1993); culturally differing prevalence of anorexia (Rathner, Túry, Szabó, Geyer, Rumpold, Forgács, Söllner and Plöttner, 1995; de Azevedo, and Ferreira, 1992; Nakamura, Yamamoto, Yamazaki, Kawashima, Muto, Someya, Sakurai and Nozoe, 2000), may represent differing cultural assumption and celebrity influence.

Culture influences medicalization (Cornwell, 1984), reflecting cultural differences in diagnosis. All cultures experience aberrant behaviour, but the extent it is abnormal is subjective (Heinimaa, 2002; Jenkins and Barrett, 2004); auditory hallucinations in America may be medicalized as schizophrenia, whereas some African tribes would attribute it as a quality of the Shaman (who acts as a medium
between the virtual and the spiritual worlds) (Lin and Kleinman, 1988; Lefley, 1990; Karno and Jenkins, 1993). This accentuates the considerable effects of the issue, elicits distress and results in a misinterpretation of symptoms (Draguns, 1980).

Societal stereotyping result in anorexia being a women’s issue (Bordo, 1997), however men represent up to a one fifth (Woodside, Garfinkel, Lin, Goering, Kaplan, Goldbloom and Kennedy, 2001). This misrepresentation of knowledge induces additional stigma, especially if male.

Medicalization is 'defining behaviour as a medical problem or illness' (Conrad, 1975; 12); a 'process whereby more [...] of everyday life has come under medical domain' (Zola, 1983; 295); the individualization of social problems. Explanations of health issues are sought in the individual as opposed to the community, producing victim blame and attempts to correct the victim, not society (Ryan, 1971). Medicalization isolates the sick from their surroundings, complicating health issues such as anorexia by obscuring the causes. Treatment programs can exercise a Foucauldian power (Eckermann, 1997) by replicating conditions that caused the disease (Gremillion, 2003; Warin, 2005) and, in labelling the person, others are inspired to live up to that diagnosis (Warin 2005, 2006).

Within the diagnosis of anorexia there are discourses of individual responsibility, promoted by the public and health agencies; urging the perfect person to eat sparsely, exercise regularly, avoid health risks, and be attractive. Becker (1986) describes the obsession with healthy living as ‘a new religion, in which we worship ourselves, attribute good health to our devoutness, and view illness as just punishment for those who have not yet seen the Way’ (p.21).

Medicalization can be a form of social control (Pitts, 1971; Kitterie, 1971; Foucault, 1965; Szasz, 1970). Individual baises are significant in medicalization (Conrad and Schneider, 1980a), for example runaway slaves were diagnosed with drapetomania (Chorover, 1973). Responsibility is discarded; a problem is due to an imbalance rather than reflecting personal traits; medical treatment becomes the norm. Lennard (1971) insisted that: 'psychoactive drugs [...] tend to restrain individuals from behaviour and experience that are not complementary to the requirements of the dominant value system' (p57).

Online pro-anorexia communities reject the sick role and thus de-medicalize anorexia, either by viewing their eating as a lifestyle choice or by conspiring to avoid medical treatment through safely managing their eating.

Despite advances in the aetiology of mental health, the majority of illnesses in the DSM depend on observations by medical professionals, which could lead to social control (Foucault, 1965; Szasz, 1970; Rosen, 1972; Parsons, 1951; Turner, 1984; 1987; Pitts, 1971);

'the greatest social control comes from having the authority to define certain behaviours, persons and things' (Conrad and Schneider, 1980b, p8).

Many normal conditions are regarded as medical issues; hyperactive children have an illness rather than being disruptive, disobedient and active.

'When drunkenness, juvenile, subpar performance and extreme political beliefs are seen as symptoms of an underlying illness or biological defect the merits and
drawbacks of such behaviour or beliefs need not be evaluated' (Reynold, 1973; 220-221).

Defined as 'deeply discrediting' (Goffman, 1986; p3) and presenting the individual as 'not quite human' (p5), stigmatisation comprises selective exaggerated categorical perspectives; negative stereotypes (Townsend, 1979). Stereotypes involving those with mental health issues sees them as pathetic, dishonest and at blame. Further stereotypes which appear in jokes, advertising and the media include being barking mad, crackers, crazy, dotty, a head case, loony, nuts and having a screw loose (Wahl, 1995; Philo, 1993).

Stigma is the second illness (Finzen, 1996), added to the experience of maladaptive mental health (Brockington, Hall, Leving and Murphy, 1993; Huxley, 1993; Kelly and McKenna, 1997; Rose, 1998; Satcher, 1999; Corrigan and Pen, 1999; Link, 1987). It induces social exclusion and delayed help seeking (Link, 1982; Fink and Tasman, 1992; Rosenfield, 1997; Angermeyer, Matschinger and Riedel-Heller, 1999; Holmes and River, 1998), particularly when the media depict those with maladaptive mental health as dangerous and violent (Signorielli, 1989; Wahl, 1992; Cutcliffe and Hannigan, 2001). Many individuals have experienced comments, been treated as incompetent, been avoided or advised not to aim highly in life (Wahl, 1995), this is highlighted in the high unemployment and reduced societal interaction (Stuart, 2006). In contrast, those with mental health issues can hold careers as doctors, nurses, and psychologists (Foderarol, 1994). These individuals describe the stigma themselves as shame, blame, secrecy, isolation, social exclusion, and becoming the black sheep of the family (Byrne, 2000). Due to the detrimental repercussions stigma needs serious consideration.

Those holding negative stereotypes distance themselves from those with mental health issues (Madianos, Madianou, Vlachonikolis, and Shefanis, 1987; Levery and Howells, 1995). Corrigan (2000), based on Weiner's (1995) attribution theory, explained that people may behave emotionally because of the stereotype, leading to a fear response; the avoidance results in apprehension (Johnson-Dalzine, Dalzine and Martin-Stanley, 1996), consistent with research demonstrating that people perceive those medically diagnosed with a 'disorder' as being dangerous (Angermeyer and Matschinger, 1996; Philo, Secker, Platt, Henderson, McLachlin and Burnside, 1994). Those experiencing prejudice are likely to withdraw to avoid negative responses, which further exaggerates their discrimination (Link, Cullen, Struening and Shroult, 1989). Stereotypes lead to labelling, 'deviant behaviour is behaviour that has been labelled as such by others' (Becker, 1963; p9). This person is associated with the undesirable traits, and exposed to segregation and discrimination (Link, Struening, Rahav, Phelan and Nuttbrock, 1997; Link and Phelan, 2001). Familiarity reduces stigmatisation (Holmes, Corrigan, Williams, Canar and Kubiak, 1999; Link and Cullen, 1986; Penn, Guynan, Daily, Spaulding, Garbin and Sullivan, 1994), however many families may attempt to hide the diagnosis (Phelan, Bromet and Link, 1998).

There is a modern prejudice where fat people are seen as 'letting themselves go', and stigmatised as weak, whilst slim people embody strength and goodness. People judge their own eating, speaking of sinning with desserts and being good with vegetables; the body has become a moral arena, eating and exercise have come to
These negative stereotypes arise from the media (McKeown and Clancy, 1995; Anderson, 2003; Borinstein, 1992; Philo, 1993; Thornton and Wahl, 1996; Conrad, 1997; Wilson, Nairn, Coverdale and Panapa, 1999; Wahl and Roth, 1982; Fruth and Padderud; 1985). Coverage such as that of ‘Mental patient kills mother after quitting hospital’ (O’Neil and Fletcher, 1996) is just an example of the oppressing media. Representations are predominantly drawn from discourses of dangerousness, of political transition and medicalization (Bilic and Georgaca, 2007). People engage with the media, accepting, challenging or rejecting, using discursive resources of language and stories (McCreanor, 1993; Fairclough, 1992; Potter and Wetherell, 1987; Wetherell and Potter, 1992). Furthermore, people are not aware of the origins of these resources and use is defined by heuristics of availability and representativeness (Nisbett and Ross, 1980; Johnson, Hashtroudi and Lindsay, 1993). The frequent exposure to the same portrayals of mental health can create self-validating impressions of their accuracy.

Those producing newspaper articles draw upon discursive resources which will be familiar with their intended audience (Henderson, 1996; Philo, 1996b); different audiences respond in different ways to the purpose of language (Wadok and Ludwig, 1999). The media is powerful in changing current perspectives, before the murder of a man by an individual with schizophrenia the main concern was the well being of patients, afterwards focus shifted towards public protection (Laurance, 2003). Newspapers make significant links between mental health, criminality and violence (Ward, 1997; Day and Page, 1986; Signorelli, 1989; Hyler, Gabbard and Schneider, 1991; Shain and Phillips, 1991; Wahl, 1992; Gerbner, 1993; Philo, 1996a; Wahl, 1995). Such stories are given more exposure than positive articles. Yet Allen and Nairn (1997) challenged the idea that the media knowingly present negative depictions of mental health as journalists are not always well informed regarding mental health issues.

Critical discourse analysis is based upon a tension between Idealism and Materialism. Ideology is created through social interaction (Volosinov, 1973), and is conceived as a set of false beliefs, constituted by a dual relation, first, to the reality of which it is an inverted reflection and secondly, to the true, scientific knowledge of that reality (Callinicos, 1983). Ideological ideas conceal exploitation and reproduce inequitable social realities. Analysis is based around capitalism, which is ever present in our society. Capitalism refers to the division of society into classes who are defined by their social relationship to the mode of production. Capitalism is inherently exploitative, and allows for middle class journalists to have a more positive view of capitalism because they are better insulated from the more obvious injuries of class experienced by the working class. Minorities do not revolt because they have been taught not too. Human beings collectively and individually created their own reality in response of changing circumstances (McLellan, 1986).

**Methodology**

Language is complex, active and enacts identity; reflecting and shaping our reality (Gee, 1999) and constructing our societal involvement with others; there is no such
thing as non social language’ (Lupton, 1998: p. 24). Discourses create existence and are constructed to serve specific interests. These perspectives of the world are discovered by deconstructing linguistic properties through discourse analysis. Mental health is a meaningful products created by discourses, not something that prevails outside of societal and cultural influence; language is crucial to diminishing stigmatisation. A methodology rooted in linguistics is relevant for the present study.

Critical Discourse Analysis (CDA) is gaining recognition (Lupton and McLean, 1998; Allen and Nairn, 1997; Seidel, 1993; Hepworth, 1994; Harper, 1994; Hazelton, 1997; Nessa and Malterud, 1990) as illustrating the ‘relationships between the text and its social conditions, ideologies and power-relations’ (Wodak, 1996: p20). Fairclough (1995) endeavoured to increase the awareness of the advantageous use of power in language (Hesmondhalgh, 2006; Wodak, 2001; Hutchby, 2006) through his triadic method incorporating discourse, power and knowledge (Carabine, 2001; Titscher, Meyer, Wodak and Vetter, 2000). Discourse analysis links ‘linguist analysis to social analysis’ (Woods and Kroger, 2000: p. 206), as we understand language based on social knowledge. CDA should be regarded as a social practice, this implies a dialectical relationship; the discursive is shaped by situations, institutions and social structures but also shapes them (Fairclough and Wodak, 1997). This procedure appeared most felicitous to the present study as Fairclough’s methodology ‘primarily studies the way social power abuse, dominance, and inequality are enacted, reproduced and resisted by text and talk in the social and political context’ (van Dijk, 1985); in our society celebrities are an important form of power, as is culture.

CDA is diverse (Blommaert, 2005; Brown and Yule, 1983; Cameron, 2001; Phillips and Jorgensen, 2002; Weiss and Wodak, 2003; Wodak and Meyer, 2001), amalgamating sociolinguistics, psychology and the social sciences to identify the social problem (Birnbaum, 1971; Calhoun, 1995; Fay, 1987; Fox and Prilleltensky, 1997; Hymes, 1972; Singh, 1996; Thomas, 1993; Turkel, 1996; Wodak, 1996; Lupton, 1992). There is controversy over a unitary definition (Henry and Tator, 2002); Stubbs (1983) describes it as concerned with language beyond the utterance, with linguistic and societal interrelationships and everyday communication. Fiske (1987; 1994) interpreted discourse as socially constructed representations where words are never neutral, similarly Fairclough (2003) emphasised the involvement of emotions and the social life (Fairclough, Jessop and Sayer, 2004); identifying discourse as ‘a mental world of thoughts feelings, beliefs and the social world […] different discourses are different perspectives on the world, and they are associated with the different relations people have to the world’ (p.124).

In essence, ‘nothing meaningful exists outside of discourse’ (Foucault, 1972; as cited in Wetherell, Taylor and Yates, 2001, p73); discourse is not about existence but about meaning (Laclau and Mouffe, 1990). Discrimination is a relationship between the text, its producers and inequalities in society, social change is possible through people acting upon the world. Discourse analysis resists social inequality and is essential for focusing on victims of oppression and empowering them to challenge their injustice (Foucault, 2000); serious social dilemmas are naturally complex and require an interdisciplinary approach (van Dijk, 1993). Another world is possible. It is the point of CDA to show how discourse conceals this from us (Lukes, 1974; 55).

Qualitative methods allow for exceptional amounts of detail to be unearthed where as quantitative methods categorise; those with mental health issues are defined by
these categorisations. This research, however, is not proposing that classification is fundamentally wrong but that it is necessary to examine the underlying assumptions. Qualitative techniques are cathartic, self acknowledging, self aware, empowering and data rich (Cooligan, 2006; Hutchinson, Wilson and Wilson, 1994; Smith, 2008) as well as providing a voice for the under-represented, due to the nature of the issues to be discussed this seemed most appropriate. Critical discourse analysts offer interpretations of meaning rather than quantifying textual features to deriving meaning, 'objectivist science and quantitative methods have been insufficient to perform these tasks' (Lindlof, 1995; 22).

Critical discourse analysis (CDA) was applied to the texts in the present study in an attempt to explore the media portrayal of mental health, involving a specific focus on media, celebrity and cultural power forms. Discourse analysis accentuates how language is used to reproduce dominant ideologies ingrained in syntax and rhetorical devices.

The focus of analysis will be newspapers; news journalism is powerful, existing to enable citizens to better understand their lives and position in the world (Richardson, 2007). Journalism has social effects; through its power to shape issue agendas and public discourse it can reinforce beliefs and opinions. Newspaper discourse can be divided into a 'complex of three elements: social practice, discursive practice (text production, distribution and consumption), and text, and the analysis of a specific discourse calls for analysis in each of these three dimensions and their interrelations' (Fairclough, 1995b; 74). The language of authority is reproduced as society adopts the same language to show adherence to their values (Crowe, 1998). People reading the newspapers will take up their view, in the same way people mirror the opinions of their favoured celebrities. The discourse analysis of journalism concerns language, processes of production and consumption and social institutions. The corpus of the analysis is drawn from opposing newspapers chosen as they represent mental health and celebrities. These articles were found in the archive of the newspapers websites and amounted to six in total.

Discursive practices involved in production and consumption of texts focus on 'how authors of texts draw on already existing discourses and genres to create a text' (Phillips and Jorgensen, 2002; 60). Each discursive genre is a product of a constellation of discourse practices. Journalistic texts are 'the outcome of specific professional practices and techniques, which could be and can be quite different with quite different results' (Fairclough, 1995a; 204).

Critical discourse analysis is interpretative and explanatory, implying a systematic methodology (Wodak, 1996). Richardson (2007) provides a framework of CDA specifically for newspapers, based on Fairclough's (1989) CDA. The compilation of texts were examined with recurrent linguistic properties, semantics and discourses being documented (Parker, 1992). This grammatical and textual analysis is central to Richardson's initial textual analysis stage which describes 'the way propositions are combined and sequenced' (Richardson, 2007, p.38). Two predominant aspects of text to consider; structure of the propositions and the combination and sequencing of the propositions. The features considered entail classification schemes, over and re wording, emotional and relational values as well as incorporating the physical and grammatical structure of the article.
The next sequential stage of Richardson's (2007) employs an analysis of 'discursive practice' and issues of intertextuality; which insists that texts cannot be studied in isolation as they are not consumed or produced in isolation (2007; p.100). 'Every text incorporates, reformulates, reinterprets or re reads previous texts' (Blommaert, 1999; 5). The different elements are not discrete, fully separate elements (Fairclough, 2000; 122). This mirrors Fairclough's interpretation phase which concerns an amalgamation of the textual and background features of knowledge and assumptions (Fairclough, 1989). 'Once we identify a text as an instance of a pattern, we happily dispense with the mass of its detail and reduce it to the skeletal shape of the familiar pattern for purposes of longer term memory and recall' (Fairclough, 1989, p.160).

The conclusive stage implicates the wider social practices; integrating Foucaultian notions of social relations and power (Foucault, 2002; Titscher, Meyer, Wodak and Vetter, 2000). This involves exploring the issue, message and response within the discourse. This is based on Fairclough's explanation phase and scrutinises the relational interaction between the discourses and social practice. The combination of Richardson's (2007) technique with the analysts insight will create a innovative methodology.

Overall, this research is in demand as perspectives still require clarification. Stigmatisation is degrading and seriously affects those living with it, and so illumination of the involvement of power in respect to mental health in the media is essential. Richardson's (2007) CDA will now address the results established in this study, including condensing the data into analysable themes and applying the methodology to each theme. Reflexivity will be considered in the discussion and throughout the interpretation.

Corpus:
Kate Moss: In 2009 celebrity model quoted to an online magazine, fashion news website, that one of the quotes she lives her life by was 'Nothing tastes as good as skinny feels'. After this quote many anti anorexia charities and anti size zero campaigns accused her of supporting and encouraging anorexic behaviour. This created a debate about whether her comments were taken out of context or whether she really did support starving yourself to look good. The articles were all written from two standpoints; one supporting that Kate supported that lifestyle (Article Two; Article Three; Article Six) and those who asserted the comments were taken out of context (Article One; Article Four; Article Five).

Ethics

Ethics occur in all research (Orb, Eisenhauer and Wynaden, 2000); in qualitative research ethics tend to be subtle, problems will arise if ethics are not considered (Batchelor and Briggs, 2004). Ramos (1989) identified three main areas of ethics in qualitative research; the researcher's and participant's relationship, the researcher's own interpretation and lastly the design of the study. The non intrusive nature of the proposed study should not present any problems and will not be using participants. Under deeper scrutiny, some of the articles may present celebrities in an unflattering light. In order to accommodate this all comments will be reviewed by an independent
third party. When interpreting, the researcher has a responsibility not to over generalise or misrepresent the groups, the researcher's own beliefs and values shall inform the interpretation (Punch, 1994), the effects of this will be considered reflexively (Richards and Emslie, 2000). The researcher will be presenting her own views and will be open to criticism. Consent is not an issue as the articles will already be available from mass distribution or will be available on the internet. Ethical approval was sought from an ethics board through the use of ethics forms (Appendix Seven and Eight); all ethics were in accordance with BPS (BPS, 2011).

Analysis

The main themes identified throughout the corpus, in accordance with Richardson's (2007) analysis, were embodiment of health, negativity, normalization of thinness, medicalization of inconsistent behaviours and celebrity influence. Implicit discourses of femininity, control and society emerged within the analysis. In the nature of intertextuality these themes will be discussed intertwined with each other and in relation to societal discourses in which they interplay.

Embodiment

Mental health is an embodied state; 'first the world of physical objects or physical states; secondly, the world of states of consciousness, or mental states, or perhaps behavioural dispositions to act; and thirdly, the world of objective contents of thoughts' (Popper, 1973; 106).

Embodiment is a crucial discourse which emerges in three interwoven themes; embodiment of culture, embodiment of health identity and experience and embodiment in regards to a lack of body.

Within the corpus a general other is attributed as being disordered; 'emaciated teenagers' and 'young women' (Appendix Five), with specific references to physically experienced states of 'skinny' (Appendix Six) and 'starvation' (Appendix Two). Personal experience of mental health is omitted, eliminating the voices of those with diagnosed health issues and allowing for society to speak for them. This parallels with how celebrities articulate for those with mental health issues throughout the corpus and with how celebrity portrayals are manipulated by society. This discards their identity and constructs an objective representation of diseased bodies, impervious to emotions applicable to an individual person.

'If [an] individual does not succeed in having their voices heard then the reasons for this […] usually has to do with slowly or dramatically emerged forms of inequality sedimented [sic] in differential allocation of speakers rights, attribution of status and value to speaking styles, uneven distribution of speech repertoires and other historical developments' (Blommaert, 1999; 8).

The inequality is accentuated, enforcing stereotypical mental health categories and disregarding their unique experience.

Health is inseparable from our identity. Maladaptive health, a maladaptive object,
arising from another person's perception of our idiosyncrasies as a deviant body in the form of physical or psychological states such as the encumbered body; as depression induces slow bodily movements (Lindeman and Abramson, 2008). Ill health disrupts the body (Toombs, 1988); and represents 'the meaning of one being significantly and distinctly different from the [...] other'. (Toombs, 1993, xi), affecting the way society responds to the individual and their identity construction (Williams and Bargh, 2008). '[health] is experienced as present in the body. But for the sufferer, the body is not simply a physical object or psychological state but an essential part of the self. The body is subject, the very grounds of subjectivity or experience in the world, and the body as 'physical object' cannot be neatly distinguished from 'states of consciousness' (Good, 1993, 3-4).

Bodily experience, therefore, manipulates psychological processes (Glenberg, 2010; Gibbs, 2006; Boroditsky and Ramscar, 2002; Barsalou, 1999; Glenberg and Kaschak, 2002) and is essential to improving the lives of those with mental health issues. Within the corpus the body of those with diagnosed anorexia is not presented as the problem, it is the body of the 'cult of stick thin model[s]' (Appendix Three; Appendix One) that is the problem. In a similar approach the Daily Mail utilises normalizing tendencies to down play the seriousness of anorexia; by referring to pro anorexia sites as merely 'slimming sites'. This contradicts the 'sad sad world' presented by the Times 'awash with lacerating self loathing, loneliness and an obsession with consuming as little food as possible'. As a result of how the Daily Mail is downplaying this serious health deficits as a normal experience, anorexia does not get the attention it requires.

Across the corpus referential strategies (Reisigl and Wodak, 2001) are used to identify individuals through anorexia, by choosing this category over another they are included within this category and exclude from others. Society judges them through the stereotypes associated with this category. With anorexia this includes notions of vulnerability and weakness which are elaborated on later on.

Maladaptive mental health is a cultural phenomena (Marsella, 1980); words convey cultural assumptions (Richardson, 2007). Cultural experience is embodied with traits of thinness and attractiveness resulting in success and happiness. This 'superficial society' (Appendix Five) is blamed for mental health like anorexia and an 'obsession with how we look' (Article Five). This is detrimental leading to '10% of girls [...] routinely missing two meals a day' and '40% of 11 year olds believing they need to slim' (Article Two). Society is detached from blame of failing these individuals and so the audience can read the article without having the experience of guilt.

Culture plays on our dissatisfaction with our bodies to achieve personal profits through cosmetics, extreme diets and surgery. The body is a material object reducible to a collection of physical parts. This reduction, again, causes the individual identity to vanish. There is a tendency in our culture to exaggerate symptoms and experience, such as attributing extreme eating disorders to those who are merely skinny or curvy. These perceptions are mediated by the media (Fairburn, Welch, Doll, Davies and O'Connor, 1997; Thompson, Heinberg, Altabe and Tantleff-Dunn, 1999). This may reflect a society that is intolerant of behaviour which is deviant from our own image of promised perfection.
Negativity

Much research demonstrates negativity in the media (Signorielli, 1989; Hyler, Gabbard and Schneider, 1991; Wahl, 1995; Prescodililo, 1999). The lexis surrounding anorexia includes 'sufferer' and 'sick' with 'psychosis' (Appendix Six). Referring to 'madness' and 'crazy' (Appendix One) with 'conditions' (Appendix Five). In contrast the approach of the Mirror is to label this skinniness as 'slender' which adds a positive and elegant slant. Positive linguistic frames are more effective to deter behaviour then negative frames (Maheswaran and Meyers-Levy, 1990), but only when the individual is unmotivated (Meyerowitz and Chaiken, 1987; Rothman, Saloveym, Antone, Keough and Martin, 1993). Within the corpus there is a reluctance to discuss anorexia. This avoidance goes against the apparent relevance of anorexia as celebrities are 'encouraging many more [eating disorders]' (Appendix One) and encouraging individuals to 'develop a mental illness and die' (Appendix Five). This avoidance suggests that the issue itself is unimportant to society and it is the controversy which is the issue as it is this which will sell the newspapers.

Individuals with a diagnosis of anorexia are categorised within the stereotype of an 'anorexic'. Within the stereotype the individuals are all women, all young, vulnerable, unable to talk for themselves and obsessed with celebrity culture of skinniness and attraction. They are breakable and pathetic. These terms all constitute the public's perception of anorexia, and all those diagnosed with anorexia are assumed to possess these characteristics.

Lack of knowledge produces stigmatisation (Hillert, Sandmann and Ehmig, 1999; Angermeyer and Matschinger, 1999) which deepens the negativity felt by those with mental health issues. The lack of knowledge emanates from the media (Sieff, 2003; Byrne, 1997; Granello, Pauley and Carmicheal, 1999). Buckingham (1993) attacked the media asserting that 'it must be the media that provoke delinquency and violence, cause moral depravity and undermine family life. It must be the media that reduce educational achievement, destroy children's intellectual and imaginative abilities and brainwash them into racism, sexism and consumerism.' (Buckingham 1993, p.2). With anorexia the misunderstanding is twofold; foremost anorexia is assumed to exclusively affect 'young women' (Appendix One; Two;Three; Four and Six), only the Times (Appendix Five) makes reference to 'those boys' with anorexia. In reality anorexia is prevalent in 3% of men (Hudson, Hiripi, Pope and Kessler, 2007) and so can not be excluded. Further misrepresentation occurs with how eating disorders are reduced to apply exclusively to 'anorexia and bulimia' (Appendix Four); there is no mention of obesity. There is controversy over whether obesity constitutes a psychological disorder (Hamin, 1999; Stearns, 1999a; Sobal, 1995), causing the individuals to be blamed and stigmatised (Allon, 1982; Cahman, 1968; De-Jong, 1993; Fontaine and Barofsky, 2001; Mannucci, Ricca, Barciulli, Di Bernardo, Travaglini, Cabras and Rotella, 1999; Niero, Martin, Finger, Lucas, Mear, Wild, Glauda and Patrick, 2002; Puhl and Brownell, 2001; Wang, Brownell, and Wadden, 2004). For example the media constantly discusses the cost of obesity to the NHS (Hope, 2010), society, and how they should not be allowed free surgery as it is their fault (Dunne, 2004).
Normalization.

Health within the corpus is inconsistent as thinness is both normalized and medicalized. The body of those with a diagnosis of anorexia is not the problem, it is the body of 'the cult of stick-thin model[s]' (Article Six – the star; Article Three – the telegraph) with 'legs so skinny they look like concentration camp inmates' (Article Five – the times) which is the concern. The definite article triggers presuppositions; a stick has no curves, a stick is breakable, a stick is not a healthy nor desirable look, however a link is forged between being stick thin and being a model and successful.

Journalists are unable to provide unbiased and objective reports (Thomson, 1996); however the Times' (Appendix One) extreme opinions may promote the normalization of an unhealthy lifestyle stating that being 'thin is better then being fat' claiming that even being 'chubbish' is as 'miserable as hell'. Normalizing behaviours such as 'eating nothing at all and going on an hour long run [...] which will make [me] feel sick which a bit of luck, and not want to eat' 'if over 12st 10lbs' (Article One) is unhealthy. This view is so extreme that 'a few emaciated teenagers is a small price to pay' to prevent 'mass fatness' (Article One). Opinion statements embedded in argumentation makes them 'more or less defensible, reasonable, justifiable or legitimate as conclusions' (van Dijk, 1996; 24) and are accepted easily.

Medicalization.

The use of the 'legs so skinny they look like concentration camp inmates' (Appendix Six) metaphor is intriguing, as it creates the impression of a deathly thin appearance and additionally introduces the assumption of thinness being beyond their control; a third party is forcing the thinness upon them. Metaphors such as this reveal the way abstract concepts are perceived, these result from bodily interactions with the world (Lakoff, 1987; Gallese and Lakoff, 2005). Within medicalization this third party may be biological abnormality, however within the corpus it is apparent that this third party is the celebrities.

Terms of being 'sick', having 'conditions' and possessing 'disorders' (Appendix Six) are medicalized terms, however there is no mention of a biological impairment within the corpus as the blame is attributed to celebrities and our 'superficial society' (Appendix One; Two; Three; Four; Five and Six). Medicalization removes culpability; and if blame is removed so is the stigmatisation. Kate Moss's response in the corpus to her critics is not consistent with medicalization: 'Kate does not support [anorexia] as a lifestyle choice' (Appendix One; Two; Three; Four; Five and Six). For anorexia to be a choice there is a conscious decision involved, if people with the diagnosis of anorexia were to blame for their skinniness then all blame is removed from society for failing these individuals and there is no motivation for change.

Celebrity Discourse

Celebrities 'legitimise' (Appendix Two) 'glamorise [...]and] encourage disorders' (Appendix Four) even 'launch[ing] a thousand eating disorders' (Appendix Six). It is
reductionist and unfair to assume celebrities purely induce eating disorders, 'the trouble is [...] [our] increasingly superficial society' (Appendix Six).

Celebrities are powerful (Jackson and Darrow, 2005); this is reflected in the corpus through references to celebrities as 'super models', 'role models' and 'stars' (Article Four). In any process there are three components that can be changed; the participants involved, the process itself and the circumstances associated (Simpson, 1993); all the corpus misquote Kate Moss, this has differing effects on the audience and shows that Kate Moss has no control over her influence as a celebrity. The media directs how subjects in their articles are perceived. This makes Moss a victim of cultural power.

Celebrities additionally utilise their power to normalize behaviours. The use of neologisms such as 'ana' and 'rexy' (Article Five) makes the anorexic identity trendy, especially to teenagers which are most concerned with celebrity culture (Vollstadt, 1999). Women are stereotypically more involved with how they look and are pressured by the media. These audiences may be targeted specifically. However as the Times (Article Five) implies more pressure has recently been put on men to look good.

Femininity

The femininity discourse associates success with being thin and attractive for women (See Appendix Five). Historically women were repressed and denied success, there is still a 'glass roof' between genders in top jobs (Albrecht, Bjorklund and Vroman, 2003) and so women may exercise their sexuality to achieve success. Semantic fields of vulnerability surround mental health within the corpus (Appendix One; Two; Three; Four; Five and Six); vulnerability is associated through the corpus as an individual prone to illness (Appendix One; Two; Three; Four; Five and Six).

this embodies women within the stereotypical feminine trait which perceives them as secondary citizens. This is noticeable in the Times (Appendix Six) where the man is seen as the primary partner and the wife as secondary.

Additionally there are discourses that appear consistently throughout the corpus, but are more implicit such as discourses of control which may represent society's attempts to control and reduce behaviour deemed to be deviant. Discourses of society consistently appear which suggests that society has an importance in the articles and could reflect societies control over the content of the media.

Through the emerging themes reflect the cultural and celebrity discourses of normalization and medicalization/ pathologization mental health is presented as a complex social phenomena. Additionally, themes arose of femininity, negativity, control and society.

Discussion.

A considerable amount of support was found for previous research. Analysis identified a negativity towards those with mental health issues, in this case anorexia.
This however was different from most in previous research, such as those with mental health issues being barking mad, crackers, crazy, dotty, head cases, loony, nuts and having a screw loose (Wahl, 1995; Philo, 1993) or being avoided and advised not to aim high in life (Wahl, 1995). The majority of research into mental health tends to focus on diagnoses such as schizophrenia and mania (Jorm, Korten, Jacomb, Chirstensen, Rogers and Pollitt, 1997; Angermeyer and Matschinger, 1999; Sieff, 2003; Wahl, 2003), in these categories symptoms are more obvious, whereas with anorexia the symptoms are subtle and often hidden (Hecht, Fichter and Postpischil, 1983). Negativity directed towards the individuals with the diagnosis of schizophrenia compromise stereotypes of dangerousness and violence to others (Philo, 1996b), with anorexia the negatively is questioning their own capacity to look after themselves with striking stereotypes of vulnerability causing the individual to almost disappear behind society.

Stereotypes of anorexia are directed internally whereas in contrast stereotypes of schizophrenia are directed externally to harming others. Therefore it is essential not to categorise individuals under the all encompassing term of mental health, as different types of mental health dilemmas attract different prejudices and experiences. Research indicates that the public must have a greater knowledge of mental health then the use of the all embodying term mental 'illness' suggests. Between 30% (WHO, 2000) and 46% (Kessler, Berglund, Demeter, Jin, Merikangas and Walters, 2005) of the population experience mental health which portrays a heightened knowledge (however this is debatable; See Demyttenaere, Bruffaerts and Posada-Villa, 2004) and so it is an insult to the complexity of the phenomena to attempt to use a single undefinable term to categorise the entire experience.

Analysis revealed a tendency to attribute mental health as an embodied state, affecting individual reality, this is consistent with previous research which locates the origins of mental health within the individual. The picture presented within the analysis however is not so straight forward; whilst mental health is inferred as a personal experience, the 'problem' was not sought within the individual but within our superficial and individualistic society and within the discourses of celebrity influence.

The bodies of those with the diagnosis of anorexia differ from the norm. Through normalizing the discipline of extreme diets and exercise women particularly become focused on self modification, and in doing so experience feelings of inadequacy (Bordo, 1997).

Due to the time, effort and sacrifice put into maintaining the anorexic lifestyle anorexia, in the form of self regulation and dieting, becomes the individuals' identity. This allows them to dissociate from who they really are in the same sense that society disregards the person behind the label. Controversially there is an identity crisis, as the label of anorexia becomes their identity; their misrepresentation by society causes them to lose sight of who they are as a person. Young (1990) provided a theoretical account of the embodied identity; tensions of embodiment are women's attempt to become embodied subjects not mere bodies. Anorexias become an object through the gaze of society and a subject in their individual plight.

Congruous with previous research the analysis reinforces the separation of the
normal from the abnormal (Madianos, Madianou, Vlachonikolis, and Shefanis, 1987; Levery and Howells, 1995; Link, Cullen, Struening and Shrout, 1989). This is achieved through the lack of embodiment theme resulting in the individual being less human (Goffman, 1986). By dissociating those with mental health issues it magnifies their stigmatisation and lures the public into the false belief that not everyone can be afflicted by a phenomena such as mental health. Normality however is confused, with some articles associating extreme thinness with beauty, success and perfection.

Normalizing mental health can affect social relationships, such as feelings of rejection and embarrassment. Labelling theory suggests that in some cases of mental health, a diagnosis can result in undesirable consequences such as social rejection. Eccentricity and unconventionality may be labelled as mental health deficits. When one is labelled, one gains embarrassment, shame and humiliation (Goffman, 1986). We feel like a 'somebody' when we are accepted and like a 'nobody' when we are not (Fuller, 2003). However the desire for control and thinness is placed above health, which can hardly be seen as normal behaviour as it is unquestionably detrimental.

The theme of celebrity power accentuates the potential of celebrities to minimise discrimination. Celebrities endorsing an unpopular view increased the acceptability of the view (Jackson and Darrow, 2005; Sukhdial, Aiken, and Kahle, 2002; Miciak and Shanklin, 1994). Where all articles assert the celebrity with immense power to the extent of causing an increase in eating disorders, this could be used to educate public and assert that there are individuals beyond the diagnoses.

Femininity arises within the analysis as a core theme. Central to femininity is the perception of women as the weaker sex (Bolin, 1992). Ideological dilemmas of patriarchal and feminist (Billig, Condor, Edwards, Gane, Middleton and Radley, 1988) are imposed on anorexia through the empowerment and strengthen to maintain the lifestyle of dieting and exercise and the disempowerment and vulnerability within lack of representation in society. One article within the analysis even asserts this dietary control as a strength (Appendix Five) which is incompatible with the societal notions of vulnerability.

Society and culture are inscribed on women's bodies. Female anorexia may be a product of these cultural meanings imposed in western societies, produced in bodily techniques such as dieting, cosmetic surgery, exercise and feminist notions of empowerment and liberation (Wesley, 2003). This body modification may be a way of resisting men's objectification on how women should look (Pitts, 1999), as the individuals objectify themselves through thinness and this is core to feminism (Dworkin, 2000; MacKinnon, 2000). However as mentioned previously it is not just women that are effected by the anorexic label (Woodside, Garfinkel, Lin, Goering, Kaplan, Goldbloom and Kennedy, 2001).

Predominantly the role of culture and embodiment dominated the analysis. Our culture is obsessed with this idea that everyone has the ability to live 'normal' lives and achieve their dreams. This is an utopian ideal. Generally the articles tended to support the medicalizing model of mental health, however societal responsibility for health was highlighted in terms of the importance of cultural discourse and practice.
and the consequences for those not conforming. This reinforces the notion that mental health cannot be understood separate from culture and society.

The implications for such negative imagery are potentially damaging, for both readers with a mental health issue and those without, as they reinforce and weaken the position of those with mental health issues, and strengthen the position of those readers without a mental health issue. This study highlighted a need for change in the way newspapers portray mental health and provides an example of the complex meaning interlinked with mental health. Exposure to thinness endorsing media appears to increase likelihood of developing an eating disorder (Harrison and Cantor, 1997). Little has been done to ease the stigmatisation (Phelan and Link, 1998).

Stereotyped attitudes are acquired at a young preschool age due to socialisation (Weiss, 1994; Wilson, Nairn, Coverdale, Franz and Panapa, 2000). Children create their understandings out of talk and representations of the world they are exposed to (Siegal, 1991). Similarly it was found that there was a consistently negative public opinion at five separate points over 22 years (Green, 1987), further studies have replicated that consistency (Brockington, Hall, Levings and Murphy, 1993). This contradicts suggestions that public opinion will develop to reduce prejudice as improved understanding of the disorders and their mechanisms are developed (McGuffin and Martin, 1999).

Unlike some of the literature presented within the report, the present study was qualitative. This was considered successful as it provided a flexible approach, imposing no predetermined bias on the research analysis allowing the themes to naturally arise. Despite relatively little experience prior to the study the researcher encountered few problems.

The researcher felt that although there was little constraints in the scope of the analysis due to the lack of specifically defined categories, the framework of analysis may have been chosen with previous biases in mind. As critical discourse analysis is centred on the misrepresented, it assumes that the sample are misrepresented prior to analysis and therefore equalities may be sought and seized upon. Although the researcher endeavoured to remain unbiased and objective. Simply acknowledging this reflexively does not give a more truthful representation of the phenomena.

There were a number of limitations. Critical discourse analysis allows for data rich analysis of oppression and the role of social practice, however it does have disadvantages. Unlike quantitative techniques the results are not generalizable to an entire population and are only relevant for the specific situation studied with the specific researcher. Discourse analysis techniques require a large amount of learning both in principles and practice as they are less thoroughly taught within the researchers' university setting. As the researcher has no psychiatric defined mental health issue it could be argued that she can not accurately represent and understand mental health issues. As there was no case study specifically followed for the study it might pose a limitation especially as a lot of previous research was quantitative.

When looking back at the research questions, they have all been answered. The
first research question asked how is anorexia presented in the media, it appears that the media presentation is negative however in a different way to other mental health issues. Further studies could provide a more in-depth study of the differing negative presentations and investigating what causes these to differ. The second question is how are the medicalizing and normalizing interconnections of culture and celebrity portrayed in the newspaper articles. It was found that some both normalize and medicalize health, this depends on whether the newspapers stance on the anorexia was more positive or negative. The third question was what discourses of anorexia are presented within the portrayals of celebrity and culture. The emerging themes represented various interconnecting discourses that are important in our culture.

All in all the study was a success and highlights how important culture and celebrities could be to combating the stigmatization. It also strengthens the previous research to which support was found.

The researcher is not outside the discourse that they describe as their own views are discursively produced. The beauty of critical discourse analysis is that my account of mental health in the media will be different from others on a basis of my own ideals and values. ‘Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, [...] then, urges us to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research’ (Nightingale and Cromby, 1999, p. 228). I, as the researcher, am an influential agent allowing my intimate values to interact with the analysis. Throughout analysis I have been amazed at the enlightening issues that have arose, I have learnt a lot and the views and embodied identity have been challenged and acknowledged. I have an enthusiastic interest in mental health and aspire to become a clinical psychologist which impels me to explore the various influences on those with mental health issues. Working with mental health patients as a voluntary nurse inspires me to help them to live as full a life as the rest of the population, and also allows me to see the effect of stigmatisation first-hand. The influence of powerful people in relation to mental health has always intrigued me, for example the size zero fad in relation to anorexia. I am also extremely motivated; striving for a highly marked project and so will ensure a more accurate and fair study. The researcher's interests in language and origin of mental health issues, as well as social construction and labelling may direct the flow of literature in the review. The researcher is a woman, and as a result may think differently. Women think differently to men (McGlone, 1980) and find traits such as empathy more important (See Gilligan, 1987), this may allow me as the researcher to respond to the stereotypes and prejudice in the media in a different manner to men. However this wouldn’t necessarily produce a better result, just results from a different perspective. My relatively young age in some respect may limit my analysis due to my lack of personal life experiences in the area, however on a more positive note, due to my lack of experiences I will not be biased by them. Individuals should not have limitations imposed on their power because they are classed by the majority within a minority category of mental health.

Despite having taken up a lot of prior reading, the analyst has little experience in working in the realms of CDA. Despite being confident of the researchers abilities this still needs to be acknowledged.
References


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