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Multimodality: Examining Visual Representations of Dementia in Public Health Discourse

Gavin Brookes, Emma Putland, and Kevin Harvey

1 Introduction

The approaches to discourse introduced so far in this book are all best suited to the analysis of language and therefore to texts that contain just, or primarily, this mode of communication. This monomodal perspective has undoubtedly proved fruitful for analyses of texts in which language is the primary (or only) communicative mode, such as patient records and transcripts of healthcare interactions. However, most genres of contemporary communication, including websites, print media, advertising and public health information, convey health-related discourses (i.e. attitudes, ideas, assumptions and values to do with health) in decidedly

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G. Brookes (✉)
Department of Linguistics and English Language, Lancaster University, Lancaster, UK
e-mail: g.j.brookes@lancaster.ac.uk

E. Putland • K. Harvey
School of English, University of Nottingham, Nottingham, UK
e-mail: emma.putland@nottingham.ac.uk; kevin.harvey@nottingham.ac.uk

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multimodal ways. That is to say, such texts often make use of not just language but a combination of semiotic resources which include (but are not limited to) visual images, fonts, layouts, colours, sounds, gestures and even textures (Machin and van Leeuwen 2007). In this chapter, we introduce multimodality as a range of perspectives on discourse analysis which are all broadly concerned with studying the ways in which these and other semiotic resources work together to create meaning within texts (Kress 2010). We will argue that analyses of health-related discourse stand to benefit from interrogating such multi-semiotic forms of communication since, as well as being highly pervasive, they are able to subtly naturalise and reproduce certain versions of reality and thus ‘provide us with views of how things should be’ (Harrison 2002: 857).

Doing sufficient justice to the range of approaches within multimodality is no easy task, and any introduction to multimodality will almost inevitably be shaped by the author(s)’ particular approach of choice, as well as the guiding principles that underpin it. It is thus advisable to make these explicit from the outset (Bezemer and Jewitt 2018). The case study at the heart of this chapter will provide a worked demonstration of one approach to multimodality in particular—that is, multimodal critical discourse analysis (Kress and van Leeuwen 2001, 2006; Machin 2013; Machin and Mayr 2012). The critical multimodal approach we introduce in this chapter is consistent with our previous work in this area, which draws upon the approaches set out by other critical multimodal discourse analysts, including Bob Hodge, Gunther Kress, Theo van Leeuwen and David Machin, and is underpinned by a social semiotic theory of communication (introduced below). We direct readers to the edited volume by Jewitt (2014) for a more comprehensive overview of approaches in multimodality and to Galasiński and Ziółkowska (this volume) for a summary of critical discourse studies more generally.

We begin this chapter by outlining the social semiotic theory of communication which is central to our own and much contemporary multimodal discourse research. We then review existing applications of multimodal approaches to discourse in the domain of health(care) communication. Following this, we report a case study in which we carry out a multimodal critical discourse analysis of a series of texts produced as part of a recent UK public health campaign surrounding the topic of dementia. In reporting this case study, we not only provide a practical introduction to multimodal critical discourse analysis but also set out to show how such an approach can enhance the analysis of visual health communication by providing predictable and adaptable tools for describing and critically examining texts beyond the linguistic level. Finally, following the case study, we conclude this chapter by reflecting on the contribution of multimodality to health communication research, outlining its strengths and limitations, and by considering how multimodal approaches might be not only applied but also developed in the area of health communication research in the future.

2 Social Semiotics, Multimodality and Health Communication

A social semiotic view of communication is concerned with the ways in which language and other communicative modes are used in social contexts and to create and shape identities and social relationships within society. Researchers adopting this perspective will typically begin by describing the choices of signs that are available to a text's producer(s). The choices evident in the design of a given text, including both its linguistic and non-linguistic components, are then interpreted as motivated; that is, as having been made to suit the text producers' interests. In viewing semiotic choices this way, a key assumption underlying social semiotics is that individuals are aware of the meaning potentials, or 'affordances', of the particular words and other semiotic resources they make use of in their communication. This assumption is influenced in particular by the work of Michael Halliday (1978), and later Kress (1993), who argued all choices by language users to be ideologically significant. As Machin and Mayr (2012: 17) put it, text producers 'will be aware that certain words can carry particular potentials […] as can certain visual elements and features[.] […] They will be aware that different modes of communication offer different kinds of affordances or different means for communicating meanings[.] […] [T]hey will have a sense of the way that an image can communicate something about […] broader ideas' (ibid.). Halliday's influence over the social semiotic theory of communication is also evident in the assumption that text producers understand that all communicative processes are to an extent rule-based. Like language, modes such as image, font, colour and so on are interpreted as functioning and creating meaning within a rule-based system or *grammar* (Kress and van Leeuwen 2006).

Analysts adopting a social semiotic approach are therefore interested in documenting the selection of signs from an underlying repertoire of available choices and interpreting their use in terms of the discourses they convey in context. These discourses are viewed as not just representing people, places and things in the world but, crucially, as having the power to constitute those phenomena. As Machin and Mayr (2012: 19) phrase it, '[i]n a social semiotic view of visual communication, […] choices of visual elements and features do not just represent the world, but constitute it'. Like language, visual communication plays its part in shaping and maintaining society's ideologies and can also serve to create, maintain and legitimise certain kinds of social practices. Social semiotic studies of multimodal health(care) texts are therefore concerned with the choices that text creators make, which are then interpreted as working in combination to create meaning and to circulate, elaborate or challenge health-related discourses in accordance with the text creators' motivations, interests and ideological standpoints.

As we noted at the beginning of this chapter, the majority of discourse-based studies of health communication have adopted decidedly monomodal perspectives on the texts they analyse, focusing on how such texts create and convey health-related meanings through language, often at the expense of other modes. In one respect, this reflects a general bias towards studying language in discourse research more widely. Yet at the same time, it is also likely to result from the fact that the majority of health communication studies are based on data that are either monomodal, employing just language, or at least primarily linguistic in their design, including (but not limited to) transcripts of interactions, patient records, research interviews, emails to providers, online support groups, written patient feedback and suicide notes. In recent years, a small but growing body of health communication research has begun to buck this monomodal trend by incorporating multimodal perspectives into their analyses. We can divide this literature according to its focus on either written, computer-mediated or, more recently, spoken communication. The remainder of this section will present a brief overview of multimodal studies of health discourse concerned with each of these registers. This review is not intended to be exhaustive but rather aims to give a flavour of the range of themes and domains that have been addressed within this emerging body of work.

Most multimodal studies of health communication are based on written texts in which visual modes like image, font and layout loom large, such as health product advertisements and public health campaign documents. In an early study of this kind, Koteyko and Nerlich (2007) analysed the multimodal discourse of online probiotic advertising, with the analysis showing how corporations seek to add values such as ‘health’ and ‘naturalness’ to their products in order to distinguish themselves from their competitors. Adopting a similar approach, Brookes and Harvey (2015) studied the relationship between multimodal scare tactics and commercial strategies in a UK-based diabetes public awareness campaign. This analysis showed how the campaign designers combined linguistic and photographic choices to warn about the dangers of diabetes and to advocate personal responsibility for diabetes risk, employing what was interpreted as a range of fear-inducing, stigmatising and commercial strategies to this end. Investigating a similar topic, Mulderrig (2018) used multimodal critical discourse analysis to examine emotional manipulation and ‘nudge tactics’ in social marketing produced as part of a UK government public health campaign targeting childhood obesity. Her analysis identified three intersecting strategies that were realised multimodally: ‘the representation of (northern, working class) lifestyles as delinquent’, ‘a discourse of risk and threat mobilised through emotional manipulation’ and ‘a discourse of “smarter” consumerism’ (p. 39). Brookes et al. (2016) adopted a multimodal critical discourse approach to compare discourses of baby-feeding in public health texts about bottle- and breastfeeding. Comparing two parallel texts from a recent *Start4life* campaign (one dedicated to breastfeeding, the other to formula feeding), this analysis demonstrated how the campaign employed a series of recurring, multi-semiotic strategies through which breastfeeding was promoted as nutritious, natural and morally responsible, while conversely formula feeding was framed as unnatural, nutritionally deficient and morally irresponsible. In a study relevant to the case study reported in this chapter, Brookes et al. (2018) used a multimodal critical discourse approach to explore the linguistic and visual representation of dementia and people with dementia in a small sample of recent UK press articles. Amongst other things, this study showed how dementia was linguistically and visually portrayed as a 'killer' and something that causes social death.

Much like written texts, multimodal studies of computer-mediated texts tend to focus on texts that make heavy use of visual elements—particularly websites and social media. Thompson (2012), for example, adopted a multimodal critical discourse approach to study visually personalising and responsibilising discourses in an online mental health community website. Brookes and Harvey (2016a) similarly studied personalising visual discourses in their multimodal analysis of an adolescent health advice website. Harvey (2013) adopted multimodal critical discourse analysis to critique the linguistic and visual medicalisation of male baldness in online pharmaceutical advertisements for hair loss 'remedies'. His analysis identified four multimodal discursive strategies through which the websites depicted male hair loss and the treatment on offer, specifically: representing the balding man as type and outcast, promoting the attractiveness and self-assurance of the hirsute man, situating male hair loss within a scientific discourse, and encouraging consumers to self-evaluate their risk of hair loss. In a critical multimodal study of diabetes pages on Facebook, Hunt (2015) explored the ways in which visual and linguistic markers of social intimacy were used by page owners to simulate personal relationships with their followers and to foster followers' personal investment in the organisation. The visual promise of 'living well' with diabetes offered on such pages is argued to serve the agendas of the organisations, whose revenue depends upon sustaining users' engagement as consumers and fundraisers. Another study exploring the interface of health and commerce online was carried out by Brookes and Harvey (2016b), who analysed multimodal discourses of commercialisation and privatisation in the website of a UK healthcare provider. This study showed how the use of language and image in this text conspired to frame health and social care matters within a corporate and neoliberal set of ideas, values, identities and social relations which positioned patients as consumers.

Multimodal studies of written and online health texts have thus tended to focus, in addition to language, on modes such as images, photographs, layouts, fonts and colours, which act as significant carriers of meaning in these contexts. By contrast, a small but growing number of studies of face-to-face healthcare interactions, for example between patients and healthcare professionals, has focused on other modes, including gesture, eye gaze and other forms of embodied conduct. A good example of this is the recent research carried out by Bezemer and colleagues on the multimodal dynamics of education and practice in surgical and operation settings. For example, Bezemer et al. (2011) examined how healthcare staff use gestures to communicate with one another during operations. Their discussion also draws attention to the absence of such situated meanings in medical training. Similarly, Hindmarsh and Pilnick (2002) studied the use of paralinguistic communication, including embodied conduct, by anaesthetists working in ad hoc surgical teams, while Korkiakangas et al. (2014) explored how bodily orientation and gaze feature in the transferral of surgical instruments between practitioners. Also in the context of operating theatres, a recent study by Weldon et al. (2015) examined the impact of music played during operations on the communication between the healthcare practitioners involved. Their analysis demonstrated a potentially inhibiting effect, whereby music played in the operating theatre could interfere with team communication, including leading to members becoming inaudible or being misheard by others.

Although far from comprehensive, even this brief review attests to the increasing take-up of multimodal discourse approaches amongst linguists and other social scientists with an interest in health communication. The case study of dementia public health materials presented in the next section aims not only to provide a worked demonstration of what a (critical) multimodal discourse analysis looks like, but also to add to the growing body of multimodal health discourse research by providing insights into a topical but still under-researched public health issue.

3 Multimodal Discourses of Dementia in a Public Health Campaign

Dementia is a syndrome that encapsulates a range of diseases which cause cognitive impairment symptoms, including problems with memory, reasoning, perception, and communication (World Health Organization [WHO] 2017). The most prevalent type of dementia is Alzheimer's disease, but other types include vascular dementia, dementia with Lewy bodies and frontotemporal dementia. People experiencing each type of dementia are likely to present with different symptoms, while experiences of any single type of dementia are likely to be unique to the individual affected by it. Put another way, the experiences of one person living with Alzheimer's disease are distinct from those of another person living with the same disease (Clare 2003). As a progressive syndrome, the symptoms of dementia are likely to worsen over time.

Dementia is widely perceived to be one of the biggest public health challenges facing the world today. Worldwide, 47.5 million people are estimated to be living with the syndrome, with 7.7 million new cases each year (WHO 2017). Based on these figures, the total number of people living with dementia is projected to rise to 75.6 million by 2030. In 2016, the British Office of National Statistics (ONS 2016) published a report which claimed that dementia had now replaced cancer and heart disease as the leading cause of death in England and Wales, accounting for over 11 per cent of all deaths registered in 2015. At present, there is no pharmacological cure for dementia, meaning that people who have been diagnosed with the syndrome will still have it when they die. With no cure in immediate sight, there is a pressing need for research which focuses on people's lived experiences and understandings of dementia in the here and now (Lock 2013). This includes studying how the syndrome is constituted through discourse, including through both linguistic and non-linguistic means, in prominent public texts such as awareness-raising campaigns. This is the ambition of this case study.

3.1 Data and Approach

Our critical multimodal discourse analysis is based on a set of three parallel images produced as part of a recent awareness-raising campaign run by the UK charity, *Alzheimer's Society*, in conjunction with the National Health Service (NHS). These images are shown in Figs. 10.1–10.3.

Our analysis of these images is chiefly concerned with two related areas of multimodal representation: (1) dementia and (2) the person living with/at risk of dementia. We explore these areas of representation through close examination of the lexical and visual choices which constitute them. In terms of lexical choices, we are interested in the words that are used to denote dementia and people living with the syndrome, as well as the attributes and processes that are assigned to either. Regarding visual choices, we consider how these representations are further accomplished through choices relating quite directly to the depiction of the represented participants who are offered to us as people either with or at risk of dementia. Specifically, we consider the use of poses, facial expressions, eye gaze and angle of interaction, as well as choices pertaining to other textual aspects, such as the use of font, colour and layout.

3.2 Analysis

Although the three posters display different individuals and scenarios, it is immediately obvious that they form a collective campaign, since repeated semiotic choices relating to colour, formatting, text and participant positioning provide a consistent scheme to viewers. It is such choices that are of particular interest to this analysis, since they reflect deliberate and recurring discursive representations for the campaign. These are discussed in relation to three main themes that we have identified: firstly, that dementia is synonymous with memory loss and regarded in terms of disaster; secondly, that cognition (including memory) is the defining feature of human identity (Post 2000; Van Gorp and Vercruysse 2012) and so dementia entails a loss of the self; and thirdly, that people with dementia are socially distanced and disregarded, with other people being made responsible for their care and well-being.

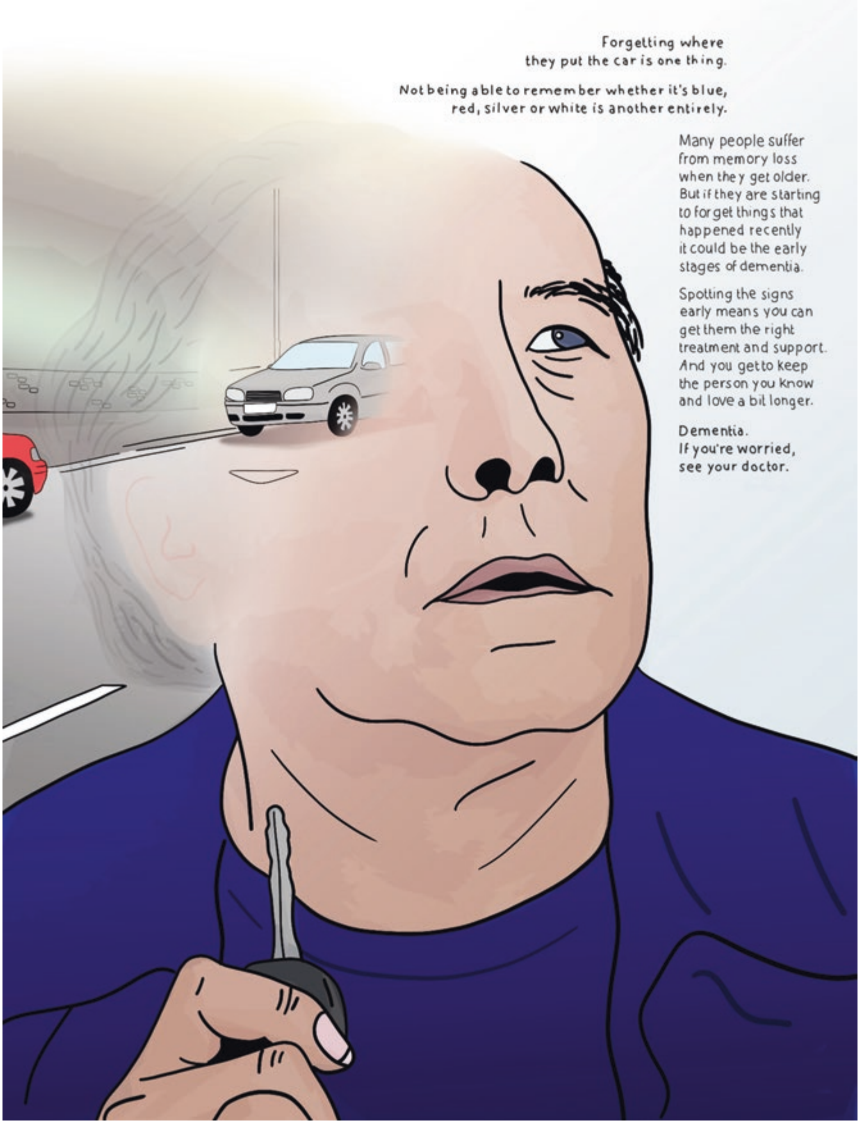

Fig. 10.1 Campaign image of a man with dementia holding a car key

Adding the bubble bath is easy to forget.

Not remembering they ran the bath in the first place could be a sign of something more serious.

Many people suffer from memory loss when they get older. But if they are starting to forget things that happened recently it could be the early stages of dementia.

Spotting the signs early means you can get them the right treatment and support. And you get to keep the person you know and love a bit longer.

Dementia.
If you're worried, see your doctor.

Fig. 10.2 Campaign image of a woman with dementia holding a toothbrush

How far do you let someone's memory loss go before you say something?

When they forget a birthday, leave the front door open, or nearly burn the house down?

Many people suffer from memory loss when they get older. But if they are starting to forget things that happened recently it could be the early stages of dementia.

Spotting the signs early means you can get them the right treatment and support. And you get to keep the person you know and love a bit longer.

Dementia.
If you're worried, see your doctor.

Fig. 10.3 Campaign image of a man with dementia holding toast

Dementia as Memory Loss and Disaster

Immediately drawing the viewer's eye to each poster is the represented participant, who is offered as an example of a person who either has dementia or is perceived to be at risk of it. Each participant is arguably the most salient aspect of their respective campaign image; they are situated in the centre of the image, take up the majority of the frame and are shown in sharp focus, contrasted against the blurry background (Kress and van Leeuwen 2006). Each figure holds a prop representing an everyday item associated with a scene set in an ordinary context (namely car keys, a toothbrush and toast, set against the background of a road, bathroom and kitchen, respectively). These objects and the overlaying of the scenes and participants (which blurs the distinction between them) explicitly ties the people to their scenario, providing a visual contrast to the individuals' gaze and facial expressions, which position them as mentally removed from their situation. These participants appear to be caught in an act of forgetting, something linguistically confirmed by the opening sentences of the accompanying text, which present an increasingly 'serious' narrative of forgetfulness and memory loss. For instance, Fig. 10.2 states (our emphasis):

> Adding the bubble bath
> is easy to **forget**.
> **Not remembering** they ran
> the bath in the first place could be
> a **sign** of something **more serious**.

A clear progression is established here from normal (evaluated as 'easy to forget' things) to pathological ('more serious') memory loss. As the posters' following paragraphs reveal, this 'something more serious' is (the early stages of) dementia. Being widely recognised as 'an almost universal early symptom of dementia' (Burns and Zaudig 2002: 1963), memory loss is an important sign to highlight. However, it is the *only* symptom displayed across these posters.

Such foregrounding of memory reflects and perpetuates the 'obsession' of the contemporary 'hypercognitive' Western culture with memory and memory loss (Basting 2009: 24; Post 2000). Indeed, the importance of 'memory and its partner, forgetting' (Basting 2009: 20) to the campaign is indicated by the consistent repetition of 'forget(ting)', 'not remembering' and 'memory loss' throughout the three posters (with 6, 2 and 4 repetitions respectively). This pathologisation of memory loss overlooks that, actually, a 'certain amount of forgetting is a necessary and positive feature of our humanity', since it prevents us 'getting hopelessly lost in the details of life' (Basting 2009: 19). Equally, presenting dementia only in terms of memory loss grossly oversimplifies the reality that there are many ways of experiencing dementia, with each subtype presenting a variety of potential manifestations, including difficulty concentrating, hallucinations, personality changes and communicative difficulties (Dening and Babu Sandilyan 2015; NHS 2017). In these campaigns, as in much of popular culture, a crude formula is suggested, that dementia = memory loss.

This is not to say that all forms of forgetting broached in the adverts are equated with dementia. In fact, the campaign explicitly constructs a distinction between memory loss that is normal and memory loss that is not. Mitigation of the suggestion that 'memory loss = dementia' is provided in two key forms beside that of the contrast between normal and abnormal scenarios discussed above. Firstly, the conditional verb 'could' positions dementia as a possible rather than certain outcome of forgetting, and secondly, each poster's third paragraph begins by acknowledging that 'Many people suffer from memory loss when they get older', only suggesting dementia as a cause following the contrastive conjunction 'but', which again establishes a divide between normal and abnormal memory loss. The latter mitigation is especially interesting since, especially when coupled with the use of older adults as models, it reflects and reproduces ageist discourses which assume that memory loss (and dementia) only occurs in older adults. Again, however, this is not in fact the case. For instance, young onset dementia (also known as working age dementia) tends to affect people aged between 30 and 65 (YoungDementiaUK 2019). Foregrounding later life arguably ignores the fact that people across the age spectrum can experience memory loss and dementia, and pathologises the declining memory of older adults above all other age groups.

Accompanying this association between ageing, memory and dementia is a fear-inducing emphasis on the suffering associated with dementia and memory loss. This is common across biomedical and ageist discourses, in which ageing is held as a source of illness, suffering, loss and degeneration. The lexical choice of 'suffer' in these posters exemplifies this foregrounding of the frightening aspects of memory loss—associations of 'suffer' include pain, anger, upset, distress and hurt—rather than providing a more balanced picture. Fundamentally, memory loss need not always be a source of suffering; people living with dementia can and do lead meaningful and fulfilled lives. Dementia is not wholly an experience of suffering—people can live well with dementia, as subsequent campaigns, including by the same organisations, have tried to promote (e.g. see the *Alzheimer's Society* and *Public Health England*'s 'Dementia Friends' campaign). Yet, as will materialise throughout this analysis, these representations of people with dementia seemingly fail to acknowledge the possibility of living well with, or beyond, dementia (see Swaffer 2016a).

The implication of these posters is instead that dementia is accompanied by, even characterisable as, increasing disaster. Notably, Fig. 10.3 offers a tripartite list of memory loss consequences, each more serious than the last: 'forget a birthday', 'leave the front door open', 'or nearly burn the house down'. Here, an individual's forgetfulness progresses from the everyday (potentially causing emotional hurt or upset for the person whose birthday has been forgotten) to a more serious consequence that leaves the individual's home vulnerable to criminal activity, before finally culminating in near disaster. This significant jump in gravity is presented through this list of three as a natural progression for individuals with dementia, thereby furthering the association of dementia with degeneration, suffering and misfortune. The representation here and in the accompanying visual scenes misrepresents the early stages of dementia that the campaigns lexically discuss by presenting a set of scenarios which are characteristically more likely to occur (but which are far from inevitable) for people with *later* stages of dementia. This perpetuates an emphasis of much popular media upon the later stages of dementia—traditionally the more extraordinary—as representative of the whole experience of dementia (Van Gorp and Vercruysse 2012). Throughout this campaign, then, dementia becomes synonymous with, firstly, memory loss and, secondly, disaster.

Loss of Memory, Loss of Self

We now turn our attention back to the three individuals (presumably people with or at risk of dementia) who first draw the eye—not only because of the choices of layout, colour and detail previously noted, but also because of the 'psychological salience' that humans, particularly the human face and head, have for viewers (Kress and van Leeuwen 2006: 61). Especially noteworthy about these three faces is that none of them are whole. Since, in 'hypercognitive' societies (Post 2000), heads and faces are popularly regarded as the centre for mental life and signifiers of a person's intellect, personality, character and identity (Archer et al. 1983: 726), a partially eroded face acts as a metonym for a partially eroded self.

Reflecting the widespread disembodiment of people with dementia across visual representations found in popular culture, in which individuals are reduced to dysfunctional body parts such as the brain (see Harvey and Brookes 2019), here the three figures are defined by their memory loss and the consequences of this, which are visually indicated by the 'disaster' scenarios superimposed onto the participants' faces. Specifically, the scenes are situated such that they obscure the person's eye and at least half of their brain. Their fading into these scenarios not only indexes the figures' forgetfulness and association with the consequences of this, but also visually reproduces the longstanding discourse that a loss of memory in dementia entails a fading, or 'unbecoming', of self (Fontana and Smith 1989: 35). The figures' body language reinforces this; they appear vacant, even zombie-like (see Behuniak 2011), in their lack of engagement with their worlds, including by facing away from the scene they are entangled with, and away from viewers (discussed in the subsequent section). They also appear paused, indicating that the material processes they are indexing (e.g. of eating toast and brushing their teeth) seem thwarted by the act of forgetting. They are presented as people who have lost the ability to meaningfully act and engage with their surroundings—as listless, vacant and fading souls.

These individuals subsequently become defined through their defective cognitive capacities and lack of being, which is further supported through the adverts' use of colour and setting. The overwhelming use of dull, blanched colours, with a palette restricted to white, blues, greys and beiges, presents a lower visual modality (in terms of colour saturation and colour range) than the naturalistic standards by which viewers tend to judge reality (Kress and van Leeuwen 2006). This wan palette serves to drain the participants of vitality and further indicate suffering, especially since the colour tones used are commonly associated with depression, lethargy and ghostliness (as evident in the negative connotations of the colours for phrases such as 'grey world', 'beige personality', 'white as a ghost' and 'feeling blue'). Indeed, Kress and van Leeuwen (2002) propose that within a general red-blue hue continuum, regardless of context-specific colour meanings, colours at the blue end tend to connote 'cold, calm, distance, and backgrounding' (357). Here, we argue that such hues evoke misery, loss and isolation.

Other than the road, bathroom and kitchen scenes, the backgrounds used are blank, positioning the participants against light shades of grey. They are therefore simultaneously contextualised and decontextualised. That no other details of their personalities or lives are provided removes them from all other aspects of their identities, instead positioning them purely in terms of the scenarios being discussed. Only being contextualised by these unfortunate scenes reduces the individuals to being defined as incompetent and dangerous. The visual formula for forgetfulness (i.e. the blank background, scenes and objects of forgetting, and the participants' pause-like status) here also becomes a visual formula for emptiness of mind, identity and life. Such positioning undermines what Kitwood (1997) describes as 'personhood', namely 'the standing or status that is bestowed upon one human being by others' (8). Being bestowed by others, personhood is therefore vulnerable to being undermined by 'malignant positioning' (Sabat 2006); here, portraying people with dementia as 'defective' and empty damages their personhood and socially oriented selves (Sabat 2002: 28).

Although most of the messages that people with dementia somehow become devoid of mind and identity are restricted to visual semiotic choices (of colour, format and participant positioning, etc.), such ideology also manifests linguistically. All three posters use discourses surrounding loss of self to promote early diagnosis, with the promise that this means that 'you get to keep the person you know and love a bit longer'. Here we see a problem-solution structure (Hoey 1983) commonly utilised in advertising and health campaign texts. However, the accuracy of the discourse that dementia entails a loss of self is never challenged; instead, the solution is simply to slow down this degeneration. Implicit in this sentence is a rather static notion of selfhood; once an individual with dementia changes past a certain point, they are no longer the person that others 'know and love'. Again, embedded in this view is the assumption that 'self-control, independence, economic productivity, and cognitive enhancement' define humanity (Post 2000: 245), rather than, for instance, emotional connection or physicality. This makes a person's body 'a mere passive envelope' (Van Gorp et al. 2012: 389) rather than a fundamental source of self-identity. Discourses of loss of self that reflect the privileging of cognition and memory are inherent at almost all semiotic levels here and are used to motivate engagement with the campaign's advocated action, as we shall discuss below.

Social Distancing of People with Dementia and Responsibilisation of Family Members

Furthering the assumption that dementia entails a loss of self, this campaign consistently distances people with dementia and effectively removes them from the dialogue it seeks to construct with its reader-viewers. This is true both for the people depicted as having dementia in the posters and for reader-viewers who (might) have dementia themselves. In both instances, people with dementia are positioned as individuals that viewers without dementia know, care about and are responsible for, but not as agentive people with whom others can engage in any interaction or social relationship.

Visually, despite being the only people featured, all of the represented participants with/at risk of dementia are distanced, both from their own surroundings and from reader-viewers. Within their world, they are positioned as isolated individuals, with (asides the wedding ring that the lady in Fig. 10.2 wears) nothing to suggest that they have any relationships with others. Equally, none of the participants acknowledge the viewer, since, regardless of their head angle, they direct their gaze away from the central point of the image at which imaginary eye contact could be made. Consequently, the three individuals are isolated on both levels since they make no 'demand' of viewers to interact and connect with them; instead, they are passivised by being impersonally 'offered' up, to be scrutinised as items of information, like 'specimens [of people with dementia] in a display case' (Kress and van Leeuwen 2006: 119). This 'offer' image constructs a clear divide between the viewers and the people featured. It is harder to 'put ourselves in someone's shoes' when the person does not directly ask us to relate to them as a fellow being and is instead positioned as an object to be gazed upon.

This visual divide between 'us' without dementia and 'them' with or at risk of dementia is reinforced through particular lexical choices. Throughout, the campaign uses synthetically personalising language designed to make members of the campaign's mass audience feel that they are being personally addressed (Fairclough 1989). For this, the campaign linguistically addresses and adopts the worldview of people who know someone who might have dementia, but do not identify as potentially having dementia themselves. This is exemplified by the statement, 'you get to keep the person you know and love a bit longer', where what is foregrounded is concern for the experience and emotional well-being of the people around someone with dementia and the impact that a dementia diagnosis might have on *their* lives, rather than the person with dementia themselves.

Throughout, the envisaged reader-viewer, who is directly addressed and thus engaged with through the second-person pronominal 'you', is the person without dementia. Meanwhile the person being discussed, but who is not acknowledged as a potential reader-viewer, the 'they' of the campaign, is the person with or at risk of dementia. This construction of an 'us' of people without dementia and a 'they' of people with dementia is common across popular culture (Behuniak 2011; Harvey and Brookes 2019) and helps to establish boundaries between healthy/unhealthy and normal/abnormal groups. Dismissing people with dementia as conversational participants also strips such individuals of agency, resembling what

Swaffer (2014: online) describes as 'Prescribed Disengagement', whereby a diagnosis of dementia is accompanied by an expectation that the person receiving that diagnosis will cease engaging with certain aspects of their life, setting up 'people with dementia to become victims or sufferers, their partners to eventually start behaving like martyrs and to take over for the person diagnosed' (ibid.). As Swaffer highlights, this harmful approach can also be irrelevant for many, especially considering that the 'push for earlier diagnosis [means that] in reality most of us are in a much earlier stage of our dementias'—a fact that 'the health care sector has not yet caught up with' (Swaffer 2016b: online). This campaign is certainly no exception.

In this campaign, the person with dementia, who is passivised and stripped of agency, can be juxtaposed against the people who know them, who are responsibilised for the care and well-being of their relatives or close ones who they perceive to be at risk of dementia, or who have already received a diagnosis. Whilst a barrier of disengagement and difference is undeniably constructed between the represented participants and reader-viewers, it is notable that close shots (head and shoulders) do mimic the 'close personal distance' of people that viewers may know in real life (Kress and van Leeuwen 2006: 124). These isolated individuals are therefore simultaneously positioned as people who are familiar to and cared for by viewers, if without social engagement. This responsiblisation is more explicit lexically and is epitomised by the opening of Fig. 10.3, which asks, 'How far do you let someone's memory loss go before you say something?' This rhetorical question is followed by another, which lists the potential scenarios that might follow from undiagnosed dementia ('When they forget a birthday, leave the front door open, or nearly burn the house down?'). Such a structure resembles an interrogation more than a conversation and uses fear-inducing tactics (particularly the association of dementia with increasingly disastrous scenarios and the attribution of responsibility for these to 'you', the reader-viewer) to motivate people to closely watch their relatives and friends for signs of dementia. This 'surveillance culture' leads to frequent violations of the privacy and human rights of many people with dementia, but often goes unchecked (Cahill 2018; Swaffer 2016a), likely at least partially due to the popular conceptualisation of people with dementia as hazardous and lesser versions of their past selves (Behuniak 2011; Swaffer 2016a).

Viewers are therefore pushed towards seeking an early diagnosis and intervention from doctors. This biomedical pathway is presented as the 'right treatment and support', privileging this as the only response, particularly in the conclusion 'Dementia. If you're worried, see your doctor', where the imperative leaves no room for alternative decisions. However, several considerations are excluded from this assertion. Namely, the life-changing nature of dementia diagnoses is backgrounded, including stigmatisation, 'Prescribed Disengagement' and associated shifts in conceptualisations of self, life and relationships with others, which generally accompany diagnoses. These need to be factored into the decision to see a doctor, particularly considering the currently incurable status of most dementias. Difficult conversations and consequences such as these are conveniently excluded from this narrative, which consequently offers a one-sided, overly simplistic view of dementia and the 'right' way to respond to it.

4 Conclusion

In focusing on the multi-semiotic content of the *Alzheimer's Society*'s dementia awareness campaign, we have sought to show how researchers interested in flushing out ideological motivations in health communication texts need to look beyond language. Our multimodal analysis of the campaign texts reveals a number of discursive strategies (some less subtle than others) that are realised through linguistic and visual semiotic choices and which cumulatively operate to depict memory loss and loss of self as the *sine qua non* of dementia, thereby underscoring the social distancing effects of the syndrome.

Now it might seem perfectly natural for health promoters to emphasise the cognitive deficits associated with dementia and the need for vigilance and support—after all this is a promotional campaign designed to raise public awareness of the syndrome and to encourage people to seek timely help and support. What we have shown, however, is that the campaign turns more on fear-inducement than genuine awareness-raising, and hence the text producers in this case arguably risk doing more harm than good: reproducing dehumanising imagery that equates dementia with social death and loss of self is only liable to reinforce the considerable stigma already associated with the syndrome.

So on the face of it, it would seem odd—to put it mildly—that a charity whose *raison d'être* is to support people with dementia should endorse and promote such depersonalising depictions of people living with the syndrome. This pointed irony becomes all the more acute when one considers the charity's own guidelines respecting the ways in which people with dementia should be depicted (both in their own communications and in public discourse more widely):

> The way we talk about dementia has a direct effect on how people living with the condition feel … For those living with dementia, using words or phrases that label, belittle or depersonalise people can have a big impact on them and their family and friends. It changes the way they feel about themselves, shaping their mood, self-esteem, and feelings of happiness or depression. It can also change the way other people think about dementia, and increase the likelihood of a person with dementia experiencing stigma or discrimination. (Alzheimer's Society 2018: 2)

Following this impeccable reasoning, the guidelines issue a number of stipulations designed to avoid the negative labelling of people with dementia (e.g. 'Avoid… using terms that place the emphasis on the condition or behaviour') and to promote their personal and social standing ('Always use language that recognises dementia is not the defining aspect of a person's life'). Note that the emphasis here is on language and, as we have seen, the *Alzheimer's Society* campaign texts examined in our study visually violate almost all of these person-centred circumscriptions and recommendations. Instead, they blithely trade on scare and shock tactics, designed more to elicit anxiety and disquiet in people than to educate and inform them in a reasonable, non-alarmist fashion. How does one account for such a morally compromised and compromising contradiction—a contradiction that rests on denigrating people in order to secure support for them?

Although scare tactics have always featured in health education discourse, Gagnon et al. (2010: 254) observe that a rhetoric of fear now dominates the domain of public health promotion, a trend 'symptomatic of a broader political context where public health campaigns are inadequately funded'. This is because such shortfalls in funding necessarily translate into health charities having to resort to more drastic and controversial measures in order to pique public interest and secure donations. The semiotics of fear (the use of textual and visual materials designed to induce anxiety over personal health) is an effective, if morally questionable, means of securing attention and provoking attitude change (Borland and Balmford 2003). A premise at work in many fear-based mass-media campaigns—and the *Alzheimer's Society* campaign is no exception—is as follows: the greater the amount of fear that can be aroused in the audience, the greater the audience's intention to execute the recommended course of action will be. Yet, for many people, fear-inducing messages might well make them feel worse, engendering, for example, feelings of anger and defensiveness (Hastings et al. 2004), not to mention hopelessness and despair. And with dementia the stakes are particularly high; given its protean nature, that it defies straightforward definition and remains incurable, dementia has become a 'modern medical bogeyman' (NHS 2011)—a fear-freighted syndrome encapsulating society's worst terrors (Zeilig 2014: 12). Fear-inducing dementia campaigns, therefore, do little to challenge such attitudes, let alone provide alternative positive narratives of living well with the syndrome. For as the *Alzheimer's Society* itself observes (and indeed seeks to promote the idea of), it is possible to live a meaningful and fulfilling life with dementia. A diagnosis of Alzheimer's disease or any dementia is 'not the end of the road' (Mental Health Foundation 2015: 82), even though Fig. 10.1 would literally seem to suggest the contrary.

It also needs to be pointed out that, as well as resorting to a dehumanising rhetoric of fear, the campaign texts harness and reproduce stereotypical notions of memory and memory loss. In our analysis we revealed how memory was portrayed as being an exclusive hallmark of dementia, grossly oversimplifying the fact that there are various ways of recognising and experiencing dementia: it can't all be reduced to memory loss. The view of memory and forgetting adopted by the campaign texts is not only popularly clichéd but draws on what Brockmeier (2014: 70) describes as an 'amazingly unproblematized' version of memory, whereby memory is treated as a discrete and 'substantial entity, a natural kind'. But memory is just as much a creative process as it is a discernible aspect of the brain, a process rooted in a personal, social and cultural context. The traditional idea of autobiographical memory as an archive presupposes the commonly held view, which the campaign texts readily exploit, that the 'erosion' of memory is synonymous with the loss of personal identity (recall the smeared and perishing visages of the participants in Figs. 10.1–10.3). Yet adopting a more person-centred view of dementia and memory compels us to think about 'the full range of actions and interactions through which individuals localize themselves in terms of identity and personhood' (Brockmeier 2014: 81). Through conversations, through narrative and other social practices, people with dementia are still able to retain a sense of themselves without remembering and orienting to their 'autobiographical whereabouts' (Brockmeier 2014: 87). It is therefore not surprising that this more socially embedded view of memory is absent in the campaign texts—at odds as it is with the traditional archival notion of memory and the concomitant dread and disquiet that memory loss engenders.

To date there has been relatively little research that has critically examined multimodal depictions of dementia in public health information texts—or for that matter in the realm of health communication more widely. Much health communication research draws on content analysis approaches, focusing on the 'what-is-said' rather than the 'how-it-is-said' (the way in which content is rhetorically composed (Fairclough 1995)). One of the setbacks of this type of focus is that it is liable to overlook the more deeply embedded kind of meaning that only a close, multi-semiotic analysis is able to achieve. We are not suggesting that our semiotic analysis is in any way unquestionably authoritative, the best and only way of methodologically and analytically proceeding. But given the richly semiotic design of health communication texts, multimodal discourse approaches are able to shed a powerful light on the subtle ways in which beliefs and assumptions permeate health communication. In short, multimodal discourse analysis provides researchers with the tools and concepts to see *through* discourse, rather than taking it purely at face value.

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