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Direct-To-Consumer Advertising: Obliged to Be Healthy

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ABSTRACT

Direct-to-consumer advertising (DTCA) of prescription drugs is a relatively recent form of marketing communication. Advocates suggest that DTCA both informs and empowers patients/consumers. But viewed from a wider sociological perspective, DTCA is premised upon and extends aspects of lifestyle choice, self-responsibility and risk assessment. As a result, DTCA promotes a medicalized view of society, where everyday aspects of life come to be defined as medical problems seeking the input of medical specialists and medical technology. The anti-obesity drug Xenical provides context for DTCA in this paper. Xenical, as an example of a 'lifestyle drug', uses the body as a focus of disciplinary power for surveillance medicine. Within a health promotion framework, individuals targeted by DTCA are obliged to govern themselves in the interests of their own health.

Direct-to-consumer advertising

The advertising of prescription drugs was once targeted solely at health care professionals through medical journals and health care trade publications. But more recently, the advertising of prescription medications has begun to bypass these traditional communication channels. Pharmaceutical companies are increasingly targeting their marketing messages directly at the patient/consumer through efforts such as direct-to-consumer advertising (DTCA). DTCA is defined here as the communication of product-specific information on prescription drugs that is targeted at end-users and designed to encourage consumers to take a more active role within the prescribing process.

Since the easing of advertising restrictions by the US Food and Drug Administration in 1997, the US has seen rapid growth in DTCA (Mintzes 2001). Spending on DTCA in the US for the year 2000 was approximately $2.5 billion (Jewesson 2002) and budgets look set to increase with DTCA predicted to be the fastest growing major advertising category, outperforming technology, fast food, and soft drink categories (Pinto 2000). Despite this rapid growth, the United States and New Zealand remain the only two developed countries that currently allow DTCA of prescription drugs (Calfee 2002).

DTCA enables pharmaceutical companies to bypass the traditional and long-standing conventions governing the doctor-patient relationship where the health care professional was seen as the possessor of 'expert knowledge' (Nettleton 1995). Surrounded in medical mystique, the role of the doctor was once seen as manager of disease, having authority to dispense medical therapies and working in the interests of what was best for the patient (Pines 1999). In contrast, the role of the patient was passive with diminished capacity for independent thinking (Henderson and Petersen 2002). But Pines (1999, p. 498) asserts that 'the mystique of the medicine chest has eroded' and in this new 'information age' patients as consumers often have access to as much information as physicians about possible health care products. This new active citizenship, where the 'patient' is the client or consumer (Henderson and Petersen 2002) implies that individuals are able to make decisions independently and use information that is available to them.

Advocates suggest that DTCA is beneficial, because patients as customers are likely to be more participative in the decisions that affect their health (Wolfe 2002). Supporters of DTCA also point to the potential for patient empowerment through health education (Berger, Kark, Rosner, Packer, & Bennett 2001).

But critics question whether DTCA really represents progress in empowering patients or if instead, it is a way for pharmaceutical companies to make additional money (Drazen 2002). While providing educational information may be one of the industry's motives, Hollon (1999) suggests that "the bottom-line desire for profit is undoubtedly another". Jenkins (1998) describes DTCA of prescription medicines as a 'wonder drug' for the pharmaceutical industry itself because of its ability to affect patient demands that in turn might affect doctors' prescribing behavior.

This paper argues that DTCA, despite being a relatively new phenomenon, is a natural consequence of what Petersen & Lupton (1996) have termed the 'new public health', where health is seen as a moral enterprise that dictates and prescribes how we should live our lives individually and collectively. Since the mid-1970s, there has been a clear ideological shift away from the notion that the state should protect the health of individuals towards the idea that health is a self-governed lifestyle choice and that individuals should take responsibility to protect themselves from risk (Petersen 1997). As will be argued, the existence and growth of DTCA is a direct and natural consequence of this same ideological shift.

Having a healthy body and having the ability to achieve good health are predominant concerns of our age with a focus on lifestyle manifested by the increased attention given to body shape, diet and exercise (Burrows, Nettleton, & Bunton 1995; Petersen & Lupton 1996). DTCA privileges a medical perspective that is inherently bound up in the political and cultural discourses related to health and lifestyle. In addition, it is an important contention of this paper that the reality of DTCA, while ostensibly offering choice for consumers under the guise of freedom, actually suggests that power rests in the hands of marketers (Rose 1990; Venkatesh, Meamber, & Firat 1997).

Lifestyle drugs

Pharmaceutical companies have identified 'lifestyle' drugs as a growth market (Lexchin 2001), and DTCA has been intricately linked with the release of a number of these highly publicized 'lifestyle' drugs over recent years. Indeed, much of the growth in DTCA parallels the growth in the lifestyle drugs market. Lifestyle drugs can be defined as products that are used for health problems that might be better treated by a change in lifestyle (Gilbert, Walley, & New 2000). Sevon & Mitrany (1999) suggest that one consistent definition of lifestyle drugs is that they improve patients' satisfaction with the quality of their lives but do little to improve medical outcomes or reduce overall health care costs. According to Gilbert et al. (2000), lifestyle drugs are intended or become used for conditions that currently lie at the socially constructed boundary between lifestyle wishes and health needs.

In 1999, nearly $325 million was spent on DTCA for just four lifestyle drugs in the US (Lexchin 2001): Propecia (finasteride) for the treatment of male pattern hair loss; Viagra (sildenafil) for the treatment of erectile dysfunction; Xenical (orlistat) for the treatment of obesity; and Zyban (bupropion) for the treatment of smoking.

DTCA has proved to be an ideal vehicle for promoting the conditions that lifestyle drugs are designed to treat because such conditions are easily understood, easily self-diagnosed and often self-evident (Lexchin 2001). Product development in the pharmaceutical industry is both difficult and expensive, and as a result, drug companies have increasingly focused on the unmet medical needs of the aging 'baby boomer' population. Age, gender and

lifestyle as risk characteristics mean that baby boomers become an ideal target because, as a population, they have easy access to medical information, are increasingly dissatisfied with the performance of healthcare systems and, most importantly, they have grown up being conditioned as consumers (MacNaught 2001). The growth in DTCA owes much to the confluence of these same factors. DTCA can be seen as an example of what Thompson and Hirschman (1995, p. 144) refer to as promotional discourses, where "the correct lifestyle and the correct application of consumer technologies offer a means to resist the forces of nature that might otherwise affect the body."

In late 1999, Americans were exposed to an average of nine television advertisements for prescription drugs a day (Mintzes 2002) and according to Mintzes (2002 p. 909), these advertisements portray "the educational message of a pill for every ill–and increasingly an ill for every pill". As a result, critics accuse the pharmaceutical industry of actively sponsoring the definition of diseases and promoting them to both prescribers and consumers: 'the social construction of illness is being replaced by the corporate construction of disease' (Moynihan, Heath, & Henry 2002, p. 886). According to Moynihan et al. (2002), informal alliances between the pharmaceutical industry, doctors and consumer groups are often created with the intent of raising the public awareness of undiagnosed and undertreated problems. But in the process, these alliances also promote the view that health problems are widespread, serious, but medically treatable. As a communication vehicle for disease awareness in itself, DTCA plays an integral part in this process. Moynihan et al. (2002) contend that health campaigns are commonly linked to companies' marketing strategies that aim to expand the market for new pharmaceutical products. Alternative approaches, such as the self-limiting or relative benign natural history of a problem, or the importance of personal coping strategies–are played down or ignored. "To tell us about a disease and then to imply that there is a high likelihood that we have it …is to gnaw away at our self-confidence" (Payer 1992, p. 6).

Medicalization

Such concerns are not new and serve to illustrate the way in which medicine operates as a powerful institutional tool for social control. This is a central thesis of the current paper, where it is alleged that DTCA is yet another means of communication that furthers the medicalization of society. The medicalization critique was one of the most dominant perspectives in the sociology of health and illness in the 1970s and it still remains a dominant approach as evidenced by recent articles within the *British Medical Journal* (for example see Mintzes 2002; Moynihan et al. 2002). Rather than improving people's health, Illich (1975) argued that contemporary scientific medicine actually undermined it, both through 'iatrogenesis' side-effects caused by doctors, and by diminishing people's capacity for autonomy in dealing with their own health care. Medicalization then, can be described as the definition of a problem in medical terms, the use of medical language to describe a problem, the adoption of a medical framework to understand a problem, or using a medical intervention to 'treat' such a problem (Conrad 1992). It should be clear that DTCA promotes the medicalization of society on all four counts. Within Western society a medicalized view that privileges medical technology and intervention benefits the pharmaceutical industry as a whole, but other beneficiaries include insurance agents and the media, as well as health professionals such as physicians, psychologists, psychiatrists, and therapists. As consumers, we are constantly urged to conduct our private lives in order to avoid potential disease or early death. DTCA encourages us to take stock of our lives, to question our appearance and the way we function, and to make certain choices in terms of the way we choose to live.

The pharmaceutical industry and other advocates of DTCA propose that through DTCA, people become more informed about medical matters, and that the information provided enables greater freedom of choice and consumer empowerment through health education. Ironically, critics of medicalization also emphasise freedom of choice and consumer empowerment through health education, where patients as consumers are urged to take control of their health and to challenge the decisions and knowledge of health professionals. But encouraging individuals to be more active in acquiring medical knowledge and urging participation in preventative health activities, actually adds to the medicalization process. Paradoxically, making people more aware moves medical and health concerns even more into our everyday lives and we become even more dependent on contemporary scientific medicine (Lupton 1997).

An example of DTCA: Xenical as a medical solution for obesity.

For many obese people, the launch of Xenical (orlistat) by Hoffman-La Roche/Roche Pharmaceuticals was seen as a 'magic bullet' for the treatment of obesity. As an anti-obesity drug, Xenical inhibits the action of pancreatic lipase thereby reducing fat absorption (Ballinger & Peikin 2002). Hoffman-La Roche spent over $75 million promoting Xenical to consumers in the United States (Lexchin 2001) where the DTCA campaign began in 1999. In New Zealand, the DTCA campaign began in 1998 and was one of the first DTCA campaigns for a prescription drug to be launched in the country.

The decision to use DTCA for Xenical in New Zealand was based upon research suggesting that patients/consumers were unlikely to discuss weight loss with their doctor and that doctors were reluctant to initiate treatment for potential patients (Purdom 2002). From the pharmaceutical industry's perspective then, DTCA for Xenical was justified and fits within the definition provided at the beginning of this paper: to inform potential consumers of the health risks associated with being obese/overweight, and encourage discussion with a doctor. Ryan & Carryer (2000 p. 34) suggest that the DTCA campaign for Xenical in New Zealand was also "designed to link both social and health outcomes to body size by depicting large-bodied people as unhappy, socially maladjusted and in need of assistance." DTCA for Xenical positioned obesity as a medical and social problem for which Xenical was offered as a medical solution.

The timing of the worldwide launch for Xenical was ideally suited to the growing concern among the medical and health professions of the increasing prevalence of obesity/overweight worldwide. In the *British Medical Journal*, an article headed "Fat is a medical issue" (Ferriman 1999) reported that The Royal College of Physicians favored using drugs to combat obesity in certain circumstances. Ferriman (1999) cites a report by the College (Royal College Of Physicians of London 1999) on the increasing prevalence of obesity as a "serious medical issue rather than a perversity of current fashion." This same report maintains that the rise in prevalence is due primarily to environmental and lifestyle factors (Ferriman 1999).

Within the last few years, medical journals (along with the media in general) have been proclaiming obesity as a chronic disorder and an increasingly serious health problem worldwide (Noel & Pugh 2002) that has reached epidemic proportions globally (*The Asia-Pacific perspective: Redefining obesity and its treatment* 2000). Manson & Bassuk (2003) report that obesity has become pandemic in the United States, where currently 2 in 3 US adults are

classified as overweight or obese. Obesity is a risk factor for a vast (and expensive) range of illnesses/diseases including hypertension, diabetes, degenerative arthritis and myocardial infarction (Jeffcoate 1998). Indeed, Jeffcoate (1998, p. 903) states that "obesity should be regarded as a disease" in its own right. To this end, various health professions within the medical community have successfully negotiated a disease designation for obesity that is listed in the *International Classifications of Diseases* (ICD-9-CM 1990) (Sobal 1995).

The perception that one is overweight is a highly aversive state, particularly for women (DeJong & Kleck 1986). Consumer culture promotes slimness, and slimness has become associated with health. Askegaard, Jensen, & Holt (1999, p. 331) suggest that modern societies are 'lipophobic' (scared of fat) and that the slogan "'Fat is bad' has become one of the most widespread and commonly recognized dogmas of our daily consumer lives in the course of the 20th century." Health promotion messages warning of the health risks associated with being obese/overweight have become absorbed into our conventional wisdom (Featherstone 1991), and the DTCA campaign for Xenical was based upon these same discourses.

Xenical (along with Viagra) has been labeled a lifestyle drug in the popular imagination (Gilbert et al. 2000). Importantly, the use of the label 'lifestyle drug' is not meant to trivialize the serious medical conditions that are associated with obesity (Gilbert et al. 2000). Instead, the term lifestyle drug is meant to convey the idea that such a drug could be regarded as an issue of personal choice rather than illness. DTCA for Xenical illustrates the arguments that are central to this paper, namely that DTCA is built on the premise that the individual is responsible for protecting herself/himself from risk and that individuals should make appropriate lifestyle choices as a result.

Obesity can be described in terms of biological phenomena (for example as genetic deviance or endocrinological disturbance), but importantly, to medicalize obesity, fatness has had to be designated and officially recognized as a disease (Sobal 1995). As already discussed, various health professions within the medical community have successfully negotiated a disease designation for obesity. Disease status adds legitimacy to DTCA of drugs (such as Xenical) purporting to treat obesity. DTCA for Xenical promotes a medical solution to the medical problem of obesity. Importantly, competing medical perspectives are ignored. For example, as Lewis (1997) asks, should obesity be treated at all? Some researchers believe that the direct medical risks associated with obesity have been overstated (Ernsberger & Koletsky 1999); and Miller (1999), suggests that we need to question the notion that thinness necessarily equals health and fitness.

The example of DTCA for Xenical provides a useful introduction to sociological perspectives that relate to studies of the body, medical sociology, the socially constructed nature of disease and the role of medicine in regulating individuals through the regulation of their bodies. Discussion now turns to the way in which DTCA is premised on discourses of risk and the responsibility of one's health, medicine as a new religion, and the body as a focus of disciplinary power. In conclusion, it is argued that DTCA is primarily a communication vehicle for shaping people's behaviour.

Risk and self-responsibility for health

A number of authors (Beck 1992; Giddens 1990) have suggested that we live in a society characterized by the 'politics of anxiety' (Turner 1991). This anxiety relates to the concept of risk–now a common theme in news media headlines and increasingly the subject of health promotion campaigns (Lupton 1999), and as argued here, a prevalent theme within DTCA campaigns. Beck and Giddens suggest that the risks of modern-day living are products of social organization and decision-making. Armstrong (1993) contrasts the health risks of today against the health risks of the nineteenth century, suggesting that the environmental factors that impact on present day health are a consequence of human actions. As a result, Armstrong (1993) argues that we now live under a new form of governance, one that is outside the walls of the hospital and beyond the doctor/patient relationship. This new form of governance includes a whole range of agencies dispersed throughout society that require the individual to extend his/her concerns 'with body boundaries' and 'individual psychology' to 'lifestyle' more generally (Armstrong 1993). Bunton & Burrows (1995) describe the contemporary citizen as someone who is increasingly faced with the responsibility of maintaining and improving her/his own health via the recommendations of 'experts' and 'advisors' from a diverse range of institutional and cultural sites, and DTCA can be seen as one further means of communicating this form of governance.

These changes have meant a transformation in health care, described by Nettleton (1995) as a new paradigm. The focus is no longer on 'dangerousness' but instead 'risk' (Castel 1991). According to Castel (1991), health professionals once erred on the side of caution to prevent any manifestation of disease and patients deemed ill were treated as potentially 'dangerous'. But there has been a shift away from the *symptoms* of individuals to their aggregated *characteristics* (age, weight, social class, gender, lifestyles and so on). The new targets for medical care are risk factors that are in turn reflected within the discourses of health promotion and prevention and as argued here, these same discourses underlie DTCA, as evidenced by the campaign for Xenical already described.

Medical sociologists propose the term 'healthism' as the idea that one's health is the enterprise of oneself (Greco 1993, p. 357). Healthism suggests that the individual has a choice in preserving his or her physical capacity from the event of disease (Petersen 1997). Increasingly, we are living in a healthist society that is associated with commercialization, commodification and consumption of health and healthy lifestyles (Nettleton 1995), and the failure of the individual to regulate his/her lifestyle and modify her/his risky behavior becomes, at least in part, "a failure of the self to take care of itself" (Greco 1993, p. 361). A woman is able to communicate to those in power that she is managing herself when she is able to gain control over her body and shrink in size (Sault 1994). To have a healthy body is "the mark of distinction that differentiates those who deserve to succeed from those who will fail" (Crawford 1994, p. 1354). Importantly, the terms 'healthy' and 'unhealthy' are now synonymous with being normal and abnormal. Individuals whose behavior is at variance with the pursuit of a 'risk-free' existence are likely to be seen, and to see themselves, as lacking self-control, and "not fulfilling their duties as fully autonomous, responsible citizens" (Petersen 1997). Provocatively, Skrabanek (1994, p.17) likens the concept of healthism to religion:

> Healthism is a powerful ideology, since in secular societies, it fills the vacuum left by religion. As an ersatz religion it has wide appeal, especially among the middle classes who have lost their links with traditional culture and feel increasingly insecure in a rapidly changing world. Healthism is embraced eagerly as a path to surrogate salvation. If death is to be the final full stop, perhaps the inevitable can be indefinitely postponed. Since disease may lead to death, disease itself must be prevented by propitiatory rituals. The righteous will be saved and the wicked shall die.

Medicine as a new religion

Although provocative, the comparison made by Skrabanek (1994) between healthism and religion should not be so surprising. Many writers have acknowledged the trend for religion to give way to science, where the scientist has taken over the role of priest and where a process of secularization has become a feature of modern western society (Fitzpatrick 2001). As cited by Belk, Wallendorf, & Sherry (1989, p. 12), Miner (1956) "pointed out that contemporary body care rituals regard the bathroom as a shrine, the medicine cabinet as a treasure chest of magical potions, and doctors and pharmacists as priests."

In the early 1970s, the American sociologist Irving Zola (1972, p. 487) argued that medicine was becoming a major institution of social control, 'nudging aside, if not incorporating, the more traditional institutions of religion and law' (see also Freidson 1970). Echoing Zola's sentiment, Lupton (1999) goes even further and contends that medicine and public health have replaced religion as the central institutions governing the conduct of human bodies. Turner (1992) suggests that the growing importance of preventative medicine and the concept of lifestyle as a form of social self-control means that in areas of family life, the local GP has replaced, at least in functional terms, the confessor and the priest. Diet and lifestyle choices, according to Lupton (1999), can be seen as viable alternatives to prayer and righteous living and provide a means of making sense of life and death where 'healthiness' has replaced 'Godliness' as the yardstick of what can be considered right. As the surveillance of the village and church has declined, the individual has been increasingly expected to scrutinize him/herself, and "self-policing becomes an expected behavioral practice" (Crawford 1994, p. 1359). The increased emphasis on the aesthetic quality of the body in relation to consumerism promotes virtues such as thinness and self-regulation in the interests of looking good (Turner 1992), and the DTCA campaign for Xenical becomes an example of this process.

Even though people in Western society live longer and healthier lives than ever before, we are increasingly preoccupied by our health. As evidenced by the increased prevalence of obesity, our modern Western diet and lifestyle are seen as being distinctly unhealthy and as major contributors to the contemporary epidemics of cancer, heart disease and strokes. The DTCA campaign for Xenical illustrates the manner in which the *body* can be used as a site of control for individual conduct (Joy & Venkatesh 1994), and where the body has become a focus for disciplinary power. As suggested by Meamber & Venkatesh (1999, p. 190) "It is through the use of the body as a symbol that societies come to create the mechanisms which control."

The body as focus for disciplinary power: surveillance medicine

Of particular relevance within the present research context is the work of Foucault (1926-84). Foucault's work has become widely used and quoted within sociological analyses of health care (Symonds 1998). The body was of major significance in Foucault's work, and his unique perspective on the body as a focus for disciplinary power and control served to recast thinking about the nature of the body and about the operations of power in modern societies (Turner 1997).

Foucault was interested in the forms of governance involved in the investigation and regulation of the body of the individual and bodies of populations (Nettleton & Bunton 1995). Foucault described a system of control and surveillance which emanated from Jeremy Bentham's notion of the Panopticon, a system which involved maximum supervision with minimum effort (Armstrong 1983; Foucault 1980), (for a description of the Panopticon concept, see Thompson & Hirschman 1995). The analogy of the Panopticon is useful in describing how people come to govern themselves through regulatory processes. Governance in this sense relates to disciplinary power that is manifested through a relationship of observations, where individuals, knowing they are under surveillance, transform their actions and their identities (Armstrong 1987). The Panopticon's potential for surveillance nurtures self-discipline by causing individuals to 'gaze upon themselves' (Eckermann 1997).

Within medicine, epidemiology, statistical techniques for aggregating social data, clinical medicine and the application of science to the social sphere means that bodies can be transformed into 'objects' where 'self-surveillance emerges as a practice of control' (Eckermann 1997, p.157). Armstrong (1987, p. 70) discusses the parallels between medical and Panoptic power: "The prisoner in the Panopticon and the patient at the end of the stethoscope both remain silent as the techniques of surveillance sweep over them."

Medical power is a particular form of influence that is closely associated with perspectives of the body, especially in terms of the discipline of the body and body control. Medicine (along with law and religion) was described by Foucault as being an institution of normative coercion (see Turner 1992) because of its ability to discipline individuals and exercise forms of surveillance over everyday life so that actions are both produced and constrained (Turner 1997). Medicine as an institution does not need to be coercive in a violent or authoritarian sense because the institution of medicine is accepted as legitimate and normative at the everyday level, where it exercises a moral authority over the individual by explaining individual 'problems' and providing solutions for them (Turner 1997). As a communication vehicle for the institution of medicine, DTCA operates within this same moral discourse, where individual medical problems are portrayed as having medical solutions.

DTCA: obliged to be healthy

DTCA, under the rubric of public health and promotion, is a vehicle for shaping people's behavior. Minimal justification is needed for such efforts because they are in the interests of our health. Rather than being subjected to overt punishments for being obese/overweight, we tend to largely self-police ourselves. Individuals not conforming to 'health messages' expose themselves to the mechanisms of self-surveillance, evoking feelings of guilt, anxiety and repulsion towards the self, as well as the admonitions of those close to them for 'letting themselves go' or inviting illness (Lupton 1999; Thompson & Hirschman 1995). Self-scrutiny is a constituent of modern, individual autonomy and freedom where self-policing is an expected behavioral practice (Crawford 1994). Nikolas Rose (1990) usefully articulated the conceptualization of 'the self', which in turn, he argues, is inseparable from modern forms of 'government'. According to Rose (1990), consumption requires individuals to make a choice from a number of products in response to a repertoire of wants that are shaped and legitimated by advertising and promotion, but which must be experienced and justified as personal desires. Every aspect of life, according to Rose, is like every commodity, "imbued with a self-referential meaning; every choice we make is an emblem of our identity, a mark of our individuality, each is a message to ourselves and others as to the sort of person we are, each casts a glow back, illuminating the self of he or she who consumes" (Rose 1990, p. 227).

For Rose, the self is not just enabled to choose, but *obliged* to construe a life in terms of the choices, powers, and values available:

"Individuals are expected to construe the course of their life as the outcome of such choices, and to account for their lives in terms of the reasons for those choices" (Rose 1990, p. 227). Importantly then, this paper has argued that DTCA should not be seen as a practice that overtly seeks to constrain individuals' freedom of action, but rather DTCA invites individuals *voluntarily* to conform to their own objectives, to discipline themselves, to turn the gaze upon themselves in the interests of their health. In doing so, DTCA offers medical solutions for medical problems and in return, we as consumers are obliged to choose from a repertoire of solutions according to our lifestyle needs and wishes.

Future Research

Within this paper, DTCA discussion is focused at the macro-level, where it is argued that DTCA contributes to the medicalization of health and lifestyle choice. Future research will analyze DTCA at the micro-level by deconstructing a series of three advertisements used for the promotion of Xenical to potential consumers. While the construction of message content within advertisements must be seen within the wider context of the cultural, political and historical perspectives from which it originates, a micro-level analysis of DTCA for Xenical will examine advertising meaning from three perspectives. Based upon interviews with the advertising agency/ marketing manager of the campaign, advertising meanings will be analyzed from the perspective of the 'producer/author'; advertising meanings will also be analyzed from the perspective of the 'consumer/receiver', based upon interviews with people who perceive themselves to be overweight/obese; and finally, advertising meanings will be examined from an 'analyst/ interpreters' perspective through a process of advertising deconstruction and discourse analysis.

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