From 'cleanliness is next to Godliness' to 'without perfect health, there is nothing': discourses of healthy lifestyle in the construction of young adult identities in urban South Africa.

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Abstract

This research explores popular constructions of "healthiness" as individual lifestyle choices in the context of contemporary South African consumer culture, and how these constructions relate to formations of subjectivity. This is a qualitative study conducted within a social constructionist, theoretical framework. Data was collected using in-depth, semi structured interviews and are analysed using a Foucauldian inspired version of discourse analysis. A critical stance is taken towards the assumption in these discourses that their version of healthiness is always and unquestionably positive. Special attention is paid to the lifestyle and marketing media discourses appropriated in understandings of personal health through self-management, and of the optimization of health in the pursuit of well-being. The ways in which different discourses of healthiness facilitate the construction of specific identities are considered in order to untangle some of the problems created by the moralism underpinning popular consumer health discourse. How constructions of healthiness and aspirant healthy lifestyles support, and are supported by, the ideologies and practices of neoliberal capitalism are also explored. From this perspective, healthiness as lifestyle consumption choices can be seen as an ideological apparatus that produces the subjects necessary to reproduce the social order (Althusser, 2001), functioning not only positively amongst the social classes with the leisure and economic resources to pursue these options, but also negatively as victim-blaming of those who are excluded. The argument here is not that health is bad or that people should not be bothered with activities aimed at promoting good health, but that in a context where the concept of health is idealised as always positive and beneficial, the potentially harmful consequences of some of the health discourses we make use of may be occluded. This idealisation of health or 'healthism' may also function to divert attention away from some of the challenges to health that are not the direct result of personal behaviours and are unlikely to be remedied through individually focussed interventions, for example, inequality and inadequate access to basic resources. Six discourses which were used to construct understandings of health are analysed. These include Happiness, Freedom, Control, Care, Balance and Goodness. The ways in which these discourses played a role in constructing the kinds of subject positions which were made available to participants, and the possible implications this has, are explored in depth.

Keywords: Health; lifestyle; consumer culture; neoliberalism; youth subjectivities; social constructionism; discourse analysis

Contents

Preface

I come from a position within the multiple discourses of health where the status quo benefits me in a number of ways. I have a good medical aid plan, I am generally healthy (in the biomedical sense of the term) and have been most of my life. I have been educated about nutrition and how to maintain a healthy lifestyle and avoid disease. I have been given emotional resources which allow me to care for my psychological health, all of my basic physical, emotional and social needs are met and I benefit from relative financial stability. I am definitely approaching this topic from a position of privilege. At the same time, my education and social environment have brought to my attention the difficult conditions in which most people live, especially most people in my country and the need for change. When approaching this topic and interacting with the individuals who agreed to participate in this study I tried to reflect on and critique how I think about health, the questions that I chose to ask, and the issues that seemed important to me to explore. I attempted to consider what my project would look like if I focused on different issues or approached the topic from a different angle in an attempt to identify my role in the research process and the analysis that I have produced. Despite these attempts I am certain that I have not entirely revealed the impact my position has had on the claims that are constructed within this paper. My hope is that by disclosing my motives for choosing this topic, how I think about and experience health, some of my concerns and the ways I am aware that I benefit from some of the discourses of health that are used, others may be able to interpret this project in ways that are potentially more useful.

I chose the topic of health based on my own interest in staying healthy and living a healthy lifestyle and a course I did in my honours year called 'Love and Money'. This course encouraged the contextualization of our experiences within our social, economic and political environment and the exploration of seemingly everyday constructs and where our ideas about them come from and the potential implications they might have. My supervisor Prof Collins encouraged me to select a topic for my PhD that I would find interesting to explore and so I settled on health.

When I was asked by others what my PhD was about and I mentioned that it was about health I was often confronted with the idea that of course health was definitely always positive and it should definitely be promoted and that more people should be healthier than they currently are. I began to feel that critiquing how health is constructed may be not only pointless but potentially damaging and I felt a pressure to orient my research towards the ultimate goal of furthering public health promotion agendas. I also felt that perhaps I was only able to approach health critically because of my relative privilege concerning my physical wellbeing and access to resources. However, thinking more about my own experiences with health as well as those of friends and family members I could see how the way we talk about and view health can also cause people a lot of anxiety and pain and I felt that exploring why we have come to approach health in the way that we do has value.

Through this research, I considered a number of different ways in which the discourses we use to construct health can lead to a variety of problems. However, I did not notice my own investment in health dwindling the more I learned. When reflecting on my own attachment to healthiness and the constant pursuit of a certain body and, related to that, a certain self, I began to realise the subjectivity implications that healthiness has for me and the important role health plays in my sense of self and my self-esteem. In this way, this research is also a personal project to which I feel emotionally attached.

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Introduction

The assumption present in most discussions about health, whether they are focused on a public health promotion agenda, 'lay' accounts of healthiness and health behaviours, or discussions of health and illness in the media, is that health is an obvious good which all individuals should aspire to. This assumption is especially relevant in a South African context where the prevalence of illnesses such as HIV/AIDS, TB and heart disease suggests that health is precarious and needs to be promoted and protected. The devastating effects of illness and death are close to many South Africans, and as a result, an urge to improve health in South Africa seems compelling.

In South Africa, a range of health problems are considered pressing, including HIV/AIDS and tuberculosis but in recent years increasing attention has been paid to non-communicable diseases (NCDs), conditions which are often casually referred to as 'lifestyle diseases'. These include some cancers, cardiovascular disease, hypertension and diabetes (Nojilana et al., 2016) and are understood to be a significant financial burden to individuals, families, businesses and the state (Mchiza et al. 2016). Many of these diseases are often argued to be more likely to occur among individuals who are categorized as obese (Otang-Mbeng, Aderonk & Afolayan, 2017; Joubert et al. 2007; Okop, Levitt & Puonane, 2015). Proposed remedies to these kinds of health issues almost always include, and are sometimes exclusively focussed on, educating and informing individuals about how to make better lifestyle choices to improve their health (Mchiza et al., 2016; Nojilana et al., 2016; Otang-Mbeng, Aderonk & Afolayan, 2017; Maredza et al., 2016). Although structural inequalities and inadequate access to resources are often acknowledged as a contributing factor, addressing these issues is considerably more expensive than interventions focused on individual behaviour change such as promoting exercise and the purchasing and consumption of 'healthy foods' (Joubert et al. 2007).

South Africa is also influenced by western media notions of beauty and the ideas surrounding the required behaviours and consumer choices necessary to comply with dominant notions of

the 'body beautiful'. Neoliberal ideals relating to individualism and personal responsibility also permeate South African contexts through western media and ideological globalisation. This research does not wish to deny the necessity of ensuring that the rights to adequate health care and to a safe and healthy environment, with sufficient financial resources to adequately nourish and care for the self and for one's communities, are met. Instead, the intention of this study is to illustrate the ways in which our context facilitates certain constructions of health in the everyday lives of South Africans, certain constructions of the self, and how some of these constructions may actually undermine or at least distract from addressing some urgent health-related issues. In addition, this research is interested in how the discourses used in conversations about health function to construct certain experiences of subjectivity. The tendency of public health policy to promote individual interventions into lifestyle practices in order to improve health, along with moral discourses around what it means to be a healthy person, and the linking up of healthiness with discourses of the body beautiful, are facilitated by a context of neoliberalism and consumer culture where constant self-improvement is necessary to remain a relevant and desired 'commodity'.

Thesis structure

This thesis will be structured into three parts. The first part, including chapters 1 and 2, will contain an overview of the literature relating to the topic of study and the theoretical framework which will be used to ground the methodology and analysis. The second part, chapter 3, is a method section, explaining how the research was conducted. The third part will contain an analysis and discussion of the data which includes six chapters each focussing on one of six discourses which were drawn upon by the participants in this study when discussing health.

The review of the literature will present existing research considering how health has come to be understood and the ways in which these constructions of health interact with social and economic contexts. Attention will also be given to the ways in which health has been addressed in the media and the implications of this for subjectivity and experience. The gendered aspects of health discourse will also be considered with a specific focus on health and beauty ideals,

and health and gender stereotypes. A discussion of the two main forms of consumption relating to health- food and exercise consumption- will follow. This will include a brief exploration of the interactions between politics, economics and food consumption and the relationship between food and subjectivity, as well the ways in which exercise services are consumed and how this relates to bodily appearances, health and subjectivity. Finally, research relating to the ways health has been moralised will be discussed and the implications this has for how individuals and communities think about health and about themselves and their bodies will be explored.

The second chapter focusses on the theoretical tools which were drawn upon when approaching this research topic. The research is grounded in a social constructionist approach, mostly based on the work of Vivien Burr, and also makes use of theories put forth by Michel Foucault- specifically those relating to power and the self-, Jean Francois Lyotard's work on postmodernism and Nikolas Rose's work concerning the construction of identity and power.

The third chapter will describe the methodological approach taken when conducting this research. This project is a qualitative study focussing on how understandings of health are constructed in individuals' accounts, how these constructions interact with broader social and economic structures, and the implications these constructions have for identities. Twenty in-depth semi-structured interviews were conducted and focussed on experiences with and understandings of health. The data from the interviews were analysed using Carla Willig's approach to discourse analysis with the addition of the suggestion to focus on *Technologies*.

Chapters four to nine consist of a discussion and analysis of six health-related discourses which were used to structure constructions of health and subjectivity in this project. Chapter 4 is the first in the analysis and discussion section, and explores discourses of happiness which were used by most participants at some point in the interview to structure their speech around health. The ways in which health and happiness are linked up and what this means for how individuals understand both concepts are explored.

Chapter 5 looks at discourses of freedom. The idealization of both freedom and health were especially significant in interview discussions. At some points, health was constructed as a means through which freedom could be achieved, and the two terms were sometimes conflated-to be healthy is to be free.

Chapter 6 focusses on discourses of control. The ways in which individuals discussed exerting control over their bodies and minds in order to achieve healthiness and the way these acts of control played important roles in constituting subjects who understood themselves to be acceptable and admirable are discussed. Chapter 7 pays attention to discourses of care. Participants often talked about health practices as acts of care towards the self and so care as a form of managing the self as well as care as an act of resistance to oppressive ideals of perfect self-control are considered. Chapter 8 explores discourses of balance and how these discourses were often used to negotiate a path through the sometimes seemingly competing discourses of care and control.

The final chapter discusses ideas of morality in relation to health, the ways in which the moralizing tendencies of health are talked about and experienced, and how the moralization of health in participants' speech has roots in both religious and neoliberal ideologies.

The aim of this research is to demystify the ways in which taken for granted assumptions about health and what it means to be a healthy person, function to reproduce and resist dominant discourses of neoliberalism and individualism, as well as play crucial roles in the constitution of certain types of subjects. The ways in which these discourses facilitate certain experiences of the self and the body while limiting others will also be considered, as well as the ways in which these health ideas relate to the current South African context which is characterized by, among many other things, high levels of inequality and poverty.

Key Terms

In order to explore these questions about the way health is constructed, several key terms, namely, neoliberalism, freedom, individualism and consumer culture, will be briefly defined in relation to the scope of this project in order to provide a broad understanding of how contextual influences shape the constructions produced.

Neoliberalism

In this research, the construction of health is considered within the context of globalised neoliberal capitalism and an emerging South African consumer culture. This research considers how the way our economy is designed and the global influences we as a country experience interact with our conceptions and experiences of health. Below is a brief explanation of neoliberal capitalism in so far as it relates to this analysis.

Neoliberal capitalism is the most recent form capitalism has taken and is characterised by deregulation of market forces and the elimination or reduction of social welfare programs amongst other social, political and global changes (Kotz, 2015). Foucault's (1978-1979 as cited in Foucault, 2008) lecture series entitled *The birth of biopolitics* explores neoliberal forms of government in both post-war Germany and in America. He argues that American neoliberalism came about as a response to Keynesian economic policies that had been put in place after the financial crisis and the New Deal, an increase in government involvement in social policies; for example, plans aimed at alleviating poverty, providing access to education amongst others as well as 'social pacts of war' which involved reassuring soldiers of employment and protection upon their return. Foucault explains that the form of government characterised by these three elements was criticised by both conservatives and liberals. Those on the right were suspicious of what they believed were the socialising tendencies of the current form of government and those on the left were concerned about the possibility of the development of

'an imperialist and military state' (p.218). Foucault describes how American liberalism as it appears now (neoliberalism) is, 'a whole way of being and thinking…a method of thought, a grid of economic and sociological analysis' (p.218). He quotes Hayek when he discusses the utopian focus of neoliberalism. Hayek argued for the creation of a liberal utopia as opposed to the utopias usually found in socialist thought. He did not want neoliberalism to be just an alternative form of governance but a 'general style of thought, analysis and imagination,' (p.219).

Although neoliberal economies tend to be characterized by cuts in welfare spending in the US and European countries, which have implemented austerity measures, South African health care spending has been increasing year on year (2010-2015 South African National Treasury). However, because of the high levels of inequality in South Africa many of the health care problems associated with neoliberal austerity measures are also faced here (Moult & Müller, 2017). These include issues like the under-resourced public health system, the increased reliance on privatized health care, a decrease in available services, and increased waiting times (Quaglio et al. 2013). In addition, 'neoliberalism, as an ideology that holds market exchange and economic rationalism as ethics in themselves, and as being capable of acting as a guide for all human action, has seeped into public service provision in South Africa as much as elsewhere internationally' (Moult & Müller, 2017 p.219; Harvey, 2005).

In this project the focus will primarily be on the social values that are prevalent as a result of these economic changes. These include individualism, competition and freedom as well as the concurrent development of consumer culture and the marketing of products and lifestyles through various media such as advertisements, lifestyle magazines and programmes (Lury, 2011), all of which will be explored in more detail below.

Freedom

Firstly, it is important to consider the value of freedom in relation to how neoliberal capitalism is linked with personal and moral ideals. Empowerment and freedom are often deployed in discourses around competitive capitalism. In Milton Friedman's (1962) book Freedom and Capitalism he says, 'I know of no example in time or place of a society that has been marked by a large measure of political freedom, and that has not also used something comparable to a free market to organize the bulk of economic activity.' (p.16) and that, 'it is clear how a free market capitalist society fosters freedom.' (p.24). Rose (1999) argues that it has been neoliberal thinkers who have been some of the most vocal and powerful advocates of individual freedom over the thirty years before the end of the 20th century. He especially notes Hayek as one of these thinkers who eloquently and consistently argued for the kinds of governments which allow individuals to pursue their desires free from government interference in order to preserve and protect this freedom which will then lead societies to flourish.

The kinds of social and personal values that neoliberal capitalism espouses and fosters will be explored in relation the kind of health discourses which are available to individuals and the implications these discourses have for neoliberal subjectivities. These values are also closely related to, and supported by, consumer culture.

Consumer Culture

The term consumer culture or consumer society was originally made popular by authors such as Marcuse, Galbraith, Packard and, later, Baudrillard and was understood to refer to a society which is a 'particular variant of capitalism characterised by the primacy of consumption' (Sassatelli, 2007, p.2). Roberta Sassatelli (2007) adds to this definition by paraphrasing Max Weber and arguing that a consumer society is one which satisfies daily desires by purchasing and using commodities. Celia Lury (2011) defines consumer culture, in her book by the same title, with a list of fifteen characteristics. These include:

'the availability of a large and increasing number and range of types of goods for sale; the tendency for more and more aspects of human life to be made available through the market; the expansion of shopping as a leisure pursuit; the rise of brands, their increasing visibility inside and outside the economy; the pervasiveness of advertising in everyday life; the difficulty of avoiding making choices in relation to goods and services, and the associated celebration of self-fashioning or self-transformation and the promotion of lifestyle as a way of life' (Lury, 2011 p. 1-4).

Consumer culture in South Africa is thought to have originated during colonial times when colonial powers would encourage the consumption of Western products in an attempt to promote a Western way of life (Hunt, 1990). Christian missionaries in South Africa have also been known to link Christian living and consumerism in their sermons- for example encouraging their congregation to dress smartly when attending church and prizing wealth and the consumption of material goods (Oyedele & Minor, 2012). More recently, it has been argued that South Africa can be considered a 'cultural protégé of the United States,' (Bernstein, 2002 p. 218) due to the wide proliferation of American television as well as the increasing dominance of English in South Africa. Focus groups held by the Centre for Development and Enterprise voiced the opinion that South Africans do not have African or South African role models, instead, they look up to and aspire to be like Americans and as Americans are seen to be rich this is what they desire for themselves (Bernstein, 2006). In June 2006, the government released its "A Nation in the Making" report which confirmed that consumerism was becoming more prevalent in South Africa as it discussed how consumer goods and conspicuous consumption were becoming one of the most important sources of status and self-worth (Bruce, 2007).

In this project, specific attention will be paid to the consumption of healthy food and exercise services as a means through which subjectivity is constituted. The ways in which seemingly personal choices around what foods to eat and which forms of exercise to engage in have broader political and economic roots and implications will be explored.

Individualism

The rise of neoliberal capitalism and consumer culture has facilitated a permeation of individualistic values. Individualism is defined by Callero (2013) in his book *The Myth of Individualism* as follows:

> *Individualism is a belief system that privileges the individual over the group, private life over public life, and personal expression over social experience; it is a worldview where autonomy, independence, and self-reliance are highly valued and thought to be natural; and it is an ideology based on self-determination, where free actors are assumed to make choices that have direct consequences for their own unique destiny.*

Individualism and Health

In Western societies, particularly the USA, as well as those influenced by globalised western culture, the idea that individuals are responsible for their own health has become increasingly prevalent, (Peterson & Lupton, 1996). This means that they are responsible for taking various preventative actions to avoid disease and to protect themselves from environmental risks, (Peterson & Lupton, 1996). In the context of growing environmental concerns, this means individuals are expected to consider how they can improve the state of the environment and therefore safeguard their health to some extent. The methods most often suggested and taken up by the public involve 'lifestyle' adjustments.

These concerns and actions are referred to by Peterson and Lupton (1996) as characterising "the new public health". The new public health is conceptually inclusive, and psychological, social and physical environments are taken into account and examined in relation to population health. Peterson and Lupton (1996) express concern over the lack of critical analysis regarding this more modern perspective on public health considering the impact it has on so many aspects of our lives. They argue that accepting this new perspective without critical engagement is especially worrying considering that, within this approach, almost all aspects of social and personal life are vulnerable to scrutiny and regulation in the name of improving public health.

This brings up the issue of power in the lives of the public. Michel Foucault views power as more than that which is utilised through direct force or coercion. Power operates through the construction of expert knowledges about the 'normal' human subject. This form of power relies on the agency of individuals to voluntarily govern their own activities through their construction of themselves as certain kinds of people. Health experts have reinforced this idea of individuals governing themselves through the advice they give to patients and through the promotion of social institutions that facilitate healthy lifestyles. This is evident in our present context for example in the case of Discovery Health Medical Aid, a South African health insurance company. This company has a program called Discovery Vitality which allows members to log their physical activity, the results of health checks they are encouraged to go to, and the number of healthy foods they buy. In exchange, they receive discounts on various products, for example, sporting apparel, gym memberships and airline tickets.

This form of self-governance relies on a specific conception of the self which Peterson and Lupton (1996) refer to the 'entrepreneurial self'. This idea about the self arises out of neo-liberal forms of governance- those which rely on limited state intervention, increased reliance on the markets as regulators of economic activity and individual responsibility for wellbeing. Peterson and Lupton (1996) also discuss a 'duties discourse' which has emerged out of this form of governance. This discourse implies that along with the freedoms people are granted they also have a number of duties and obligations to fulfil as successful, productive citizens. This means that being a healthy, responsible person requires a great deal of individual hard work, diligence and self-control. Citizens who find themselves to be unhealthy, especially those with ailments referred to as 'lifestyle diseases', are assumed to be lacking in these areas and are then blamed by others in society as well as themselves. This is because they are viewed as not living up to what is constructed as a successful person and leads to the assumption that they are unworthy of the respect and love of others and themselves.

PART 1: Literature Review and Theoretical Framework

Chapter 1: Literature Review

The review of the literature which follows highlights some of the key ideas relating to the topic of this study. It was impossible to cover and include all of the relevant literature and so the literature that was selected tended to make use of critical social constructionist epistemology in accordance with the framework used to explore this topic. However, some research which applied more positivist or essentialist ideologies were also included if it was felt that they provided a more balanced view of the literature context in which this study takes place, or if they explored an area of interest related to this study. The following section reviews some of the literature addressing the formation of our current constructions of health as well as literature critiquing these constructions and their impacts on subjectivity, society and institutional structures.

Constructions of Health

A brief history of health.

Ancient Greek (300BC-400AD) philosophers were among the first to see health, and in particular, illness, as related to how a physical body was functioning as opposed to the result of spiritual forces (Lyons & Chamberlain, 2006). However, they did not always agree on the relationship between the physical body and the mind. Plato, for example, believed the mind and body to be separate (Lyons & Chamberlain, 2006; Friedenberg & Silverman, 2006). He understood illness to be a bodily malfunction completely unrelated to the mind which he thought to be nonmaterial as opposed to physical, like the body. Plato's student, Aristotle, on the other hand, viewed the mind and body as one, a philosophical understanding which is termed 'monism'. Despite Aristotle's view dualism remained the prominent understanding of the mind/body relationship in Greece and the Roman Empire until the 5th century when the Roman empire fell and the Catholic Church gained influence (Rohleder, 2012).

After the fall of the Roman Empire ideas about health again became situated in religious and spiritual beliefs and so the monistic view of the mind and body as one returned (Lyons &

Chamberlain, 2006). This way of understanding health changed again after the Renaissance when medical knowledge progressed rapidly. Rene Descartes proposed the idea that the body and mind were actually separate but they were connected by the pineal gland and could, therefore, communicate with one another (Lyons & Chamberlain, 2006). The enlightenment period experienced great advances in knowledge about how the body functions, how to diagnose and treat illness and how the body is affected by diseases. These developments resulted in the biomedical approach to health and illness. This approach places primary importance on the physical body and explains illness as a result of purely physical imbalances. The mind and social processes are largely excluded from this approach (Lyons & Chamberlain, 2006). The biomedical model led to major technological advancements in the treatment and diagnosis of illness including surgical procedures, antiseptics, anaesthesia, X-rays and MRI machines which we rely heavily on today. This approach to health has been criticised heavily, however, due to its disregard of non-physical factors relating to health, its intrusiveness, and its tendency to prioritise fighting disease over promoting health. The biomedical model has also been criticised with regards to its contribution to upholding a patriarchal, capitalist status quo (Lyons & Chamberlain, 2006). This critique is related to medical professionals traditionally being mostly men and the ways in which, 'the division of labour between health professions is socially negotiated and mediated by gender, 'race' and class,' (Nettleton, 2006 p. 7).

The biomedical model became increasingly inadequate as the kinds of health problems people suffered from began to change. Acute illnesses such as pneumonia and influenza were replaced by more chronic illnesses such as cancer and heart disease (Lyons & Chamberlain, 2006). These health problems are often referred to as 'lifestyle diseases' as everyday behaviours and circumstances can affect the likelihood of people contracting them. The way people started to understand health also became broader and began to include mental and social aspects. This lead to changes in the way health is defined. There are a number of different definitions of health used today, the most commonly used one in recent years being the World Health Organisations definition that was formalised in 1948 which defines health as 'a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.' Other definitions of health include Bircher's (2005 as cited in Usten & Jakob, 2005) which states health to be 'a dynamic state of well-being characterized by a physical and mental potential, which satisfies the demands of life commensurate with age, culture, and personal

responsibility.' Saracchi's (1997) definition of health is as follows: 'a condition of well-being, free of disease or infirmity, and a basic and universal human right' (p. 1409). According to the Australian National Health and Medical Research Council (1996), Australian Aboriginal people generally define health as follows: '…Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community' (National Health and Medical Research Council, 1996). All these definitions draw attention to the idea that if we want our populations to be healthy we need to focus on promoting wellbeing in addition to treating and preventing disease. Most of them also indicate that health is also linked to our social and cultural environment. This is most evident in the Australian Aboriginal concept of health. This means that when exploring health, we cannot just look at individuals in isolation but have to consider how their society is functioning as a whole. From these ideas about health, we can see that understanding health in a certain way places emphasis on certain aspects and leaves out others. Becker's (1974) Health Belief model provides an explanation of how our different ideas about what health is might result in different behaviours when we are confronted with our own ill health. A variety of different factors influence our understanding of health but this project will focus more specifically on the discourses around health that arise within the context of consumer culture and neoliberal capitalism in contemporary South Africa.

How did we get here? Contemporary constructions of healthy lifestyles and aspirant healthiness.

Early health practices, even in prehistoric and early historic societies as well as through to medieval times tended to emphasise personal hygiene (Rosen, 2015; Smith 2008). This was understood to involve various practices which aimed to prevent the spread of disease in societies such as those in Europe during the Middle Ages (Rosen, 2015) when diseases like influenza were fatal. However, there has been a long history of association between personal hygiene and religious beliefs for example, among the Egyptians, Mesopotamians and Hebrews. Keeping clean was understood to be pleasing to the God or Gods and was evidence of the purity of an individual's soul (Rosen, 2015). The Calvinist assertion that 'cleanliness is next to godliness' (Wesley, 1778) creates a link between hygiene (as a health practice) and morality. Societies began to associate the successful pursuit of health with the ideal, hardworking self of the Protestant work ethic. In the 19th century and as a result of medical discoveries and various

technological developments relating to hygiene, notions of public health and the role of the individual as part of a more national project to promote health became evident. In the 20th century, focus shifted to include an emphasis on vaccinating individuals against disease (Smith, 2008), and it became the duty of the state to intervene in the hitherto more private domain of health. These notions of public health converged at the advent of the 20th century with the rise of the welfare state, with its particular focus on protecting the health and well-being of its citizens. More recently the rolling back of the welfare state and the rise of neoliberal capitalism has increasingly shifted health from being primarily the responsibility of the state and becoming the responsibility of individuals (Kennedy and Markula, 2011). This shift is particularly noticeable in the USA, however, individualistic forms of sense making are also present in South Africa, which is particularly problematic given the high levels of inequality and poverty which also leave many citizens without access to health care resources. Neoliberal capitalism is also characterised by the development of consumer culture and the marketing of products and lifestyles through various media such as advertisements, magazines, blogs, television and movies. These historical, economic and ideological changes facilitate an increase in an 'aspirant' element to what comes to be seen as a 'healthy lifestyle'. This is increasingly packaged as a set of saleable consumer products including the consumption of 'super-foods' and nutritional supplements, buying organic food, and frequenting fitness centres. Today, what to aspire to, and how to achieve particular states and models of ideal healthiness, are pervasive in the media (particularly health-related websites, blogs, social media and health and fitness magazines), and 'healthy lifestyle' consumption is promoted as an avenue to the ideal self.

The shift in the understanding of what health is, from a focus on hygiene and the avoidance of disease to the pursuit of an aspirational 'optimal' state of health, is even notable in the World Health Organisation's definition of health, mentioned above. Their definition is widely regarded as evidence of significant progress as it was developed in the context of states starting to see that they had to care for a wider range of issues, more proactively. For some, the 1948 definition of health is a monument to communitarian ideals and antithetical to neoliberal ideology. However, as neoliberal ideals such as the importance of independence and individual responsibility for the self began to become entrenched, the responsibility for the health goals proposed in the WHO definition of health shifts. We see this with the antismoking health movement and from the beginning of the 1960s with the fitness movement. The broad reach of

the WHO definition, in the context of individualism, means that individuals are responsible for avoiding or preventing illness and also for becoming optimally healthy, in the range of ways this is conceived.

Petersen and Lupton, (1996) argue that contemporary western societies have a remarkable preoccupation with health-related concerns. There has been an increasing proliferation of knowledge and actions relating to health and the health of populations since the 1970s. There has also been a pervasive interest in body shape, diet and exercise in more recent years. This focus on 'lifestyle' includes an emphasis on individual responsibilities for health maintenance and improvement. There has also been an acknowledgement of certain risks to personal and population health that are not under the control of the individual. These include pollution, global warming, toxic chemicals present in food, cosmetics and household cleaning items as well as the greenhouse effect and reduced biodiversity (Petersen & Lupton, 1996).

What Petersen and Lupton (1996) refer to as the new public health can be seen as one of many recent regimes focussed on the regulation and surveillance of individuals and society through power and knowledge. They point this out in order to critique the dominant view of health as only liberating and empowering. This is not to say that there is no room for individual agency but rather that the individual agency that is actively encouraged may be restrictive in its own way (Petersen & Lupton, 1996). In this way, agency can be viewed as an effect of power. Foucault's (1977) conception of power is both restrictive and productive. The encouragement of individuals to take responsibility for their health is an example of an effect of power which incites action rather than only preventing it.

The way health is understood and experienced in modern societies is also influenced by and in turn, influences consumer culture.

Consumer culture and health.

Skrabanek (1994 p.7-8) explains that,

'until the 19th century, the term 'to consume' was used mainly in its negative connotations of 'destruction' and 'waste'. Tuberculosis was known as 'consumption', that is, a wasting disease. Then economists came up with a bizarre theory, which has become widely accepted, according to which the basis of a sound economy is a continual increase in the consumption (that is, waste) of goods. This principle has been applied, in capitalist societies, to 'health' itself: 'health' has become a marketable commodity. The product, wrapped in salesman's rhetoric, is 'delivered' to the 'consumer''.

Welch (2009) argues that medical industries have a profit motive and as a result seek out patients to convince them to purchase medication or products aimed at health improvement whereas in previous times in history individuals would seek out doctors because they were ill (Welch, 2009). In order to be healthy in our current context and within the current constructions of health we need to be customers. Our health is measured based on what we consume (Welch, 2009).

Health has also been critiqued as a normativizing rhetoric by scholars such as Irving Zola and Talcott Parsons (Metzl, 2010). This means that the idea of healthy as the normal state of being is considered natural and unchallengeable which in turn constructs illness as abnormal or deviant. Current understandings of health among medical professionals as 'the absence of abnormality' means that conceptions of health have become unmanageably broad and have meant that individuals are required to become customers of medical products or services to make sure that they are healthy (Welch, 2009). These products or services may include routine 'check-ups', vitamins or other supplements or even surgeries (Welch, 2009). However, it is not only medical products and services which are consumed but also those which have come to signify a healthy lifestyle, for example, organic foods or memberships at fitness centres. The healthy lifestyle is understood as a tool not only to treat current ailments or even to avoid potential future risks (as 'anticipatory medicine') (Peterson, 2015) but also to achieve a state of excellent health where there is not only the avoidance of feeling bad but the hope of feeling wonderful.

The idealisation of health is related to one of the most significant aspects of how health is constructed in contemporary societies: the association of health with morality.

Health and morality.

Crawford (2006) coined the term 'healthism' in 1980 to refer to the moralization around health that has occurred (Crawford notes particularly among middle-class Americans). Crawford (2006) argues that this moralizing is cultivated by health promotion efforts which have lead to the increasing medicalization of our lives. Health has also been criticised as a medicalizing rhetoric by scholars such as Adele Clarke, Peter Conrad and Deborah Lupton. They argue that health, which was previously confined to the area of biology and disease, has permeated into almost all aspects of life (Metzyl, 2010). Health then starts to become viewed as a 'moral imperative' (p.6) and an essential aspect of social status and self-worth (Metzl, 2010). Crawford (2006) also points out that understandings of health has become much broader and now encompasses much more than just medical concerns. Crawford (2006) attributes this to the advancement of the 'holism' discourse of health and the increasing popularity of ideas relating to mind-over-matter health practices and effects. Crawford (2006) argues that holistic versions of individual responsibility are, 'among the most repugnant' (p.411) as the punishment for failing to achieve health, which in this case has become increasingly broad-encompassing most aspects of life, is even greater as not only do individuals deserve to be ill, they are understood as *wanting* to be ill (Ignatieff 1988 as cited in Crawford, 2006). The 'holism' discourses are used when employing phrases such as 'healthy lifestyle' which encompasses all of the ways one exists in the world. 'Lifestyle change' a euphemism for dieting, slimming or reducing according to Heyes (2007) has, 'an aura of enlightenment, progress and self-improvement' (71). In these examples, the language ('healthy lifestyle') used to construct health and dieting has a moralistic underpinning and is very broad and vague regarding the aspects of our lives that need attention.

For some, health has become a *'super-value'* which means that health has come to be understood as encapsulating everything that could lead to personal wellbeing, and is idealized as an avenue to and an outcome of the good life (Crawford, 2006). Peterson (2015) argues that healthism, 'promises salvation of the self- resurrection or transcendence through intensive

work on the self' (p.7). Cederström and Spicer (2015) in their book *The Wellness Syndrome* touch on the idea of health as a *super-value* when they discuss how wellness has become an ideology, how the pursuit of wellbeing has become indicative of a person's worth or value in society. Halse (2009) discusses the pressure to adopt healthy habits as a component of being a responsible 'bio-citizen'. The implication here is that individuals are expected to take responsibility for ensuring their good health as the effective operation of a society depends on it.

Cederström and Spicer (2015) explore how the problematic aspects of wellness as an ideology are especially noticeable when considering how individuals who do not attempt to adopt an ideal healthy lifestyle, or those who do not bare the socially accepted signifiers of health i.e. a specific body type (slim and toned) are perceived and treated in our society. In the documentary film*, Fed Up (Soechtig, 2014)* a number of widespread beliefs are presented about health and the reasons for such a high level of obesity in America. These include: 'kids are obese for two reasons: they have voracious appetites and they don't exercise enough', 'Americans view overweight people as lazy, unambitious and lacking willpower,', 'all we have to do is have people eat less and exercise more- not a very big problem,' (Soechtig, 2014). These views, as pointed out by doctor and chairman of the institute of Functional Medicine Mark Hyman, all have the same underlying message: people who are overweight have only themselves to blame, they need to take responsibility for their behaviour and their failure is a sign of their own weakness (Soechtig, 2014). As a result of the expectation for individuals to be responsible 'biocitizens'[1] if one fails to attain a suitable level of health, not only are they constructed as personally failing, but also as failing to play their part in supporting their society (Halse, 2009) and are therefore a burden on the system, requiring the efforts of others to make up for their shortcomings. Susan Bordo (2004) in her book *Unbearable Weight* describes the moralisation related to the physical appearance of the body. A slender body (which would also be labelled by many as a healthy body) is visual evidence of a person's successful management of 'impulse and desire' (p.74 as cited in Heyes, 2007). Bordo (2004) argues that within consumer capitalist societies individuals are constantly vacillating between two moral poles: 'as producers of goods

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[1] The bio-citizen is a 'new species' (Halse, 2009 p. 50) of person which has emerged from a context of 'fat-panic' about the obesity 'epidemic' which is believed to be affecting societies. A virtuous bio-citizen is expected to play an active role in taking care of their own health for the benefit of society.

and services we must sublimate, delay, repress desires for immediate gratification; we must cultivate the work ethic. On the other hand, as consumers we must display a boundless capacity to capitulate to desire and indulge in impulse; we must hunger for constant and immediate satisfaction' (p. 199). This illustrates the contradicting demands placed on individuals and how this makes it impossible for individuals to comply with all of society's moral expectations.

The moralization of health is also linked to the pursuit of happiness. Cederström and Spicer (2015) discuss the term *biomorality* which refers, 'to a moral demand to be happy and healthy,' (Cederström and Spicer, 2015 p.5). Illich (1995) expresses how the pursuit of happiness and health has been conflated: 'in the case of institutionalized hygiene, the pursuit of happiness is translated into the pursuit of "health"'. Alenka Zupancic when explaining the meaning of the term *biomorality* argues that 'negativity, lack, dissatisfaction, unhappiness, are perceived more and more as moral faults- worse, as a corruption at the level of our very being or bare life. There is a spectacular rise of what we might call a bio-morality (as well as morality of feelings and emotions), which promotes the following fundamental axiom: a person who feels good (and is happy) is a good person; a person who feels bad is a bad person,' (p. 5 as cited in Cederström and Spicer 2015). Ahmed (2010) argues that the association of healthiness with happiness, functions in a way that legitimates health as a moral good. Happiness is evidence of the goodness of health (Ahmed, 2010). In neoliberal capitalist societies, or societies which place a high moral value on productivity and efficiency are increasingly susceptible to the moralisation of health through its association with happiness. According to Binkley (2014) happiness is increasingly viewed as a resource in these kinds of societies and functions to grant those who project happiness with a competitive advantage over those who do not. Health as a precursor to happiness, therefore, is afforded moral value through its association with happiness.

By linking health and happiness together and by making both a moral imperative the pursuit of happiness and ideal healthiness is impossible to disentangle from endeavours to reduce risk and avoid pain and ill health. Marcuse (1968) describes this rationality in relation to pleasure, where individuals calculate the value of a pursuit based on the potential for negative consequences rather than potential pleasure, as 'nonhedonism'. He suggests that the rational mind limits and moderates potential pleasure in order to reduce the risk of pain (Marcuse,

1968). We see this in relation to health too as, despite the aspirant goal to achieve ideal, perfect healthiness, health practices are constantly linked to mitigating risk by preventing disease and avoiding fatness. For example, eating certain foods which are meant to prevent certain illnesses, exercising to avoid heart disease, engaging in weight loss strategies in order to attain a 'healthy' BMI and going for regular screenings and tests to detect possible diseases. In this way, it seems that the contradictions within our discourses of health prohibit the attainment of aspirant healthiness. Our aim to look forward and construct a brighter future and a perfect self are held back and tied down by a constant, fearful looking behind us at what needs to be defended against and warded off.

The argument that Cederström and Spicer (2015) make is that the demand to prioritise wellness encourages the relentless pursuit of self-improvement which leads us to become 'passive nihilists' who turn inwards and focus on themselves to an extent that precludes an active involvement in the world and engaging in activities to transform and improve society for everyone. They also argue that the excessive pursuit of wellness leads us to become alienated from each other and is therefore not necessarily even that individually beneficial. It may also lead to feelings of anxiety and guilt relating to the weight of the responsibility placed on us to constantly monitor and improve our health. Again, their argument is not that it is a bad thing to exercise or eat more vegetables, but that doing those things does not inevitably make an individual morally superior, nor should these activities be prioritised to the extent that they become all-consuming or impede meaningful interaction with others.

Health, Individualism and Inequality

Constructions of health are linked to a range of political, social and economic institutions. Current conceptualizations of health emphasise an individual approach to pursuing and improving health. However, external, environmental factors which are beyond the control of individuals play a significant role in the health realities different societies face. Folland (2007) addresses the importance of social context in relation to health and specifically the role of interpersonal relationships when he considers the question: Does social capital improve population health? Studies focussed on this topic have established a consistent relationship between the two variables and Folland (2007) suggests several possible ways in which social

capital might affect health. One option is that strong social bonds help to reduce stress by providing a buffering effect. Stress is implicated in numerous health problems and so reduced stress is likely to lead to an improvement in community health. Seppala (2013) discusses compassion in relation to health and argues that research has shown that compassion has unexpected benefits for both our physical health and our psychological wellbeing. The psychological benefits may be explained by the research done by Moll et al. (2006 as cited in Seppala, 2013). Their study found that the act of giving to others was shown to be as pleasurable for participants as the act of receiving. A study done by Aknin et al. (2010 as cited in Seppala, 2013) showed that people reported greater feelings of happiness after spending money on someone else or making a charitable donation than when they were given the same amount of money, or 4 times more, to spend on themselves. These studies show that expressions of compassion seem to lead to an increased sense of emotional wellbeing.

The benefits compassion may have on our physical health include, reduced inflammation, lower levels of stress and longer lifespans (Seppala, 2013). People who described themselves as being very happy had lower levels of inflammation only if their reported happiness was related to living a life of purpose or meaning. These peoples' lifestyles were more focussed on serving others than on satisfying themselves (Fredrickson et al. 2013 as cited in Seppala, 2013). Konrath, Fuhrel-Forbis, Lou and Brown (2012 as cited in Seppala, 2013) found that of volunteers who volunteered for other-focussed or altruistic reasons lived longer than those that did not volunteer. Compassion may also help to ward off depression and anxiety as it requires a state of being focused on others. Research done by Mor and Winquest (2002 as cited in Seppala, 2013) noted that negative emotions were associated with self-focused attention. Seppala (2013) suggests that by shifting our attention away from our own struggles and towards those of others we may be able to improve our wellbeing. However, focusing on others may be especially difficult in unequal societies which emphasise individual responsibility for health and do little to foster a sense of collectiveness and community. Individuals may tend to be more inward focussed not because they are selfish but because our societies socialise us in this way and a concern for the self has become a necessity within the culture we have cultivated. It cannot be taken for granted that if individuals direct their attention away from themselves and towards others that their needs will also be taken care of. However, Seppala (2013) also argues that compassion may help to increase our feelings of connectedness to others (2013). When we act on feelings of compassion we are more likely to relate positively with others and create

social bonds (Seppala, 2013). As also mentioned by Folland (2007), social connectedness influences health in a number of positive ways including an improved immune system and increased longevity, lower rates of anxiety, depression and a higher self-esteem (Seppala, 2013). Therefore, if we can find ways of resisting capitalistic, individualistic ideals and creating more equal communities that care for and support each other we may be able to improve population health.

However, at present, many societies have very high levels of inequality. South Africa for instance, has a Gini coefficient of 0.95 and the top 10 percent of the population control between 90-95% of the country's wealth (Orthofer, 2016). Wilkinson and Pickett (2007) pose the question- 'what determines the proportion of people in the wider society belonging to different social classes, different income groups, with different levels of educational qualifications?' (p.2). In their paper, *The problems of relative deprivation: Why some societies do better than others* (2007) they focus on one answer to this question. The authors present the argument that many problems relating to relative deprivation including poor health are strongly correlated to income distribution. Societies which are more unequal tend to have higher incidences of both health and social problems and income inequality is shown to be linked to the processes through which social differentiation occurs. Bourdieu's (1984) concept of habitus[2] is discussed by Williams (1995) who puts forth that the differences in health and illness between the classes are determined by the class related habitus (Wilkinson & Pickett, 2007). Wilkinson and Picket (2007) argue that it is not necessarily only low incomes that lead to poor health but wide discrepancies in income within countries. They use the example of black American men in 1996 who had a median income of $26522. The average life expectancy of these men was 66.1 years. In Costa Rica, men had a much lower mean income of $6410. However, their average life expectancy was 75 years. Marmot and Pickett (2001) argue that 'the explanation for the poorer health of black people in the United States must have more to do with the psychosocial effects of relative deprivation… than with the direct effects of material conditions themselves' (p. 1235). This is not to ignore the real problems of access to health care services, clean water

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[2] Habitus refers to the interrelationship of the individual and the social world. Instead of two distinct entities, Bourdieu (1984) views society and individuals as two dimensions of a single reality. These two dimensions are constantly interacting both creating and restricting the other. Habitus, therefore would be the adjustable, structured principals which both limit and facilitate certain behaviours and experiences.

and healthy food that poor communities face, but to illustrate the compounding effects of inequality.

Obesity was found to be correlated with income inequality in a study done by Pickett, Kelly, Brunner, Lobstein and Wilkinson (2005). They found that obesity rates were higher in rich countries that were more unequal than in rich countries that were more egalitarian. They also noted that individuals consumed more calories in unequal societies than in more equal ones. Teenage birth rates are often considered a health problem and incidences of teenage births were found to be closely linked to income inequality (Gold, Kawachi, Kennedy, Lynch & Connel, 2001 as cited in Wilkinson and Pickett, 2007; Pickett, Mookherjee & Wilkinson, 2005). Analysis of WHO estimates of mental illness done in 2004 for 8 developed countries found a statistically significant correlation between income inequality and the prevalence of mental health problems (Pickett, James & Wilkinson, 2006).

Wilkinson and Pickett (2006) also reviewed 24 studies which considered the relationship between homicide and inequality and concluded that there is a 'robust relationship between greater inequality and higher homicide rates,' (p. 5). Trust is another aspect of social relations which is damaged by inequality within societies. Studies investigating levels of trust in societies with varying levels of inequality report much lower levels of trust when societies have wide wealth disparities (Uslaner, 2002 and Kawachi, Kennedy, Lochner & Prothrow-Stith, 1997 as cited in Wilkinson & Pickett, 2007). Social capital is also thought to be related to inequality in a negative way (Putnam, 2000 as cited in Wilkinson and Pickett, 2007) and levels of racism and hostility are significantly higher in populations where income is less equal (Wilkinson 2005). Wilkinson and Pickkett's (2007) study finds strong associations between income inequality and other social problems including poorer educational performance, low social mobility, higher proportions of the populations being imprisoned and more drug-related deaths.

There are numerous studies which support the relationship between income inequality and poor health (Wilkinson & Pickett 2006; Subramanian & Kawachi 2004; Marmot & Bobak 2000 and Wilkinson, 1996 as cited in Wilkinson and Pickett, 2007). It is also noted that an increase in

income inequality is followed by a deterioration of population health, suggesting a causal relationship. This relationship has been explained as a result of a lack of trust, the biological implications of chronic stress and limited social support (Sapolsky, 2005; Elgar, 2010). 'As social class differences widen, class conflict, hostility, violence, and psychological stress increase, whereas moderators of stress (e.g., social support and cohesion) decrease,' (Elgar, 2010).

It is interesting to note that less regulated capitalist societies tend to value the ideal of individual responsibility, competitiveness and limited social support structures while also being more likely to have high levels of income inequality and therefore high levels of stress. As a result, they are likely to experience poorer population health. However, within this context, individuals are expected to take responsibility for their poor health despite the fact that the causes of these health problems may be systemic and therefore beyond their individual control. Hart and Poole (2001) explain how individuals living in societies where individualism is prevalent will be socialised to value self-sufficiency and independence. Ben Goldacre (2009) notes the dangers of individualism in relation to health. He argues that nutritionism- the preoccupation with the nutrients in foods as determinants of health- is a 'manifesto of right-wing individualism' (p.132) as it places the individual and his/her specific food choices as the primary causal factor of personal health. He shows that the implication of this is victim blaming- that individuals deserve the poor health that they suffer and that they brought it upon themselves. Many authors have written about the tendency to victim blame those who are suffering from an illness. Stacey (1997), for example, discusses how cancer is sometimes constructed as a symbol of an individual's weakness or self destructiveness. Willig (2011), in her account of dominant cancer discourses discusses how cancer is constructed as a moral concern where an individual's lifestyle before the diagnosis is examined and critiqued to pin point where they went wrong and allowed the disease to attack them. She points out how this ignores environmental and social factors play a role in disease prevalence. It also functions to isolate individuals by positioning them as the only one's responsible for their illness and the only one's who can overcome it. According to Ehrenreich (2009), this can, 'weigh on a cancer patient like a second disease' (p. 43). In this way, health (as it is constructed in individualistic societies) could be critiqued as a stigmatizing rhetoric as, 'affirmation of one's own health depends on the constant recognition, and indeed the creation, of the spoiled health of others,' (p. 5). Metzl (2010) explains that health with its criteria of what is normal and good splits

individuals into groups and those that fall outside of the range of acceptable health indicators- those who are disabled, ill or overweight- become victims of stigma. We see this in South Africa with HIV/AIDS and how some individuals who are believed to have contracted this virus are rejected and judged (Meiberg, 2008).

These arguments illustrate that social connectedness and support play a significant role in improving the health of others and ourselves, however, individualistic societies actively impede the formation of these bonds (Callero, 2013) while at the same time insisting that individuals work towards improving their health. Arguments which emphasise social capital as a determinant of health have also been labelled 'community blaming' as they do not sufficiently take into account economic factors which may impede health and place the responsibility for health within communities (White 2017).

In the South African context, current minister of health, Aaron Motsoaledi, often emphasizes the importance of health care for all, pointing out that South Africa's constitution protects the right of all South Africans to health care services. The ANC government's proposed plan for a National Health Insurance (NHI) system and Universal Health Coverage (UHC) is intended to be implemented by 2030 (Lopez Gonzalez, 2017). On the surface then, it appears that the South African government is committed to promoting a collectivist attitude to addressing health problems and improving the health status of South Africans. The government has also funded projects which were aimed at improving the health of communities through improved access to health care and health prevention services such as free HPV vaccinations for school going girls. However, a number of factors undermine this effort to acknowledge the social and structural determinants of health and complicate the context in which South African seek to make sense of health. These include extremely high levels of inequality in the country which have resulted in a 'two-tier' health care system where those who can afford it purchase private medical aid schemes and make use of private healthcare services. Those who cannot afford this additional expense are forced to make use of the often understaffed and under resourced state health care system (Moult & Müller, 2017). This is an example of what Ong (2007) points out: neoliberalism is not a hegemonic set of policies and ideals which are taken up uniformly across the globe. Instead, neoliberal ideology interacts with local context to produce variations on the kinds of neoliberal practices found in the west. In the South African context, a lack of access

to health care services as well as nation wide initiatives to reduce certain health problems which tend to focus exclusively on individual behavior change (such as obesity and smoking) function to construct health as an individual problem. This is in addition to the constant exposure to privately funded media and advertising as well as globalized neoliberal influences which often work to construct all problems as individually solvable or preventable.

The media plays a significant role in the kinds of constructions of health which modern urban societies are exposed to. Below a discussion of the relationship between health and the media, as it pertains to this research, is presented.

Health and the Media

In order to understand the context in which this study is taking place it is important to look at the media and the messages about health that individuals are interacting with. How we get our information about health and whose health knowledge is credited as legitimate have changed with the rise of the internet and celebrity culture and these factors shape the context of health in which we find ourselves.

Neoliberalism, health and individual responsibility in the media.

The context described in the previous section illustrates the problematic health consequences of neoliberal, unequal and individualised societies. This section aims to consider some of the ways in which the media has played a role in disseminating the individualised ideals which have, to a degree, come to take hold in South Africa. Specifically, the focus will be on how individualism is idealised within media depictions of healthiness and how to successfully pursue health. The idea of personal responsibility when it comes to health was considered in relation to Marcuse's (1964) analysis of advanced capitalism by Eskes et al. (1998). Bodies that are considered healthy looking are seen to be the individual's responsibility. They are required to put in the hard work necessary for their health- and their appearance. And if they cannot achieve this appearance they must accept that they have failed and have not worked hard enough.

Dworkins and Wachs (2009) noted how fitness magazines emphasised neoliberal ideas about individual responsibility in relation to health. People are expected to find individual solutions to health problems and to maintain their health through activities that they are individually responsible for. Women's health is, 'culturally expressed in aesthetic terms as a thin, healthy looking body,' (Kennedy & Markula, 2011, p. 4). Although this body is not attainable for the majority of women they are persuaded to continuously strive to achieve it. This often requires constant self-management and policing of the body in order to effectively discipline it (Duncan, 1994). Conditions such as body image distortion have also been related to the association of healthiness and thinness on women's magazine (Markula, 2001). These discourses also function to reproduce a specific form of heterosexual, white, middle class femininity and thereby allow for the perpetuation of problematic gender norms (Dworkins and Watts, 2009). As a result of these concerns, these authors argue that women are being oppressed by this aesthetic ideal.

Smith Maguire (2008) analysed exercise manuals and argues that these books tend to understand fitness as a motivational problem. In this way, fitness is individualised and the manuals themselves come across as motivational experts. She further asserts that the work of these manuals functions to intertwine 'self-work' and 'broader political, economic and social agendas and goals,' (Smith Maguire 2008, p. 126). People are encouraged to engage in this 'self-work' by listing the health benefits associated with exercise such as a decrease in the likelihood of illness, as well as feeling more confident as a result of achieving an appearance more like the one which is socially constructed as attractive. This also illustrates a link between health and self-esteem. Exercise is presented in these manuals as an activity requiring discipline and commitment. In this way, these manuals are similar to the fitness magazines as they too create an environment where the reader is asked to reflect on past behaviours and acknowledge and confess his or her personal shortcomings which have resulted in the need to improve their fitness. After they have done this they need to change and begin to behave in the prescribed manner (Kennedy & Markula, 2011).

A range of media sources influence the ways in which individuals understand their health and the kinds of health-related behaviours they engage in. One form of media which is often critiqued as detrimental to general population health, is advertising. While individuals are often provided with the message that the need to exercise restraint and discipline if they are to improve or maintain their health (Gill, Henwood & McLean, 2005), advertisements are intended to increase consumption. Below is a brief discussion of some of the ways in which health is related to both media messages as well as broader capitalist structures and the ways in which corporations function in order to improve profits.

Food advertisements.

According to WHO (2003), obesity is a highly significant contributor to chronic disease and disability around the globe. It has also been noted that obesity among children and adolescents has been rising over the last years. According to The Institute of Medicine (IOM) (2006 as cited in Bargh, Brownell & Harris, 2009), the increased occurrence of obesity is attributed to people being generally less active than in the past and an increase in consumption of foods which contain a high amount of fat and sugar. Food advertising to children has been accused of being one of the leading causes of these 'unhealthy' eating habits (Brownell & Horgen, 2004 and IOM, 2006 as cited in Bargh, Brownell and Harris, 2009). Studies done in the United States of America by Foita et al. (2006 as cited in Bargh, Brownell and Harris, 2009) and Harrison and Marske (2005 as cited in Bargh, Brownell & Harris, 2009) noted how food advertisements targeted at children tend to communicate benefits such as good taste, fun, happiness and fitting in or being 'cool' as results of consuming the advertised product. This shows how advertisements attempt to manipulate children emotionally in order to increase their desire for unhealthy foods.

Although it seems intuitive that food advertising increases the preference for, and purchase of, the foods that are advertised a number of researchers have illustrated this link in their studies (Hastings et al., 2003; IOM, 2006; Story & French, 2004 as cited in Bargh, Brownell and Harris, 2009). It has also been observed that children who consume a large amount of media tend to have less healthy diets as well as a higher weight (IOM, 2006 as cited in Bargh, Brownell & Harris, 2009). This is explained as potentially being partly a result of being

encouraged to partake in unhealthier eating habits as well as consuming media instead of being physically active.

Studies done by Hastings et al. (2003 as cited in Bargh, Brownell & Harris, 2009) and the IOM (2006 as cited in Bargh, Brownell & Harris, 2009) looked at the way food advertising influenced food choices among children. Gorn and Goldberg's (1982 as cited in Bargh, Brownell & Harris, 2009) study unsurprisingly found that children were less likely to choose fruit and orange juice as a snack after being shown advertisements for candy than children who were shown advertisements for fruit. Children shown the candy advertisement were also less likely to choose fruit than those who were shown no advertisements. Other studies aiming to find a causal link between food advertising and eating behaviours found not only that children shown 8-10 advertisements ate more immediately after viewing them but that they ate food not necessarily included in the advertisements, (Halford, Boyland, Hughes, Oliveira, & Dovey, 2007; Halford et al., 2008; Halford, Gillespie, Brown, Pontin, & Dovey, 2004 as cited in Bargh, Brownell & Harris, 2009). This is in agreement with what Berger (1972) argues when he says that all advertisements confirm and reinforce the message of all the others which is essentially to buy more, have more and consume more. In this case, proposals to use advertising to encourage healthy food consumption, seeing as though it works so well for unhealthy products, become questionable.

Bargh, Brownell and Harris (2009) refuted industry claims that food advertising does not have an effect on overall nutrition but only influences brand preference (Young, 2003 as cited in Bargh, Brownell & Harris, 2009). They showed that food advertising causes an increase in snack consumption. This result occurred among children but adults were also affected especially men and those who were trying to go on a diet and were not linked to the initial hunger the participants reported feeling (Bargh, Brownell & Harris, 2009). Increased snacking was observed while watching television where snack advertising was featured but also afterwards and at subsequent meals.

In order to defend against the effects advertising might have, Wilson and Brekke (1994) argued that being aware of and understanding how external influences could be having an effect on

our behaviour may be useful when trying to resist these influences. The adults in Bargh, Brownell and Harris's (2009) study were not aware of the ways the advertisements they were shown might influence their behaviour. This means that it may be useful for future studies to explore the effects of snack advertising when the adults are more aware of how advertising may affect them. Some studies consider the way motivation and ability to defend against food advertising might mitigate their effect on eating behaviours and note how self-control and self-regulation can be depleted after time. This may lead to a higher susceptibility to food advertising after a long day at work or among those who are dieting. It is important to be aware though, that focussing on individuals' ability to resist the effects of food advertising again makes health the responsibility of the individual and fails to hold companies' responsible for promoting unhealthy foods accountable, and fails to question our consumer-centric, capitalist society. It creates two opposing forces, the companies who want to increase the consumption of unhealthy foods and inadvertently the public risk of obesity and poor health and the individual who is constantly surrounded by these messages and must always be on high alert for incoming messages that may be detrimental to them. They must be constantly vigilant and self-controlled and if they fail they are responsible for their failure and subject to the judgment of society. Bargh, Brownell and Harris's (2009) argue that although methods of resistance to advertisements are important to explore in more depth, unhealthy food advertising to children needs to be reduced urgently. However, Berger (1972) argues that capitalism would not survive without publicity and that advertisements constitute the 'culture of the consumer society' (p.139). In recent years the proliferation of advertising images has only increased (Klein, 2000) and so a reduction in advertising may be unlikely within our current structures.

Celebrities and health.

Poole (2012) argues that we are living in the Age of Food, evidenced by the range of media devoted to the celebration, exploration and promotion of food- magazines, television shows, documentaries, books and movies, food blogs, Instagram profiles devoted to food, restaurant reviews and advertisements. An example of this preoccupation with food in the media is seen in one of the most widely debated health topics in the South African media in the past few years: the health advice of local celebrity sports scientist Timothy Noakes. Professor Noakes' new book, *Real Meal Revolution,* is a best seller and in it he argues that people would benefit from a diet which is low in carbohydrates and high in protein and fat, especially those at risk

of or suffering from diabetes or obesity (Geffen, 2014). He advises the removal of refined carbohydrates, most fruits, starchy vegetables and all legumes (Health-e News Service, Witness reporter, 2014). These claims have proved especially controversial and media reports are frequently addressing the validity and safety of his advice. One report quoted a cardiologist labelling Professor Noakes as 'criminal' (Health-e News Service, Witness reporter, 2014 p. 4), for encouraging heart patients to adopt his dietary recommendations in place of taking their cholesterol-lowering medication. Supporters are said to praise him for uncovering the truth about nutrition and health despite being persecuted by medical professionals (Health-e News Service, Witness reporter, 2014). Noakes was recently criticised again for encouraging his Twitter followers to view online videos questioning the effectiveness and safety of the measles, mumps and rubella vaccine (Geffen, 2014). The videos suggest the possibility of a cover-up with regards to the link between vaccinating children and the development of autism (Geffen, 2014). The decision about whether or not to vaccinate one's children is another hot health topic in the media recently and Geffen (2014) argues that spreading doubt about the safety of the vaccine, especially by someone with such considerable support and influence, is, 'not merely arrogant, it is irresponsible' (Geffen, 2014 p. 8).

These reports illustrate an interesting trend in health promotion about where we get our health advice from and the mediums which are becoming more popular. The article mentions Noakes's twitter followers and how he directs them to a YouTube video about vaccines. This shows how online sources of health advice are becoming increasingly popular and how those in the public sphere are often relied upon for guidance about health. It is also worth noting the increase in books, websites, YouTube channels and blogs about health written by celebrities. Alicia Silverstone, Gwyneth Paltrow, Jessica Alba, Rikki Lake, Arnold Schwarzenegger, Michelle Obama, Jane Fonda, Jenny McCarthy, David Lynch, Alison Sweeney and Miranda Kerr are just some of the celebrities who have taken to giving healthy lifestyle tips and advice. The health issues and advice of celebrities seem to make a notable difference in the behaviour of many people. Hoffman and Tan (2013) illustrate this using examples of health behaviour changes in populations correlating to a celebrity health event which was widely reported on in the media. Katie Couric allowed her colonoscopy procedure to be televised and during the month following this, colorectal cancer screenings rose by 21% among 400 American endoscopists (Hoffman & Tan, 2013). Appointments for mammograms rose by 40% in 4 Australian states following the breast cancer diagnosis of Australian singer Kylie Minogue

(Hoffman and Tan, 2013). Jade Goody, a reality television star, died from cervical cancer in March 2009 and in that same month, cervical cancer screenings doubled compared to those conducted in the same month a year before (Hoffman & Tan, 2013).

Some celebrities use their sphere of influence to positively influence people's health behaviours and to support health-related causes. For example, Elton John's charity has raised over $300 million to fund research on HIV/AIDS (Hoffman & Tan, 2013). However, sometimes celebrities give advice or endorse certain behaviours or practices that could be detrimental to people's health, may be against medical advice, or contradict the research done in the area. Sir Michael Parkinson, a British television presenter endorsed a method to self-diagnose prostate cancer which involved standing 2 feet away from a wall and attempting to urinate against it. According to him, if you were successful this meant that you did not have prostate cancer. This method is not supported by the medical community and is not proven to be an effective test of whether or not someone has prostate cancer (Hoffman & Tan, 2013). Misinformation such as this could be very harmful to people and the level of influence celebrities have makes this a significant concern (Hoffman & Tan, 2013).

Whether celebrities provide helpful or harmful information about health matters less to the focus of this project than the fact that they are choosing health as a topic to engage with at all. Celebrity interest in health and their willingness to share their health practices and advice legitimates the idea that health is important and a topic worthy of time, money and concern, as Poole (2012) would put it, it has become a safe and obligatory passion. Celebrity interest in health also legitimates the idea that a healthy lifestyle is something to aspire to. Celebrities are often positioned as role models in some respects and when they position themselves as healthy it is implied that healthiness is a state to emulate.

Whereas the above examples are of celebrities who take an interest in health, in recent years there has also been a notable trend of health promoters achieving celebrity status. One of the first notable examples of this trend is physician, Dr Oz (Bootsman, Blackburn & Taylor, 2014). Dr Oz was frequently featured on the Oprah Winfrey show, as Oprah's personal doctor, where he would give viewers advice about diet and health (Crouch et al., 2016). He continues to host

his own show, 'The Dr Oz Show', which is watched by approximately 3.4 million people (Crouch et al., 2016). Social media developments have also facilitated the ascendance of a number of health, food or fitness bloggers to celebrity status. These include individuals such as Australian fitness star, Kayla Itsines, who has 5.6 million Instagram followers and promotes her exercise and diet programmes (Bohjalian, 2017). Health celebrities such as these have a notable impact on the health behaviours of individuals and their popularity illustrates the increasing importance of, and interest in, health and the pursuit of healthy lifestyles.

The media does not only affect what we eat but also how we view ourselves and how we understand what health means. The following section explores how images of thin, toned, 'attractive' bodies have come to constitute the appearance of health.

The media and the ideal fit body.

The influence the media has within the sphere of health is notable in relation to the perpetuation of social norms and is seen in the way individuals understand what healthy looks like. More research has been done on women's health and fitness magazines and female body image, which will be discussed now, however, this is an issue that is increasingly having an effect on men too. Berger pointed out in 1972 that cities have become saturated with visual media. These media often contain images of bodies and the concentration of these images encourages a constant comparing of one's own body to those represented in the media (Featherstone, Hepworth & Turner 1991). In subsequent decades the saturation of media images has increased dramatically exacerbating this tendency (Klein, 2000).

Kennedy and Markula (2011) critically discuss how ideas about fitness and exercise interact with dominant gender norms and how the media plays a role in reinforcing these ideas. They argue that the fit body is portrayed as, 'thin, toned and sexually attractive for heterosexual relationships,' (Kennedy & Markula, 2011, p. 2). In this way, women's fitness reinforces heteronormative ideas (Lloyd, 1996; MacNeill, 1998). This ideal fit body is also seen as oppressive because only one kind of women can be considered attractive and seeing as though women have a variety of different body shapes and appearances, the majority of them do not

fall within this narrow definition. Women of all ages are affected by these cultural norms of attractiveness. As Spitzack (1990) notes older women are evaluated more and more in terms of how healthy their body appears according to the fit body ideal. Fitness is also an extremely common tool for achieving the appearance which is deemed feminine and attractive by society and is often promoted in this way (Kennedy & Markula, 2011).

In the media, one's physical appearance and one's health have become very closely connected. The attractive, ideal bodies depicted in magazines, movies and advertisements are also presented as the way one should look if they are healthy (Kennedy & Markula, 2011). Dworkins and Wachs (2009) note how the idealised healthy appearance is gendered. The images on the covers of health and fitness magazines targeting men usually feature, 'an athletic man posing in a tank top, or shirtless. Usually, he is white, has a "healthy" tan, and his vascular, cut form implies the successful engagement in and cumulative repetition of a variety of bodily practices. Bulging biceps, defined broad shoulders with rippling striations, cut six- or eight-pack abs, and wide, pumped chests merge into a singular ideal.' (p.1). The image featured on women's health and fitness magazines usually wears tight revealing clothing or a bikini, she has a firm, toned, smooth, hairless, narrow and usually white body. Her muscles are less visible and much smaller than the male figure (Dworkins & Wachs, 2009). Although there has been a shift from excluding images of strong women altogether to idealizing fit toned female bodies gender norms are still upheld through these modern images (Dworkin & Wachs, 2009). Gender and health discourses will be discussed more in the section *Gender and Health.*

By equating beauty with health, fitness magazines emphasise the idea that physical attractiveness should be prioritised not only because of the idealisation of beauty but also because it is positioned as a visual indicator of healthiness. According to Eskes, Duncan and Miller (1998) this assimilation of beauty and health makes it less likely that women's health will really improve or that they will achieve gains, 'in the public arena in general,' (p. 317). Bartky (1998) argues that resistance to patriarchal systems of oppression is undermined when women engage in the disciplinary techniques designed to bring their appearance closer to beauty ideals. Another problematic aspect of the association of beauty and health is that it makes one's health available to all for evaluation and criticism. People who are considered unattractive are also then considered unhealthy and this equation legitimates their negative

evaluation as unattractive as it is made less superficial. An example of this is the association of the appearance of body fat with health terms like obesity. Those who are believed to be 'overweight' are evaluated as both unattractive and unhealthy. The observer's disapproval lies not merely with the individual's unappealing features but with their perceived inability or lack of desire to take responsibility for their health. We see here that the emphasis of physical attractiveness in relation to health reinforces both the idea that a women's worth lies in her appearance as well as the moralisation of health and the view that one's health state is an indicator of one's moral quality.

Duncan (1994) considered the "Success Stories" columns in the magazine *Shape* using Foucault's Panoptic power arrangement as a framework for her analysis. She argued that the stories in these columns always required the women to publicly confess their perceived lack- they would mention what was wrong with their body initially and the reason for this, for example, their body was too large because of their inability to control their eating. She compared the magazine columns to Foucault's panopticon where the women internalise power structures and police their own behaviour. This facilitation of a constant self-monitoring is explained as the result of two 'panoptic mechanisms'- the use of the rhetoric of 'initiative' and that of 'feeling good means looking good'- both of which, 'ideologically conflate private and public' (Duncan, 1994 p. 49). The emphasis on taking initiative in the Success Stories directs the individual to take personal responsibility for a public goal by emphasising the need to constantly evaluate the body for areas in need of improvement and then making a personal commitment to themselves to right this wrong. The second mechanism, 'feeling good means looking good', involves the covert promotion of public beauty standards under the guise of personal health promotion (Duncan, 1994). Individuals featured in the Success Stories are shown to have transformed their appearances and to have moved themselves closer to the ideal female figure. Women are therefore encouraged to pursue their health through constant monitoring, measuring and working on the shape and appearance of their bodies (Duncan, 1994). The possible negative psychological effects of this continuous comparing of one's own body to an unattainable ideal are usually also constructed as resulting from an individual failure of some kind (Markula, 2001). This makes resisting these panoptic mechanisms even more challenging as the individual is constructed as the only one who could possibly remedy their situation.

Markula (2001) explored how women's fitness and lifestyle magazines address Body Image Distortion. She found that these articles often admit that the images present in the same magazine can be damaging to women's self-concept and can be a cause of Body Image Distortion. These articles also distance the magazines from their responsibility in this when they add that the women viewing these magazines are already inherently mentally unwell as they, 'misperceive the media images and consequently, their minds have lost a sense of reality,' (Kennedy & Markula, 2011, p.3) This means that the solution to this problem is not for magazines to remove unrealistic images, it is for the individual to ignore the images by better controlling their mind. This illustrates the individualisation of both the responsibility for one's mental and physical health. Although Markula (2001) is discussing the effect of these images on women it is also important to note that it is increasingly common for men to also experience symptoms of body dysmorphia (Dworkins & Wachs, 2009).

Much of the research discussed above has focussed on women however the next section will consider the differences between the genders in the ways societal constructions of femininity and masculinity interact with constructions of health to influence individuals' experiences and beliefs relating to health.

Health and Gender

Judith Butler's (1999) theoretical approach to gender will be drawn on in order to explore the relationship between gender, subjectivity and health. Butler discusses how gender is performative (Salih 2002). She argues that there is no subject that is innately one gender or another, nor is there a blank subject which selects a gender to perform, in fact, there is no pre-existing subject at all. She suggests that our language, culture and society repeatedly construct gendered subjects with behaviours, thoughts and feelings which we define and reproduce as one gender or another and have come to appear natural and inevitable (Salih 2002). The construct of gender as real and inescapable influences the way we experience ourselves as subjects and the way we construct our world in order to continually sustain the assumption of the existence and naturalness of gender. Our understanding of gender then changes from something that one *is* to something that one *does* and is done upon us, within a process of

constituting a self (Butler, 1999; Salih 2002). The following sections will address the social construction of gender and how it relates and interacts with discourses of health.

Viewing gender as something that individuals *do* as opposed to something that they *are* means that gender can be viewed as a sequence of behaviours. In this way, health behaviours can also be viewed as an avenue through which individuals can construct and participate in their gendered perceptions and identities (Fleming & Agnew-Blume, 2015). Saltonstall (1993) conducted a study among white middle-class men and women aiming to explore their concepts of health and their everyday health practices. She considered the gender differences in the way men and women conceptualise health and noticed that the male and female participants shared similar ideas about what health was. Both genders associated health with wellbeing and their definitions indicated that they understood health as a state of being from which certain functions could be performed or certain capabilities would result (Saltonstall, 1993). One way in which the genders did seem to differ in their conceptualisations of gender was with regard to interpersonal relationships. The men in the group rarely mentioned those close to them, for example, family or friends, when explaining what health meant to them. Women, on the other hand, mentioned loving relationships and the ability to care for others as important in relation to their experiences of health. All of the men and women in the study referred to embodied experiences when conceptualising health. They mentioned how their bodies felt when they were healthy- energetic- and the appearance and shape of their bodies (Saltonstall, 1993).

Gender differences have been noted in relation to mortality, morbidity and utilisation of health care services. Researchers have concluded that women are more likely to access health care and are more likely to be afflicted by a variety of diseases, however, men are more likely to die at a younger age (Kandrak, Grant & Segall, 1991). Differences in engagement in health-protective or promoting practices may also be linked to gender norms and power dynamics. Phillips et al. (2005) and Wingood and DiClemente (2000 as cited Fleming & Agnew-Blume 2015) argue that in patriarchal societies women may have less power to take control of their health. Studies on gender differences relating to exercise suggest that women are significantly less likely to engage in physical activity than men, especially physical exercise that is likely to have heart health benefits (Garcia et al. 1995). This may be related to a concern about appearing less feminine (Spencer, Rehman, Kirk 2015 as cited in Fleming & Agnew-Blume, 2015).

Whereas men may be less likely to get screened for potential diseases or seek out health care treatment in general because of a concern about appearing insufficiently masculine (Odimegwu, Pallikadavath & Adedini 2013 as cited in Fleming & Agnew-Blume 2015) or heterosexual (Sanchez, Blockland & Vilain, 2013 as cited in Fleming & Agnew-Blume 2015).

Cooney (2014) discusses some of the ways men and women's attitudes regarding health, and specifically, food consumption may differ and suggests possible reasons for these differences. Rimal (2002), Ruby (2012) and White et al. (1999 as cited in Cooney, 2014) argued that women, in general, are more likely to be informed about nutrition and to be concerned with their own health and weight. Cooney (2014) also discusses how certain eating patterns are considered to be more masculine than others. Eating meat, for example, is considered a masculine activity whereas men who follow a vegetarian diet are considered less manly (Ruby, 2012; Ruby & Heine, 2011 as cited in Cooney 2014). As a result, food consumption is performative and is an avenue through which individuals can both embody idealised identities while distancing themselves from being associated with undesirable categories. In this example, certain foods or ways of eating may be coded feminine in which case some men may want to avoid them in order to successfully *do* masculinty (Barthes, 1957/2009; Rothberger, 2013; Adams, 1991 as cited in Bailey, 2007). A study done by Rothberger (2013) found that people were more likely to eat meat and less likely to eat vegetarian meals when they held or approved of more stereotypically masculine values. These values included ideas around what men should be like, for example that they should be strong, athletic, dominant and that they should not be too emotional or reveal if they were in pain (Rothberger, 2013). Adams (2003) discusses how meat is not only used in the constitution and expression of masculinity, but heterosexual masculinity in particular. The comparison is made between media portrayals of women and meat both meant for the pleasure or 'consumption' of heterosexual males (Adams, 2003). Cooney (2014) also noted economic and social differences in how much meat different societies eat. For example, countries which have better gender equality tend to eat less meat than societies which are more patriarchal (Phillips et al., 2011 as cited in Cooney, 2014). We see here that discourses of health, food, gender and sexuality have become intertwined. In this way, our food consumption and perceived health play important roles in the construction and expression of gender and sexual identities.

Gender and Dieting.

Dieting is mostly done by women as studies have shown that women are more likely than men to feel the need to diet to lose weight due to a dissatisfaction with their bodies. This is despite the fact that medically their bodies are within the healthy weight range (Grogan & Wainwright 1996; Tiggemann & Pennigton 1990). Continuous dieting has become common among women who are not an unhealthy weight, dieting has become the normal way of eating for them, and this can be detrimental both psychologically and physically as it often leads to weight cycling or what is known as 'yo-yo dieting' where weight fluctuates up and down fairly frequently (Grogan & Wainwright 1996).

Although dieting behaviour and the desire of many women to attain the thin ideal depicted in the media such as fashion magazine and movies can be explained by the effects of societal influences, capitalist interests and oppressive patriarchal cultures, these explanations tend to depict women as passive victims of these influences as they do not recognise resistance to the thin ideal. However, it has also been argued that women, 'play a prominent role in the reproduction of, *and* resistance to, the thin ideal.' (Germov & Williams, 1999 p. 118). For example, some women are able to cease dieting and find a way to accept the size of their bodies despite the fact that they may not conform to the thin ideal. In Germov and Williams' (1999) research this was sometimes possible through the drawing on of alternate discourses, including discourses of health and discourses of sexual desirability.

Gender and the social construction of the thin ideal.

The way the body is perceived by society effects the way it is experienced both emotionally and physically. There are significant gender differences in the expectations of bodies in society. These differences are produced and reinforced through discourse. Some of the discourses which play a role in constructing the gendered body include discourses of, 'beauty, health, food, cosmetics, fashion and exercise,' (Germov & William, 1999 p.118). The thin female body has come to represent health as well as beauty, youth and success. This means that pressure to achieve the thin body ideal is reinforced within multiple contexts. For example, if the body is not thin, not only is the individual assumed to be unhealthy, but also unattractive and unsuccessful. This shows how social standards for the body influence multiple facets of

subjectivity. Fat on the body is seen to be unattractive, unfeminine, and a symbol of a body that is undisciplined. Wolf (1990) argues that this aversion to fat is misogynistic as female bodies naturally have fat in areas such as the breasts, buttocks and hips. She argues that this fat is inherently feminine and to reject it is to reject femininity as not good enough. Because of the saturation of media images in our cultures, the thinnest bodies, which only represent between 5-10 percent of the population are perceived as normal and bodies which do not look like this are abnormal and offensive (Seid, 1994 as cited in Germov & Williams, 1999).

Germov and Williams (1999) found that men seemed to have a much broader range of acceptable body shapes than women did. They also found that women's bodies were scrutinised in situations where men's bodies would not be. For example, female superiors in the workplace were judged based on their weight when a male superior's weight would not be considered relevant. The success of a woman is more dependent on her appearance than a man's is. Seid (1994 as cited in Germov & Williams, 1999) discusses how the thin fit body ideal was initially supported by feminists as being healthy and strong were positive things for women to attain whereas in previous centuries this was not culturally permitted. However, in more recent times the goal when trying to achieve this ideal has become less about health and more about an aesthetically pleasing body shape. In some cases, achievement of this body shape undermines physical health as well as emotional and mental wellbeing. Bartky (1990) articulates this in the following quote: 'A tighter control of the body has gained a new kind of hold over the mind' (p. 81).

More recently there has been resistance to narrow depictions of women's bodies as thin and to attempts to encourage women to diet in order to reduce their weight. There has been an increasing focus on 'choosing health' as opposed to focussing on moulding the body's shape (Cairns & Johnston, 2015). Cairns and Johnston (2015) discuss what they term the 'do-diet' which However, these attempts at resisting the thin ideal and turning attention to healthiness instead, 'does not free women of feminine body ideals; rather, it repackages these expectations through the language of postfeminist empowerment and consumer choice. In this way, the do-diet places women in a double bind. Those who openly restrict food choices risk being viewed as disempowered and image-obsessed, but those who do not monitor and control their eating may fail to embody the healthy (read: thin) ideal' (Cairns & Johnston, 2015 p.162).

Masculinity, health and the body.

Male bodies are also increasingly subjected to similar objectification, commodification and eroticisation that was previously applied to female bodies. As a result, men are more likely to feel pressure to alter their bodies in order to bring them closer to masculine ideals to be fit, athletic and muscular (Atkinson, 2008; Gill, Henwood & MacLean, 2005; Pope et al., 2005). Norman (2011) discusses how men, 'aggressively reshape their bodies through practices of consumerism (Patterson & Elliot as cited in Norman, 2011 p. 431) including food and exercise consumption (Monaghan as cited in Norman, 2011) and undergoing aesthetic surgery procedures (Atkinson, 2008). This illustrates the significant effects that cultural expectations about what the body should look like has influenced men (Bordo, 1999). Other authors also explore what Susan Bordo (1999) refers to as the 'double-bind' of masculinity where conflicting discourses, such as those ideals of masculinity associated with rationality, stoicism and a disconnection and denial of bodily vulnerability, construct a masculine concern with the appearance of the body as unacceptable (Davis 2002, Connell 2005; Robertson 2006). This illustrates how although both men and women are vulnerable to societal pressures to conform to a specific bodily form, the experiences of these pressures may be different relating to other interacting discourses.

Previous research has often viewed masculinity as a risk to health (Rosenfeld and Faircloth as cited in Norman, 2011; Mahalik, Burns & Syzdek, 2007). In South Africa in particular (although researchers have found similar trends in other countries), masculinity has often been implicated as a factor increasing the risk of contracting and spreading HIV due to a lack of condom use, multiple partners, and violent sexual encounters (Morrell, Jewkes & Lindegger, 2012; Fleming & Agnew-Blume, 2015). When focussing on HIV infection masculinity is problematized specifically in relation to race and violence (Morrell, Jewkes & Lindegger, 2012). When addressing so-called 'lifestyle diseases', for example, diabetes and heart disease, however, masculinities which are characterised by a reluctance to appear overly concerned with the body, maintaining a sense of stoicism (Kauffman, 1994 as cited in Courtenay, 2000), a denial of vulnerability, or perceived weakness, and a desire to sustain autonomy and control of their lives and bodies are the focus of concern (Courtenay, 2000). Crawford (2006) views the current attention focussed on transforming masculinity in order to encourage health-

promoting behaviours as symptomatic of a broader culture of 'healthism' (discussed later) where health is highly valued and viewed as a strategy for ensuring overall wellbeing and happiness as well as being morally relevant.

Gender norms and discourses around what it means to be an acceptable man or women interact in complex ways to shape understandings and experiences of health. The meanings attached to consuming food, exercise as well as other health behaviours such as screening and monitoring activities are also filtered through dominant gender norms. Body ideals relating to prevalent understandings of what healthy *looks like* affect both men and women, however, the experiences of these pressures vary as they function to reproduce existing gender relations in heteronormative cultures.

The ways in which men and women attempted to influence their health and the shape of their bodies tended to focus primarily on the consumption of food and exercise. The following section discusses these two commonly practised strategies for improving health.

Food and Exercise.

The most prominent and most discussed aspects of healthy lifestyles are related to food consumption and physical exercise. These two factors- the successful regulation and limitation of what foods are consumed, and the disciplining of the body to perform certain physical activities, can be linked to the biblical sins of gluttony and sloth. The condemnation of over-eating and laziness has persisted even in secular societies, and so adequately avoiding these sins remains important especially when a healthy diet and exercising are also associated with increased physical desirability, increased productivity, decreased dependence on health care institutions and others, and longevity.

The following section deals with the consumption of food and its role in efforts to transform the self. Social and economic factors will be discussed in terms of how discourses of food consumption are used in relation to health and the body.

Food.

Corporations and food consumption.

The context in which we consume food is made up of a range of different interacting institutions. An example of these are the corporations which sell food. Within a context of capitalism where the profit motive is a driving force in how business is conducted and how our society is structured, corporations go to great lengths to ensure that their products are consumed by as wide a range of individuals as possible. In the section on health and the media, the role of advertising in the consumption of food was discussed. Here, the way food corporations influence research and public policy is considered.

In an interview, Dr Marion Nestle (Soechtig, 2014), author of *Food Politics* and professor of nutrition at New York University, explained the conflict of interests in academic research focussing on food. She asserts, 'Food companies are interested in selling more food, that's their job as a corporation and one way to do that is to co-opt potential critics. Soft-drink companies fund research in universities, they donate to professional societies and in fact, I just saw a new major analysis that says soft-drinks have nothing to do with obesity and that study was sponsored in part by Coca-Cola' (Soechtig, 2014).

This is also evident in the film *Fed Up,* which explores the role of the food industry in governmental guidelines about food and health. Specifically, the film focuses on the McGovern report of 1977 which originally aimed to provide United States citizens with dietary goals with the intention of improving health. The reported noted that the diet of most citizens had become too high in high-fat meats, saturated fat, cholesterol and sugar (Soechtig, 2014). Before the report was published, however, the beef, dairy, sugar and egg associations intervened as they feared the report would result in a decreased consumption of their products which would lead to a drop in their profits (Soechtig, 2014). The associations rejected the report and demanded a rewrite which did result. The words 'reduced intake' were removed from the report and instead consumers were encouraged to buy more food with less fat (Soechtig, 2014). This led to the widespread practice of companies offering low-fat options of their products. In order to

make the low-fat options more appetising sugar was often added. This tendency corresponds to the doubling of American daily consumption of sugar between the years 1977 and 2000 (Soechtig, 2014). Excess consumption of sugar has been implicated as a contributing factor in a number of metabolic diseases associated with obesity including diabetes, heart diseases, strokes and cancer (Lustig, 2014 as cited in Soechtig, 2014).

Another group of corporations which influences the context in which we experience health is the dieting industry. In the United States, a survey showed that 84% of women and 58% of men had tried to lose weight through dieting (Garner, 1997 as cited in Heyes, 2007). Heyes (2007) describes how the power that weight loss and dieting have has come about, partly, through inducing a state of 'false consciousness'. She argues that certain social realities are concealed which function to benefit oppressive systems. Examples of this concealment include, the fact that weight loss does not always lead to better health, BMI is not necessarily an accurate indicator of health (Halse, 2009), diets usually fail and it is possible to be so-called 'overweight' and still be healthy. Systems such as the beauty and diet industries benefit from this 'false consciousness' and continue to perpetuate fat phobic ideas and resist body acceptance as well as effective, accurate education about health and weight.

You are what you eat.

Poole (2012) argues that food has become overemphasised by many people as a source of pleasure as well as the cause of many psychological or physical ailments. This attribution of experiences to the consumption of food leads to a sense of being able to personally control one's life and wellbeing as a change in diet is understood to have wide ranging psychological and physical implications. However, this also means that when things go wrong in one's life or with one's body it is viewed as their own fault and it is up to them to resolve it (Poole, 2012).

Food has also taken up a significant role in the construction and expression of identity. Foucault argued in 1983 that sexuality had replaced a concern with diet as a medium through which the subject constitutes itself. Taylor (2010) and Poole (2012) disagree with this assertion suggesting that food still plays a significant role in self-constitution. Manton (1999 as cited in

Taylor 2010) argues that food consumption enables individuals to demonstrate their membership to specific groups and, as Barthes (1957/2009) points out, enables individuals to distance themselves from groups with which they do not wish to be identified. Cathryn Bailey (2007) discusses how her vegetarian diet and her enthusiasm for food from non-American cultures is part of an exercise in differentiating herself from those less 'enlightened' white middle-class Americans in her hometown. Poole (2012) argues that an investment in food is often used to present one's self as especially cultured or interesting. By eating a diet that is considered to be healthier than average, or by making a special effort to only consume foods believed to be healthy individuals can also express aspects of their identity. This practice can be linked to the moralisation of health which was discussed previously. In this way, food consumption can be seen as performative and related to the process of constantly constructing an identity for ones' self. Performativity involves the repeated actions and rituals which have come to represent certain kinds of selves (Butler, 1999). Health has come to be performative in relation to the moral values which are signified by certain health practices. For example, eating a non-fat diet constructs the self as a subject who is self-disciplined and responsible for her health. A healthy person is not then a label describing a person's innate self, but instead as the result of a set of performative actions. This again suggests a view of the self which is not preexisting and fixed but constantly constructed and reconstructed within the boundaries of social norms. Nicolosi (2007) illustrates this performative aspect of food consumption below:

> *'Food in contemporary capitalist society is a commodity consumed subjectively, more so for its identity dimension than its organoleptical features (still less for hunger). Today, consuming food/commodity means introjecting this identity dimension and transferring it to the very self in individualised context/manner'* (p. 49).

Cairns and Johnston (2015) discuss an identity dilemma which neoliberal subjects find themselves in, in relation to food. Neoliberal subjects are supposed to exhibit characteristics such as self-control and discipline while at the same time express their freedom through consumption (Cairns & Johnston, 2015). The ability to choose from a range of consumption options is seen as an opportunity to exercise one's freedom. This situation makes living up to neoliberal ideals particularly challenging. Cairns and Johnston (2015) argue that the women in their study navigated this tension through the use of what they term the 'do diet'. This refers to the practice of consuming healthy food options. This way, individuals are able to engage in

what is presented as empowering consumption while at the same time demonstrating their self-control by carefully selecting foods believed to enhance one's health and avoiding those which are seen to be health-harming (Cairns & Johnston, 2015). This practice of healthy food consumption, however, requires constant and spontaneous 'calibration' in order to avoid both extremes of either consumption or self-control (Cairns & Johnston, 2015). If the individual engages in *too much* consumption or is *too* self-disciplined with their food consumption choices this could have negative identity implications and could place them in categories such as: self-indulgent, ignorant or fat or a health fanatic, rigid or obsessive. To avoid these categorisations, as well as to gain access to positive identifications such as 'healthy', 'confident' and 'balanced', individuals must carefully select their food with just the right amount of restraint and pleasure (Cairns & Johnston, 2015). 'The do- diet celebrates healthy food choices, while emphasizing the need for continual bodily discipline, allowing the seemingly contradictory neoliberal logics of continual consumption and corporeal control to co-exist' (Cairns & Johnston, 2015 p.170).

The moralization and identity implications healthy eating has come to imbue has coincided with the proposition of a relatively new eating disorder- Orthorexia.

Orthorexia.

A controversial and less-known eating disorder- Orthorexia Nervosa is a condition where an individual has become '[fixated] on righteous eating' (Bratman, 2014). It is proposed that individuals with this disorder be differentiated from a person who would not be classified as having a mental disorder but is health conscious would be an 'extreme preoccupation with health' and a 'judging attitude towards others who do not follow a healthy diet' (2014: 2). Poole (2012) argues that proponents of 'nutritionism', for example, Patrick Holford and Gillian McKeith, are at least partly responsible for the rise in orthorexic behaviour due to their insistence on the power of the individual to control their health and wellbeing through careful food choices. Poole (2012) goes on to suggest that perhaps society more broadly could be characterised as having some orthorexic tendencies due to our preoccupation and moralisation of food consumption. In the 1970s and 80s (as cited in Metzl, 2010) Ivan Illich, in his lecture series '*To hell with health',* makes a similar argument that contemporary societies have a

harmful preoccupation with health. He argues that health is, 'the most cherished and destructive certitude of the modern world. It is a most destructive addiction' (p.5 as cited in Metzl, 2010). He argued that the way health is constructed in Western societies leads to the pursuit of unattainable ideals while at the same time American industries are benefitting substantially from this endless preoccupation (Metzl, 2010). Nicolosi (2007) also criticises the way in which food consumption has become increasingly individualised and moralised (eating is often less a social ritual and more an individual expression of choice) and that the production of food has become more opaque (fewer people farm their own foods or cook for themselves regularly). There has also been an increased focus on finding the 'ideal diet', with a range of scientists, health professionals as well as individuals who have had successful heath results from following certain diets (e.g. Deliciously Ella) providing advice on how to eat. This means that individuals feel a lot of anxiety about making correct food choices from the increasingly vast array of options (Nicolosi, 2007). The identity consequences of food consumption add to this anxiety, and lead to the activities of selecting and consuming foods being experienced as extremely important, worthy of a great deal of consideration and time (Nicolosi, 2007).

In addition to food consumption, exercise services are also consumed as a means to both performing and achieving healthiness.

Exercise.

The fitness industry is often accused of promoting and reinforcing stereotypical, narrow ideals of health, specifically the ideal, attractive body shape, and so is often criticised by feminist research (Markula, 2011a). Some researchers see the fitness industry as completely inseparable from women's oppression as it is so intertwined with consumerism and the discourses associated with it (Markula, 2011a). Dworkins and Wachs (2009) point out how in some ways the fitness industry has co-opted feminist ideals in order to promote consumption when they argue that, 'fitness is sold by modifying feminist ideas of liberation and resistance into so-called commodity feminism' (p. 4). They discuss how the neoliberal marketplace is essential in the process of constructing the healthy self. This makes the negative consequences of consumer culture less clear and diverts attention away from social injustices which need to be addressed (Dworkins & Wachs, 2009). Their conclusions align with Duncan (1994) and

Markula (2001) that magazines, 'sold a body that looks and enacts gendered 'health' through sufficiently gendered signifiers' (p.4). Smith Maguire (2008) argues that the way fitness is presented in the media promotes a fitness lifestyle which enables continuous consumption of the fitness and health industry. Fitness and exercise are also constantly promoted and encouraged by government health campaigns. In this way, the aim to improve health is again blurred with attaining an aesthetically pleasing body and our cultural ideas about what that means (Markula, 2011a).

Foucault uses the term anatomo-politics to refer to the way power operates through disciplinary techniques. This means that individuals will police their own behaviour in order to behave in a way that is acceptable to society and to create selves that are useful and docile (Duncan, 1994). Markula (2011a) argues that within the discourse of aesthetics of the body beautiful, exercise legitimises the image of the ideal body. Exercise also becomes a disciplinary technique which individuals are committed to in their quest to achieve the beautiful, healthy body that has been idealised. This also results in individuals who comply with the requirements of the state and are healthy, productive and will not drain the state's health-related resources. They will also accept the status quo as they are promised that if they work hard enough they will be beautiful and healthy.

Markula (2011a) demonstrates the use of disciplinary techniques using the example of how women attempt to shape their bodies in a way that fits more closely with the feminine ideal which is not an ideal that they came up with but one which is external to themselves but which has been internalised and come to shape their beliefs, feelings and actions. Deleuze (1988) argues that we as individuals are constantly searching for our true, ideal selves and in doing this tend to comply with a number of disciplinary techniques including exercising and dieting but also the technique of confessing all the things about us that need changing or eliminating so that we can get to our true selves.

Exercise and weight.

Before 1953 exercise was not encouraged by health professionals and was even suspected to cause heart disease and a reduced sex drive (Soechtig, 2014). However, Dr Jean Mayer conducted experiments on mice where he found that the mice which were overweight ate a very similar amount to those that were a normal weight (Soechtig, 2014). The only notable difference between them was that the overweight mice exercised less. This led to him concluding that being inactive was linked to weight gain. His ideas led to a rapid increase in the popularity of exercise and to the expansion of the exercise industry (Soechtig, 2014). Between 1980 and 2000 in the United States of America memberships at fitness clubs and gyms increased by more than double (Soechtig, 2014). Strangely, during the same time period, the number of people with obesity also doubled (Soechtig, 2014). In 2016 the obesity rate in the United States was 31.8% and in South Africa was 26.8%.

Margo Wootan, the director of nutrition policy at the Centre for Science and Public Interest, explains that the message that people are given- that we need to exercise to combat obesity- is simply not going to work. She says that exercise is definitely an important part of a healthy lifestyle but we will not solve the problem of obesity through exercise alone (Soechtig, 2014).

Heyes (2007) points out that despite that fact that these activities may not lead to weight loss, being overweight is not necessarily unhealthy. She explains that the Body Mass Index scale does not effectively predict morbidity or mortality (Gaesser, 2002 as cited in Heyes, 2007) Gaesser (2002 as cited in Heyes, 2007) argues that it is possible to be 'fit, healthy *and fat*' (p. 69) and our societies preoccupation with weight loss and the 'war on obesity' is more complex than just trying to improve population health.

A critical attitude to these taken for granted assumptions about health- thin people are healthy, fat people are unhealthy, fit people are healthy- is useful when attempting to understand the complex power dynamics at play and the experiences of individuals engaging with health discourses. Markula (2011b) applies such a critical lens to these assumptions below.

Fitness and health.

Markula (2011b) in an article published in *Psychology Today* responds to the question: 'Are fit people healthy?'. In her response, she mentions how although this question may seem strange, as it seems logical that fit people are healthy, there are a number of instances where the pursuit of fitness or engaging in fitness related activities seem to impede health in some ways. For example, she mentions a number of people she knows personally who have become injured as a result of their fitness activities and how other researchers have found that many athletes continue to participate in their sport even when injured or in pain despite the fact that they could cause serious, permanent damage to their bodies by doing so (Markula, 2011b). Markula (2011b) also finds that asking the question: 'Are fit people healthy?' raises other questions such as: 'What is health?', 'Is being in pain healthy if it means becoming fit?' and 'What is fitness?'. She notes that when the benefits of exercise and being fit are discussed in the research they are often talked about in relation to illness. For example, if you exercise more you are less likely to contract a variety of diseases. Another example of this is seen in McDermott's (2011) study, *"Doing Something That's Good for Me': Exploring Intersections of Physical Activity and Health"* where the participants discuss how they try to be healthy to avoid illness such as heart attacks, or osteoporosis. To avoid these illnesses, it is not sufficient just to be physically active, these benefits are associated with being fit which requires that individuals exercise in a very specific way. It is necessary to do different kinds of activity to make sure they are fit in all the important areas (cardiovascular fitness, muscle strength and endurance, flexibility and body composition) and not just one (Markula, 2011b). There are also guidelines which suggest the frequency with which we should exercise and we are advised to change the intensity and duration of our exercise as we get fitter so that we improve (Markula, 2011b). Markula (2011b) notes that a large amount of exercise is required and that this could be painful and result in injury, particularly if beginners start with too much exercise too soon. She suggests that if we have more freedom to choose the way in which we are physically active we are more likely to find something we enjoy and want to do often and that this would be a 'healthier' way to approach exercise than only aiming for physical fitness Markula, 2011b.

However, in later work Markula (2013) critiques the idea that exercise should be enjoyable or 'fun' in her article *Are we having fun yet?* Discussing group fitness classes and the expectation that individuals should be 'having fun'. She argues that finding the activity enjoyable is more

likely when the 'goals' or the 'point' of exercising is pushed aside and the individual focusses their attention on the present and what they are doing- so-called 'mindful' exercise forms are meant to emphasize this practice and will be discussed next. This seems to require a kind of double consciousness, as individuals often might not engage in exercise activities if it were not for the external benefits they expect to receive as a result. In this case, the individual would have to forget their motives temporarily while engaging in the exercise practice in order for them to gain more enjoyment from the class or activity. Markula (2013) is also sceptical of the idea that it is indeed necessary to have fun while exercising and while she suggests that it might be beneficial to avoid the exercise activities we actively hate in favour of others; maybe fun need not be yet another requirement from an exercise practice.

This research considers the way the exercise and food consumption, and the pursuit of health in general terms, has certain implications for individual experiences of selfhood and the production of certain kinds of subjects. Below mindful fitness forms are discussed as an example of exercise which, in recent years has become increasingly popular and tends to involve the assumption of certain lifestyle signifiers and certain identity markers which indicate to the world that an individual is healthy in a certain way. Its focus on a holistic self and the union of mind and body also 'hails' a certain kind of subject who understands the self in a certain way (Althusser, 2001; Godrej, 2016).

Mindful fitness.

Mindful forms of fitness usually include exercise practices such as yoga, pilates and tai chi. Mindfulness in exercise usually involves an emphasis on being present in the class or focussing on how you move and feel rather than a more goal-oriented approach to achieving certain positions or attaining perfection at the practice (Monroe, 1998). Many fitness forms have been critiqued based on how gender norms and norms surrounding sexual preferences are reinforced through the way these exercises bring the body of the exerciser closer to the ideal feminine shape- thin, young and toned (Markula, 2011a). Markula (2011a) argues that exercises that incorporate the mind may offer an alternative to the focus of other exclusively physical exercises which are directed towards making the body a particular shape. Mindful forms of fitness attempt to unify the body and the mind through focussing the attention inward,

concentrating on the breath, noticing when the mind begins to wander and guide it back to the present, moving slowly with intention, and being aware of where the body is in space (Monroe, 1998). Mindful fitness, unlike other fitness forms, are focussed on the process of the exercise whereas other forms of exercise are more focussed on achieving a certain goal and the exercise itself is merely a means to achieve that. This is seen in gyms especially where many options are offered to enable exercisers to divert their attention away from the exercises they are doing. For example, many gyms have televisions on, music playing and some even offer puzzles such as sudokus on the aerobic machines. Some people bring their iPod with them to exercise or a book to read. All these examples redirect the attention of the exerciser away from what their bodies are doing. This may be because the exercisers do not actually like or enjoy exercising and to distract them from their discomfort or boredom they prefer to focus on something else (Markula, 2011a). The only reason they do the exercise is for the results it leads to, especially an improved physical appearance (Markula, 2011a).

Mindful forms of exercise are aimed at reconnecting mind and bodies in an attempt to create a more holistic self (Markula, 2011a). Although this may seem like a goal which challenges the sometimes oppressive aims of other fitness forms, from a Foucauldian perspective they must be considered in relation to how they are situated within other dominant discourses in our society. For example, according to Crawford (2006) the goal to create a holistic self may be problematic when, in order to achieve this goal, it becomes necessary to police all aspects of one's life. Because of the vague and all-encompassing nature of terms like 'holistic health' all forms of self-improvement can come to be related to health practices (Crawford, 2006). For example, Delaney (2017) argues that societies which have become less religious may find mindful fitness practices like yoga fulfil a desire for spiritual or moral guidance. By involving the mind as well as the body these forms of fitness more overtly instruct individuals on how to become the ideal, healthy citizen in all aspects of life, and in so doing link together health behaviours and moral superiority.

Mindful fitness forms also form part of the commercial fitness industry, the same industry that the non-mindful forms of exercise belong to. This means that mindful fitness forms are influenced by the way exercise is understood generally within this industry (Markula, 2011a). Markula (2011a) identifies two prominent discourses present in the fitness industry. The

discourse of, 'aesthetics of the ideal, healthy looking body,' (Markula, 2011a p. 62) concerns the way fitness is understood to be a means to an end. It is a tool necessary for achieving the ideal, desirable, lovable, enviable body. This body is young, thin and toned and is also observed and evaluated as healthy. The medical discourse also shapes the understanding of exercise as a means to end. This end, however, is a disease-free body (Markula and Pringle, 2006). Both of these discourses emphasise individual responsibility for the appearance and health of the body (Markula, 2011a). These discourses also influence how mindful forms of exercise are promoted, understood and experienced.

Mindful fitness forms are easily influenced by discourses of the body beautiful, as they too are a part of the fitness industry. We see this when celebrities or models claim to have achieved the body that they have as a result of doing yoga. This results in yoga being understood as a means to a more desirable body and, related to this, a more desirable self. These forms of exercise are often promoted as ideal for the achievement of the body beautiful as they claim to tone the muscles but not to create a bulky shape which is not desirable as this would detract from the femininity of the body (Markula, 2011a). The media will also sometimes refer to a woman who practices pilates as having the highly enviable 'pilates butt' (Tyzack, 2012).

Mindful exercise can also be understood as a disciplinary technique as it explicitly encourages a better control of the mind, this may facilitate the promotion of a certain kind of subject who is less stressed, more productive, healthier and calmer. Yoga classes, in particular, encourage a strong focus on the individual and their personal responsibility for their health. Individuals are often directed to thank themselves for treating their body with care and for working towards improving their personal health through their individual choices (Godrej, 2016). In this context, mindful fitness can operate as a technique of the self, allowing a constructing of the self which aligns with, 'market logic and consumer culture,' (Godrej, 2016 p. 10).

Mindful fitness forms have also been commoditized and a wide variety of associated consumer products are available to purchase in order for an individual to more fully assume the 'yoga lifestyle'. Lululemon is an example of a brand in the United States of America which has achieved notable corporate success selling expensive yoga clothing and accessories through

the use of healthist ideology and a promotion of the holistic health ideal (Stokes, 2008). Although South African yoga resellers are not as widely known or successful, 'athleisure', or active wear, has grown by 36% in South Africa over the last 5 years (Euromonitor International, 2017).

These discourses which are dominant within the fitness industry mean that even mindful exercises which attempt to divert attention towards alternative ways of understanding and interacting with the body and mind can be easily influenced and co-opted by these dominant ideas. However, Godrej (2016) argues that it is not sufficient to argue that mindful fitness forms like yoga were originally pure and free from neoliberal ideologies but have been twisted to support a neoliberal project. She acknowledges that this is the case in some instances but that there are certain aspects of 'original' or 'authentic' yoga practice which is simply well suited to a neoliberal context and others which are more challenging to the status quo. In this way, mindful fitness forms can function both to resist and to reproduce dominant discourses around the body, health, fitness and the self (Godrej, 2016).

Conclusion

The literature above addresses some of the complex ways in which constructions of health interact with political and economic contexts, as well as the ways in which health is situated within cultural understandings of morality and what it means to be a successful 'biocitizen'.

Previous research has explored the ways in which health discourses absorb and then reproduce neoliberal ideals of personal choice, individual responsibility and certain kinds of subjects. These subjects tend to be understood as 'entrepreneurial' when it comes to constructing their identities and make use of 'techniques of the self' such as exercising, healthy eating and reflexivity or mindfulness to improve the self. This self-improvement mandate is related to the culture of consumerism which often accompanies societies which are categorized as neoliberal. Consumer culture relates to conceptualizations and experiences of health through the ways in which individuals understand themselves as commodities which need to be constantly enhanced in order to increase their values. Understandings of consumption as an avenue

through which the self is constituted also influences how health is *done.* The way certain kinds of exercise practices and food consumption function to facilitate the construction of particular selves was also addressed.

Beauty ideals are also often linked up with health goals, and an ideal appearance according to western media is also viewed as a healthy appearance. These beauty ideals are also incorporated in the ways in which health discourses can function to reproduce normative gender roles. The ideal appearances of men's and women's bodies are often based on unattainable beauty standards but legitimated and reinforced through the use of discourses of health. Certain health practices also function to signify femininity and masculinity as they are traditionally defined.

Finally, the ways in which health status indicates either moral superiority or moral failure has also been explored. The construction of health as an individual's personal responsibility and the idealization of personal qualities such as self-control, productivity and happiness has fed into a social understanding of health as an indication of a person's worth to society and a determinant of whether or not an individual is understood to deserve self-respect and acceptance.

The current research aims to contribute to this existing literature by expanding on the ways in which health discourses relate to notions of subjectivity as well as the ways health discourses function to reinforce as well as resist the social order. The literature discussed above often comments on general trends in North American and European societies and focus on media sources and other forms of popular culture. This project looks at young adult South Africans and explores how health discourses are constructed within personal interactions and the ways in which these discourses are used to perform identity work.

Chapter 2: Theoretical Framework

In order to conceptualise the question of how health is constructed within South African consumer culture and neoliberal capitalism, this research draws on the work of Vivien Burr, Jean-Francois Lyotard and Michel Foucault. A social constructionist theoretical framework is used and special attention is paid to concepts including consumer culture, neoliberalism, postmodernism, the self, knowledge and power.

Social Constructionism

Social constructionism and postmodernism.

Burr (1995) argues that social constructionism took shape against the cultural backdrop of postmodernism and absorbed many of the ideas postmodernism is based on. Therefore, a brief overview of some of the important ideas of postmodernism (which are relevant to the focus of this project) may provide a useful background to the social constructionist theory which is drawn on throughout this thesis. Lyotard's work on postmodernism illustrates the progression from modernist to postmodernist thought and how understandings of knowledge have shifted. Therefore, the following section will focus briefly on his discussion of postmodernism and its relation to consumerism as it is presented in his book *The Postmodern Condition* (1984). Postmodernism challenges the ideas characterising the period of modernity. Lyotard (1984) understood modernity to be characterised by a belief in grand narratives that focus on human progress. In *The Postmodern Condition,* he argues that there are two main metanarratives that were prominent during the period known as modernity. They are 'The Speculative Grand Narrative' and 'The Grand Narrative of Emancipation'. The Speculative Grand Narrative was influenced by the writings of German philosopher Hegel in the early 19th century. Hegel proposed the idea that all true ideas could be synthesized into one philosophy which would explain everything and would not contain any contradictions. In a similar way, the Speculative Grand Narrative is a metanarrative which provides rules for all statements ever uttered and truth is judged according to how well a certain statement complies with the rules of this all-encompassing metanarrative.

The Grand Narrative of Emancipation is the second metanarrative Lyotard (1984) believed characterised modernity. This metanarrative equates knowledge with freedom and came about, according to Lyotard (1984), at the time of the French revolution where the enduring idea that education for all citizens would allow them to be freed from the current system of domination initially arose. Knowledge is valued very highly within this narrative as it is believed to be the means to ending the suffering of humanity. The enlightenment form of this narrative focussed on the ability of knowledge to allow people to question religious doctrines which had been oppressive and disempowering. This narrative framed knowledge as a tool which would lead to the end of exploitation, oppression and suffering, in other words, it was believed to be the means to empowering the disempowered. Both of these narratives encompass all other narratives and direct them towards the aim of bettering society as a whole and combining for the good of everyone. Lyotard (1984) argues that over the last 50 years these grand narratives have begun to be questioned and the changes in the way knowledge is organised has led to what he refers to as the postmodern condition.

Knowledge and neoliberal capitalism.

Lyotard argues that capitalism has become the force which drives research and the acquisition of knowledge now rather than knowledge for its own sake. A lot of research is dedicated to investigating ways of improving the efficiency of businesses and of making production and consumption quicker which would lead to increased profits. Lyotard (1984) argues that capitalism has resulted in the old grand narratives being destroyed and that this shift has changed both the way we think about what knowledge is, and its importance, as well as how we relate to one another.

Lyotard discusses how knowledge has become commodified and how it has become the basis for achieving power. He describes how countries with the best technologies, medicines and means to collect information about others have the most power. However, he points out that corporations (for example, pharmaceutical and computer companies) are the biggest challenges to the power governments of countries hold due to their access to research and knowledge which can be sold to make money. Naomi Klein (2000) discusses this argument in more depth

highlighting how in more recent years, companies have become directly involved in government policy. An example relating to health in South Africa involves the patents placed on anti-AIDS drugs (Malpas, 2003). In 2001 a group of pharmaceutical companies took the South African government to court as they claimed that they were not being adequately compensated for the research that had gone into developing these drugs. This was as a result of the government attempting to provide affordable medicine to its citizens but it was accused of not respecting the patents the companies had placed on them and therefore stealing their knowledge. We see here how the commodity the companies were trying to control was knowledge itself. The situation was eventually resolved and the medicines were sold at a lower price to South Africans however, 'the fact that a state could be taken to court by private companies for breach of patent shows how politically charged the ownership of knowledge has become,' (Malpas, 2003 p.31). The ways in which power and knowledge interact and the way knowledge is used for political purposes is significant when exploring constructions of health. Lyotard (1984) also argues that the change in the way knowledge and truth are perceived has led to a change in identity constructions.

These ideas, the fracturing of grand narratives and the shift in how knowledge is understood and valued, are important for the development of social constructionist theory.

What is Social Constructionism?

When explaining Social Constructionism, Burr (1995) argues that although there is not one single defining feature that all social constructionists possess, there are certain assumptions that a social constructionist approach may be grounded in. She lists four assumptions and suggests that a social constructionist approach would have at least one of these assumptions at its foundation (Burr, 1995). The first assumption is, 'a critical stance towards taken for granted knowledge' (Burr, 1995 p. 3). This means that we must question the way knowledge itself is understood and be critical of the assumption that what we observe is a reflection of the true nature of the world. We must become suspicious of the categories used to structure society and wonder about whether these categories are based on innately distinguishable things and what might result if we were to categorise things differently. Burr (1995) uses gender categories as an example of this and argues that, as social constructionists, we must question whether men

and women are a truly distinct binary and whose interests these categories serve. How these categories function in society and the kinds of possible actions and experiences they both allow for and prohibit are also important to consider. We could think about what it would be like if people were divided up using different criteria (for example, those who are tall and those who are short), or about what would happen if we decided not to separate people into groups at all. Thinking this way helps us to see more clearly how the categories we use, structure our lives and the way we think as well as how we understand ourselves and the world.

The second assumption refers to the historical and cultural specificity of the categories and concepts we make use of (Burr, 1995). Lyotard (1984) discusses the significance of culture arguing that people cannot objectively judge events as impartial observers of culture as we are all intricately tied to our culture. Our culture shapes who we are and how we are in the world, it shapes our way of understanding and viewing the world and the way we feel and experience it, it shapes how we relate to each other and the meanings we create. We cannot shake off our culture and see it from the outside. Living in a different place or at a different time would mean that the categories we used and the knowledge we took for granted would be different (Burr, 1995). This shows how the idea of universal truths is called into question as what we understand to be true is different depending on the culture and period in history. The implication that this has for social constructionist research is that when analysing ideas or discourses, it is important to locate them within their historical and cultural context in order to show how certain contexts facilitate or silence certain discourses.

This research focuses on the body and health, both of which are traditionally viewed in positivist terms situated in medical and scientific disciplines. The body (and particularly health) are often talked about as objectively observable, unmarked by culture. However, how the body is perceived has varied throughout different historical periods and differs according to geographical location. Bordo (2004) argues that in some nonindustrialised societies a body which is larger is identified as attractive and is a symbol of wealth. This is certainly not the case in more contemporary developed countries, where a body which is considered 'overweight' is seen as a health risk, a sign of a lack of self-control and a problem which needs to be rectified. This historical shift shows that the way different bodies are perceived and judged is not linked to any innate goodness or badness in any one body shape but is socially

constructed. The same body shape was judged and valued differently at different historical and cultural moments which illustrates the importance of context when attempting to understand the body and how it is viewed and experienced.

The third assumption is that knowledge is sustained by social processes. This means that what we regard as truth and the way that we understand the world and ourselves are constructed in and by our interactions with others, especially through the way we use language. Lyotard discusses the process through which meaning is constructed by likening it to the idea of a game played between people. He makes use of the term 'language games', credited originally to Ludwig Wittgenstein to refer to the different discourses which make up society (Lyotard, 1984). For example, literature, physics, laws and customs would all be referred to as language games and each language game would have its own set of rules. This research is interested in the use of health discourses in the construction of identity. When thinking about identity, psychological language games are often drawn upon to understand what constitutes a self, what kinds of selves we can be and why. Psychology constructs narratives about the self and this language game has certain rules about what facts are considered true and what kinds of knowledge is important. Lyotard observes that the rules of different language games are constructed by a community of people and are not innate or natural. He suggests that everything we say could be thought of as a 'move' in that particular language game. What this means is that social bonds are constructed through 'language "moves"' (1984 p.11) and the way we use language, and the rules we create to establish what kinds of things are acceptable, unacceptable, or even possible to say, structure our world. The different language games we participate in overlap and influence each other to structure who we are, how we relate to one another and how we make sense of the world.

The last assumption is that knowledge and social action go together. This means that the way we think about and understand certain things will invite different actions or ways of dealing with them. Certain constructions might, 'sustain some patterns of social action and exclude others,' (Burr, 1995 p. 5). For example, understanding health as the result of hard work and dedication may invite individual action aimed towards improving one's health, for example exercising or going on a diet. Discourses linking health with hard work function in ways that support this kind of action and in turn this behaviour allows individuals to embody certain

experiences of the self- one that is hardworking and virtuous. On the other hand, constructions of the self that value autonomy and are critical of dependence may forbid the direct interference in the health of others against their will. Examples of this might be the resistance to free national health care programmes or laws which prohibit certain behaviours because they are viewed as unhealthy, such as smoking or consuming alcohol.

Burr (1995) expands on these four assumptions to illustrate how social constructionism differs from more traditional psychological approaches to understanding ourselves and the world. Social constructionism is anti-essentialist. This means that social constructionists do not believe that people and things have innate essences which can be observed objectively. They believe that we are constantly constructing that which we perceive as the nature of things, through our interactions with each other. In the case of this research, health is treated as socially constructed instead of as a value-free and fixed biological state. The ways in which constructions of health are linked to ideas around morality and identity, and the ambiguity surrounding what ideal health includes/refers to, are explored. As a result, how we experience our bodies, and how we view ourselves and who we are, changes in different cultures, moments in history and interactions with others. For example, within current understandings of health, our bodies are often experienced in relation to risk (Petersen & Lupton, 1996). Environmental toxins, diseases, and food that is 'unhealthy', genetically modified or sprayed with pesticides are all considered threats to one's health. As a result of this experience of the body as 'at risk,' individuals are compelled to act in ways to decrease or avoid this risk. Those who are unsuccessful and contract a disease or who do not bear the social signifiers of good health are often stigmatised as a result.

Social constructionism also rejects the idea that what we see and know is a reflection of an external reality, in this way it is anti-realist (Burr, 1995). This means that the concept of truth becomes problematic. From a social constructionist perspective, it would be argued that all knowledge is fluid and depends on the contexts within which it is produced. Truth is viewed as situated within systems of meaning which determine which claims are understood to be true and which are not. Different truths serve different people and purposes and it is important to consider how these different truths came into being and their relationship to power (Burr, 1995). This is where we must pay particular attention to our culture and history. Different

cultural contexts and historical periods may facilitate certain truths or realities and deny others and this relationship works in the reverse too. In other words, our truths about what reality is create certain types of cultures.

Contrary to most psychological theories on the development of thought, social constructionism positions language as a pre-condition for thought rather than an expression of thoughts that pre-exist language. Language structures the way we come to think and the concepts and categories found in our language enable us to comprehend different things and provide us with, 'a framework of meaning' (Burr, 1995 p. 7). In relation to health, concepts like 'the body' or 'disease' are not seen as objective pre-existing things that language allows us to refer to and identify. Instead, language creates our ideas of these things (Lyons & Chamberlain, 2005). The ways in which our experiences of pain, distress, joy or calm are understood and addressed are contingent on the social reality we have created through language (Nettleton, 1995 as cited in Lyons & Chamberlain, 2005).

Social constructionists emphasise the importance of social interactions as the site of construction. In other words, the argument is that the systems of meaning which are used to structure our word are collaboratively constructed and reproduced through language and between people. This means that we should focus on language when attempting to understand the way people behave in these interactions (Burr, 1995). This study aims to explore the constructions of health that are produced within personal interactions. Language is crucial to these processes of construction and so it is important to consider how the ideas we have about health are facilitated by our language. When we understand language in this way it means that using language can be viewed as performing an action (Burr, 1995; Lyotard, 1984). The things we say and the words we use perform different functions and change the way we see ourselves and the world. It then follows that knowledge is not something inside of us that we possess but rather something that we *do* during our interactions with others (Burr, 1995). In other words, the focus of social constructionism is on the processes whereby knowledge, experience and identity are created through language.

The social construction of the self.

Identity, from a social constructionist perspective, cannot be viewed separately from language. It is also not enough to say that language affects the way that we think because this implies that our thoughts and language are separate things that can be examined individually (Burr, 1995). We tend to think about language as a tool to express our pre-existing thoughts or to assign labels to internal, separate ideas and feelings. However, social constructionists view language as inseparable from the person, his/her ideas and feelings or what we understand as his/her personality (Burr, 1995). Language is understood as, 'bringing the person into being in the first place,' (Burr, 1995 p. 33). This means that language creates and determines *how* we think and even *what we can* think about. Lyotard (1984 as cited in Malpas, 2003) asserts that 'A self does not amount to much, but no self is an island ... [E]ven before he is born, if only by virtue of the name he is given, the human child is already positioned as the referent of a story recounted by those around him, in relation to which he will inevitably chart his course,' (p.15). This illustrates how we are socially constructed beings and are part of a network of ideas and constructions which shape us, even from birth. Language provides us with possible thoughts, characteristics, ideas and feelings and in this way structures our experience as a person. It also means that people speaking a different language (with its specific concepts) or growing up encountering different discursive norms could have a very different experience of what it means to be a person and what the world is like. Language also provides us with categories, which are used to structure our existence. Categories distinguish things in the world and allow us to understand ourselves as separate from people or things which are placed into other categories. In many ways, we understand ourselves in relation to what we are not. For example, it would be fairly meaningless to identify oneself as a woman if the concept of man did not exist. It is also important to remember that the categories and concepts we use are not random, even though they may be arbitrary. They have come into existence as a part of a particular society and so are a part of creating and reinforcing the way we think about the world within these societies.

Lyotard (1984) argues that as a result of the old grand narratives being destroyed there is no longer a single guiding metanarrative. This has led to the identity of the individual becoming dispersed. "The social subject itself seems to dissolve in the dissemination of language games. The social bond is linguistic but is not woven with a single thread. It is a fabric formed by the

intersection of at least two (and in reality an indeterminate number) of language games, obeying different rules" (Lyotard, 1984 p. 40). Richard Sennet (1998) examines the construction of the self within the social and economic context of the transition to neoliberal capitalism. He speaks to this fragmentation of the self when he asks:

> *How can long-term purposes be pursued in a short-term society? How can durable social relationships be sustained? How can a human being develop a narrative of identity and life history in a society composed of episodes and fragments? The conditions of the new economy feed instead on experience which drifts in time, from place to place, from job to job . . . short-term capitalism threatens to corrode . . . character, particularly those qualities of character which bind human beings to one another and furnishes each with a sense of sustainable self.*

The social construction of the individual explains why we behave differently or *are* different in different situations. It tends to be commonly accepted that we have one true, authentic self and that this self remains constant, this is sometimes called 'personality'. When we enter into different situations we often put on the behaviour that is socially required of us. If this behaviour differs from what is understood as our 'true self' we are viewed as being inauthentic, betraying our 'real identities'. Rose (1998) and Atkins (2005) argue that societies which are influenced by the modernist narrative understand the self in a specific way. The self is seen to be fixed, inherent and coherent and can be understood through introspection. Social constructionist views of the self question this conceptualisation. Foucault (as cited in Mills, 2003) provides us with an alternate understanding of the self and views it as constructed through the social, historical and discursive processes we find ourselves surrounded by. Burr (1995) argues that there is no innate fixed self that we carry with us but that our self is constantly constructed through our interactions with others, especially through the linguistic interactions or conversations (Burr, 1995). This means that we do not have one authentic self but multiple selves that are constructed during the interactions we have in different situations. Foucault discusses subjectification, one of the processes through which individuals become subjects (Rose, 1998). Subjectification refers to the active process of transforming oneself into a certain kind of subject. This is done through creating the subject as well as recognising the self as a subject and relating to the self as such. This view of the self as an active agent in the

process of self-formation means that the self is an effect of power- the self is created- and an instrument of power- the self-creates (Rose, 1998).

In addition, Foucault's notion of 'technologies' are relevant when considering how subjects are constituted. 'Technologies of power seek to govern human conduct at a distance while technologies of the self are techniques by which human beings seek to regulate and enhance their own conduct.' (Arribas-Ayllon and Walkerdine, 2008 p.99). Technologies of the self are particularly useful for the focus of the project which is concerned with how discourses of health function to constitute certain kinds of subjects. Foucault (1988) defines technologies of the self as those which, 'permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality' (p. 18). From this perspective, the self is viewed as a work of art which is created as opposed to a self that simply exists. While this view effectively resists the notion of an innate 'true' self, in some ways the aspect of self-work for the purposes of transformation seems to have been co-opted to reinforce the idea of a fixed, single identity. The modernist view of the self as preexisting, within the context of consumer culture (which, through advertising, both creates, critiques and offers solutions to alleviate the problems of the self), has lead to an understanding of the self as innate but obscured. The sense is that there is a real, true self inside of each of us, but we can only access and reveal this self through a range of self-improvement strategies that often seem to involve consumption of some kind. Consumer culture offers up a wide array of subject positions which can be taken up through consumption of certain types. Buying and consuming certain products or experiences can be used to construct a certain kind of self with particular values, qualities, and also a particular physical appearance and health state. Foucault (1978) refers to these actions of using available resources to constitute oneself as a certain type of self as 'tactical productivity' (p. 433). Two good examples include how both exercise and food consumption can be viewed as efforts to work on and improve the self or 'technologies of the self'. Certain discourses construct certain ideal ways of being as well as guidelines or rules to abide by in order to achieve the ideal (Wright, O'Flynn & Macdonald, 2006).

Within a context where health is constructed as an aspirant ideal and in which consumer culture is prevalent, the constitution of certain kinds of subjects with certain structured subjectivities is facilitated. Gill, Henwood and McLean (2005) argue that the body and health have come to be viewed as malleable, and so individuals experience the body as susceptible to transformation provided that sufficient willpower and discipline is practised. Rose (1998) argues that unlike sovereign power, the form of power at work within these practices are governed by a 'reflexive hermeneutics'. Rose (1998), drawing on Foucault's work concerning technologies of the self describes the processes through which individuals are trained to develop a style of thinking about the self and reflecting on the adequacy of one's alignment to a set of moral norms. These reflections are then translated into actions of various kinds aimed towards self-improvement. This emphasises the role of the self in moving itself towards a certain state through the manipulation of the way one thinks and acts, and also through the physical form one takes.

The kinds of subjects which are viewed as ideal in certain societies at certain historical moments are influenced by and in turn influence the kinds of societies in which they come to be constituted. Contemporary, western influenced societies increasingly idealise subjects who are independent. This has implications for the kinds of subjects and the kinds of societies which can exist.

The individual in society.

The fragmented society.

The destruction of the old grand narratives and the dispersion of identity has meant that society and individuals are no longer unified in the same way that they were (Malpas, 2003). The old narratives bound humanity together in an ideal hope for the future which is no longer meaningful in the way that it was. Margaret Thatcher in the 1980s even went so far as to make the statement that there is no such thing as society, only individuals. The fact that people could feel no connection or unity at all with their fellow humans shows how much society has changed (Malpas, 2003). This kind of individualism has played a role in many other problems which will be discussed later.

German theorist, Jürgen Habermas, responded to the fragmented situation society finds itself in by suggesting that we should try to reconcile all the conflicting language games through negotiation and that this would allow us to try to achieve the goals of modernity again and reunite society (Malpas, 2003). Lyotard (1984) on the other hand does not believe that the grand narratives were ideal for many reasons and sees them as being politically problematic especially with regards to colonialism. He, therefore, argues that language games need to be fragmented even more. His concern is that if knowledge is united under a single metanarrative again and judged against a single set of rules it will become enslaved to capitalism and all knowledge which does not further capitalist development will disappear as it will no longer be valued. Lyotard (1984) views capitalism as 'a vanguard machine dragging humanity after it, dehumanising it' (p.63) because all knowledge is evaluated based on how well it serves capitalism's profit motive. One of Lyotard's greatest concerns about capitalism is its potential to reduce and restrict everything until it complies with the rules of the system. He contends that capitalism, 'necessarily entails a certain level of terror: be operational, or disappear' (1984 p.xxiv). Lyotard believes that if language games become more fragmented there will be a wide variety of language games which will be considered legitimate and so knowledge and research can be pursued in a wide range of areas.

Implications for future research.

Lyotard argues that the differences between language games need to be respected and by allowing a range of different ways of thinking new language games can be created. This occurs when someone breaks a rule of the language game and in order for the language game to not become contradictory, a new language game must be developed. He argues that this should be the goal of critics today, to resist universal systems by pinpointing their destabilising power and this will be a 'power that destabilises the capacity for explanation' (1984 p.61). This will lead to, 'new norms for understanding,' (1984 p.61). Fraser and Nicholson (1990) however argue that Lyotard's suggestion for social criticism to be 'local, ad hoc and non-theoretical' (p.25) does not allow for, 'generalisation or a critique of relations of domination and subordination' (p. 29). They argue that Foucault provides a useful template for a criticism that rejects universality but still exposes general trends and power dynamics while retaining a degree of locality by locating them within their cultural and historical context (McLaren, 2002).

Institutions and power.

Foucault's (1977) conceptualisation of the way individuals are regulated through what he describes as techniques of discipline is especially relevant for this topic. In Discipline and Punish (1977), he examines the way that discipline as a form of self-regulation is encouraged by institutions and permeates modern societies. He discusses how individuals internalise pressures from external institutions and then sustain the power relation by regulating their behaviour in order to conform to societal norms. These disciplinary pressures function in a way that makes it unnecessary for institutions to coerce individuals into conforming as these systems of control are internalised and enacted on the self. An example of this might be the decision to go on a diet in order to improve one's health. This decision may be experienced as a personal choice which results from an individual's desire to avoid illness or pain. This individual may carefully monitor the kinds of foods they eat and how much they consume. As a result, an external institution is not required to insist that this individual improve their health and force them to engage in health-promoting practices as they are taking care of this on their own.

The individual plays the role of the oppressor and the oppressed. These disciplinary practices are experienced as natural and originating from within the self rather than as being externally imposed (Mills, 2003). This process is not linear, so individuals are not passive recipients of cultural, social and economic norms. Instead, they interact with these ideas and adopt certain practices while rejecting others (Fox, 2016). Deleuze (1988) argues that we as individuals are constantly searching for our true, ideal selves and in doing this are regulated by a number of disciplinary techniques including exercising and dieting. If individuals cannot achieve the perceived 'ideal' appearance they must accept that they have failed and have not worked hard enough. In addition to inciting anxiety and self-doubt within the self, the proliferation of these discourses justify the economic and health inequalities observed in capitalist societies by victim-blaming the poor and unhealthy. Because these disciplinary practices are experienced as natural, we do not think about how we are constantly regulating our behaviours and emotions and we cannot imagine a life in which we did not do this. We transfer these patterns of self-regulation to our children through parenting and through the educational system (Mills, 2003).

Certain institutions have specific demands and requirements for the types of citizens that are acceptable. They, therefore, endorse strategies that will alter people's behaviours in a way that aligns with these expectations. Over time these strategies and behaviours become detached from the institutions they were associated with and begin to filter into all aspects of life. Foucault uses the example of the Panopticon in Discipline and Punish (1977) and The eye of Power (1980) to illustrate the way in which disciplinary strategies are internalized. The Panopticon is a prison constructed in such a way so that the inmates do not know when they are and are not being surveyed. As a result, they begin to behave as if they are constantly being observed.

Foucault refers to the way governments use their power to regulate the bodies of the public as biopower (Foucault, 1978). Within the concept of bio-power, the body becomes the site of the oppression and resistance of discursive power (Mills, 2003). Metzl (2010) argues that from a Foucauldian perspective, 'such biopower subjugates utterances that we do not agree with and utterances that we do, both of which serve to remove us ever more from the possibility of real resistance' (p.5). Governments often promote being active, consuming foods labelled as healthy and generally living a 'healthy' lifestyle in order to prevent illness in their populations. Foucault views health as a discourse of power and his discussion of bio-power illustrates how techniques of discipline interact with state interests for good health (as relating to 'increased force and productivity' (Dreyfus & Rabinow, 1986 p.8)). Biopower is reinforced through scientific research addressing health and fitness and linking them together (Markula, 2011a) and is supported by the fitness industry which offers fitness services which research has indicated promote health.

Markula and Pringle (2006) note that together governments and the medical discourse act to construct, 'certain forms of exercise as the correct way to prevent illness' (p.62). It may be seen as a good thing that exercise can prevent illness and improve health and that individuals can be informed about it. However, there are some negative implications for understanding exercise in this way. One of the rationalities used to encourage a regular exercise practice in relation to health promotion is that exercise can reduce stress. When we understand fitness in this way the responsibility for all aspects of health, again, falls on the individual and the cause of our ill health- relating to stress- is obscured. In other words, ill health is seen as a failure on

the behalf of the individual to properly manage their stress and not as a result of stressful circumstances. These sources of stress might include high-pressure jobs, economic concerns, or the demands placed on citizens to be successful and useful (Markula, 2011a). Understanding exercise as a means to improved health diverts our attention away from societal causes of stress and other health risks. It also reproduces individualism (Markula, 2011a) and so not only are individuals entirely responsible for their own health but we are, generally, not responsible for the health of others.

This research will be grounded in a social constructionist framework with a Foucauldian inspired consideration of power dynamics, the self and institutions to explore the discourses used to discuss health and identity within a South African context. These discourses will be situated within their social, economic and political context in order to better understand how power functions in relation to the governing of citizens and to the reproduction of the status quo.

PART 2: Method

Chapter 3: Method

Aims

Drawing on the scholarly literature in this developing field, this study aims to map how healthy lifestyles are constructed, and the subjectivities, behaviours and emotions that these constructions facilitate. It critically engages with the perception that the pursuit of health and wellness is always positive and will inevitably lead to a better, more fulfilling life. It also explores how consumer capitalism provides the context for certain health discourses to become ascendant, and how these discourses support and reproduce those very social arrangements.

Research Design

This research made use of a qualitative research design. Qualitative research tends to focus on how people experience the world around them (Willig, 2008). Qualitative research can be defined as, 'The interpretative study of a specified issue or problem in which the researcher is central to the sense that is made,' (Banister, Burman, Parker, Taylor & Tindall, 1994 p.2) as it is concerned with how people use language to construct meaning. The aims of this research, mentioned above, are best served by a qualitative approach as according to Burr (2003) these are, 'often ideal for gathering linguistic and textual data and are viewed as less likely to decontextualize the experience and accounts of respondents,' (p.149). In accordance with the theoretical tools drawn on in this research, which were discussed in the previous section, this qualitative project will be grounded in social constructionist understandings of the role of language and the social construction of reality, along with Foucault's conceptualization of the self and power.

Social constructionist theory influenced the way in which the topic of health was approached and the kinds of research questions which were deemed significant to explore. As a result, this research is not concerned with uncovering a single and essential underlying reality which has been previously obscured, but instead hopes to tease out some of the ways in which the use of language and social processes function to entrench taken for granted assumptions about health,

and to explore the ways in which these assumptions work to produce certain subjectivities and certain social realities.

Foucault's theories concerning the self were used to approach the topic of subjectivity, not as a result of an active agent with a consistent discoverable personality, but as an effect of discourse which is constantly reproduced in different forms depending on which discourses are selected in which social and historical context. Understandings of power as a productive as well as repressive force shaped the assumptions made throughout the study about the effects of discourse as well as about the role of the researcher. This concern with power made attempting to assume a degree of reflexivity throughout the research important. This was in order to facilitate disclosure of some of the ways in which the researcher herself is an effect of power as well as some of the potential ways in which power dynamics between the researcher and participants as well as institutional or disciplinary power facilitated certain constructions while limiting others.

Research Questions

1. What accounts of health, fitness, vitality, and illness and disease are offered by young urban South Africans?

2. How do constructions of health impact on the way individuals behave in relation to their health?

3. What kinds of emotional experiences do health discourses facilitate?

4. How do accounts of healthy lifestyles facilitate constructions of particular subjectivities?

5. How do constructions of health interact with dominant socio-economic structures like neoliberal capitalism and consumer culture?

6. Who benefits, and who is disadvantaged, by these constructions of health?

Sampling and Participants

Purposive and snowball sampling were used to recruit a total of 20 South African men and women between the ages of 18 and 45 and from urban areas to participate in the project. Purposive sampling involves approaching individuals according to their ability to assist with answering the research questions (Willig, 2008). In this case, purposive sampling was used to approach individuals who would be able to provide a range of perspectives on health: individuals who were interested in health but are faced with the economic challenge of accessing health improvement resources, students studying to become medical practitioners, individuals interested in 'alternative' health practices such as eastern medicine and yoga, individuals interested in 'lifestyle blogging' and those who described themselves as not consistently engaging in health-promoting behaviours. Some of these individuals were accessed through the author's personal and professional networks. In addition, local fitness centres and yoga studios were contacted in order to gain access to individuals who worked in health and fitness environments. However, responses to these requests for participation at fitness centres and yoga studios were extremely limited, with only 2 participants being recruited through this method. From there, snowball sampling was used to gain access to additional participants in order to increase the pool of interviewees.

The sample for this study included an equal number of men and women and included participants from the historically defined Indian, White, African and Coloured social groups across different economic classes. Participants from urban areas in Durban, Johannesburg and Cape Town were approached and individuals from middle-class and working-class backgrounds were asked to participate. The aim in doing this was to explore the similarities and differences in the way health is constructed across differences in race, religion, social background and income. Although the aspirant healthy lifestyles referred to are engaged with most actively in terms of consumption by middle-class individuals, this study also explores how these ideas about what it means to be healthy are engaged with intellectually, emotionally and socially by individuals who are economically excluded from many aspects of 'lifestyle healthiness', or who draw on other cultural resources that distance them from the increasingly hegemonic constructions of 'healthiness'.

Table Describing Sample

Pseudonym	Age	Race (As described by participants)	Gender	Occupation
Adele	40	White	Female	Teacher
Alex	23	White	Male	Unemployed
Amelia	18	Black	Female	Student
April	26	White	Female	Dance Instructor/ Health Blogger
Ben	26	White	Male	Yoga Instructor/actor
Callie	20	White	Female	Student
Christina	23	White	Female	Student
Derek	21	White	Male	Student
George	22	Black	Male	Student
Isobel	26	Indian	Female	Doctor
Jackson	25	Coloured	Male	Fitness Manager
Jo	22	White	Female	Unemployed
Lexi	28	White	Female	Teacher's Assistant
Mark	25	White	Male	Student
Meredith	21	White	Female	Student
Miranda	24	White	Female	Sales Agent
Nathan	35	Coloured	Male	Student
Owen	37	White	Male	Equity Salesman
Preston	22	Indian	Male	Student
Richard	19	Black	Male	Student

Data Collection

Data was collected using semi-structured interviews. Interviewing is generally understood to be, 'a conversation with a purpose' (Berg, 2001 p.66) this purpose was to explore the discourses

participants drew on to construct health and how these discourses functioned to constitute certain kinds of subjects with certain behaviours and emotions. This purpose differs from those traditionally associated with interview research and phenomenology, to access authentic understandings of an individual's 'inner world' (Fadyl & Nicholls, 2013). Although the use of interviewing in research which makes use of a Foucauldian understanding of the self has been critiqued by some scholars (see limitations), others have argued that a Foucauldian discourse analysis can be performed on any spoken or written text including interviews (Burr 2003; Willig, 2008). Interviewing has also been defended as a method which would provide a text containing statements that, 'while present in discourse, were somehow hidden or unarticulated in otherwise available texts,' (Fadyl & Nicholls, 2013 p.27). This research is not attempting to uncover secret discourses that do not appear in other texts, but instead has a particular interest in how broader discourses which are used to structure our society are used by participants in conversations to reproduce or resist the social order, as well as in the process of their own subjectification. Although a research interview is not the same as a 'naturally occurring' social interaction, the discourses drawn on in interview contexts reflect the discursive repertoires available to participants (Potter & Wetherell, 1987). In addition, a number of the same social norms and guidelines present in other social encounters are brought to bear on the kinds of conversations which can be had. Therefore, in this study the researcher has made an attempt to acknowledge how the power dynamics and 'materiality' of the interview event facilitated the use of certain discourses while limiting others. This study is interested in the discourses participants have available to them to make sense of issues of health and subjectivity. Interviews will provide an appropriate context in which to allow the researcher to explore the kinds of discourses which are drawn on by participants when discussing these issues.

The approach to interviewing most suited to this study and most compatible with discourse analysis and social constructionism is known as active interviewing. This form of interviewing was discussed by Holstein and Gubrium (1995) and involves viewing the interview as a 'dynamic, meaning-making occasion where the actual circumstance of the meaning construction is important,' (Holstein & Gubrium, 1995 p. 68). Semi-structured or semi-standardised interviewing was used, which lies in-between the very rigid question and answer format of standardised interviewing and the unstandardized interview which does not make use of an interview schedule at all (Berg, 2001). This approach makes use of a few broad questions or topics which are to be covered in the interview but allows for follow up questions and

deviations from the original intention of the questions depending on the responses of the participant. After having asked a scheduled question the interviewer asked follow up questions or probes to gain a deeper understanding of the participant's accounts (Berg, 2001).

Interviews were in-depth and lasted 44,5 minutes on average, however, one interview was quite short at only 25 minutes whilst a few were over an hour. The semi-structured nature of the interviews and differing experiences and communication styles of participants were the reason for this broad range. Interviewees were asked where they would prefer to be interviewed, and the location of the interviews included coffee shops, the interviewer's home and the interviewees' home. Interviews were based on a brief interview schedule (See Appendix 2) listing the main topics to be discussed and were recorded using a digital audio recorder as well as a cell-phone audio recorder and notes were taken using a notebook. Audio recordings of the interviews were then transcribed. Oliver, Serovich and Mason (2005) distinguish between naturalism and denaturalism when it comes to transcribing interviews. Naturalism refers to the mode of transcription where every vocal expression is transcribed, including pauses, nonverbal utterances and as many other details about the speech patterns of participants as possible. Denaturalism still includes a verbatim transcription of the speech of participants but excludes these additional details and instead focuses mostly on the, 'substance of the interview, that is, the meanings and perceptions created and shared during a conversation,' (Oliver, Serovich & Mason, 2005 p. 1276). The transcription mode used for this research was closer to the denaturalised version, however, utterances that were deemed relevant to the meaning making which occurred in the interview such as laughter, shudders, response/non-response tokens were included. Denaturalised transcription is considered appropriate for discourse analytic methods by theorists such as Fairclough (1993) whereas naturalised transcription is essential for conversation analysis (Oliver, Serovich & Mason, 2005). When research is concerned with the, 'content of the interview rather than the mechanics of conversation, denaturalised transcription is typically the chosen method' (Oliver, Serovich & Mason, 2005 p. 1277). Once the transcribing of the interviews was complete, online data analysis tool, Dedoose was used to assist with organising the data and making preliminary notes to aid the analysis process.

Data Analysis

Once the interviews had been transcribed the data were analysed using Willig's (2008) model of discourse analysis. This method requires the examination of the participants' speech and the underlying ideas structuring it. The theoretical framework which was used to ground this research draws on social constructionist theory with specific attention paid to a Foucauldian understanding of power and the self. These theoretical assumptions make discourse analysis an appropriate method for exploring the selected research questions.

The discourse analytic method relies on the social constructionist assumption that the way we speak does not reflect an external objective reality but is structured by dominant discourses in our society with which we interact to construct meaning. A discourse is made up of certain assumptions that are often taken for granted as true (Cheek, 2004). Parker (1994) defines discourses as, 'sets of statements that construct objects and an array of subject positions,' (p.245). Within this approach, our identities, social relations and the way we experience our environment are all viewed as constructed through the language we use at specific moments in history (Scott, 1992; Burr, 1995; Cruikshank, 1999). By considering participants' experiences through a social constructionist theoretical framework, taking into account historical, social and political processes, we are able to explore the construction of different experiences. The meanings assigned to experience are understood as constructed through the discourses in which individuals are enmeshed (Cruikshank, 1999). In other words, the language we have access to, the norms we are exposed to, and the systems of judgement we are a part of, work together to produce our experiences (Rose, 1998). The way we attach meaning to our experiences also has certain implications for our subjectivity. Different experiences make available certain ways of being, feeling, speaking and thinking (Scott, 1992; Cruikshank 1999). So while we may think that the way we experience the world is determined by the kind of person we are, social constructionists would argue that it is our experiences which make available certain subject positions and therefore determine the types of people we can be (McDermott, 2011; Burr, 1995).

This study made use of a Foucauldian model of discourse analysis because this model pays specific attention to the way discourses facilitate power dynamics (Willig, 2008). 'Discourse

is, with respect to the relation of forces, not merely a surface of inscription, but something that brings about effects' (Foucault, 2003 p.xx) and so we should view discourse 'as ways of conquering, of producing events, of producing decisions, of producing battles, of producing victories' (Foucault, 1974, p. 539 as cited in Marshall, 1999). In this way, Foucault's conceptualization of power is productive and not only restrictive. Things to consider include how discourses facilitate and legitimate this use of power and which discourses could or do challenge the dominant power structures. The dominant discourses in our cultures are usually intertwined with the institutions of our societies and they serve to support and sustain one another. This means that discourses are not only exercised through our speech but through the structures that have been brought about because of our language which now validates them (Willig, 2008).

It has been argued that 'there is no *method* to discourse analysis' (Potter & Wetherell 1987, p.175). Instead, discourse analysis involves drawing on a theoretical framework which guides the way in which discourse is understood, in terms of how it is defined and its role in society (Potter & Wetherell, 1987). Although there is no method in the traditional sense, there are a range of suggested approaches relating to how best to study discourses and Cheek (2004) argues that in order to avoid 'poor scholarship' (p.1141) and an 'anything goes' (p.1141) approach which simply makes common sense comments on a text (van Dijk, 1997), it is important for researchers to be explicit about the way in which the analysis of discourse was approached and conducted. The data in this research was analysed using a Foucauldian inspired version of Discourse Analysis which is concerned with the link between language and subjectivity and how our use of language constructs our social and psychological experiences (Willig, 2008). Foucauldian discourse analysis also explores how discourses have changed throughout history and how our subjective experiences are shaped by these historical changes (Willig, 2008).

For this research Carla Willig's (2008) 6 steps were used to guide the analysis of the data. Willig's version of Foucauldian discourse analysis was selected as it provides detailed guidelines focussing on the exploration of subjectivity, action orientation and subject positioning which are key aspects of the research questions. In order to effectively answer the research questions concerned with identity, in addition to following Willig's (2008) six steps,

one of the five methodological guidelines offered up by Arribas-Ayllon and Walkerdine (2008), the category of 'Technologies', were also drawn on. Willig's (2008) steps are as follows:

Stage 1: Discursive constructions.

During the first stage, the discursive object of the research was identified by going back to the research questions (Willig, 2008). In this case, the discursive object was health. The transcripts were examined and all the instances where health was mentioned were identified. Attention was also paid to instances where health was not explicitly mentioned as silence around the discursive object can also reflect dominant discourses relating to it.

Stage 2: Discourses.

During the second stage of data analysis, the different constructions of health were located within wider discourses (Willig, 2008). For example, the discourses of control can be situated within a wider discourse of individual responsibility. This is especially prevalent within individualistic, capitalist societies where individuals are expected to be entirely responsible for their lives.

Stage 3: Action orientation.

During this stage, the function of discussing health in certain ways was considered. Issues such as what the speaker gains by constructing health using different discourses at particular times were addressed (Willig, 2008). An example of this is when participants made use of the freedom discourses in the interviews and they discussed the idea of an openness around how health should be done. By qualifying their beliefs with the idea that these were just their opinions and what worked for them but should never be used to restrict others, they ensured that, should I believe different things to them, I would not feel criticised or offended. They would also be able to feel assured that they would avoid criticism from me as I would not be able to disagree with their personal experiences.

Stage 4: Positioning.

Stage 4 involves looking at the subject positions offered up by different discourses (Willig, 2008). In other words, talking about health in certain ways constructs the speaker as a specific kind of subject. For example, by constructing healthiness as a balance between indulgence and restraint (as in the balance discourses), the participants' made available the subject position of the easy-going, relaxed, confident and free individual who is also self-controlled and responsible. This construction allowed individuals to position themselves as healthy while still being able to cheerfully indulge in so-called 'unhealthy' practices on occasion. They could then constitute themselves as subjects who are not overly invested in health to the point of 'fanaticism', which would reveal undesirable personality traits such as insecurity or obsessiveness (Cairns & Johnston, 2015). At the same time, they were also able to enjoy the social benefits of being and appearing healthy.

Stage 5: Practice.

During this stage, the actions that were made possible through the use of different discourses were explored (Willig, 2008). Different subject positions and different constructions allow for different practices. For example, the chapter on balance discourses discussed the ways in which using these discourses allow individuals to negotiate social situations more easily. When attending family meals or social events centred around food, through using a balance discourse, individuals are permitted to consume food that in other situations they might avoid due to them not being considered sufficiently healthy. These discourses allow individuals the option of doing this and avoiding social tension while at the same time avoiding feelings of guilt or decreased self-esteem that might result from deviating from the 'correct' way of eating.

Stage 6: Subjectivity.

In this stage, the consequences, specifically in terms of emotions and experiences, of taking up certain subject positions were considered (Willig, 2008). The way different discourses allow the subject to see, feel and experience different things was explored. The freedom discourses, for example, allow individuals to experience their lives as open-ended and to feel that anything is possible and that they can choose their own path. As a result, individuals may experience

feelings of hope and empowerment. However, the use of these discourses may also lead to individuals feeling restricted and disheartened if they are not currently experiencing good health.

Technologies.

Willig (2008) explains that the six stages she outlines for the analysis of discourse cannot be considered a full Foucauldian discourse analysis due to the lack of attention paid to Foucauldian concerns such as the genealogy of discourses and processes of subjectification. She suggests that for guidance on how to approach issues such as subjectification, researchers should refer to Arribas-Ayllon & Walkerdine's (2008) methodological suggestions. The research questions for this study are not concerned with issues of genealogy, however, processes of subjectification are important to consider when attempting to answer the research question asking how accounts of healthy lifestyles facilitate the constitution of certain kinds of subjects. In order to answer this question and to explore the work that is done by participants to take up certain subject positions, I have added Arribas-Ayllon and Walkerdine's (2008) *Technologies* category to the method of discourse analysis that was used for this study. Arribas-Ayllon & Walkerdine (2008) suggest that researchers address the technologies of self and the technologies of power which play a role in the government of self and others. In this research, for example, the ways in which healthism plays a role in facilitating a constant monitoring and management of the self was considered. The ways in which the self is presented needs to be constantly 'calibrated' (Cairns & Johnston, 2015) in order to reaffirm and comply with the demand to stay healthy.

These guidelines were used to identify and discuss 6 discourses which were prominent in the speech of the participants and which had various implications for constructions of health, for subjectivity and in terms of the social order. These 6 discourses were: Happiness; Freedom; Control; Care; Balance and Goodness. These were not the only discourses which were drawn on by participants, however, they were selected for a deeper analysis and discussion based on three main factors. The first criteria for inclusion relates to ability of a discourse to address one or more of the research questions for this study. For example, research question 5 is concerned with how health discourses interact with dominant socioeconomic structures such as neoliberal

capitalism and consumer culture, therefore, discourses were selected based on their relationship to broader discourses which make up the social, economic and cultural networks in which they occur, specifically their relationship to neoliberal capitalism and consumer culture. Second, the consistency with which discourses were drawn on both within and across interviews was taken into account (Potter & Wetherell, 1987). The discourses which were drawn on heavily by individual participants as well as discourses which were used by many of the different participants were selected for further analysis. Some discourses which were drawn on frequently are not discussed in an individual chapter and are instead explored in relation to other discourses for example discourses of individual responsibility permeated a number of the other discourses which were used by participants and so this discourse is discussed throughout part 3. The third criteria involved the variability of accounts. Potter and Wetherell (1987) argue that reporting only on the areas of consistency between participants does not provide insight into the range of discursive resources individuals have available to them to construct their realities. Therefore, the discourses which were used in different ways or to perform different functions by different participants or by the same participant were selected. The balance discourse is a good example of a discourse which was used to both reinforce and resist idealised healthiness.

Ethical Considerations

All participants were given informed consent forms which were explained to them. They were made aware of the purpose of the study, what information was going to be used, how much time it would require should they choose to participate and how the information they provide would be stored and disposed of. The participants were also informed about who would have access to the transcriptions of the interviews. Consent to audio-record all interviews was obtained. Participants were kept anonymous and their names were changed, as well as the names of others they refer to. It was made clear that participants were free to withdraw from the study at any stage up to publication. It was not compulsory for participants to answer all the questions and so if they felt uncomfortable disclosing certain information they were not pressured to. I attempted to avoid any unnecessary emotional distress on the part of participants by refraining from asking questions which I believed to be intrusive or insensitive. However, participants were not discouraged from exploring issues which they seemed to find stressful or emotional. Through my studies in psychology and trauma I believed that I was capable of

containing the situation should participants become upset or anxious and I made sure that participants had contact details for me and my supervisor. Although it is usually not possible to know for sure the effects that we as researchers have had, I only noticed one participant express signs of distress during an interview. During a discussion about mental health, which was probably about halfway into the interview, I noticed her voice become a little uneven and she seemed tense in her body. She did not seem sad or very emotional, but she did seem a bit anxious. As she continued talking about other topics she did seem to relax again and so I did not question her about how she was feeling. I did send her an email the following day thanking her again for participating and asking her how she was. She took a few days to respond but said she was fine and when I saw her again she did not seem sad or anxious however seeing as though we are not close friends it is difficult for me to know for sure if the interview had any lingering effects. This experience reminded me of the ways in which discussions which at first may not seem to be focused on sensitive topics can still trigger emotional responses. Issues relating to health can be extremely personal and painful and participants discussed topics like chronic disease, depression, stigma, anxiety, insecurity, acceptance and physical pain. All of these topics could be experienced as stressful or uncomfortable or even seriously upsetting and so I attempted to be vigilant about observing the speech, body language and general disposition of participants during and after interviews for any signs of distress.

Limitations

One of the limitations of this study is related to the lack of diversity in the sample. Although individuals from a range of racial categories and class backgrounds were interviewed, the majority of the participants identified as 'white' and were from middle class backgrounds. Therefore, whilst the analysis provides an in-depth exploration of a small group's use of health discourses, discourses used by individuals from poorer or rural backgrounds or from racial categories other than 'white' may not have come through as strongly as they would have had the sample been more diverse. The relatively small percentage of individuals who were from working-class backgrounds may be partially a result of the level of wealth or leisure time required to actively engage in the kinds of health promotion activities that are socially valued. A relatively good level of health- which is likely related in certain ways to class and race groups- may have played a role in the willingness of participants to be interviewed for this study.

The lack of diversity mentioned above also relates to the reported health statuses of the participants. The group of individuals who were interviewed all described themselves as relatively healthy at the time of the interview, none were chronically ill and none were disabled. This may have influenced the kinds of discourses which were taken up and the ways in which these discourses played a role in the constitution of subjects. This also meant that this study wasn't able to explore the effects of these discourses on the subjectivities and experiences of those who would be marginalised by them. This could be an area to explore in future studies.

Another limitation could be the use of interviewing as a data collection method. According to Fadyl and Nicholls (2013), the use of interviewing as a data collection method in studies which draw on Foucauldian understandings of the self is methodologically problematic. This is because of the interviewer's role in the process of subjectification during the interview. Their concern is that the findings presented may simply be echoes of the original problems the researcher was interested in (Fadyl & Nicholls, 2013). In order to address this limitation, they suggest an inclusion of the material practices (Hook, 2001; Fadyl & Nicholls, 2013) that assisted in the creation of meaning, for example, the location in which the interviews took place, the physical positioning of individuals, and other aspects of the actual interview situation which may influence meaning making. In an attempt to incorporate these suggestions, above I included examples of how I attempted to reflect on my own position within the discourses used to construct health and on some of the ways in which I noticed my own behaviour or even just my physical presence play a role in the statements which could be uttered and as a result the kinds of discourses which were given prominence in the interviews. In the analysis section, I attempt to acknowledge certain situations in which I felt that the participant's constructions of health could be partially based on my presence as *witness of their speech* or *judge of their character* and the social norms surrounding our interaction that may have played a role in the discourses that were selected. This, however, would not constitute a thorough inclusion of the materiality of the interview event in my analysis and as a result, my discussion of the data may be limited.

Reflection

Most qualitative scholars emphasise reflexivity as an essential component of conducting useful qualitative research (Gill, 1995; Banister, 1994; Berg, 2001; Willig, 2008). This involves the process of thinking about where in the world the researcher is situated and how her subject positions may play a role in the kinds of findings which are discovered and how these are understood and presented. I attempted to consistently maintain a critical approach towards myself throughout the research process and kept notes as I progressed through the different stages of the research in order to facilitate this reflective process. By identifying how my views, my physical presence, my emotions and insecurities as well as my own personal values and beliefs played a role in constructing these findings, I aim to position myself as accountable (Gill, 1995) for these ideas and to facilitate a contextualized reading of the data presented.

I found the data collection phase of this project to be the most challenging. Recruiting participants and conducting the interviews took a long time and was an interesting yet stressful experience, and thus is an aspect that requires careful and critical reflection. Several important comments can be noted. Firstly, my involvement in, and influence over, the discussions and dynamics that were created in the interviews is unavoidable and although I consistently tried to reflect on and modify my behaviour to give the participants more space to express their views, I was definitely still a part of the meaning making that occurred. When listening to the interview recordings I noticed several subtle ways in which my behaviour varied both within and between interviews making my presence an integral part of the meaning making process. These included my voice changing depending on who I was speaking to, my mood, my involvement in the conversations, my willingness to share my own experiences and the level of intimacy I encouraged. Perhaps one of the most important ways in which my person influenced this process involved my concerns about being a "good interviewer", and remaining likeable and accessible to the participants I had recruited. Below I explore a few examples of how I attempted to manage these anxieties and the role they may have played in shaping the conversations I had with the participants and how they presented themselves in the interviews.

Firstly, I often found myself overly eager to agree with the views participants expressed, irrespective of whether they were consistent with my own opinions or not. For example, during the first interview I conducted, Meredith discussed her scepticism about and mild distrust of medical doctors and even though I do not share this view I chose to explicitly agree with her. I even added the supportive comment that doctors had a tendency to be dismissive of patients who mention information or research that they have discovered themselves, perhaps through the internet or other sources. Although I am aware of others noticing this, it has never been my own experience and I have a very positive relationship with my own doctor. I found it notable that I would not only express agreement with the participant but feel it necessary to illustrate my solidarity with her by elaborating on why I hold a particular view (which might not even be my honest opinion). Although I cannot be entirely certain why I did this, exploring some of the possible reasons which might have motivated me to act in this way may provide useful insight into these social exchanges. I could have been hoping that if I expressed agreement with her opinion she might feel comfortable enough with me to elaborate more on this. I may have thought that she was expressing a more moderate position than the one she really held because she wasn't sure if it was an acceptable view to me. If this was the case, then my behaviour was quite manipulative. I could have agreed with her because I wanted her to like me and to bond with her and thought that this was more likely if she believed us to be similar in certain ways or if she believed that I supported her views. Or I could have wanted her to feel comfortable with her own view.

In addition, I have noticed that I have a desire to make the participant I'm talking to feel good about themselves and I really have to fight my instincts to prevent myself from trying to make their opinions 'nicer' than they might be, or than I view them anyway. For instance, I also noticed myself repeating back to Meredith the ideas she had just given me but smoothing them over so they sounded more kind and "acceptable". For example, she expressed the view that people who do not experience good health should exercise more frequently. In responding, I said that I agreed that busy lifestyles make frequent exercise challenging and that this could negatively impact our health. I attempted to reframe her statement in a way that I viewed to be less victim-blaming. This may have been associated with my own discomfort around what I perceived to be problematic discourses and my own desire for the participants to view the world and health in a way that I deemed more accepting or

sympathetic. However, it also may be linked to the desire described above to agree with the participants in order to bond with them. I found it relatively easy to agree with some of the ideas the participants had for example if they aligned with my own or if they were ideas which I did not necessarily hold personally but also considered valid. However, I could not express agreement with some of the participants' views. In the example above, I could not agree with the participant's view as I felt that she was arguing that unhealthy people were lazy and I believe this to be a harmful idea. Therefore, in order to continue to bond with participants through the expression of solidarity, I needed to adjust their statement to move it closer to an idea I felt comfortable endorsing. When I did this, in this and other interviews, the participants agreed that that was their intended meaning when expressing their point. However, it also seems possible that they are agreeing because they believe I think that the reframed version of the idea is more appropriate. This shift illustrates some of the contradictory discourses that it is sometimes necessary to draw on in order to comply with healthiness ideals. In the first instance, it was necessary for the participant to draw on discourses of self-discipline, she needed to differentiate herself from the lazy, unhealthy people in order to position herself as healthy. However, discourses of goodness and amiability also came through frequently in constructions of health. This meant that in order to be considered healthy it was important to be kind, warm and positive towards others. By introducing this second aspect of health I may have been revealing a possible area in which the participant was not currently enacting ideal healthiness and so she felt compelled to incorporate my variant of her view too.

Reflecting on this kind of behaviour in the interviews made me feel uncomfortable with the kind of influence I might be having on the meanings created. Despite believing that positivist values such as objectivity are not really achievable or even valuable in the research process, I still felt attached to some of the ideas about 'good researchers' and how they should not 'contaminate' the research data by influencing the participants' answers. Once I had noticed this behaviour, in an attempt to avoid imposing my own filter over the participants' responses in the interviews, I tended to become more quiet and instead tried to select more open ended probes to encourage participants to explain their views further, one word prompts (okay, oh I see) and chose non-verbal ways of engaging with them for example nodding or smiling. I attempted to ensure that they still felt that I was interested in and was listening to them while at the same time attempting to reign in my need to frame their responses in a certain way and

avoid encouraging them to shift their positions. This illustrates a tension I experienced between wanting to bond with participants as well as to produce useful data to analyse and to be considered a 'professional' researcher. It also illustrates the tension I experienced between the contrasting ideals present in more critical social constructionist research and positivist research traditions.

However, it is unclear if my method of withdrawing more in the interviews was an improvement on my previous form of engagement as Potter and Wetherell (1987) encourage a more confrontational approach to discourse analytic interviews while Burns (2006) uses the interview space as an opportunity to challenge dominant discourses which can have negative implications for participants or which are viewed to be politically problematic as well as to make available alternate discourses. One possible reason for my reluctance to do this kind of confronting in interviews may have been related to my anxieties around recruiting participants. It took me a very long time to recruit the twenty participants who were interviewed for this study and perhaps I felt that if participants felt uncomfortable during the interviews they would be less likely to assist me with referrals. However, I am also generally fairly passive and non-confrontation in other contexts, and so would have felt uncomfortable challenging the ideas participants had. This also presented a challenge because although I wanted to be liked by the participants and I did not feel comfortable challenging their ideas, I also feel a deep concern about the way health is constructed and some of the negative implications these constructions may have. This is a significant reason underlying my decision to explore this topic and so listening to the kinds of discourses which I and others have experienced as harmful and allowing them to go unchallenged was unsettling.

Another important observation includes how my physical presence seemed to have an effect on the assumptions participants made about my health and related to that, the ways in which they were willing to construct health with me. One participant discussed a scenario where he was observing patrons at a popular fast food chain. He commented that I 'don't look like the kind of person who goes to KFC' (a fast food restaurant) implying that I appeared healthy or thin to him and so in this situation he felt more comfortable criticising those that did frequent this restaurant as he felt confident that he would not be insulting me. In this example, 'my body existed as a resource for participants' sense-making' (Burns, 2006 p.11). My body was

interpreted as a representation of what my beliefs and behaviours might be, which facilitated the expression of certain discourses in certain situations while silencing others. Dominant discourses associating slenderness with health and the idealisation of both functioned, in this interaction, to shape both the kinds of discourses participants could draw on to make sense of their own health as well as my own physical body (Burns, 2006). Another example of how the kind of person I was interpreted to represent influenced the interviews was in an interview with a different man where he appeared to be about to criticise the 'body-positive' movement on Instagram (where women who are traditionally considered to have 'overweight' bodies post pictures of themselves celebrating their bodies in an attempt to resist dominant discourses about female attractiveness). The participant spoke about this phenomenon in a disparaging tone however he stopped himself from finishing his sentence as he became conscious of my presence and the fact that the interview was being recorded. It may have been because I am a woman and he feared he may be insulting me or that I might disagree with him or think that he was being unkind or unfair or it may have just been that being critical of people's bodies (particularly those of women) has become increasingly socially unacceptable and so he felt that pressure and then decided not to speak.

Finally, I found the analysis process to be the most interesting and enjoyable aspect of the research process despite the fact that it was also challenging and time consuming. These positive associations may have been partly because I felt I was able to make up for my lack of confrontation in the interview process in my analysis. Through my analysis I was able to challenge and critique some of the views participants had expressed in interviews but that I was unwilling or unable to confront at the time. During my Masters research project, I found the analysis process quite a bit more difficult mostly because I felt uncomfortable with the idea that I felt that I was criticising the views of the participants by illustrating some of the problematic consequences of views like theirs and the ways that these potentially damaging discourses served them. I felt that I would not want the participants to read my discussion because I worried that they would be hurt or offended and I experienced a sense of guilt as a result of this. During the analysis for this project however, I felt less concerned about this as I felt that I too shared a number of the participants' views about health and so when critiquing these discourses, I felt that I was both the one analysing and the one being analysed. I felt that I was a participant in this research myself, who is constituted by the same discourses that were used by interviewees (Burns, 2006). This enabled me to feel less like I was placing

myself in a position of superiority to the participants and I felt that I was better able to empathise with the ways in which discourses like these feel necessary. This enabled me to more deeply explore some of the emotional implications for the discourses used to make sense of health, as I have had experience with some of these feelings myself.

PART 3: Analysis and Discussion

Introduction

This section includes an analysis and discussion of 6 main discourses which were drawn upon by participants in their speech around the topic of health. These discourses are a few of many which were used during interview conversations and would not constitute a complete account of how health is discussed, experienced or understood by the participants. The discourses which will be discussed in the following chapters are Happiness, Freedom, Control, Care, Balance and Goodness. These discourses are considered in terms of the work that is done through them, the kinds of understandings and experiences of health they construct and the kinds of subjects they serve to constitute. All of the discourses discussed in the following chapters are interrelated and, at times, difficult to separate out from each other. For example, discourses of happiness at times incorporate discourses of goodness when health is constructed as an avenue to happiness based on its ability to facilitate self-acceptance. Another example is when discourses of care are used to introduce a sense of balance to one's health which may otherwise be shaped primarily by discourses of control. In addition, wider discourses of individual responsibility, productivity and a moralism surrounding health are woven through all 6 discourses. The relationships between discourses are explored as well as their position in relation to wider discourses which structure the participants' and researcher's realities.

Chapter 4: Happiness

'The groundwork of all happiness is health'

Hunt (1859 p. 174)

'I have begun to be somewhat merry because I have been told that that is good for one's health'

Voltaire (1761 as cited in Orieux, 1979 p.313)

The concept of happiness played a prominent role in participants' discussions around health. Happiness was incorporated into the participants' constructions of what health means, as well as implicated as a prerequisite for health, and as a signifier of healthiness. Happiness was often viewed as one of the more significant goals that were aspired towards through the pursuit of health. It appeared that happiness was seen as a likely outcome of a healthy lifestyle. This belief relates to a number of other discourses surrounding health, particularly the morality associated with health pursuits, the commodification of happiness, the idea that there is a healthy appearance which can be achieved and is desirable, and the internalization of the responsibility for effectively managing one's emotions. The dominant neoliberal idea that one's life is a project that only the individual can create and therefore all outcomes, positive or negative, are expressions of what an individual deserves, is also threaded through these discourses of happiness and health.

In the interviews with participants, happiness was associated directly with health in three main ways. The first was the way in which happiness was viewed as a signifier of health- healthy people were seen as more likely to be happy, and the expression of happiness was a characteristic used when evaluating whether or not someone was healthy. In the second way, health was also constructed as in service of achieving happiness, some of the reasons relating to the pursuit of health were associated with the ultimate goal of achieving happiness. Finally,

happiness was constructed as an important contributing factor to improved health. It began to appear that it is extremely difficult to be considered healthy if one is not happy. In the first section of this chapter, these three relationships between health and happiness will be discussed in more depth. Then the relationship between health and happiness will be explored, paying special attention to morality and then to the construction of happiness in the context of health discourses (in other words when discussing health, what does happiness mean?).

Healthiness Leads to Happiness

Happiness was constructed by some participants as evidence of someone's healthiness as well as the likely outcome of a healthy lifestyle. In the quotes below, participants were not discussing their motives for engaging in health behaviours but rather their experiences of what healthiness was like and how health is perceived in others.

Amelia: *you feel the difference in health obviously… because your health makes you feel happy and energized*

Jo: *for me, my personal experience, those who are healthy tend to be happy, happy and friendly…*

In the above two quotes health is constructed as leading to happiness, happiness is a result of one's healthiness. This construction allows the subject a sense of agency and control over their emotional state and it positions feelings of happiness as deserved. In other words, happiness can be viewed as a reward for sufficient effort or self-discipline. The notion that positivity and happiness are achievable through health pursuits and the attainment of a certain health status is related to the individualization and internalisation of the responsibility for one's life in neoliberal contexts. Binkley (2014) discusses the 'new happiness' (p.1) discourse prominent in neoliberal societies and explores how happiness is constructed as 'enterprise'- emphasising the internalised responsibility for working upon the self in order to improve one's emotional wellbeing. Happiness is often treated as a resource, in these societies, to be exploited in order

to gain a competitive advantage over others in the neoliberal marketplace (Binkley, 2014). Personalities have become important resources in neoliberal societies (Fromm, 1956) and Jo emphasizes the importance of healthiness in relation to a desirable personality when she associates healthiness, happiness and friendliness. On the other hand, unhealthy people are seen to be unhappy and negative, as described by Miranda below.

Miranda: …*you know you can see if someone's looking good and they seem to have a fresh positive outlook on life. I don't know, they don't seem to be having all sorts of issues and things. I mean sometimes, you know just from a brief conversation with a person, you can hear that maybe they do have a certain chip on their shoulder about something…*

In Miranda's quote, the healthy person is constructed as one who both looks 'good' and is 'positive' and cheerful. From the above quote, it seems that healthiness is sometimes thought of as preventing negative experiences or protecting individuals from their effects as, perhaps, if they are healthy they are understood to be less negatively affected by unpleasant situations or problems in their life. Within this construction of happiness and its relationship to health, there is a conflation of positivity and happiness. Miranda describes healthy people as having a 'fresh, positive outlook on life'. To be happy, in this context, does not necessarily mean to be subjectively content or satisfied with one's life, it is also not to be momentarily joyful, instead, it is an attitude of positivity that is carried with an individual into any situation they may encounter.

These quotes also imply a perception of healthy people being more likeable, it is more enjoyable to be around someone who is in a good mood and who is energetic and friendly. The tired, withdrawn, unhealthy person with a 'chip on their shoulder' is not described with the same warmth or positive associations. Within this way of thinking, individuals considered unhealthy are constructed as more difficult to like and the implication is that if they were to improve their health, not only would they feel better about themselves but they would also be more valued by others. Halse's (2009) notion of the 'biocitizen' addresses this idea. Individuals should ensure that they are healthy not only to facilitate greater productivity, happiness and

vitality within the individual, but also for the sake of their society. Happy healthy individuals are believed to be members of society who assist in it's successful functioning and take responsibility for themselves, unlike the unhappy, unhealthy individuals who are stigmatised in relation to their dependence on others.

Health Behaviours as a Source of Happiness

Some participants described finding joy in specific health practices. In these quotes, it is not necessarily a sense of healthiness or an overall state of good health that leads to feelings of happiness but specific health-related behaviours.

Nathan: *one of my pleasures that I used to enjoy was exercising overseas … I mean, it's been a dream of mine to always like run in [park] and I got to do it like on two occasions and it's quite massive. And towards the end of my career with doing the [race] running past [place] and [monument] and once you finish you feel such a sense of accomplishment, and sense of joy. And… the last one I did was December and finishing crossing that finish line, whether you like last or first, ok I don't ever finish first, but like for me more in the middle or last, I mean it's one of the biggest satisfactions ever. But what I do realise also is if I do any of those races, and I'm not fit to do those races, I don't really enjoy it.*

Jo: *I enjoy boot camp but that is really intense though. I don't know if you've been to a boot camp. It's really intense… So there like a whole bunch of exercises we use our body weight and it's like you die and the next day your muscles are like aching and sore and but it's good. I really enjoy that.*

Miranda: *I really enjoy eating um and I enjoy cooking as well you know I find that's quite a creative and relaxing thing for me even after a long day at work generally or more often than not I will enjoy cooking and I enjoy cooking things that I know are healthier um it just makes me feel good, knowing that I'm putting something into my*

body that's more healthful than destructive ja I definitely enjoy eating and cooking for other people, ja.

Owen: *I think it's something I enjoy I think when I know that it supports me … and really the nutrition, and the like medicine that I need, then it makes me almost happy. Like I feel very happy.*

Owen describes how his efforts to engage in practices of support and self-care, by making sure that he provides himself with the 'nutrition' and 'medicine' that he needs, lead to feelings of happiness. His kindness toward himself and his commitment to successfully maintaining his good health are rewarded with feelings of happiness.

The participants above explain that they '*enjoy*' engaging in healthy behaviours. Although the idea that exercise and healthy eating can be enjoyable might serve to resist 'no pain/ no gain' ideas relating to health and fitness, the construction of *ideal* health behaviours as enjoyable may place additional pressure on individuals as not only do they have to discipline themselves physically, they also have to monitor and modify their mood to ensure that they are 'having fun' while they exercise (Markula, 2013). If an individual does not particularly like exercising or eating healthy this may be experienced as an additional burden as in order to make sure that their health behaviours are *really* healthy they need to appear to be enjoying themselves.

From Nathan's quote, it also appears that enjoying health behaviours is, in some cases, dependent on having already attained a certain level of health. Nathan does not enjoy his run as much when he is 'not fit'. Engaging in challenging exercise practices when one is already in a state of good health may reinforce a positive self-concept. Feeling comfortable and not too exhausted or strained while exercising may provide a reminder to individuals of their health journey and the hard work and discipline they have put into their exercise practice. These kinds of traits- disciplined, hard working and autonomous- are valued highly and may allow individuals to feel good about themselves. However, feeling tired and unfit while exercising may lead to negative feelings towards the self due to the reminder of the absence of sufficient

previous exercising. Conversely, feeling exhausted and having 'aching', 'sore' muscles as a result of exercising is not always shameful as we see in Jo's experience. She finds an extremely challenging workout practice enjoyable, possibly because the pain inflicted on the self during exercise enables individuals to view themselves as willing to struggle and suffer for the sake of their health, illustrating their hard-working, committed natures.

Endorphins.

A number of participants mentioned the role of endorphins when linking positive mood or happiness to health behaviours. Mark responded as below when asked what it feels like to be healthy.

Mark: *Very much improved mood, endorphins and that…*

By drawing on knowledge of endorphins to describe their mood after exercise, participants are making use of a scientific discourse to construct their experiences. By explaining their improved mood through hormonal changes as a result of physical activity they can be assured that exercise is a reliable source of happiness as a *physical* reaction is taking place which is proven by scientific studies to exist. In addition, the scientific field, in general, is upheld as a knowledge authority through this way of understanding happiness and health.

A link between health, happiness and endorphins is also constructed in the two quotes below which describe a need for endorphins to both prevent negative emotions and to promote positive ones.

Jo: *To a point I also think it's the body that says look I need these endorphins. For example, if you're feeling sad or feeling gloomy, to get that extra boost. Because the body and the psychology they're, they relate*

Callie: *And she [her roommate] can't go a day without exercising, yesterday she couldn't fit it into her schedule so she ran up thirteen flights of stairs twice 'cause we live on the thirteenth floor so she just did the stairs twice I was just wow! I'm happy just watching T.V. thanks, I haven't exercised for two weeks maybe two months ja... 'cause exercising makes her happy it gives her endorphins and what not and she gets really happy about it.*

Callie's quote above describes her perception of her roommate who 'can't go a day without exercising'. She does not explain why her roommate must exercise every day or what would happen if she did not exercise on a certain day but her commitment to ensuring that she exercises despite her circumstances shows that it is an important priority that is not easily forgone. Callie explains that her roommate gets 'really happy about' exercising and attributes this happiness to endorphins. However, if considered in the context of the social pressure to exercise and take care of one's health and, for women, in particular, to attain or maintain slim bodies with little fat, the need to exercise may be understood to result, in part, from a sense of anxiety. Individuals who do not sufficiently 'take care' of themselves or their appearance are often judged harshly and assumed to be morally lacking in some ways (Crawford, 2006). There are a number of reasons why individuals might feel pressure to exercise regularly. In this context, we may consider the effects of reframing the cause of the positive emotions individuals experience after exercising. If individuals did feel anxiety about not exercising sufficiently, they might feel a great deal of relief after they had effectively lived up to social expectations. Freedom from guilt and a sense of pride may also lead to positive emotional experiences after exercising. In contrast, making sense of these feelings through the concept of endorphins allows individuals to discount any of the pressure or anxiety they may feel about pursuing health or managing their body in an acceptable way. These kinds of feelings are not considered healthy and reveal a sense of insecurity which is socially discouraged (Gill & Orgad, 2015).

Her description of her roommate running up and down the stairs to ensure that she exercised that day may have been perceived by some of the other participants as excessive as some of them tended to be critical towards individuals who were unable to react nonchalantly to situations where their ideal health practices were made impossible or uncomfortable. Callie however, does not criticise her roommate or view her actions as problematic, even though she

does not share her roommate's enthusiasm for exercise, because she sees her roommate as being happy as a result of her behaviour. In the chapter discussing discourses of balance in relation to exercise practices, it appeared that excessive healthiness or a rigidity around pursuing health was perceived negatively. However, this may be because the assumption was that individuals who practice health in this way are unhappy, anxious, unkind or lonely as a result. Callie's roommate is described as happy not in spite of her need to exercise daily, but because of it. In this example we could draw the conclusion that if the individual is sufficiently happy, health behaviours that could otherwise be judged to be excessive or unbalanced could be overlooked. The tendency towards viewing happiness as an obvious good means that this discourse, which links up health and happiness, also functions to legitimate health as a moral and worthy pursuit. As Ahmed (2010) argues, 'when happiness is assumed to be a self-evident good, then it becomes evidence of the good' (p. 13). Happiness, therefore, participates in making healthiness good (Ahmed, 2010).

Below, Nathan describes his experience of the effects of endorphins.

> Nathan: *Whenever I'm fit and stuff, I feel like I've got more energy. I feel… the feeling of endorphins, the hormone, you almost feel happy after exercising. I won't say that I'm not happy when I'm not exercising, I mean I try, but I mean you just feel like your mood and everything, like- look, like yesterday for example, I haven't ran in two months, I ran in the morning and I had all this energy and then- so I went for a haircut and normally I'd go in my car, but because I took it in yesterday to the dealer, it had some problems that they sorted out, so I took a nice walk to the hairdresser, and I haven't done that in years, and the weather was nice, and I just felt so energetic and I felt like I didn't have any assignments, and I felt like I wanted to go out in the evening, so I think ja, that definitely plays a role compared to when you are not exercising.*

In Nathan's quote, he attributes his happiness after exercising to endorphins but he also makes sure to mention that he is not unhappy when he is not exercising. This reluctance to admit to feeling negative emotions or the need to distance oneself from being perceived as experiencing sadness again illustrates the social pressure to appear happy at all times (Ehrenreich, 2009).

Nathan also says 'I try' meaning even when he is not exercising he is trying to be happy, showing an internalisation of the responsibility to improve one's mood through one's own efforts.

Another interesting aspect of this quote is Nathan's description of his walk to the hairdresser. He mentions that the weather was nice and he 'didn't have any assignments' however he attributes his good mood to the walk itself. This is not to say that his exercising could not have played a role in his positive emotional experience but illustrates that there were other options that he could have chosen to construct his experience. For example, he might have explained the relief he felt as a result of not having the pressure of university assignments or the freedom he felt as a result of being outside on a nice day rather than being in a classroom, however, he selected exercise as the main source of his happiness. Through doing this he is able to validate his belief that his mood can be controlled through his own efforts and that exercise is a pursuit which leads to improved mood. This belief may play a significant role in motivating himself to engage in physical activity. Framing his experience in this way may enable him to sustain a degree of this motivation to continue to exercise in the future seeing as though the reliability of its positive effects was reinforced. This description also supports and reproduces the prevalent belief that engaging in health practices is personally beneficial and is a worthy pursuit. In this way efforts to take responsibility for the self and one's emotions leads to a facilitation of additional attempts to do the same. Nathan 'ran in the morning' and then 'took a nice walk' because his run had left him feeling like he 'had all this energy'. Disciplinary efforts are framed as rewarding which motivates a continuation of the disciplining of the self. Nathan has also constructed a reality in which he is permitted to feel proud of his efforts to exercise as he is taking his mood into his own hands and working to improve it. Through the use of these discourses he is able to constitute himself as an active agent who takes responsibility for himself.

Happiness as the Goal of Health

The idea that it was important to pursue health because good health would lead to happiness was also noted in the speech of participants. The following quotes illustrate how health was

constructed as a reliable path to achieving happiness and how the association of happiness as an outcome of health legitimated health as a worthwhile and important pursuit.

Interviewer: *So do you think it's the physical benefits of health that encourage people to be healthy?*

Amelia: *Also the emotions as well, ja definitely ja. Because if you feel healthy, you are healthy, you happy.*

Christina: *…you desire for your friends to be happy and I think that health, a healthy lifestyle, a holistic healthy lifestyle, is one of the easiest ways for someone…. I mean obviously circumstances, like you can be a healthy person and still be in a car crash and it doesn't help, but I mean like for a baseline of life, it's often your health is something that I feel like we can have some control over. But I think that if you feel like you can control, like you want them to make the healthy decisions, because it's one thing that they can control, and they can like help them to be the best type of person they can be, and they can feel happy within themselves.*

Nathan: *I think you know, for a longest part you know, when I wasn't happy in my airliner year, I mean obviously when I was there, I was you know, like I never like lashed out at a customer or at my colleagues. The exercising basically helped me a lot, like overseas, basically helped me to put myself in a good mood. I mean apart from doing it for myself, ja my mood at work was totally better. There used to be a time before a shift, I would maybe like train twice already before a shift. Like I'd run in the morning or go for a cycle and then still go do a shift. I would be tired but I would be more happier.*

In this context happiness discourses were also related to discourses of control as health pursuits are seen as ways to achieve happiness through one's own efforts. Other people and our environments are viewed as unreliable, inconsistent sources of, or even hostile in relation to

the achievement of, happiness. Health is positioned as '*one thing that they can control*' and so individuals need to take the responsibility for health and happiness into their own hands. This is not only because happiness cannot be assured otherwise but also because happiness is understood as an obvious good. Individuals are rewarded for being or appearing happy, independent and self-controlled and punished for appearing unhappy, dependent or weak-willed (Ehrenreich, 2009; Cederström & Spicer, 2015). In many ways happiness has become a moral obligation which signifies not only health but also the moral value of an individual (Cederstrom & Spicer, 2015). This obligation towards positivity heightens the stakes of our health and happiness pursuits as it is not only the individual who is personally disappointed or who struggles emotionally as a result of not achieving health and happiness but also because individual failure to appear happy is viewed as socially and economically damaging (Ehrenreich, 2009; Davies, 2015). The idea that happiness is related to economic benefits is touched on when Isobel discusses the productivity of a healthy happy person below.

Isobel: *Like in my mind a happy healthy person like gets more done in the day and might be more active and more keen to try something new or like go to a class or go to a talk or something like that. Whereas an unhealthy, unhappy person, who is just feeling more run down, would be more likely to stay in or really not want to be out and about.*

Isobel does not explicitly mention work here but the active individual who is interested in improving her skills and getting '*more done in the day*' is an ideal employee. Isobel describes a happy and healthy person as efficient, willing to learn ('*keen to… go to a class or…a talk*') and as a more active social participant. The unhealthy person is painted as '*unhappy*', '*run down*', more susceptible to the harsh effects of the environment and withdrawn from society ('*really not want to be out and about*'). Happiness in neoliberal capitalist economies is often conceptualized in financial terms relating to the expensiveness of unhappiness. Increasing the happiness of a population is presumed to lead to a decrease in costs relating to work missed as a result of mental health challenges, disengaged employees and public health costs (Davies, 2015). On the other hand, improving the happiness of populations is believed to improve their productivity and as a result the economy of a country (Davies, 2015).

The duty to be happy comes through in quotes which emphasise health's association with happiness when defining what healthy means and what constitutes a healthy behaviour. In other words, even practices which are generally agreed upon as healthy may be considered unhealthy if they do not bring happiness. Below, Owen discusses the way his experience of happiness and the amounts and types of exercise that he does relate to each other.

Owen: *I think my views on exercise have changed, so I probably see it now as not, something I need a lot less than I thought I did. Again, I think if it's very supportive and it's kind of in the areas of my real interests in life. Then I'm very happy exercising and I'm just very careful not to take on too much. And that's just because of where I've been in the past. So the exercise I do is mostly yoga and surfing and those things make me happy.*

Owen describes a conscious decision to pursue exercises that make him happy and avoid doing too much exercise. By describing himself as previously being in a position where he exercised too much and now engaged in a more moderate, joyful exercise practice, Owen is able to illustrate his ability to be intensely self-disciplined and hardworking while avoiding any negative judgements upon his current self as too obsessive. As with a number of participants discussing their progression from a less healthy state to a healthier one, Owen is able to demonstrate an example of an instance where he has successfully transformed himself. Through this description of how he has 'changed' and how he is engaging in more 'supportive', 'happy' forms and amounts of exercise compared to 'where [he's] been in the past', Owen is able to prove his autonomy and present himself as an active agent, diligently engaged in the project of the self.

The above quotes suggest that not only does health lead to happiness but also that it *should*. In other words, if your health practices are not increasing your happiness or are making you unhappy then, within this discourse, they are probably not as healthy as you think. De Beauvoir (1948) argues that, although short-term, individual happiness should not be prioritised at the expense of the future or the freedom and happiness of others, the experience of joy is what makes our freedom and our pursuits, for example, wealth, or in the case of this research, health,

meaningful. Therefore, in this view, the pursuit of health is not meaningful if the individual has become unhappy as a result of it.

> *...in order for the idea of liberation to have a concrete meaning, the joy of existence must be asserted in each one, at every instant; the movement toward freedom assumes its real, flesh and blood figure in the world by thickening into pleasure, into happiness. If the satisfaction of an old man drinking a glass of wine counts for nothing, then production and wealth are only hollow myths; they have meaning only if they are capable of being retrieved in individual and living joy. The saving of time and the conquest of leisure have no meaning if we are not moved by the laugh of a child at play. If we do not love life on our own account and through others, it is futile to seek to justify it in any way* (De Beauvoir, 1948 p.135).

Watts (1951), however, argues that the notion that improving the self or engaging in self-work in the hope of living up to an ideal is both unlikely to lead to happiness and it is unlikely to lead to actual self-improvement. He explains: 'I can only think seriously of trying to live up to an ideal, to improve myself, if I am split in two pieces. There must be a good "I" who is going to improve the bad "me." "I," who has the best intentions, will go to work on wayward "me," and the tussle between the two will very much stress the difference between them. Consequently "I" will feel more separate than ever, and so merely increase the lonely and cut-off feelings which make "me" behave so badly,' (p.78). Rose (2003) also notes the cruel optimism present in current ways of thinking about happiness and self-improvement and how this is related to discourses of freedom. He argues that in a context where individuals are obliged to be free and to express their freedom through choices, they are provided with a range of 'styles of life' (p.93) from which to choose. In this way, the responsibility for one's life and one's happiness is individualised and understood to be the outcome of free individual choice. Psychotherapeutics provides individuals with 'common-sense' knowledges about how to relate to and act on the self, the kinds of goals one should choose to pursue in order to attain happiness and how to best go about achieving them. As a result, Rose (2003) argues, 'the norm of autonomy produces an intense and continuous self-scrutiny, self-dissatisfaction and self-evaluation' (p.93).

Related to the idea that a constant pursuit of self-improvement is unlikely to lead to happiness is the notion of health and a healthy lifestyle as a lifelong priority. When asked if individuals had a health goal or a state of health they would like to achieve, they resisted framing health in this way and instead reiterated ideas that constructed health as a lifestyle and a constant pursuit that they would engage in for their whole lives.

Jackson: *You don't have to be a health freak, you just have to better your day every single day, better your lifestyle every single day um try and improve…*

Rose (2003) argues that this constant striving towards self-improvement leads to the individual becoming bound to the project of the self. The self becomes subject to continual critique and evaluation as autonomy is dependent on constant self-improvement. Jackson's phrase '*better your lifestyle every single day…try and improve*' illustrates this constant and relentless focus on self-improvement. In order to improve and transform themselves, individuals must familiarise themselves with all the aspects of the self which are flawed or lacking and seek to remedy these problems through the techniques provided by psychotherapeutic experts (Rose, 2003). Due to the enduring, scrutinising and critical relationship to the self which must be adopted for constant self-transformation, these efforts are unlikely to lead to lasting happiness. However, although happiness may not always be attained, discussing health in this way does serve the participants in that it positions them as ideal, hard-working biocitizens who can be admired for their commitment and self-control. The rational and moderated commitment to self-improvement suggested by Jackson is captured in the phrase, '*you don't have to be a health freak, you just have to better your day every single day*'. The identity work done here serves to constitute a self which does not go to extremes or act out of panic or insecurity, instead he is perfectly self-controlled and diligent in his health pursuits. This quote also illustrates the aspirational aspect of this kind of self-improvement and functions to position the speaker as a certain kind of person. The self-improvement described here does not come from an individual who is currently unhappy with themselves but rather from an individual who is self-confident but ambitious, aspiring to be the '*best type of person they can be*'.

Happiness as a Prerequisite for Health

Most participants discussed the ways in which good health improved their mood and made them feel happier. Only a few participants addressed the inverse of this idea that in order to be healthy your mood needs to be happy and you need to feel confident and positive. This way of thinking about happiness and health was noted most prominently in April's speech however a few other participants also touched on the importance of happiness and positivity in improving overall health such as Jo, below.

> Jo: *If you treat someone really well then you feel good about it, if you've done something good you happy about it, and you will have good endorphins and you won't need to eat the chocolate to have the good endorphins. You know what I mean?*

In the above quote, Jo describes a situation where feeling happy makes her less likely to indulge in 'unhealthy' habits that she would turn to in order to boost her mood if she was feeling sad. Here we see that happiness can be constructed as an important factor in preventing unhealthy behaviours as well as a result of healthy behaviours. It is implied that if an individual is happy they will be better able to stick to healthy behaviours and resist unhealthy temptations. In this quote, we also see an example of 'unhealthy' food being used as a tool for self-care, which Lauren Berlant (2010) discusses and will be explored in the chapter on Care. Jo explains how she will not need to eat chocolate to make herself feel happier, suggesting that it would also have this effect. Below, April elaborates on the importance of happiness in the pursuit of health.

> April*: your mental state, your emotional state, your family state, like how you are in your home, how you exist in the world, it has a direct effect or impact on your health*

> April*: as soon as you have like an imbalance in negativity and positivity in like the way that you think of yourself, and the way that you see yourself, I feel like that has a huge impact in your approach to health. So it's like the less healthy I feel, the more guilty, I feel the less healthy I become.*

April describes a cycle of guilt and a subjective feeling of unhealthiness. Here the importance of happiness for increasing and protecting health is again illustrated. These ideas are also linked to discourses of balance and holism where physical, as well as mental and emotional, wellbeing need to be optimised. April also touches on the morality of healthiness, and in contrast the immorality of unhealthiness which leads to feelings of guilt which functions in a way that sabotages health.

Happiness and Confidence

Practicing health behaviours and feeling as though one was healthy was understood to lead to an increased sense of self-confidence. This was related to a few different factors including morality, physical appearance, energy levels, self-esteem and being a part of a health community. This sense of confidence was seen to lead to feelings of happiness about the self.

Miranda: *Ja, also on a maybe slightly superficial level I know exercising makes your body look a certain way, and I definitely know my self-confidence and my self-esteem is probably better when I am, you know, in shape or looking good so to speak. So definitely I know if I didn't feel like- if I looked a certain way physically, I definitely wouldn't be as confident, I wouldn't be as happy, you know with myself um ja…*

George*: I think your health does impact your confidence, your level of confidence I really do think that it does to a certain extent. Ja, 'cause if you're not healthy something's going to be wrong, it's going to be- you know and it'll kind of make itself obvious in the physical sense, people will see it and then you'll realise oh crap! I gained weight, I gained a bit of weight and people can see it. I don't know what to do about it you know? Some people kind of like throw it at other people: "I need to start training, I'm out of shape" and that immediately tells you that they're concerned about their health, they want to do something about it, but what's more important to them is what other people think. So I think in that sense confidence, ja does kind of get affected by how healthy a person is.*

The above two quotes show how confidence was understood to be higher in healthy people than in unhealthy people. The specific examples given here though are of people who 'have gained a bit of weight' or '*look a certain way physically*'. This shows the conflation of health and slimness and constructs self-confidence and happiness as dependent on complying with dominant beauty standards.

> Jo: *In other ways, it ends up being that they more open, that they more friendly to other people. That's certainly in my friendship group anyway. Because they have that confidence, they can always approach that other person they've never been able to approach before. And also I think because a person exercises, you do it with other people, you meet other people, you're like increasing your social. So it ends up being something that doesn't just work out your body but also works out your social skills so it ends up helping you in life.*

Jo connects being '*more friendly*' and socially skilled with being healthy because healthy people are constructed as confident. Jo also makes use of healthism discourses in this quote where health is understood to have wide-ranging consequences, and to filter into all aspects of one's life. Problems that may appear unrelated to one's health are viewed as being overcome through work on the body, reproducing discourses of personal responsibility and autonomy.

Gill and Orgad (2015) see confidence as a technology of the self which forms part of the Happiness Industry (Davies, 2015). They also argue that it facilitates and promotes a 'working on the self' (Cruikshank, 1993) with the explicit purpose of remodelling the subjective experience of the self towards a sense of empowerment and self-acceptance. We see this in phrases like: '*I know exercising makes your body look a certain way and I definitely know my self-confidence and my self-esteem is probably better when I am… in shape*'. However, these technologies also function to redirect blame for insecurity and unhappiness inwards and mask structural inequalities and systems of power (Gill & Orgad, 2015). An example of the way these technologies lead to self blame is provided in Miranda's quote when she says: '*if I looked*

a certain way physically I definitely wouldn't be as confident, I wouldn't be as happy, you know with myself '. If she had been exercising more she believes her body would be more attractive and she would feel more confident. A body which is not deemed attractive in accordance with modern beauty standards is understood to be a result of individual negligence or laziness and as a result so are feelings of insecurity. George also describes how individuals respond to insecurities by working on the self: '*I need to start training, I'm out of shape'*. The reinforces the notion that confidence and happiness with the self are dependent on self-work and individual effort and so the individual is seen to be at fault when they experience insecurity. The social value placed on confidence and the shame attached to insecurity may play a role in explaining the relative lack of participant discussions around the emotional consequences of some of the health-related demands that they mention. Feelings of inadequacy or anxieties about failing to achieve ideal healthiness were only talked about when referring to past selves or to others, for example, friends or family. This way individuals could project an image of their current selves as confident, happy and therefore healthy.

Happiness, Health and Morality

One of the reasons that participants believed improved health would to lead to happiness seemed to be based on the idea that improving health was likely to lead to an increased sense of self-acceptance because of the more positive moral value of the individual. Being healthy and 'treating your body better' was understood to be something a 'good' person would do. Viewing the self as good was experienced as a reason for happiness.

> Lexi: *I think I probably do feel happier, I think I feel better about myself and the choices I'm making, and how I'm living my life because yeah. I mean, it's okay to not exercise and diet you know, and eat healthily if you don't want to, but I think it does make you feel better about yourself if you do. You just feel like maybe you're treating your body better yeah yeah.*

> Jo: *people tend to, when they healthy, they tend to be happier, well from my experience, they tend to be happier, they tend to be people who are confident in themselves.*

Probably because they know how much exercise they are putting in or how much work they putting in to their food and eating and things like that, so they tend to be more confident.   On the same side, people who are obsessed with health and obsessive, also tend to be very negative. Because they always looking at that, always like "can't eat this because"...

George: *…they get on well with people, they very easy going, they um ja they just if they how do I put this even the manner in which they dress themselves and socialising with other people, they don't worry too much about what other people think about them, and they also don't get into the nasty habit of talking about other people. Like people do talk about people in conversations you know, they don't make too much of a habit of that, because for me, that immediately alerts me you're very self-conscious.*

For Lexi, engaging in health practices and '*treating [her] body better'* enables her to position herself as a kind, caring person who is worthy of a high self-esteem. As a result, she is spared a degree of anxiety, shame or guilt about who she is and how she behaves and is maybe even able to access feelings of pride about or confidence in herself. She describes this feeling as happiness and feeling better about yourself.

Jo describes a similar experience and emphasises how behaviours like '*putting work in'* to '*exercise…food and eating*' function to produce feelings of happiness and confidence through an alignment with moral expectations to work hard. At other points in her interview, Jo constructed health as highly dependent on hard work and she talked about health in many ways as an achievement that resulted from individual effort. When she associates happiness and friendliness with healthiness then, she is also linking them to this notion that they too are dependent on discipline and putting in personal effort. People who are viewed as happy as a result of their health are not understood as lucky or grateful in this context, instead this happiness is associated with the freedom and vibrancy awarded to those with an ideally functioning body but also a pride or self-confidence that comes from successfully accomplishing a personal goal, this happiness is earned and is deserved.

George describes the absence of negative characteristics like self-consciousness or '*talking about other people*' among healthy people and how they are sociable and well-liked. When considering happiness in this way, as a result of conforming to moral pressures relating to health, it seems that happiness is being constructed as partly a sense of relief for not diverging from social norms, and having to suffer the consequences, and partly a sense of self-acceptance.

George's mention of the negative association between unhealthy people and being '*self-conscious*' seems to be in conflict with the constant self-monitoring and discipline necessary to maintain an acceptable standard of health. In this ambiguity, we see how the concept of healthy has come to permeate all aspects of life and the situation-specific social norms which are reactively applied to health. For example, there are healthy and unhealthy ways to feel about the self, and healthy and unhealthy ways to interact with others. Ideal sociability and ideal self-perceptions are attached to the concept of health along with the requirements for ideal bodies, and the methods required to achieve all of these ideals, at times, conflict. These conflicts illustrate the fluidity and situational specificity of the construct of health and how it can function as a general tool to reproduce social norms and encourage compliance. Chandler and Rice (2013) make this point about happiness too when they say, 'A happy citizen is a compliant one, a productive one, and independent one, one whom the state need not care for or make (costly) accommodations' (p. 243).

Jo also describes the converse situation where individuals who attempt to be '*too healthy*' or are '*obsessed*' with their health are more '*negative*' than people who take a more relaxed, *balanced* approach. This deepens our understanding of when individuals are permitted to experience happiness on the basis of their health work and when they are not. We see here that it is not sufficient to eat 'correctly' and to exercise. Individuals also need to have a certain disposition and subjective approach to health. They should not care 'too much' about their health even if this strong sense of investment motivates them to participate in more ideal health practices.

The way happiness is constructed in these quotes supports the view that individuals 'make their own' happiness, and that happiness comes from individual efforts, not external circumstances. Individuals are encouraged to work hard to improve their health in order to enter into a virtuous cycle of health and happiness. Both are constructed as reinforcing and reproducing the other granting the individual pride, self-acceptance and relief in exchange for commitment, hard work, productivity and sociability. If an individual fails to enter into this cycle they may be caught up in a vicious cycle of unhappiness and poor health which also feed off of each other and leave individuals feeling self-conscious, negative and unattractive.

Conclusion

Binkley (2014) views happiness as representing, 'one of the chief instruments of neoliberal government, the very leitmotif of neoliberal life itself and, [he] would argue, its most radical extension into the realm of private existence' (p.4). The modern advances made in technology, for example, the development of happiness and health tracking devices, have facilitated this preoccupation with individual happiness and the effective, constant self-management of one's mood (Davies, 2015). These trends have contributed to the obligatory nature of happiness and to a social demand that individuals appear happy along with an internalisation of the responsibility for ensuring that a persistent state of happiness is individually realised. Although the ways in which pursuits of happiness and positivity have been co-opted by neoliberalism are certainly important to acknowledge and resist, Chandler and Rice (2013), in their discussion of happiness among fat and disabled people, point out some of the ways in which experiences of happiness can also be disruptive. They suggest that 'attending to the ways that we experience happiness in difference while still hanging onto the dull rage needed for necessary resistances can offer new, flexible, open-ended, non-prescriptive, non-normalizing pedagogies and possibilities of and for living in, with, and alongside difference,' (p.243).

Chapter 5: Freedom

Freedom is also unique in that it is the mother of all values. If we consider such values as honesty, love, or courage, we find, strangely enough, that they cannot be placed parallel to the value of freedom.

May, 1981 p.6

Ideas around freedom are used to structure a number of the participants' speech about health. Their use of this discourse in our conversations will be explored along with the functions that it performs, the social, political and economic structures it is facilitated by and upholds, as well as some of the consequences it may have.

Many of the participants discuss the idea that being healthy allows for opportunities. They use phrases such as '*it allows us to function optimally*' and '*to do what you need to do*'. This lack of specificity in the particular activities they would like to be doing and that a state of healthiness allows for, indicates that the specific activity is not really the point and instead it is the opportunity to choose what one will do without restriction that is appealing. Being healthy is understood to allow them a sense of freedom in how they live and what they can do. From the statements, participants make it appear that health is seen as a prerequisite for freedom, as without it- if one's health is poor, they are likely to be restricted in some ways. This idea is captured in the following statement by Nancy Milio, a vocal advocate for 'healthy public policy': 'Health is not a 'state' to be captured and dealt with; nor is it some achievement to be attained with finality. It is rather the response of people to their environments. It is a response that allows them to go about their daily activities without personal restrictions that can be prevented' (Milio, 1986 pg 1; Petersen & Lupton, 1996).

This idea of freedom also came across in the ways the participants described what health is and how to go about improving one's health. They seemed to support the view that there are a

number of different ways to be healthy and to pursue health and individuals should be free to adopt these different versions of health and to choose the lifestyle that is best for them.

Freedom discourses are used in discussions around health and, in similar ways to discourses of happiness, result in the understanding of health as an avenue to freedom, as well as an expression of it. The freedom of choice that we (who are privileged) have around what we eat what kinds of exercise we do and how we perform our health can be viewed as a communication of our individuality. It can be seen as an opportunity for self-expression.

The discourses of freedom are employed by a number of the participants in this study when describing what health is and why they believe health is so important (they all said that it was).

> Jo: *To be healthy to me is to be free… There's a reward for your effort. And that's what it feels like for me, it's something freeing.*

> April: *I think it's being balanced, actually being able to also live your life in a… I don't know what the word is... freely! Completely free of you know like pressure, you know from yourself, I think that's healthy.*

The quotes above illustrate the idea that health is necessary in order to facilitate life. The implication is that without health one's behaviour would be severely restricted and they would not be able to do any of the things they needed or wanted to. Health was an avenue to move through life without obstacles, to the opportunity for action and to the freedom to function. Below are some other examples of the ways participants equated health and the freedom to do what they needed to.

> Christina: *I suppose the most obvious would be like whether you are feeling physically well or not and then I suppose also like the psychological side whether or not you*

feeling mentally ready to get out of bed each morning and perform your wellbeing and … ja I'm not entirely sure. Ja and it's just all the different aspects that make you a sort of functioning human on a day to day basis.

Isobel*: …also being able to function well and kind of play a role in society as well.*

Owen: *They have better energy, they have better capacity, they have a socially positive approach to life…*

Owen (Talking about coaching): *…I suppose it just leads you to just be able to just manage everything, whatever that thing is. Which is just manage life. Kind of get on with it.*

Owen: *…all sorts of routines that support your health that allow you then to operate optimally.*

Miranda*: So something like yoga is and meditation is something I've been doing for the past couple of years, and that also helps to settle my mind, which you know allows me to focus on what I need to do, and then which in turn makes me less stressed when I can't do what I need to do, because my mind is just everywhere. So ja things like yoga and meditation which are seen as more perhaps, slightly more esoteric, or holistic, um things that help you stay healthy.*

Christina: *I think also we construct sort of roles and plans for our lives and dreams for our families and a lot of that is reliant on our health and how we- and to fulfil those roles -and a lot of jobs are reliant on you being well and I think so to provide for yourself and to provide for your family you actually need to be in optimal situation so*

you can retain your job. It sounds so depressing. But unfortunately, it's the way that
the world works now.

Health was also understood as a tool to overcome obstacles and as a source of protection against potential limitations

Jo: *And I don't even mind being around sick people because I know my immune system*
is good enough to combat anything that they can throw at me.

Because Jo saw herself as healthy, the health of others did not limit her in terms of what she could do or who she could be around. She did not feel anxious about becoming ill as she felt that her good health and strong immune system would protect her against this thereby preserving her freedom.

Phrases like, '*live your life … freely*', '*make you a sort of functioning human on a day to day basis*', '*function well*', '*better capacity*', '*manage everything whatever that thing is*', '*all sorts of routines*', '*do what I need to do*' show how the things that health enables you to do are wide-ranging. From this point of view, it appears that health is necessary for life in general and this can encompass any number of activities or goals. It is also a possibility that it is not only that your health needs to be good in order to live in the way that you wish but also that good health *facilitates* the life you *want*. Bauman (2000) provides a possible explanation as to why improved health is considered key to the experience of freedom when he argues that in order to achieve a balance between our desires, our imagination and our ability to act we can either moderate our desires and imagination OR we can improve our ability to act. It may be that this is what these participants are doing, they are attempting to improve their ability to act through the improvement of their health. It is possible that in a culture where we are told that anything is possible, our desires and imaginations have soared whereas our ability to act is restricted and health improvement strategies provide us with an opportunity to attempt to bring the three into balance. Importantly, within these quotes, this synchronisation of desires, imagination and

ability to act requires the individual to adapt in order to function successfully within societal constraints. Society is not required to change to better facilitate individual action.

Owen's phrase that associates health with practices that, '*allow you then to operate optimally*' may be understood using Foucault's (1978) concept of 'anatomo-politics', which describes the way in which biopower functions at the individual level. He explains that bodies are understood as a machine, and institutions function in ways that discipline individual bodies so that they may be subjugated and managed (Foucault 1978). Dominant discourses about what it means to be a good citizen may have been internalized and enacted through technologies of the self- specifically health improvement practices.

Freedom and Energy

The discourse of freedom is also seen when participants use terms like '*lightness*' or '*energetic*' to describe what the state of being healthy feels like.

> Isobel: *I think you probably have a little bit more energy…*

> Isobel*: …like in my mind a happy healthy person like gets more done in the day and might be more active and more keen to try something new or like go to a class or go to a talk or something like that. Whereas an unhealthy, unhappy person who is just feeling more run down would be more likely to stay in or really not want to be out and about.*

> Lexi*: …if you actually do something like even just like a little bit of yoga or swimming or something you do feel a bit more revitalised or energetic and then you might be able to spend your night in a different way…*

Nathan: *…he has more energy to do things where obviously if you've got the weight problem- I mean it can have an impact and even the job where you are basically sitting all the time that can also have an impact…*

Owen: *It feels well it feels very expansive, it feels very motivating…*

Lexi: I feel a bit lighter…

Jo: *…it feels like light, not even sunlight but just like the feather light. Like not weighed down but very like free, yes.*

These ideas of '*energy*' being '*revitalised*' and '*feather light*' are considered in Bauman's (2000) *Liquid Modernity*. When describing the condition of modern society as liquid he explains how we view liquids as light, how lightness leads to mobility and when we travel light we are enabled to move more easily and quickly. He also discusses how liquids can move past obstacles and are not easily restricted. This captures the sense of liberation that the participants describe as a result of good health. They describe feeling '*active*', '*expansive*' and '*free*'. They can do what they want without being held back or '*weighed down*'. The healthy person is active and adventurous within this discourse. They are capable of doing anything they set their minds to and that is usually something productive and energetic as opposed to something relaxing or passive. We see again in these quotes that the emphasis is having the option to do whatever one pleases and not necessarily a specific activity that requires energy.

The word '*energy*', in particular, is interesting to consider. In the scientific field, energy can be defined as the ability to perform work. Work in this context is not referring to employment but it is worth noting that the participants do discuss the importance of health and having energy in relation to being capable and efficient when doing their jobs. Harvey (2000) argues that within a capitalist society illness is defined as the 'inability to go to work' (p. 106) and so we again see how discourses around health take shape within a context of prominent neoliberal

capitalist ideas and these ideas in some ways permeate the way we talk about and experience health. Alternatively, in Nathan's quote, he mentions how work can be a hindrance in the pursuit of health as many jobs require a relatively sedentary lifestyle, where '*you are basically sitting all the time*'. We see here the interaction and contradictions within these discourses. Health is important in order to perform your job effectively, however, the job itself can prevent and harm health. The relationship between freedom, health and work is discussed in more depth below.

Freedom and Productivity: The Freedom to Work

The quotes below explicitly mentioned the importance of health in order to enable you to work.

Isobel: *So either you don't have any disease and you just doing your normal life, you're having a relationship, you working or whatever…*

Adele: *Ja I think it would be hard if you were constantly sick and constantly ill, missing work you know going to the doctor all the time. I would hate that.*

Christina: *when you are healthy with like your body and your mind and in everything, you have a better zest for life and you generally more inclined to go out and socialise. You go out and do things to work harder to go the extra mile…*

The WHO's goal for, "All people in all countries [to] have at least such a level of health that they are capable of working productively and of participating actively in the social life in which they live" (World Health Organisation's global strategy of Health for all by the year 2000 as cited in Peterson & Lupton, 1996 p.1) also illustrates this idea of ability of health to facilitate productivity, to '*work harder and go the extra mile*' and to avoid '*missing work*'. Some corporations provide employees with a number of health resources and yearly check-ups involving lifestyle assessments in a bid to improve employee wellbeing. This pursuit is

believed to improve productivity and efficiency. The idea is that if employees are healthy they will be happy, positive (*'having a zest for life'*) and productive. Cederström and Spicer (2015) authors of *The Wellness Syndrome,* as well as William Davies of *The Happiness Industry* (2015), discuss this idea in relation to the agenda corporations have to increase employee wellbeing and health in order to improve their mood and energy levels which in turn are meant to make them more productive. In Meredith's quote below she demonstrates the increasingly invasive and regulatory nature of some of the corporate initiatives to promote wellness.

> Meredith: *I know at [company name] at the beginning of every- you tell your project leader this is what I'm doing here and these are my goals to exercise, it's actually, the way they regiment it, it made me quite scared. You've gotta tell them that you wanna exercise this many times a week, you wanna do this this many times a week, and then at the end of the week you've gotta tick a form that says did you do this, did you do, this did you do that. So they can see if you're keeping up with your own health goals which is cool, but like I said it regiments it, and it doesn't become this free relationship and the enjoyment in exercise that it should be…Also eating healthily's definitely on there, eat vegetarian once a week… your KPIs- key performance indicators, that's what you sent in the beginning.*

Meredith describes the how this company *'regiments'* an individual's health behaviours enforcing accountability to the company and imposing an obligation on employees to ensure that they are correctly maintaining their health. Although individuals appear to be allowed to decide what appropriate goals for them are, the kinds of activities which individuals need to commit to (exercising and eating healthy food) seem to be prescribed. The dynamic Meredith describes, where individuals propose certain goals and are then supposed to account for their performance at the end of each week, is an illustration of the productive nature of power (Foucault, 1977). The kind of power exerted over employees in this instance is inciting action.

The relationship between power and an understanding of freedom of choice is played out here and functions to position a corporate demand for healthy workers as an opportunity for employees to select personal goals for themselves in order to optimise their health. The

transference of power from the company to the individual is seen in phrases like *'my goals', 'your own health goals'* and *'you wanna exercise this many times a week'*. In this way individuals internalise their own surveillance adopting it and experiencing it as a personal choice. In this way the external disciplinary pressures successfully facilitate the disciplining of the self by the self (Foucault, 1977).

Meredith is critical of this corporate wellness strategy and also constructs ideal health behaviours as existing outside of power relations between people. She says that an individual's relationship to their own exercise should be *'free'* and that individuals should experience *'enjoyment'* from exercising which appears to be viewed as less likely when exercise is more obviously imposed on someone by an external agent. This way of framing exercising as an act of free choice illustrates how more subtle and pervasive disciplinary pressures are often invisible. The choices Meredith currently makes about exercising (she is not yet working at the company she describes above) are experienced as *'free'* from external impositions. This understanding and experience of individual freedom of choice functions to successfully conceal the other ways in which power acts to govern individual conduct.

Many companies have corporate wellness strategies that are less obviously regulatory than the one described by Meredith. They may offer team building exercises, healthy food options at work, at on site exercise resources (Cederstrom & Spicer, 2015). These interventions are always positioned as aiming to facilitate individual employee choices to improve their own wellbeing. However, the goal of increased productivity underlies all corporate wellness interventions. If individuals become more productive, one would expect that they would have more time available as they would be able to complete their work more quickly and efficiently. Cederström and Spicer (2015) ask the question: 'How should we use the time that has now been freed up? The answer it seems is to find new ways to be even more productive'. Poole (2012) argues that 'the obsessive dream of productivity becomes a perfectly effective defence against its own realisation'. When there is no specific goal to reach, the pursuit of productivity, wellness or health becomes never-ending and we become stuck in the constant loop of trying to improve ourselves more and more. We become so concerned with this corporate sanctioned pursuit of a specific kind of perfection that we lose track of what we hoped to achieve as a result of our healthy lifestyle. It is possible that individuals may be undecided about what they

hope to achieve as a result of their improved health as, usually, the intention of these kinds of interventions (for them to work more and faster) is purposefully opaque. If health is viewed as key to performing any activity you could want, then it also means that improving health can be seen as mutually beneficial both to individuals as well as to corporations and *society* more generally. Corporate wellness programs are often viewed as a perk of working at a certain company as seen in the quote below, rather than as another imposition one's job makes on one's life.

> Jo: *But if businesses did encourage that like [name of business] in [place] they have their own gym on site they encourage people to use it. That's really good. Quite a few businesses are taking that on now. Gyms are including lunch hours you know and classes where you don't sweat as much so you can go back to work and not have to shower so there's that, that's good as well.*

This idea of health enabling a freedom to work is facilitated by the value our society places on working and earning money. Our definition of success rests heavily on earning a large amount of money and having the capacity to purchase symbols of success or certain lifestyles that we have agreed are indicative of success and worth (James, 2007). The ideal of a social responsibility and the mandate to be productive citizens relates to the 'duties' discourse mentioned by Peterson and Lupton (1996). The individual must fulfil her duties and obligations through hard work and dedication in order to achieve the status of successful citizen. It is interesting that within the discourse of freedom there is also evidence of this duties discourse as the two seem in some ways contradictory. It is common though, for ideas of freedom to be presented alongside ideas of responsibility and so this construction of freedom which carries with it certain aspects of duty is facilitated and upheld within our cultural context. As Eleanor Roosevelt said: 'with freedom comes responsibility'.

Health is Healthier if it Promotes Freedom

Certain forms of health were evaluated as superior to others based on their facilitation of freedom.

> Nathan: *I would never want to do bodybuilding because if your muscles are too big I feel like you're not mobile, you not agile, so I'm quite a big built person but I prefer being toned because I feel like I can still have a little bit of speed and agility so um I'm feeling I basically want to be more toned…*

Nathan explained his preference for a certain kind of fitness as it facilitated action- he could move and he experienced himself as agile when at this level of fitness. This also protects him from pressure to do '*bodybuilding'* which would require extreme dedication, commitment, effort and sacrifice as he frames it in a way that makes it unappealing- *'you're not mobile, you not agile'*. This kind of defensiveness against insecurity is often seen in the participants' speech in this study. The emphasis, in Nathan's quote, on having a body that is functional and effective rather than aesthetically pleasing was also noted in a study by Plüg and Collins (2013). Participants in their study on South African men and body image made similar defensive identity moves to protect themselves from feelings of failure or insecurity and to foster a positive self-concept. In some cases, it seems that attachment to the healthism discourse allows individuals to remove some of the pressure they feel to pursue a specific physical appearance such as one where, *'your muscles are too big'*. Health is seen as superior to attractiveness and so if individuals can take pride in their bodies as a result of their healthfulness this allows them an avenue of self-acceptance that was possibly not open to them through the pursuit of unattainable body ideals. However, in some ways health is experienced through the attainment of a certain appearance and in some cases has come to mean the same thing as the beauty ideals we interact with. Some participants mention the benefits to their self-esteem that health brings them but this is in some cases related to their healthy lifestyle enabling them to lose weight or become '*toned'*. We see evidence of health being co-opted by the fashion and beauty industries as the appearance of good health is sold as the same thing as the physical experience of health.

The freedom discourses are also used when participants justify traditionally 'unhealthy' behaviours or signifiers of poor health by explaining that if they are not impairing their functionality then they are not really bad for one's health. In addition, if these 'unhealthy' behaviours facilitate productivity they can be considered healthy for that situation.

Isobel: …*So either you don't have any disease and you just doing your normal life, you're having a relationship, you working or whatever, but if you do have some kind of disease, it depends how crippling the disease is, whether you can use medicine to stop the progression of it or slow the progression of it so that you can still kind of live your life. So I think that would be you're healthy: as either having control of their sicknesses or relative control or having no sicknesses.*

Interviewer: *Okay, so you would say that even if somebody did have some sort of like some sort of health complaint, as long as it's under control and they can still function you would still consider them to be healthy?*

Isobel: *Yes I would consider them to be healthy, ja.*

Miranda: *I have one friend who, you know, she smokes weed everyday whenever she can but she is one of the most highly functional and productive people I've ever met! … She she was studying and then she left after her undergraduate, left university after her undergraduate degree, to work for a time, but then she somehow did her honours degree full-time and you know got a cum laude for that, and she was just active all the time, and she says that she has got a lot of you know anxiety issues and if she doesn't smoke weed um those you know those completely overwhelm her, and that's why she smokes so much weed, it helps keep her calm and less anxious. Whereas if I were to smoke weed all day every day I would be the most lazy useless person, I would just sit in my room eating and watching series whereas she that actually helps her handle the hectic pace at which she does things. So you know something like that it's hugely different according person to person um but also for some people helps them be more functional whereas with other people it makes them a lot less functional so…*

Miranda's quote again links to the idea that health is important in so far as it supports productivity. The friend that she describes was considered healthy despite the fact that she smoked marijuana (which she labels as an unhealthy practice) because she was able to work and to work at a very fast pace. In this quote, Miranda defines health in relation to functionality, so if a behaviour improves how well one functions, in particular at work, then this could be included as a healthy behaviour. Isobel also touches on this idea that the physical health of the body is less significant than how well an individual can perform their daily functions.

These quotes also suggest that health can take many forms and that there is no one size fits all definition that can apply to everyone in every situation. Sophie Egan (2016) discusses this trend in her book *Devoured: From chicken wings to kale smoothies how what we eat defines who we are*. She explains that America is an independence oriented society as opposed to an interdependence oriented society and being unique and different from those around you is important for experiences of self-worth and value. When we choose certain patterns of eating or certain forms of exercise or health practice we are defining ourselves and differentiating ourselves from others. The recent popularity of restaurants offering customisable meals or 'build your own' options also allows us to have an increased sense of control over the kind of message we send out about who we are.

The openness associated with health when making use of this discourse also relates to the idea that people should not be restricted by labels like 'unhealthy' and should be free to broaden the definition of health based on their situation. This is also linked to the idea put forth in *The Happiness Industry* that there is a lot less authority and a lot more relativism in how we define what is good and what is bad (Davies, 2015). Although these participants present relatively loose definitions of health that depend primarily on functionality this is not necessarily how they experience their own health. When describing the health practices that were personally selected and avoided they tended to fit into traditional understandings of what it means to be healthy and unhealthy. Exercising regularly and avoiding processed foods were two health rules that almost all participants mentioned.

Too Much of a Good Thing

The idea of freedom and opportunity comes up regularly in the interviews when participants mention their resistance to ideal, perfect healthiness. This is also a restrictive way of being that prevents certain actions and so is perceived to be undesirable.

April: *…there's so many people who try to uh be healthy and like live the healthy lifestyle, but through that they almost push it to the other extreme where they become obsessive about, you know ticking all the right boxes and avoiding certain foods. So like on a personal level, I've gone through such a hectic journey and I think as a dancer, you know discipline has never been a problem for me, so if I put my mind to like reducing carb intake and I'll obsessively do that, or if I um put myself on like a low-calorie plan, then I'll obsessively do that. So even though um as a whole the concept is healthy or you know in inverted commas "healthy" um the mindset, and I think that's where the psychology behind it and the way that you approach it, is also really important… I think it's like ja you can make good decisions but you don't have to be like obsessed with it.*

Richard: *I've never really tried on eating healthy that's the one thing. That's what I said uh to the gym instructor when I signed up for my gym contract, like years ago…was that if any diet involves me staying away from food, that's not going to work. 'Cause I do like food right, and the perception that you have to stay away from food to be healthy, and to look, to be in physical top shape is wrong. 'Cause I grew up in (place) now in (place) we have gyms there which are informal, so so the guys there, they don't have the steam rooms and the pools and the whey proteins and stuff. What they do is they gym as much, as hard as they can, and then they go home and they eat what they eat, which is like meat. We like meat, black people like meat a lot, so we eat what we eat and we don't have a diet, and those guys are still in good shape you see. So to me it's not like I have to stay away from food to… and because eating healthy and the people that I've tried eating healthy with, their food tastes horrible. salads! Ahhh no.*

Jo: …*people who are obsessed with health and obsessive also tend to be very negative, because they always looking at that, always like "can't eat this because…" and are very restrictive in that way, you know what I mean? So ja there are opposite ends of the scale…. If I have to say anything about health, just that people should be really not too obsessed about it, because that often does just take over the life of your life, and those of others, and you end up being very unapproachable because you only see like "oh no that's not healthy, I can't eat that" ……. So to be healthy, but not to obsess about it, to live at least. To give yourself some unrestriction, that's the one thing I would say if anyone had to ask me about health.*

In Richard's quote, we see how he was unwilling to relinquish his freedom to eat whatever he wanted. However, this was facilitated by certain beliefs for example- you can still look good and look fit regardless of what you eat, as long as you exercise. Richard still wanted to be reassured that his body would still *look* healthy and fit and then he felt comfortable to disregard certain health practices such as eating healthy food. This idea also allows the individual to assume the position of the relaxed, free, confident subject. If they were to become too concerned with health and sticking rigidly to prescribed health routines, they could be viewed as uptight, insecure or vain and so this discourse allows them to distance themselves from that. Jo also describes how it is undesirable to be obsessed with health as it is restrictive and you will be perceived as being 'negative' and 'unapproachable' implying that people will not enjoy being around you.

The discourse of freedom is also noticeable when participants discussed their thoughts on whether or not we have a responsibility towards the health of others. Participants seemed anxious to distance themselves from the idea that individuals should be told what to do or that their individual freedom should be impinged on in certain ways. Even though all participants said health was essential and should be a priority they did not feel that it was acceptable to inflict this belief onto anyone else.

Miranda: *I don't think it's right to you know push your views on someone else who clearly, you know is not interested or doesn't care, (laughs) because you always get those people who like telling other people what to do, and I really hope to never be one of those people even though sometimes I catch myself a little bit…*

Lexi: *…it's quite tricky 'cause I don't want to tell people what to do and how to live their lives, and it's actually not my responsibility to tell people what to do, but I'll try and like sort of educate people, in a um non- not telling somebody what to do but just advising them basically…*

Alex: *Maybe like raise concerns about their health but I wouldn't get directly involved because I mean they their own person, they've made their own choices…*

April: *…I don't think we have a right to force anybody into changing their lifestyle until they are ready for it.*

This idea of endless possibility and freedom is seen as an ideal that is possible through the pursuit of a healthy lifestyle. But in order for health not to be restrictive, there cannot be specific criteria for healthy people and healthy bodies. A number of participants mentioned how it is unclear whether someone is healthy or not and health often depends on individual situations and is a very personal issue.

Jo: *…people are different, like my body type is different from your body type, my diet is different from your diet. So it needs to be something that can suit you as a person. I think it needs to be something very personal. It is something personal.*

From the responses the participants gave, it was implied that there is no wrong way to do health. Making use of this discourse serves the speaker in that it allows them to avoid being seen as

judgmental and it helps them to avoid guilt or shame if their behaviours or lifestyles do not conform to the expectations related to ideal healthiness. It also allows for the experience of self-determination, sovereignty and empowerment. This discourse is appealing as in theory individuals can construct a lifestyle for themselves and choose freely what activities they would like to engage in and feel no obligation to participate in activities or conform to rules that they find undesirable. The idea of health being personal and dependent on the specific individual links back to the discourse of health being the responsibility of the individual. However, even though participants make use of this discourse, it is not always experienced as true as a number of things were mentioned as clearly unhealthy (smoking, excessive drinking) and the assumptions made about what healthy behaviours entail tended to contain similarities which reveal that there are specific practices that are generally accepted as healthy- exercising, eating fruits and vegetables and avoiding fried or overly processed foods.

Making use of this discourse in our conversation allowed the participants to ensure that they did not offend me should I have different ideas about what health is or why individuals should strive to be healthier. It also allowed them to avoid embarrassment if they gave the 'wrong' answer. By keeping their answers unspecific they could not be challenged on their points. They were also enabled to assume the subject position of the accepting, non-judgmental individual who respected alternate ideas. This identity is generally considered to be 'nice' and so allows individuals to view themselves positively as morally good. The flexibility in interpretations of what constituted a healthy lifestyle and a healthy person is also essential in order to produce a self which can be secure and accepted and which is not overwhelmed by guilt and anxiety as a result of a single, rigid set of standards.

As discussed before, individuals also mentioned ideas of responsibility and social and economic obligations when discussing health. One participant even mentioned that health practices should be enforced.

> Jo: *I really like the whole- China has that rule where they make everyone do exercises for 30 minutes a day. Like some Chinese businesses actually take time out of the day and they'll go up on the rooftop to do like Tai Kwando or Tai chi or something together*

which is great. It's almost like a law to do 30 minutes exercise, in that case, it would
be really great- we don't have the law enforcement to…

This participant also described health as extremely personal and as a freeing experience. This ambiguity shows that we are free but within limits. We can have as much freedom as we want as long as our choices remain within the boundaries containing behaviours that are likely to improve productivity and prevent illness.

Poor Health as a Restriction

Participants also discussed the other side of the coin: the things that you couldn't do and that you were restricted by if you were not healthy.

Miranda: *…if they don't exercise they're going to feel unhappy with themselves physically and psychologically. They know they're just not going to be functioning as well…*

Miranda: *…when you're depressed, it's hard to study and do all the things you need to do, um and and that was a big thing for me.*

Nathan: *…but sometimes when they [people who are unhealthy] walk maybe they don't walk with the same energy and walking slow and maybe if they breathe they constantly always feel out of breath, and I mean not from running but they always feel tired and they always feel lethargic and don't have any energy…*

Derek: *I think being healthy is that you don't notice, it's like a point of not noticing that you are fit or unfit, it's just you can complete all your necessary tasks without any kind of like noticeable issue. Like I like to think your body can do everything that it needed*

of a normal human being, everything that you need to do in your daily life and you don't even notice.

A healthy body seems to be one that you do not need to think about too much, one that will not distract you from the more valuable pursuits of work and general daily tasks. If the body begins to bring itself to the attention of the individual through a subjective discomfort or ailment of some kind, if it forces the individual to acknowledge their limitations or makes them feel anchored by reality then it becomes unhealthy and a cause for concern.

In another example of how poor health is understood to restrict freedom, when discussing her father's back pain Isobel explained:

> Isobel: *...he can't go play his golf and do like- his life is a bit impaired by it so then he's like sitting around at home not that happy*

In Isobel's quote, we see how poor physical health precludes the opportunity to engage in the behaviours which bring us joy. In the Miranda's two quotes, it also seems that being emotionally unhealthy can restrict physical health (*'when you're depressed it's hard to study and do all the things you need to do'*) and poor physical health can restrict the opportunity of experiencing positive emotions ('*he's like sitting around at home not that happy'*). In this way, we see the interconnection between the experience of emotional and physical health.

Below, Owen extends the limits poor health imposes on individuals to preclude, '*the option of many things in the world'*.

> Owen: *Like I mean you don't really have the option of many things in the world if you don't have good health. So I think that's also where people let themselves down*

Owen's quote shows how good health allows individuals to have options. Should they decide they would like to pursue an activity or goal, that option is available to them, if they are healthy. Whereas, if their health is poor, it is not a possibility. This idea seems to relate to a kind of fantasy life where all our dreams are possible. These are not specific goals that we intend to realistically pursue but rather the idea that there is hope. We can, in our fantasy, have more, our future is bright and we can hope for better. This hope might be comforting when confronted with dwindling career options and social and economic problems that we cannot control and could negatively impact the ideal future that we hope for. This notion of hope in relation to health is discussed in Alan Peterson's book *Hope in Health* (2015). He notes that in neoliberal societies hope, specifically the hopes of individuals for themselves, are often attached to, 'the 'freedoms' to pursue certain suggested practices or 'technologies of the self'' (p.7).

When asked directly about his experience of poor health and if he found it to be restrictive Owen responded:

> Owen: *I think it depends, I think mental health, people can create their own restrictions and their own limitations. But I think once that issue has manifested to a physical level, it clearly creates restrictions. It just is that way.*

In this quote, Owen addresses the individual's responsibility in allowing themselves to be open and free from self-imposed restrictions. This illustrates how physical health is understood to be important if we are to have opportunities for a better life and to experience freedom but it also links to discourses of individual responsibility. There is also an idea about the power of the mind to construct reality. Owen says that '*people create their own restrictions and their own limitations*' suggesting that they could theoretically make different choices or think in different ways which would lead to more freedom. Ehrenreich (2009) discusses this modern tendency promoted by books like *The Secret* and certain interpretations of the field of positive psychology to believe, 'that our thoughts can, in some mysterious way, directly affect the physical world. Negative thoughts somehow produce negative outcomes, while positive

thoughts realise themselves in the form of health, prosperity, and success' (p.31). She argues that the message is that individuals can have whatever they want in life if only they believe that they can. Within this view there are endless possibilities all within reach, even transcending the physical body and having autonomy over the physical world. However along with this notion of possibility, hope and the fantasy of perfect self-determination, there is also the darker side of this belief that, 'if you don't have all that you want if you feel sick, discouraged, or defeated, you have only yourself to blame' (p. 310).

Why Freedom?

Freedom as an ideal is highly valued in our society. Varman and Vikas (2007) regard freedom as, 'one of the most celebrated of the human values,' (p.117). Some even consider freedom to be, 'central to human existence,' (Varman and Varkas, 2007 p.118; Sen 2000). Freedom can be understood as the power people have to help themselves, to have an effect on the world and to determine action without being hindered in any way. Bauman (2000) argues that feeling free depends on a balance being achieved between 'the wishes, the imagination and the ability to act: one feels free in so far as the imagination is not greater than one's actual desires, while neither of the two reaches beyond the ability to act.' (p.17). Freedom is also seen as being essential for progress and is closely linked to the idea of empowerment. In order to be free, individuals need to be empowered so that they can exert their will and so that they have the ability to act. Varman and Vikas (2007) describe empowerment as the 'enhancement of social, political and economic strengths of an individual so that s/he can resist domination of any form.' (p.118). Empowerment and health are often linked together and empowerment is often an explicit goal of health promotion efforts (Laverack, 2009; Rissel, 1994; Grace, 1991).

Freedom has come to be the ideal used to legitimate our political systems- 'the free world' as opposed to to dictatorships, our economies- the 'free market' as opposed to centrally planned economies and even our understanding of the self, what it means to exist as a person- the 'freedom-loving authentic individual of now' as opposed to one of a collective (Rose, 1999). Rose (1999) argues that even some of the radical political thinkers of our time are preoccupied with an 'ethic of freedom' (p.61). Freedom provides us with a personal ideal to aspire to, we are encouraged to pursue freedom for ourselves, as opposed to collectively, through practices

of self-improvement and through the way in which we organise our lives (provided that these practices do not disrupt the status quo). Freedom is valued so highly that some view it as a legitimate reason to wage wars, exert domination and commit atrocities all over the world. What freedom means and whose freedoms should be prioritised and whose should be dismissed have long been debated and disputed but there seems to be little disagreement over the fact that humans should be free and that the way society is organised and the way that we engage with ourselves and others should reflect this (Rose, 1999).

However, Zygmunt Bauman (1999; Verhaeghe 2012 p. 57) comments on the strange contradiction we experience in the context of modern, capitalist societies: 'Never have we been so free. Never have we felt so powerless.'. Verhaeghe (2012) argues that this is because, although we (the privileged middle-class) have so many more options than at other points in history, our choices have no broad political consequences, they are insignificant. Whether we choose to go for a run or do aerial yoga, makes no material difference in relation to society more broadly or to anything beyond ourselves. He also points out that in order to have access to the vast freedom and individual choice that we are promised through consumer capitalism, we need to be successful, in accordance with the narrowly defined terms that will support our economic system- we need to make money. Due to very high levels of poverty and inequality, especially in South Africa, this is not accessible for most people. This discourse constructed freedom as dependent on health and, as a result, excludes individuals who are dealing with issues relating to poor health from experiences of freedom. This discourse also functions to reproduce the status quo as underlying assumptions about the ability of individuals to *choose* health and therefore to liberate themselves from physical restrictions construct those who are oppressed by the physical and social consequences of poor health as responsible for their situations sanctioning a societal abdication from any responsibility to work towards social transformation.

Davies (2015) also puts forth the argument that the competitive culture fostered by the current form of capitalism can have a number of detrimental health effects including depression, anxiety, and character traits such as obsessive perfectionism which can manifest in unhealthy behaviours. So, although capitalism is purported to facilitate freedom, the kind of competitive culture that accompanies this economic system can restrict our health, which is viewed by the

participants as key to the experience of freedom and empowerment. It is also possible that our health is a field in which we can express a degree of freedom that we find is constrained in other areas of our life. However, this is not an avenue available to everyone and there are also stigmatising moral implications of this discourse for the chronically ill, the mentally ill and the disabled. These individuals may be viewed as responsible for the restrictions they experience and within this discourse there is no need for social change as hope is understood to come from the ability of the individual to transform themselves and to overcome their physical limits. The hope granted to those who are able to engage in technologies of the self, such as working on their bodies to facilitate freedom are not accessible to these populations and as a result they may be left feeling disheartened and powerless.

Conclusion

Rose (1998) argues that the ethic of the 'free, autonomous self seems to trace out something quite fundamental in the ways in which modern men and women have come to understand, experience, and evaluate themselves, their actions, and their lives' (p.2). This is seen above in the ways in which individuals give an account of their health and of themselves in relation to the notion of health. Health is valued as a tool to maximise freedom, and to construct a self that transcends the materiality of the body and the limitations that are associated with it. The neoliberal emphasis on productivity and individual responsibility facilitates this discourse and is supported by it. A self that is active, productive, valuable, hopeful and whole is constructed through the use of this discourse, and while individuals are enabled to view themselves as good people it also brings with it similar victim-blaming noted in other discourses of health: if an individual is suffering from some sort of disease, all that needs to be done is to choose to overcome the limits of their body by working on it and transforming it. This discourse also contains an element of fantasy, the idea that anything is possible and that we can achieve anything we set our minds to. This hopefulness directed inwards places the responsibility for the social obligations of both healthiness and freedom itself on the individual. This reproduces the belief that individuals need not concern themselves with collective action or transforming social structures or oppressive systems. Instead, transformation and improvement should be directed at the self.

Chapter 6: Control

'There are lots of things in this world we can't control. I find it really empowering that I can control my health and the way I feel through what I eat'

Anna King (2011 as cited in Henley 2011), Nutritional Therapist

'Your health really is in your hands, and your kitchen'.

Gillian McKeith (2008)

'Sometimes we like having no control and being unconscious. Usually, we throw ourselves into things without thinking much and we want that to work out well'

Lauren Berlant (2010)

Many of the participants made use of discourses of control when discussing health. Ideas of control were noted in different forms in the participants' speech. Control was understood as an important aspect of the management of disease and in the pursuit of a healthy lifestyle. It was valued highly by participants and was seen to be empowering and as the key to improving health. Discourses of control over one's health were also closely linked to constructions of a preferred self who is autonomous, independent and proactive. Even when considering some of the challenges relating to the control over one's health, the possibility of having no control was not accepted and it was understood that control should then be shifted to the management of emotional reactions to health and to self-improvement more broadly.

Controlling Health and Self-Improvement

The following quotes illustrate the ways in which discourses of control were used to structure speech around health.

> April: *I think that's really important, so it's not saying well I'm following a banting diet perfectly, it's I'm taking the lessons that I've learnt from the research, or like or I'm taking control, or I'm taking a positive step towards a healthier me. And that's enough and it really is enough.*

> Jo: *I am who I am. I love myself for who I am, so if I want to improve anything it shouldn't be about what my body looks like it, should actually be about what my body feels like…………what I can do. Persevere to endure.*

April and Jo emphasize the importance of taking control of how they feel and discuss how working towards improving themselves and how they feel is more important than achieving a certain appearance or following a diet perfectly.

> Miranda: *Um I was on mood stabilisers for a certain amount of time, but I think you know modern western medicine like you know, especially for psychological conditions, it treats the symptoms, not the root problem. Whereas you know, trying to reflect on myself and why certain things make me sad or why I'm maybe feeling sad instead of just popping a pill and hoping it'll go away. Um so I think being proactive about it is much more important and valuable. For example, my mother and sister, they are both chronically on antidepressant medication and they seem to still suffer more heavily from depression than I do. And you know I've been there you know, I've fallen apart and I know what its like to really be completely you know, like devastated and unable to do what you need to do. But now I haven't experienced that in a long time and I think that's just because I've been proactively making myself more healthy… I think also, you*

know choosing to be healthy in the case of the depression has made a much bigger difference than just say going on antidepressants.

Adele: *So I like to work on holistic things, also at school we try to build them up to be like holistically educated. So I think you can work on your body, but you also need to work on your mind and your psychological wellbeing and all those things. Stress also, all of those things have to be controlled, especially in this day and age.*

Adele and Miranda discuss the importance of taking control of one's mental health. Miranda uses herself as an example to illustrate the positive outcomes of taking control of one's health and compares herself to her mother and sister who have not been as successful as she has in overcoming her mental health challenges.

Christina: *You desire for your friends to be happy and I think that health, a healthy lifestyle, a holistic healthy lifestyle, is one of the easiest ways for someone. I mean obviously circumstances like, you can be a healthy person and still be in a car crash and it doesn't help, but I mean like for a baseline of life, it's often your health is something that I feel like we can have some control over, but I think that if you feel like you can control, like you want them to make the healthy decisions because it's one thing that they can control, and they can like help them to be the best type of person they can be and they can feel happy within themselves.*

Nathan: *I mean he's not out of control, I mean he's still fine but I mean for his own self-esteem, I mean he can get better if he can just start small*

Christina and Nathan discuss their friends and their hope that they would take control of their health as they believe that it would lead to other improvements for example in their self-esteem and happiness.

Berlant (2010) discusses control in relation to the fantasy of the sovereign man. She argues that individuals have come to idealise this fantasy of the self as powerful and in control of one's life. As having the capabilities to move a life in the direction one prefers and as having a notable impact on the world. Christina and Nathan both draw on the assumption of the effectiveness and impact of individual action in the world and on one's own life. Phrases like *'it's one thing that they can control', 'they can like help them to be the best type of person they can be and they can feel happy within themselves'* as well as, *'he can get better if he can just start small'* all illustrate an understanding that an individual's actions effect change. The sovereign man, 'is not, in theory, a dependent one: he thinks, intends, acts and has effects. He has a will that shapes life and death, and he uses it; not only that but he feels it' (Berlant, 2010 p. 29).

Crawford's (2006) study found a similar theme of control in relation to health. The individuals he interviewed used similar terms such as, 'self-control', 'self-discipline', self-denial' and 'willpower' (p. 411) as necessary characteristics in order to achieve good health. Crawford (2006) also argues that the traits were not just enacted as a means to improving one's health but they are also highly valued personality traits and practising health allowed these individuals to express those aspects of their personality. In this way health practices and the appearance of health facilitate the construction of a positive identity as they enable individuals to signal to others their autonomy, independence and self-discipline. This means that not only is control essential for the promotion of health but also that healthiness functions as a visible marker of an individuals control. Heyes (2007) in her description of her experience attending Weight Watchers discusses the attempt to modify one's health and to take control of the body as a 'complex intervention in identity' (p.66). We see this identity work in Christina's quote where she constructs health practices as helping individuals to *'be the best type of person they can be'.* Heyes (2007) explains efforts to control health as a result of the desire to transform the body into one that more accurately represents the identity one wants to project. In this way, we see that exerting control over health matters has deep-seated identity implications both for how an individual feels they are perceived by others and also for who they feel they are.

Controlling Poor Health

In the following quotes, we see participants making use of the discourse of control with reference to controlling health challenges such as disease, injury or attempting to lose weight. In Christina's quote below she emphasizes the fear attached to becoming ill and the way in which this motivates individuals to take control of their health.

> Christina: *I think for some people, I think it maybe comes out of fear. You know, you've seen a family member suffer from something so you go, you maybe your mother had osteoporosis, and you've seen her vertebrae collapse and seen the pain because she has a trapped nerve, and you see that and you go "well I'm going to make a healthy decision", and you decided to take like magnesium and you take the pills for the osteoporosis and you go and get your bones checked. So sometimes I think it's out of fear.*

Christina describes a situation in which an individual observes the pain and suffering of someone whose health has deteriorated in some way and responds by engaging in behaviours intended to prevent disease and enhance health. The hope is that by taking control of one's health, pain and suffering can be avoided. This narrative also enables individuals to avoid experiencing the anxiety or fear associated with the reality of their vulnerability and fragility. The choice to *'make a healthy decision'* may provide individuals with some relief from the fear that they are constantly vulnerable to a range of potential afflictions of the body. The dominance of these kinds of discourses of control may be partially a result of current conceptualisations of the body as 'at risk' (Petersen & Lupton, 1996). Individuals are continuously bombarded with information reporting new threats to individual health (Crawford, 2006). As a result, responding by actively managing one's perceived risk, for instance, *'you take the pills for the osteoporosis and you go and get your bones checked'*, may help to manage some of the anxiety related to feeling constantly under threat.

Participants emphasized the importance of doing what you can to prevent the disease or health 'problem' but if this is not possible one's efforts must be turned to managing it and working towards overcoming the challenge and healing the body.

> Isobel: …*but if you do have some kind of disease, it depends how crippling the disease is whether you can use medicine to stop the progression of it or slow the progression of it, so that you can still kind of live your life. So I think that would be **your** healthy, as either having control of their sicknesses or relative control or having no sicknesses.*

Isobel speaks specifically about the importance of control as a result of illness. So when an individual has not been able to effectively assert their control in order to prevent illness, it becomes essential for them to exert control over their illness. In Isobel's quote, it seems that being in control of your health is more important than your actual physical state as she was reluctant to describe a state of being that would be identifiable as healthy and instead focussed on the management of health conditions. A notable theme within this discourse of control is perseverance. It is understood that you must keep attempting to control the situations you find yourself in no matter how many times you fail. Berlant (2010) argues that we tend to forget all instances where we have not been able to effectively control our lives or when our efforts result in negative consequences but we hold on to the memories of our triumphs of will. This enables us to maintain the construction of ourselves as autonomous and in control of our lives and facilitates continual attempts to exert control over our health.

Owen's quote below also illustrates an instance where he successfully gains control over his health problem.

> Owen: *Actually life is pretty practical, so I think if you can find a way in taking very practical action in any circumstance and just doing it, then it leads to a positive outcome. So it's the more you practice these things, the more they become integrated and we see the results. They become self-reinforcing.*

Nathan: *It was so bad, 6 times a year I was at the doctor. And I, so you know what happened was, and I still sticked to my exercising, so what happened was, once I took my tonsils out in 2008, I never used to get sick anymore. And the exercising, obviously my exercising got better, but apart from that the exercising together with my tonsils not being there definitely my immune system got stronger. From 2008 when I took my tonsils out until now 2016 I can quickly count on my hands how many times I actually got sick.*

Jo: *…the body can take care of itself in terms of medication. Like I don't take medication. That's another thing for me. I think that's very healthy because often you become very reliant on medication and then your body can't combat the immune itself so, me, whenever I get sick I just drink lots of water and sleep. That's it.*

Owen's quote emphasises the importance of being practical when taking action to improve one's health and expresses a belief that action itself is likely to lead to a positive result. The use of the term practicality is interesting here as it is generally masculine coded (practicality and rationality are traditionally associated with masculine stereotypes as opposed to idealism, and irrationality which are traditionally ascribed to women) in western influenced societies and so we see here the interaction of gender norms with norms around health to inform our experiences. The ideal of control too is a traditionally masculine trait and patriarchal societies, where masculinity is preferred and traditionally masculine characteristics are aspired to, would provide a context amenable to the emphasis of these ideas.

Nathan emphasises how he took control of his health even when he was experiencing recurring episodes of tonsillitis. Although Nathan acknowledges the positive effect of the medical intervention to remove his tonsils, he frames his improved health as the result of his own actions. He uses phrases like *'once **I** took my tonsils out'* emphasising his role in taking control of his health. He also emphasises the influence of his own health practices specifically how he *'still sticked to my exercising'*. This way he is able to present his good health as a result of his

ability to be proactive, dedicated and self-disciplined. Emphasising personal health practices such as healthy eating and exercising over seeking medical interventions was often preferred in the speech of participants. Jo, for example, describes how she does not, *'take medication'* and in order to combat illness she *'just drink lots of water and sleep. That's it'*. This preference for individual action to take care of and improve the body rather than seek out medical professionals or medication functions to further distance participants from situations where their health may be dependent on other people or substances. Jo mentions that, *'you become very reliant on medication'* which she sees as negatively effecting the body's ability to prevent and overcome disease. This resistance to dependency came up frequently in the interviews and also relates to the moralisation of health. The social value place on independence was part of the reason health was understood to be so important and this value also influenced the way in which good health should be pursued. Below, Miranda criticises what she perceives to be her sister's inability to take control of her health and her reliance on medication as opposed to more challenging but holistic health practices.

Miranda: *Whereas my sister, she doesn't exercise, she now is trying to cut down on calories and so she's eating a bit healthier but she'd still kind of you know, rather you know starving herself a little bit, rather than eating a lot of healthy food and then exercising to make sure that, you know, that you burn off the calories. And then also you know, she takes medication to fix things that maybe could be fixed in a more thorough way if she actually put a lot of effort into it. (laughs)*

We see in Miranda's quote how this discourse of control can lead to victim blaming as when individuals are observed to be struggling with their health, they are seen as being responsible for doing health wrong or as not being sufficiently disciplined or self-controlled. Also worth noting is Miranda's mention of treating health problems in a *'thorough way'*. This links to the idea of holistic health and how it is important to intervene and gain control of multiple facets of life if one is to truly master health. Crawford (2006) discusses the problems of the holistic health discourse and argues that the holistic health movement is an aspect of the medicalization of our lives and advances the moralisation of health. He explains that within this construction, 'the failure to achieve health or to seek it was equated with a failure to embrace life, an inability to master one's emotions or to appreciate the spiritual dimensions of being' (p.411). We see

this moralisation in Miranda's quote when she describes her sister's health issues as a problem for her because she would not eat *'healthy food and then exercising'* or *'put a lot of effort into it'*. The preference for health behaviours and exercise as opposed to taking medication seemed to be related to the perceived ineffectiveness of some medications but also to the assumption that taking medication as being *the easy way out*. Those who took medication in the quotes above are viewed as unwilling to go through the difficult and sometimes painful processes necessary to improve health in the correct way. Jo says, '*I just drink lots of water and sleep'* when she is sick, which may be much for physically uncomfortable than if she were to take medication. Similarly, attempting to improve long term holistic health or lose weight through *'eating a lot of healthy food and then exercising to make sure that you know that you burn off the calories'* or otherwise *'putting a lot of effort into it'* may be experienced as much more challenging than taking medication. These criticisms may reflect both a resistance to dependency on medication as well as a resentment towards those who are trying to attain health through methods that are less time consuming or physically uncomfortable. It may seem unjust that these participants struggle, on their own, to attain their good health, which as a result is understood to be deserved, whereas others attempt to attain this level of health through *easier,* supported methods. This idea is rooted in the understanding that good health is not a human right but is something which needs to be earned through control, hard work and independence. Within this understanding of health, illness of any kind is also understood as deserved and is a observable representation of a persons inadequate personality. The kind of health that results from a dependence of some kind may also be viewed as inauthentic because an integral aspect of the kind of health which is valued in this context is autonomy.

The flowing section continues to explore how individuals are ideally meant to take control of their health, specifically through gaining knowledge.

Controlling disease through knowledge.

The quotes below illustrate the important place that knowledge holds within discourses of control. Individuals were encouraged to empower themselves to take action through the gathering of health-related knowledge.

Owen: *I think in many cases I was forced to just look elsewhere and then that helped me understand I suppose, both the merits and like the demerits of western medicine and helped me seek less side-effect causing medical practices, in a way to heal myself.*

Owen: *…if she's got a different approach or no approach at all, then that can lead to like endless lengths of frustration but also it means that she's not empowering herself in any way. And I think just an element of that, like there's no perfect, but like I think an understanding of being a victim is probably a priority for me and like a person in a close intimate relationship.*

Interviewer: *So what did you mean by not being a victim?*

Owen: *I think a lot of people may struggle, and it's not a good or a bad thing it's just where they are at in their life, really struggle to um some people just really struggle to absorb knowledge, or take on knowledge or find good teachers. Some people I think, the most important phrase here is "nothing changes if nothing changes". You know so and the only person that really is going to drive that change is you. And I understand that it's like incredibly difficult to drive it sometimes but it's important to find a way, and I think people will often in life, in many respects, whether it's, I mean this is a health conversation, but just really their ego gets in the way. Like they either don't want to hear, ja so they struggle to direct themselves in a positive direction.*

Owen: *So there are lots of examples of that type of thing, but I think it's important to understand. So there are a few examples that I've had myself but I had Epstein Barr, so there are absolutely no answers for that like in traditional western medicine. But there are many answers in kind of alternative, what would in practices that are labelled alternative, and so I was then able to gain that knowledge, integrate that knowledge and effectively like work my own way back to health. So there are some practitioners that you use in that process which is then not entirely self-sufficient, but the body of knowledge sets outside western medicine.*

Owen: *It would also involve self-knowledge, or acquiring knowledge around health and integrating that into my everyday life, so that to the best extent possible, things are preventable, as opposed to getting ill and then having to run around.*

Cairns and Johnston (2015) argue that 'neoliberal discourse promotes the acquisition of expert health knowledge to control one's diet' (p.157). Empowering individuals to take control of their health by educating them and granting them access to a specific knowledge base is also a common goal of public health practices and the notion that having more information about health will lead to better decision making is commonly held (Beck & Beck-Gersheim, 2002; Fotopoulou & O'Riordan, 2017). The generally accepted premise of health and fitness magazines is also that learning about health will make individuals healthier. It is unsurprising then that knowledge and being well informed/educated are linked up with health in the speech of participants. This discourse of taking control through knowledge acquisition was especially prominent in Owen's speech. He uses phrases such as *'I was then able to gain that knowledge integrate that knowledge and effectively like work my own way back to health'* and *'It would also involve self-knowledge or acquiring knowledge around health and integrating that into my everyday life'*. He discusses health in a very individualised way and often associates it with power, sovereignty and control. This is noted in excerpts such as: '*nothing changes if nothing changes. You know so and the only person that really is going to drive that change is you'* and when discussing the health of his partner he emphasises the importance of her *'empowering herself'* and having an *'an understanding of being a victim'*.

The emphasis on knowledge when it comes to improving one's health makes sense in so far as it is logical that if an individual does not know what foods are healthy or that exercise improves health or how to keep their physical body safe it is likely to be more difficult to attain good health. However, this idealisation of knowledge and of education may also have implications of the uneducated being viewed as pitiful or lacking in some way- '*the victim*'. Additionally, although, of course, all individuals should have access to an education, the emphasis on educating people about how to improve their health may lead to knowledge being used as a tool to individualise health problems.

The reliance on knowledge as a solution to health problems also conceals the economic and social realities many individuals live in. Knowledge is not sufficient if one does not have the means to purchase healthy food, the time to exercise or meditate or if the are exposed to toxins in the workplace or home. An important aspect of this idealization of knowledge when it comes to health was noted in the relative silence around other health interventions. When participants were asked what they thought would help to improve the health of South Africans, in general, most of them focused on educating people about health. Only two participants mentioned state interventions aimed at improving access to health care and avenues relating to collective social action or any fundamental restructuring of economic systems which impede healthiness were never discussed. In this way the promotion of knowledge as a solution to health problems functions in a way that individualises the responsibility for health. It may seem unreasonable to expect individuals to be knowledgeable about population-wide health problems or economics, however, this example just illustrates that the way we approach social problems is by thinking of ways for individuals to help themselves. Educating people is aimed at providing them with the tools to improve their own individual health rather than address collective social health risks.

An interesting contradiction was noted in the discussions around knowledge and health in that most of the participants emphasised the importance of educating oneself about health and being well informed about correct health behaviours. However, when asked about whether they consumed any health-related media and which sources they trusted for their health information, many of them said they did not really seek out information about health and a number of participants said that they got their health information from talking to friends and family members about health.

Callie: *Hmmm…I wanna say my mom (laughs)… I mean I think I would just trust healthy people who actually live a healthy life*

Alex: *I don't know really, like just general things… like I guess like no one in particular, or like no source, just I think a little bit of everything combined.*

This contradiction may result from a number of different factors. One may be that there was an aversion among participants to coming across as a *health freak* and appearing too invested in pursuing health related knowledge may implicate them as being a part of this undesirable category. This aversion is discussed more in the balance chapter. These participants also described themselves as currently healthy at the time of the interview. This may mean that they do not feel the need to seek out additional health information as they may feel that what they are currently doing is working for them. This positions the responsibility for knowledge acquisition disproportionately on those who are dealing with some sort of health problem. Callie says that she, *'would just trust healthy people who actually live a healthy life'.* When asked how to identify a healthy person most participants mentioned something relating to their appearance. It may seem more reliable then to follow the advice of someone who has a desirable body and is a good example of the qualities such as control, autonomy and independence which are aspired to rather than a media source or doctor's opinion. This may be related to a general suspicion towards the media and the abundance of unreliable internet sources providing advice on health which was also noted in the speech of participants. An individual that they already know and can see first hand how they live their lives and the effects on their appearance may seem like a more trustworthy source.

The importance of managing and overcoming illness and disease was described in the above sections. Participants also discussed the importance of exerting control over health in order to postpone death.

Control Over Death

A number of the participants commented on the appeal of longevity and described the purpose of their health practices as being related to the pursuit of a long life. This idea was also discussed when participants were asked if they thought it was important for the people they were close to to engage in healthy behaviours.

George: …*everyone wants a bit of a lengthy lifespan you know, you don't know when*

your last day will come but you do want to live longer…

Interviewer*: Would you say you think it's important to be healthy?*

Ben: *Ja, absolutely, not only is there the added benefit of growing older…*

Richard: *…if we want to live a longer life, which I feel like everyone does, then it is important to be healthy… Ja I would love to live longer, my my dream besides other dreams that I want to achieve along the way, my hope, my prayer is that I live long at least to be 90 or something. I would really love that, I would really love that.*

The idea that maintaining a healthy lifestyle is associated with longevity may help to ease anxieties about death and especially an early death, the ultimate loss of control. It appears as if engaging in health-promoting behaviours allows individuals to put the fear of death out of their minds and feel reassured that their bodies will not fail them or that their loved ones will not be taken from them too soon. Crawford (2004) explains that 'health consciousness and individual action to protect and improve health have become integral to the quest for security. The fear of disease, untimely death and perhaps the fear of death itself, can be stilled, or so it is hoped, by becoming informed about hazards to health and by taking steps to minimize and monitor dangers' (p. 505).

Although control was usually spoken about as essential in order to attain and maintain healthiness, participants did acknowledge that this was not always easy. Some of the challenges individuals faced in the quest to control their health are discussed below.

Challenges to Controlling Health

Participants would sometimes discuss some of the challenges they or others faced when attempting to be healthy. The following quotes illustrate how these challenges were understood and confronted.

Lexi: *There's like so much weird stuff going on at the moment to save money, yeah I don't know, and then like the fact that sugar is added to everything as well is also very weird. Like in baked beans, they add sugar to baked beans tins, so it's just it's very hard to try and control the levels of sugar, the levels of salt, 'cause I think salt's also added to a lot of stuff. So I think uh maybe it's more difficult to be healthy now because you're almost duped about what health is and what to eat to be healthy, as well as yeah trying to get natural products, even things like fruit and vegetables. It's got pesticides and stuff on it you know, how can you actually be properly natural unless you wanna farm all your own stuff. But we do- we've got like a tiny little vegetable and herb garden, so we grow like a few like tomatoes and strawberries and we've got the like coriander and stuff like that so that's nice. That's actually very satisfying, to like you know the tomatoes just about ripening and then they just taste so nice and natural and you know it doesn't have any like chemicals on it, and you know it's like- so the stuff we grow is like so flavoursome as well.*

Nathan: *I think my knees wouldn't be used to squatting and lunging so it had an effect on my knees, so last year I couldn't run the way I used to run because I always felt the pain. I tried obviously taking a lot of painkillers, I tried physiotherapy as well, and ja so then the physiotherapy didn't work so then I actually went to my GP. So I thought maybe she would like refer me to a specialist, so what she did was she just checked where the pain was. It was under my kneecap, and she referred me to a specialist and she told me basically what I should do. And I must say that was in my knee I don't feel it anymore. So I do wear a lot of strapping though, but sometimes I wear it more as a precaution.*

Jo: *On the other hand, you have people who my friend Alex, who's very very very healthy, but her body shape is very very curvy lady, and she can't seem to lose this- we call it baby fat but it's not really. But like she gyms very hard, she eats very very healthy, like very healthy to the point of measuring out her grams and that kind of thing, but looking at her people wouldn't say she's very healthy you know*

April: *one of my projects, my current projects, it's quite funny, um my next blog is like the lesser of two evils um and it's actually like going to McDonald's and making a mini menu. So like if you go to Spur with your family, what can you order that's still like the healthiest possible you know choice? Or um when you go to an Italian place you cant say "no well I'm not going to eat" like you need to go "oh ok like I don't want to have spaghetti Bolognese, but I can have this or that or whatever", and like be able to live in the real world without being terrified of it.*

In all of the above quotes, when participants describe a challenge that they face when taking control of their health (whether it is the unknown additives or processing of food, injuries, metabolism related or physical aspects or social situations) they are not deterred. They acknowledge that there are obstacles to ensuring their own health but they immediately describe what they do or have done to overcome these challenges. Lexi grows her own vegetables, Nathan tirelessly visited health care professionals and medicated himself, and April researched the menus and nutritional values of restaurants in order to choose the option she believed was least damaging to her health. These anecdotes set up the idea that there is always something that can be done to take back control of your health, and that it is not acceptable to be confronted by a threat to your control and to respond by accepting that some things are out of your hands.

April mentions that by taking these steps to overcome health-related challenges she is enabled to *'live in the real world without being terrified of it'*. Her attempts to control her health protect her from her terror of the possible threats, to her health and to her sense of control, that exist out in the real world. Control has become so important to her that it prevents her from entering relatively common social situations without fear and as a result she must prepare herself in advance for these situations so that nothing unexpected can disrupt her control.

The phenomenon of successfully controlling one's health problems is captured in the Women's Health magazine (https://www.womenshealthsa.co.za) feature: You lose you win. This

segment involves a person, who has lost a significant amount of weight, telling the story of their success. However, all of these stories are structured in the same way and are divided into the following sections: The gain, the change, the lifestyle, the reward and [name's] tips. This structure ensures that the story is told as one of successfully taking control of one's body. It shows a progression from being overweight to successfully losing weight. A similar pattern is noted in this study within the speech of participants. They describe a challenge to their health and then explain how they overcame this challenge. For example, Lexi describes how she overcame the challenge to her health by growing her own, '*tiny little vegetable and herb garden'*. This aligns with Berlant's (2010) argument that we forget the instances where we have not been successful in our efforts to control our health and hold onto the memories where we have triumphed. McKay and Bonner (2002) argue that the personal success stories or *pathographies* found in magazines are intended to inspire readers. They argue that notions of courage determination, optimism and perseverance are invoked in these stories and convey the message that *if I can do it, so can you*. Stories of individuals trying to lose weight and being unsuccessful are not published except perhaps in the 'letters from readers' section, in which case the individual will be given advice about how to best take control of their lives and achieve their weight loss goal. The message here is that a lack of control over one's weight is not an acceptable possibility. This could serve to inspire others who are aiming to lose weight, however, there are also problematic aspects associated with this discourse in this context. Individuals who have been unsuccessful in their weight loss efforts might feel very disheartened and may feel that there is something wrong with them that they cannot gain control over their bodies like the women in all these stories. It also constructs weight loss as the only measure of a health success, as always positive and as something to be proud of. This is not to detract from the hard work required to lose weight, however, the blanket assumption that weight loss entitles individuals to a moral superiority or that it is always something to aspire towards may be harmful. We see in Jo's quote the effort that her friend goes to in order to attempt to lose weight: '*she gyms very hard she eats very very healthy like very healthy to the point of measuring out her grams and that kind of thing'*. Even though Jo describes her as '*very very very healthy'* her friend is trying her best to gain control over the appearance of her body, '*her body shape is very very curvy lady and she can't seem to lose this 'we call it baby fat' but it's not really'*. Because of her appearance, '*looking at her people wouldn't say she's very healthy you know'*. This illustrates an example of the way these discourses of control function in ways which stigmatise individuals who are not perceived to be embodying sufficient autonomy and self-discipline, even if their actions suggest otherwise. Chandler and

Rice (2013) also argue that the construction of fatness as unhealthy and dangerous functions to reproduce other social inequalities. 'The framing of fat as a dangerous disease further allows deep-seated dread of fat "others" – women, the poor, and the racialized – to be disguised and expressed as fear and hatred of fat (Campos, 2004 p. 233). In this way, fear of fat masks even as it reinforces class, race, and gender discrimination' (Chandler & Rice, 2013).

In popular websites relating to health and articles specifically relating to challenges with losing weight, it is made clear that if a person is unable to lose weight they are doing something wrong and were they to correct this behaviour they would be able to lose weight and be healthy and thin. Articles entitled *Reasons why you can't lose weight* featured on websites such as Popsugar, Women's Health, Dr Oz, Mind Body Green and Independent cite misbehaviours including *'You're sitting on your ass all day'* (Sepel, 2013*), 'breathing all wrong'* (Magee 2016) and *'you don't leave time for fun' (*Fuhr, 2017*)*. The message of these kinds of articles is that your poor health is your fault regardless of your situation and you need to change your behaviour in order to correct it. The behaviours listed are so wide-ranging and bizarre (*'you wear clothes that are too big'*, *'Your gut isn't diverse enough'*) that you are sure to find at least one that you are not successfully doing. The prevalence of these kinds of ideas in the media as well as the economic and political incentives for individuals to take control of their own health shapes how we think about our role in our health and the role of our health in our experience of ourselves. These same ideas come through in the speech of participants, the message is that there is always something which can be done to gain control over one's health. April describes her efforts to prepare in advance for family meals at restaurants so that she could still eat, *'the healthiest possible you know choice'*. These discourses of control reinforce the message that there is no excuse for poor health.

Controlling Emotional Responses to Health/Illness

When participants acknowledged certain situations where health became beyond the control of the individual they would sometimes suggest that the thing you should control in that situation is your emotional response.

Owen: *No I think the thing is, it's usually like very practical, I think there are instances when your health is out of your hands, you know completely and the choice is not always that clear. Now I talk about it like it's so easy to be motivated and to go and get what you want, but you know there are instances where things aren't available to people, whether it's knowledge or actual practice or specialists and so that's a massive challenge. I think you know in the kind of terminal illnesses, you know that path of which medical route to take is not always – it's a very tough decision to make and I think the most important thing is, in many ways is, I think health is always going to be good and bad for people in life. You are always going to come up against something, it's just the key ingredient is how you respond to that challenge.*

Owen: *it's always just seeking out ways to manage all these things, but I think the real process is being able to…feel and then being able to kind of own the feeling and then finding the right response to the feeling, so that you just don't get into the feeling which I think a lot of people do.*

Isobel*: sometimes I'm super grumpy and I don't really feel in balance, so I'm probably not the best person to be around, but I also like control it, like I try not to if I'm in a really bad mood and I'm feeling really crappy, I'm not exactly going to put it out there on someone else.*

Jo: *So I feel like in certain cases I just think people are too stressed and worried about what the consequences will be when the body can handle itself.*

In Owen's quote, he emphasises controlling, '*how you respond to that challenge*' and *'seeking out ways to manage these things… so that you just don't get into the feeling'*. He acknowledges that sometimes health cannot be brought under the control of individuals but even if this is the case he argues for exerting control over the emotions and thoughts of the individual. The use of this discourse may allow individual to take up the subject position of the strong, resilient self who can manage challenges effectively. However the constitution of this subject requires

the appearance of optimism and an upbeat outlook which suggests internal positivity. Barbara Ehrenreich (2009) discusses the pressure placed on individuals to perform positivity especially when they are sick. She discusses the breast cancer community and the obligatory nature of staying strong, proactive and positive when dealing with the diagnosis and treatment of breast cancer. This is often based on the unproven assumption that this attitude will improve an individual's chances of overcoming their illness. The implication this has for individuals who do not recover is that they are responsible for their continued poor health or even death and that they should have worked harder on controlling their emotions. This illustrates the ways in which this discourse can function to revictimise individuals who are already suffering.

Isobel discusses the importance of concealing one's negative emotions, such as *'feeling super grumpy'* which arise as a result of feeling unwell or not being *'in balance'* in order to remain pleasant and to avoid burdening others with one's negativity. There is a pressure on individuals to be happy, particularly when interacting with others. This pressure may relate to what Hochschild (1983) calls *feeling rules* which provide us with scripts dictating the appropriateness of different emotions in different situations. It is also understood that if an individual is happy then others will like them more (Ehrenreich, 2009). In a culture where positivity and happiness are obligations placed on citizens, the *'grumpiness'* Isobel feels could be viewed as, 'perverse,' (Ehrenreich, 2009 p.122). This understanding may make Isobel's desire to avoid people when she is unhappy a defensive move to ensure that she does not lose favour among her friends. Happiness is also linked up with healthiness as noted in the chapter on happiness discourses. This means that Isobel's *'bad mood'* could be viewed as evidence of her poor health which would also have a range of negative moral implications for the perception of others of her personality. Unfortunately, this strategy of removing the individual from society if her emotions are not sufficiently positive means that individuals who are suffering do not have access to support networks during their most trying times. This attempt to distance the unhappy self from others may also relate to an acknowledgement of the emotional labour required to fake authentic happiness for the sake of abiding by social pressures and to maintain the perception amongst others of the individual as a happy and therefore good person (Ehrenreich, 2009). Hochschild's (1983) study on air hostesses found that the constant demand to present oneself as cheerful led to stress, feeling disconnected from one's emotions and emotional depletion. This illustrates the potentially damaging implications of internalising social obligations to be happy.

Anxiety About Not Being in Control of Health

In the following quotes, we see the emotional effect of discourses of control when events beyond the individual's control take place.

> April: *like when my mom in law passed away, it was one of the hardest times 'cause I wasn't in control of what we were eating. Like we called them the casserole parade, so a lot of, shame like loved ones, would come with with just like casseroles of food and I had no idea, like I don't cook with sunflower oil and I don't make rice and if I do make rice it's brown rice. And you know like I make healthy decisions, but they're making like pulled pork um and they're giving us pancakes with like sugar, and all which on like a day to day basis is really not a healthy approach. But it was very thoughtful of them, but for me I got really I got to a point where I was like panicked 'cause I suddenly had to eat food that I didn't know what was in it.*

> April: *I mean I think I was depressed the first week I was in (place) actually, because I went from having absolute control in what I was eating and this is, like the other day, like in South Africa, like in Pick 'n Pay, I knew exactly what aisle to go to, I'd like buy all my fresh produce and then like if I had to get boxed items or canned goods, I knew which brands to go to. Then I had to like go to the grocery store here, and the fruit and veg are fine but everything else is in [language] so I can't read ingredients, I can't read so I started panicking actually and I was like I don't know what to do, I want to be healthy*

Berlant (2010) argues that the fantasy of sovereignty produces a sense of paranoia, 'as its security force,' (p.29). We see this in April's quotes above. She felt her sovereignty threatened from outside when she was unable to control what she ate and she *'started panicking'* as a result.

Below, Adele is describing her *'obsession'* with health and eating.

> Adele: *Ja all the time. I'm not interested in it, I just constantly think about it. I'm very aware of what I put in my mouth. Possibly because I've always fought my weight so it's a little bit of an obsession. It's not great I know that but it's something I've got to live with. I've got to watch what I eat otherwise I'm overweight. So it's not a healthy way to live, I don't think, of always worrying about what you put in your mouth, but it's how I control my weight so it's what I have to do.*

The relationship between anxiety and control in relation to health is discussed in Crawford's (2006) paper *Health as a meaningful social practice.* He describes a control and anxiety spiral that occurs partially as a result of the wealth of information now available and accessible pertaining to the dangers to our health and the constant reiteration that health is essential and should be pursued and improved. He argues that a 'pedagogy of danger is combined with a pedagogy of recommended practices in a spiral of control > anxiety > control > anxiety' (p.415). In a context where information about what protects and improves health and what is harmful to health is constantly changing and contradicting itself, anxiety about one's health is likely to heighten, whereas control over improving health or warding off disease appears to become increasingly ineffective and out of reach. In April's quote she describes two instances where she *'panicked'* when she could not exert control over her food choices. What Crawford (2006) describes as a combination of a pedagogy of danger and a pedagogy of recommended practice has lead to April feeling that foods including, *'sunflower oil', 'rice', 'pulled pork', 'sugar'* and any food that she, *'didn't know what was in it'* are dangerous to one's health and should be avoided. What this means is that even loved one's cannot be trusted provide *safe* food and only the individual can be responsible for ensuring that food is healthy through being constantly informed about what they are consuming and any related health risks or benefits.

Lupton (2005) in her study on beliefs and experiences related to food risk also noted an emphasis on control, in this case specifically of what one eats and what one's children eat, in order to maintain and improve health and appearance. She argues that this has led to, 'a morally-laden victim blaming discourse,' (p. 464) which is likely to lead to individuals

internalising blame for any health problems they might face. In April's quote she describes herself as feeling, *'depressed'* as a result of her lack of control over her health. She felt a great deal of pressure to make sure that she was eating healthy foods and when she was not able to be informed and in control of her choices she felt anxious and sad. Adele blames herself both for her perceived weight problem and for her attempts to effectively manage it, which she views to be unhealthy. She describes a strong aversion to becoming, *'overweight'* and she describes herself as having, *'always fought my weight'.* We see here her commitment to *'control my weight',* she is vigilant about what she eats and takes full responsibility for ensuring that she does not gain weight. However, instead of feeling positively towards herself for her self-discipline she instead blames herself for approaching her weight management in an unhealthy way. She says *'it's a little bit of an obsession'* and *'it's not a healthy way to live I don't think of always worrying about what you put in your mouth'.* Because of the often overwhelming and contradictory demands made of individuals of how to be healthy, trying to maintain control may also be positioned as unhealthy in some circumstances. The weight of the responsibility for health and the constant pressure to improve the self means that there is an increasingly likelihood of failing to live up to health ideas in at least one area. When this occurs the individual must take responsibility for what they have done wrong as it is understood to be their fault. We again see this internalisation of blame in Nathan's quote below.

> Nathan: *I used to try [nutritional shake] and I tried [other nutritional shake] as well but apparently I wasn't- I mean those shakes; I wasn't using it properly because I mean a lot of people are losing weight but for me it was like the other way around I was like picking up.*

Nathan constructs his failure to lose weight as a result of his own incorrect usage of the product. He says, *'I wasn't using it properly because… a lot of people are losing weight but… I was like picking up'.* Individuals are encouraged to look inside themselves when trying to make sense of their problems and find solutions to them. Jo describes the emotional consequences of this kind of victim blaming below.

Jo: *with unhealthiness brings it brings sadness, it brings this kind of like guilt and loathing, self-loathing which added on to the fact that, for example, will add on like loss. Like it's not good for you. Like loss and self-loathing, not a good combination at all. It's more those kind of emotions.*

The construction of health as a moral obligation and the insistence that it is under the control of the individual means that failures to achieve sufficient healthiness can be interpreted as an individual failure of morality. The association between health and physical appearance also means that this kind of immorality is inscribed upon all bodies that do not conform to media ideals. Maintaining a subject position in which the individual can feel that they are a good person becomes more difficult when health and/or appearance are viewed to be below acceptable standards. This may lead to the feelings described by participants above- *'sadness', 'self-loathing', 'depression', 'panic' and 'loss'*.

Conclusion

Berlant (2010) argues that although sovereignty is idealised and we seek to maintain it where we can and feel anxious when we cannot, we do not really want it. In many ways we seek to undermine our own sovereignty through the actions we take to connect and collaborate with others. Part of the aspiration towards self-control among participants seemed to be related to a desire to distance oneself from dependency. We have been educated against dependence on the state strongly within our political institutions. Dependency is often associated with pity or when dependency gets linked up with laziness, disgust (Valentine & Harris, 2014). We have also been exposed to terrifying political and personal examples of sovereignty being snatched and dependency being enforced and exploited for example in totalitarian states or in abusive intimate relationships. The self-made man, on the other hand, is adored and respected and held up as the ideal citizen, individuals with the socioeconomic resources as well as the time, knowledge and luck, to relatively successfully access this ideal identity are rewarded with self-acceptance and pride as well as approval from others. It is unsurprising then that we resist dependency and try to move away from it. But the meaning of sovereignty as we practice it now is also being exploited in certain regards. Our sense of responsibility for our selves serves governments that are reluctant to spend money on welfare and public services and in the

workplace, and our everyday lives, much of our ability to control and manage ourselves has come to be, 'a measure of compliance' (Berlant, 2010 p.29). By viewing health as located within the control of individuals and by encouraging them to embrace this control through a constant 'working on the self' the political is traded in for the personal (Cruikshank, 1993) and resistance to oppressive systems of inequality comes to be experienced as unnecessary.

Chapter 7: Care

Don't you think it's time we concentrated more on our own health and complained less about the insufficient number of hospital beds, unethical practices by doctors and the high costs of healthcare? If more Australians took responsibility for their own health there is no doubt that we would have enough resources to take care of our ageing population and those people who inevitably become ill or injured for reasons other than their personal negligence.

Telford, 1993 p. v

Although the discourses discussed in this chapter are labelled 'Care' they are often self-care discourses. However, the emphasis in the participants' speech was often on care as practices of looking after and showing love towards the self not necessarily only routine personal health practices aimed at ensuring efficient bodily functioning. It was the ideas of kindness underpinning understandings of self-care that will be focused on specifically in terms of their implications for subjectivity and identity. The idea of taking care of the self/ self-care was often used to structure participant's speech concerning health. This was especially noticeable when participants were describing their health behaviours and their reasons for pursuing health, as well as when participants were justifying feelings of moral superiority. This chapter is separated into three sections. The first explores the ways in which discourses of care are used to construct health and health behaviours and the importance of taking care of one's self for the sake of one's health. The second section discusses the way these discourses are related to morality and identity and the implications this has for subjectivity. The final section provides a critique of the discourses of care and some of the ways in which they have been co-opted to support dominant health discourses of individual responsibility and morality.

Taking Care

George: Well I think health means physical wellbeing, that's what I attribute it to, physical wellbeing and basically just um how do I put it, basically just taking care of yourself.

Jo: for example, when you go to Virgin Active, they give you like a whole bunch of options: would you like to tone, would you like to ... You see all the different options and out of those you kind of decide what you want for your body

Miranda: I really enjoy eating um and I enjoy cooking as well you know. I find that's quite a creative and relaxing thing for me even after a long day at work. Generally, or more often than not, I will enjoy cooking and I enjoy cooking things that I know are healthier. It just makes me feel good, knowing that I'm putting something into my body that's more healthful than destructive

Owen: it's almost like self-compassion. It really is, like that's how I see the food.

All of the above quotes describe health or health behaviours as doing something good. These quotes are specifically referencing food and exercise and words such as *'care'*, *'wellbeing'*, and *'self-compassion'* are used to characterize these behaviours. Engaging in health promotion is viewed here as showing a kind concern for the self. Foucault discusses the concept of caring for oneself and how understandings of what this entails and the social value of engaging in self-care has shifted historically. Foucault argues that in Greek and Roman civilisations caring for the self was intimately connected with ideas of freedom and ethics: 'I am not saying that ethics is synonymous with the care of the self, but that, in antiquity, ethics as the conscious practice of freedom has revolved around this fundamental imperative: 'Take care of thyself'' (Foucault, 1997, p.285). He points out that around the time of Christianity self-care began to be criticized as a form of self-love or selfishness and that this was placed in opposition to a

concern for and love for others. In more recent times, care for the self has become increasingly normalized and idealized and is often conceptualized as a duty and a moral obligation.

Some of the main ways in which health behaviours were constructed as practices of care are discussed below. Experiences of self-care in this context was varied, in some instances it was constructed as a kind of treatment or medicine, a way of showing self-love. In other instances, it was constructed as putting the body in situations where transformation was evident through pain. Discourses of self-care were sometimes used to resist discourses of control and punishment and other times were expressions of these discourses. However, in both cases, practices of self-care were aimed at moulding the physical body in a way that brought it closer to a healthy ideal.

Self-Care and Self-Medication

Berlant (2010), in *Against Health,* discusses the idea of self-medication in her chapter about obesity. She argues that eating can be understood as a form of self-medication as it is often a practice which is used to cope with an overwhelming life- busy schedules, high stress, less time etc. The quotes below illustrate this understanding of health behaviours in general as well as eating in particular as a medication.

> Jo: *it is a form of treatment. It's like a manicure really or like ……. if you think about it 'cause it's is a ……. off of that we do every now and then, although it should be constant or normal to us and it should be something that we brought up, with something that we raised with but unfortunately we not. In this day and age, it's convenience and ease of something that's more favoured than health so yes, it is like a treatment in my opinion. It's something positive, it's something that's good for you, it's something that takes work. Yes, treatment takes work like the thing about medicine, like you know it's something, it's work, it's like healing, recovering and from something bad which is usually what it is when you're unhealthy*

Owen: *I think it's something I enjoy. I think when I know that it supports me and that it, and really the nutrition and the like medicine that I need, then it makes me almost happy.*

These quotes are discussing health behaviours and eating healthy food as a *'treatment'* or *'medicine'*. However, in her chapter Berlant (2010) is arguing that eating with a degree of mindlessness, eating too much, or eating something generally considered unhealthy, can also be viewed this way. Valverde (1998) argues that eating in 'unhealthy' ways as a form of self-medication should not be considered a weakness but rather a very normal, even logical response to feeling overwhelmed, drained or alone.

In this way, we can see how care and taking care of oneself can have different meanings and can be experienced differently. One person might experience the discourse of care as eating only extremely healthy foods, exercising regularly and aspiring to the perfect healthy life whereas others might experience it as having a slice of cake after a terrible day at work or an argument with a loved one (Berlant, 2010). Through the use of this discourse, both behaviours could allow the individual the opportunity to take up the subject position of kind, caring self. However, this seems to only be the case if the behaviours are framed as conscious choices and not momentary lapses in self-control. The practice of consciously, purposefully and temporarily rejecting ideal healthiness, for the sake of health, is touched on by Mark.

Mark: *I will sometimes wake up every two or three weeks and just have a craving for something and I just feel it's good for your mental health to just go and enjoy that, maybe a packet of chips or something but it's also mental health.*

Interviewer: *So would you say most of the time you don't really have those cravings but when you do you indulge in that?*

Mark: *Ja, then I put it away again.*

Constructions of healthiness that prioritise a balance between mental and physical health, self-control and self-care are discussed in the following chapter: *Balance*. The discourses of care, when used within the context of eating healthy foods and exercising often can lead to feelings of pride and superiority as well as gratitude and fondness towards the self. However, in the context of soothing the pain one feels with foods considered less healthy or 'too much food' (although in Berlant's (2010) view could also be considered therapeutic) is generally valued less highly and could lead to judgment from others and feelings of guilt, shame and feelings of disgust towards the self for being overindulgent or weak-willed. Individuals are sometimes able to side-step this judgement if, as Mark does above, they construct their behaviours as deliberate decisions to care for their '*mental health*'. We see here an interaction between discourses of control, discourses of happiness and discourses of care which function to construct right and wrong ways of caring for one's health. If the behaviour aimed at caring for the self is an expression of one's self-control and promotes happiness it is considered acceptable. The quotes above frame care in a way that constructs it as referring to behaviours that are supportive and promote '*healing*' and '*positive*' emotions. In the section below an example of an alternate experience of care, as one that can be painful is discussed.

No pain no gain

Although the discourse of care was often used to demonstrate kind, caring identities with self-respect, often in opposition to harsh, rigid health discourses of strict self-control, the care necessary to achieve the appearance of a healthy body was not always gentle. Richard's quote below illustrates some of the ways in which health promotion practices- which are understood, in this context, as practices of care for the self- can be a painful physical struggle.

> *Richard: so I'd be in the gym doing sit ups maybe, and then my stomach would pull in a direction it's never pulled before, like it's going to come out, like something's going to come out of my stomach, and I would actually laugh 'cause I enjoyed that, I enjoyed the pain, and I actually understood what they meant by no pain no gain. So when you feel the pain you know that something's happening. So when I felt that pain I was like yeah I'm doing something right, I would actually laugh in the gym ja, when I felt that pain*

Richard's quote shows how healthcare practices can be understood as caring even when they hurt. He describes his experience of pain as proof that he is *'doing something right'* and this brings him a lot of satisfaction. Ideas of *'no pain, no gain'* appear to contradict with discourses of care which were generally used to support more moderate, less restrictive and less punitive approaches to disciplining the body. However, dominant constructions of health often provide restrictive limits of the kinds of bodies which can be considered healthy and so in order to gain the appearance of someone who is understood to 'take care of himself' more aggressive, harsher disciplinary techniques may need to be enacted upon the body. An extreme example of this is seen in Burns and Gavey's (2004) discussion of how discourses of a 'healthy weight' can function in ways that support bulimic behaviours. Showing that taking care of one's health is not always sufficiently achieved through the gentler, moderate techniques of care.

Care, Morality and Identity

The following sections explore the use of discourses of care when discussing health and the ways in which these structures produce or reproduce certain subjects, certain relationships to the self and certain social and moral norms.

Reflexivity and the mind-body relationship

The kind of subject individuals can become through the use of discourses of care tend to be especially reflexive. Many of the quotes that draw on these discourses present a self that engages thoughtfully and analytically with their own thoughts and feelings. Ziguras (2004) discusses current constructions of selfhood in the context of celebrity obsession, modern television shows such as Oprah and the drama genre in general. He argues that individuals have become more reflexively aware of themselves, their emotions and the ways in which they are managing themselves. This he argues, coincides with an increase in the availability of examples of other individuals engaging in reflective practices about their own feelings, behaviours and selves for instance through the media mentioned above (Ziguras, 2004). A separation between the body and the mind and the reflexivity expressed in the participants' speech is essential for the creation of the internal policeman necessary to critique, manage as well as show respect

and care for the body. Foucault (1997) argues this point when he says that, 'taking care of oneself requires knowing ... oneself' (p.283).

This reflexivity is sometimes seen in the connotation of the adult self, caring for the child self, noted in participant's speech. Emotional reactions are assigned to the body as a separate entity from the self for example participants mentioned that, in reaction to poor self-care, the body will 'be angry' or the body 'will scream at you'. From these sorts of statements, it appears that the 'you' mentioned here is separate from the body and the two relate to one another in a certain way. The dualism within these quotes differs from that which is prevalent in Cartesian explanations of the relationship between mind and body. Here the body is not a machine, it is not an unconscious vessel for the mind. It appears to have a sentience of it's own (Blackman 2008). The body is also not constructed as unruly and out of control and in need of disciplining by the morally aware self. In these quotes the body is constructed as having a purity which needs to be protected and not defiled by the unruly 'self'. It is the body that seems to morally judge the self based on how it is treated. Foucault (1997) argues that the relationship subjects have towards themselves can change in different situations and contexts and so what constitutes the self can be guided or modified in different directions depending on this relationship. When engaging in self-care practices individuals can bring a degree of harmony to this relationship and individuals can feel secure in their sense of themselves as proactive, responsible and kind. However, when one is not doing sufficient care-work conflict will arise.

> *Lexi: Because actually you know, you don't know when you're going to die basically, and I think um if you're leading a life that it's almost like you're not appreciating the fact that your body is trying to keep you alive, and doing everything for you and you're just like drinking and whatever and yeah, I think it's like I've got a different perspective on it now that we should try and help our bodies and respect our bodies, because we've been given a chance to like experience life. Is that a bit cheesy? But yeah I think that's what I mean.*

Foucault (1997) discusses the importance of the practice of taking care of the self in relation to the construction of the subject and *how* beings relate to themselves (Foucault, 1997; Rose,

1998). In the quotes above, the image of a battle between the body and the self is created, illustrating an implicit dualism. Lexi explains this conflict when she says *'it's almost like you're not appreciating the fact that your body is trying to keep you alive and doing everything for you and you're just like drinking and whatever'*. This separation between mind and body may enable individuals to manage potential criticisms of selfishness or self-indulgence when they engage in self care practices. Positioning one's behaviour as bestowing care on someone or something separate, supports the conception of the self as kind and compassionate. This sense comes through when Lexi says, *'we should try and help our bodies and respect our bodies'.* It tended to be women who engaged most with this sense of dualism which may be related to the idea that the identity of the nurturing, selfless woman is one which is socially and culturally preferred as opposed to the self-absorbed, vain woman which is a construction which has been used to criticise and dismiss women. Women are also socialized to have a relatively removed relationship towards their bodies in certain situations. For example, we are encouraged to view ourselves through the imagined perspective of an other, to 'watch [ourselves] being looked at' (Berger, 1972 p.47; Spitzack, 1990). This experience may foster this perception of the body as *other*.

In some instances, the discourses of control and care seem to reflect opposing responses to social pressures to maintain health. For example, discourses of care were often used to invoke constructions of the self as gentle, compassionate and flexible but also responsible whereas discourses of control put forth ideas of the self as strong, independent and disciplined. However, both aim to bring the body into a position where it is considered 'healthy' (which in this context often means attractive and productive). Although these discourses seem in some ways to illustrate a choice to either resist or comply with the social and economic pressures to discipline the body, they both function to uphold the status of health as a *super-value* and to reproduce dominant moral ideals. They could be viewed as diverging approaches to how best to cajole the body into an acceptable state. Discourses of control may be viewed as the authoritative parent who imposes strict rules and threatens dire consequences for misbehaviour. Discourses of care may be more inline with a permissive approach which assumes that the body will thrive if only it is given a conducive environment of love and care. However, the distinction between the two is not always clear, for example, at times discourses of care were utilised to facilitate stronger, more disciplinary health behaviours as described previously.

Rose (1998) argues that the kinds of practices individuals engage in and the techniques used when relating to the self can be understood in relation to the aspects of individuals which have become problematic in some way. In the example of the care discourses, we might view the health of individuals as having become a problem for the individuals themselves, the governments who may have to spend more to address health problems and to corporations which depends on human labour for profit. The ways we engage with ourselves within the context of the primacy of health are informed in some ways by the constructions of the sick, lazy, inefficient, dependent self that has been problematised. In order to resist or address the conceptualisation of the self as problematic, discourses which function to present the individual as *'taking care of your body', 'respecting'* and *'accepting'* the body are employed. This way individuals are able to distance themselves from bad selves and adopt positive subject positions. By making use of the discourses of care in the construction of identity, individuals are able to embody identities that allow them more comfort, more social acceptance and a greater sense of self-respect.

Caring for others

Amelia mentions that showing care for others is important for their health and a lack of care from others would be evident in their poor health. This quote decentralizes the responsibility for health by constructing it as a partially shared responsibility. This sentiment was relatively unusual in the interviews as most other participants prioritised the preservation of others' freedom of choice over becoming involved in improving the health of others.

Amelia: I think so because if we don't care about each other, for example, for one thing, their health shows that we don't care about each other, so we are slightly responsible for it…

Interviewer: So do you think like… informing people about health …. do you think that's kind of a symbol of just caring about them in general?

Amelia: Definitely because you're conscious and you're worried about someone's health shows that you actually care about them, you're aware of them as people and what the long-term effects of their health would be.

In Amelia's quote, she addresses the idea that educating people about health or intervening in some way when someone is considered unhealthy, is a way of expressing, '*that you actually care about them'*. This suggests that the reproduction of health ideals and the widespread, grassroots permeation of health ideology can be constructed as an expression of concern, affection and helpfulness. Here we see how discourses of care work to produce some of the moralising effects of health discourse. Health work on the self and on others is constructed as a kindness when it is bound up with notions of care and so individuals engaged in these kinds of practices are able to adopt subject positions of good, kind people. This association also functions to further engrain and support the notion of health as a *super-value* and as an obvious good. In this quote, Amelia resists dominant discourses of individual responsibility for health while still reproducing discourses of health as a priority. In addition, Amelia's use of discourses of care is situated within wider discourses of gendered responsibilities. Women are often responsible for the majority of care work, including care work relating to health, and this may play a role ins structuring the way women make sense of health.

When making use of discourses of care to construct their healthy identities, some participants tended to draw a parallel between treatment of the self and treatment of others. The assumption was that care enacted on the self was evidence of a general propensity towards being caring in all situations.

Lexi: I know like when we used to do the 'metta bhavana' meditation as well, which is like the loving kindness one, the first step was like loving kindness to yourself, and then you do like the other people. When I discussed it with my friend, it was like "ja it makes sense" because you can't show like kindness and compassion to other people if you can't show it to yourself. It's like it's gotta like first sort of… ja I think like 'cause you do get people like that, you do get people who will always give to other people and not to themselves. And like in mental health, like it does happen in terms of trying to rescue

people, but it's it not coming from like a good place. In a way it's coming from like an insecurity to help other people, to fill, it's to fill a gap I think. So I think yeah, like I think it's you know, like when people burn out 'cause they're actually not self-caring, so I think it's sort of like that, it does make sense.

The idea in Lexi's quote is that the kindness directed towards the self is emblematic of the outward kindness one is capable of. She says, '*you can't show like kindness and compassion to other people if you can't show it to yourself'*. This understanding of healthy people as kind both to themselves and others is rooted in the idea of a consistent, coherent, stable self and that who you are in one situation is who you are in all situations. This idea could also be understood through Butler's (1999) conceptualisation of performativity. Behaviours that express a kind and caring nature are practiced on the self in order that these behaviours become cemented as an identity. These discourses may function positively and productively for individuals as showing care towards the self by staying healthy also shows others that the individual is a good and kind person who is clearly capable of caring. This may lead to social approval on two levels. They may be approved of based on their healthiness and the identity implications this has as well as based on their perceived kindness and compassion both towards themselves and others. This kind of working on the self in order to improve the self both physically and morally may be experienced as empowering and satisfying which may facilitate the continued use of and dependence on discourses such as these (Heyes, 2007). Practicing self-care also proves to others that the individual is worthy of care. It demonstrates to others that the individual respects themselves and therefore deserves to be respected and cared for by others.

By framing health-related self-care practices as a signifier of a caring, kind person individuals are able to manage the problematic association of self-care and selfishness. Self-care practices has been associated with self-indulgence or selfishness in many different circumstances. The popularity of self-care and self-help books and practices in contemporary society has been critiqued as evidence of a cultural narcissism by authors such as Richard Sennet (1974) and Christopher Lasch (1980 as cited in Ziguras, 2004). The impact of focusing intensely on self-care and self-improvement on social bonds has also been problematised. It has been argued that individualistic self-transformation techniques are partially responsible for the erosion of community and social support which has ironically contributed to health problems (Ziguras,

2004). These kinds of ideas make it necessary for individuals to position self-care as socially beneficial as well as personally important. In order to avoid criticisms of selfishness, individuals must construct their behaviours as evidence of an inner self who is concerned for others and is acting in their best interests. Through this discursive move, individuals are able to position themselves as *allowed* to pay attention to themselves, to prioritise their needs and to care for themselves. Although there has been a recent trend promoting this kind of working on the self, it is also disapproved of and discouraged in many contexts. By framing self-care as selfless individuals are able to comply with demands to improve the self and promote health while also avoiding negative critiques of selfishness or narcissism.

However, when used in this way this discourse can further stigmatise those who are suffering from an illness or dealing with any health concern. If self-care is a symbol of kindness and goodness, those who do not or cannot manage themselves in ways that are valued within this discourse could be criticized as lacking in self-respect or as incapable of care. It can also be victim blaming as if self-care is what is required to be healthy, poor health is a result of an uncaring person or one who does not put in the necessary care-work for themselves. In relation to Lexi's quote where she describes individuals who are *'trying to rescue people… to fill a gap'*, poor health is constructed as resulting from being psychologically flawed or lacking in some way

Caring is attractive

The criticism of those who do not comply with dominant beauty standards is at times legitimated through this discourse of care through the way in which care is constructed as being associated with a certain physical appearance. The below quotes illustrate some of the instances where participants discussed how they could identify whether or not someone was taking care of themselves based on their appearance.

> *George: for instance, if you see somebody that's over weight, you can really know that they're not healthy. Um sometimes they don't even have to be over-weight, you look at them, like for instance if you're familiar with someone in class and they always have*

got these dilated eyes, they always um look drowsy like tired you know, they've got dry lips, and they're not very participative, they fall asleep. Yes, you can easily attribute it, that attribute that, to hours of hard work while other people were sleeping. But also if they look like that all the time, there's something wrong you know, with them and with how they take care of their health. They probably don't eat properly, they don't exercise um or don't sleep at the appropriate times.

George: I mean if a guy has a good frame, he doesn't have to have abs and stuff but to me it's very easy to tell that a guy takes care of himself, you know, this guys takes care of himself, he's healthy, he exercises and he knows that he doesn't have to look like that…

Alex: Ja I think there would be like an acceptable range and like also not acceptable

Interviewer: Like what would be acceptable and not acceptable?

Alex: Well like if you're overweight, or if you have some condition that you not like taking care of or something like that, then that wouldn't really be acceptable.

In the above quotes we see how *'taking care'* of the self is also an aesthetic practice in that there is a certain appearance that communicates effective self-care. Being '*overweight*', '*tired*' and having '*dry lips*' or '*dilated eyes*' are understood as signs of someone failing to take proper care of themselves. In this way we see the victim blaming aspects of this discourse. Those who do not meet the ideal physical criteria are viewed as unhealthy and they are seen to be responsible for their poor health as they have not put sufficient time and effort into their self-care practices. Phrases like, '*if you have some condition that you not like taking care of or something like that then that wouldn't really be acceptable*' and '*health they probably don't eat properly they don't exercise um or don't sleep at the appropriate times*' emphasise this individualisation of the responsibility for care and the victim-blaming consequences this may have.

In George's two quotes above, exercising was mentioned as the self-care practice individuals should be engaging in. It is interesting how the quotes here are both by male participants as it is traditionally less acceptable for men to be overly concerned with their appearance. By making use of the discourse of care in relation to exercise and health they can engage in activities to 'improve' their appearance in order to bring it closer to the social ideal for men's bodies without appearing vain or feminine. It also allows for a distancing from the pressure to attain the 'perfect' body as depicted in the media. The discourses of care require an individual to be sufficiently thin and toned however it protects them from the expectation for men to be overly muscular. In Alex's quote he also touches on a sense of self-contentment and assurance that as long as one is not overweight he can be free of the anxiety about achieving '*abs and stuff*' because it is clear that he is '*taking care of himself*'.

Ziguras (2004) points out the tendency for individuals to seek out health advice from those who's appearance they want to emulate, for example celebrities. He notes how the authors of self-help books are usually highly attractive, calm and happy. 'These are the faces of postmodernity's lost souls- the faces who promise that health happiness and full self-control are within your grasp…' (Ziguras, 2004 p. 69). The appearance of healthy individuals who are taking care of themselves successfully is not only beautiful and thin but they also *appear* happy and calm. In George's second quote he mentions that one of the ways to tell if someone is taking care of themselves is related to their freedom from the anxiety about looking *'like that'* (having visible muscles) suggesting that part of looking healthy involves appearing calm and content. We see here an intersection with discourses of happiness.

The way in which discourses of self-care are used to legitimate negative evaluations of those who are viewed to be insufficiently physically attractive illustrates the ability to co-opt discourses of health and of care to reinforce dominant systems of objectification and discrimination against those who to do not conform to unrealistic beauty standards. Some of the other moralising and victim blaming aspects of this discourse are illustrated below.

Unhealthy and uncaring

Foucault (1987 as cited in Moss, 1998), when discussing the issue of self-care incorporates an element of self-improvement to this notion. Self-care, in his understanding, 'to know and improve one's self and to exercise mastery over passions and appetites,' (Moss, 1998 p.84). This component of self-care is also included in participants' speech relating to the outcomes of engaging in self-care practices. This is especially notable when participants like Lexi discuss their past selves in comparison to their current selves and the implication is that since they have been treating their bodies with more care they have improved, they are better than they were before, both in terms of their health status and as people. In the quotes below we see how the participants view their past, less caring selves and the implications this has for their current sense of self.

Lexi: we were doing a lot of like meditation and mindfulness practices and everything, and I just it's like a similar thing that happened with meat I couldn't like get away from what I was doing, so I couldn't just smoke and think about something else. I was so aware of what I was like, what I was actually doing, and it was like the same as meat. I just found I just couldn't, I felt like almost like sick when I was eating it 'cause I realised like this is like an animal, and then like then it's like really gross like going to the toilet afterwards as well, just the whole thought of it going like through my body and like ooh, it just like even now I remember having that weird like perception shift or something. I don't really know, it was quite bizarre but I told them at the Buddhist centre and they said they thought it was like maybe a good thing, maybe I was becoming like more aware or more mindful of what I was eating and how it was affecting me like mentally and physically or something. It was the same with the smoking, I just got to a point where I was just like aaah, I just don't want to do this anymore, like I don't want to do this, and then I just decided I'm just not going to smoke anymore, 'cause I couldn't, I couldn't smoke and enjoy it, because I was smoking knowing this is bad for me. It's actually killing me, like I'm breathing chemicals like into my lungs, like hot smoke (shudders). I don't know yeah, it's just like it's such a weird thing to do. And then I think as well I was more in touch with the the fact that like you know your heart is pumping and whatever to keep you alive, and by doing that you're actually just like, I don't know, it's almost like sticking a middle finger up to it or something it's just like

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it's trying so hard to keep you alive, and you're just like not appreciating that, or valuing that at all. And I just felt, I felt sad like I felt sad for my body as a sort of separate part of me. I know it's quite weird but that's probably as much as I can explain it...

Lexi: ja 'cause I think normally it's almost like you don't really think about it 'cause we're so here. But then like it's a shame like it's actually very sad for me to have thought how hard is my body working to keep me alive, to fight off illness or whatever, and then I just like light cigarettes and chemicals and everything, you just think like that's, that is not very nice.

In the above two quotes by the same participant we see both a mind-body dualism (discussed previously) within this discourse as well as the potentially victim blaming aspects of taking on all of the responsibility for self-care and health. The relationship between health and discourses of care and social norms around what it means to be a good person is observed in the second quote where Lexi uses the term 'nice'. It is particularly telling that this quote was by a woman as the social mandate for niceness is generally disproportionately placed upon women. Within this discourse we see gendered moral norms interact with neoliberal ideals of personal responsibility as well as cultural pressures to consume in order to produce certain experiences of the self. Lexi assumes responsibility for her health behaviours and if she is to fail in some way, by consuming something she should be avoiding (despite the fact that she is also encouraged to consume more in order to improve herself (Berger, 1972)) she is no longer 'nice' and has to re-evaluate her lifestyle and discipline herself before she can regain that identity. Niceness or kindness is also constructed as a prerequisite for good health as if one is not nice enough they will not be capable of effectively bestowing the care necessary for good health. Lexi's sense of autonomy in relation to her health emphasizes, again, an individual responsibility for health. An individual's health is viewed as being in their hands and all that is required is for them to find their true, good selves (Deleuze, 1988). This is done through engaging in the necessary disciplinary techniques- exercise and dieting- which will allow the *real* self to appear (Deleuze, 1988). This is a problematic idea in a variety of ways as not only does it deflect attention away from systemic problems relating to health and inequality more generally but it also makes health entirely interwoven with one's identity. Poor health then

becomes not only a failure of knowledge or time or even desire or commitment, it becomes a personal indictment of the self.

Discourses of care may serve participants when they are enabled to view themselves as having made progress in a positive direction. For example, Lexi describes how she became, *'more aware or more mindful of what I was eating and how it was affecting me like mentally and physically'* as opposed to how she was previously, *'not appreciating… or valuing'* her body. Through this discourse and the opposition that is created (between the healthy, caring, good self and the unhealthy, uncaring bad self), individuals are able to present themselves as morally acceptable and worthy of care as evidenced by their health. By confessing their past habits, *'I'm breathing chemicals like into my lungs like hot smoke',* as well as their disapproval of them, *'that's that is not very nice',* they allow their current self to appear relatively ideal, this allows them the opportunity to deflect criticisms of their current health practices or state as they can illustrate their self-discipline and will-power through the distance they have travelled between their past and current self. A redemption narrative runs through their talk about past, unhealthy selves and the transition to become their current healthy selves. Below, how these discourses of care play a role in experiences of the self is explored more, specifically focussing on self-image and respect.

Self-image/ self-respect

The discourse of care functioned to legitimate some of the moralistic values attached to health and was used to strengthen self-esteem. The pursuit of health and an engagement in health promoting activities was viewed as morally positive and were therefore things to be proud of. These behaviours were viewed as reflections of a kind and caring self who was therefore worthy of respect and self-acceptance.

> Ben: *I do think that it's a relationship with self. And people that take the time to kind of like work out or be healthy or you know take care of their diet, it's actually them taking care of themselves. And I think that people that don't make a way of it are not*

people that are, necessarily feel like they are maybe perhaps worth that, taking care of self and that's where I say the mental aspect comes in.

Lexi: I feel better within myself because I'm taking healthier lifestyle choices. I definitely feel much better about myself, even kind of things like um uh like what's the word? Things like self esteem? … Since I quit smoking, because I think like knowing that you're doing something that's hurting you, that's killing you, isn't very good for your self-esteem. And it's almost like you've got more respect for your body and more respect for your life in a way, by trying to be healthier. So I do think it does make a difference. And also you know uh with people who are like depressed or like comfort eating and not looking after themselves, neglecting themselves it tends to be linked to, you know, you can live like very sedentary lifestyle and like eat bad food if you, you know, you're not really feeling very great about yourself.

April: even though like physically she doesn't have like a model body or whatever you would call like a perfect like athletic body, she is mentally, in her approach, actually so healthy right now and so happy in the way that she's treating herself. Like respecting herself and respecting her body. You know how like your body's your temple, you need to take care of it, um and ja so I think that she is healthy now, and through that her body will start to change um and it's like this pendulum of ja. But I think your skin and how you feel in your own skin plays, okay how you feel in your skin plays like 50% um I think of whether you feel healthy and then the other 50 % is completely emotional like where are you emotionally, are you happy? Got enough friends? Are you like stimulated?

April: you have one body to live in, and it's your home, and you need to take care of it so ja I think it is just taking care of your body and ja and accepting it.

In the above quotes the participants discuss the relationship between self-esteem and self-care in relation to health. From their comments self-care is described as dependent on having a positive self-esteem *and* it is a requirement for it.

Phrases such as '*you're not really feeling very great about yourself*' and '*isn't very good for your self-esteem*' suggest that having a positive self-concept is to some degree reliant on at least the avoidance of '*neglecting*' your body and health. This sentiment illustrates some of the ways in which discourses of care and their facilitation of moralistic judgements of the self and others structure experiences of subjectivity. '*Comfort eating*', being '*depressed*', living a '*sedentary*' lifestyle and eating '*bad food*' are constructed within this discourse as sources of shame as they indicate a lack of self-respect and a lack of care towards the body. What it means to be a good person involves expressions of a caring and respectful nature and when individuals fail to adequately present these qualities they are likely to not feel '*very great*' about themselves or have a lowered self-esteem. On the other hand, engaging in health related practices and working towards improving one's health was constructed as an avenue to achieving, or perhaps earning, a sense of self-respect and improving self-esteem.

Practices of self-care can function positively for individuals in a range of different ways relating to identity, self-esteem and self-improvement. Foucault (2001) argues that self-care practices which do not function in ways that encourage the individual to withdraw from their communities are capable of helping to prepare the individual for active community involvement. Self-care practices could function to produce selves which are accepted by the self and which can function positively and radically in society to bring about change for all. However, the problematic aspects of this discourse are located in the specificity of the practices which are considered to be self-care (particularly exercising and eating according to healthy food norms), the relationship cultivated between the outward appearance of health and self-care (healthy looking individuals are assumed to be engaging in superior self-care practices) and the structural exclusion of certain populations from accessing experiences of or opportunities for self-care.

Critiques of Self-Care

Morality and barriers to self care

Amelia's quote below points out the potential for economic barriers to limit one's ability to care for the self.

> *Amelia: Most healthy people do have sort of the whole privilege to take care of their health and money-wise it's easier also unhealthy is the cheapest easiest option so there is definitely that economic ...*

It is important also to address the privilege required to engage in the specific self-care discourses which signify a taking care of the self and which are, as a result, socially acknowledged and rewarded. As shown in Amelia's quote, the ability to purchase certain health related items is available disproportionately to those who have the resources to purchase items considered healthy. The kinds of self-care practices that were discussed by participants often included the consumption of healthy foods and the consumption of exercise related services- gym/yoga studio memberships. The way in which these forms of consumption are constructed as signalling a commitment to self-care illustrates a commodification of self-care which makes accessing this discourse dependent on an individual's socio-economic status. This is not to criticize those who engage in self-care practices or make use of this discourse in their self-constitution- however, it is again important to consider the potential of this discourse to imbue moral superiority to some whilst condemning and isolating others.

The cooptation of self-care

Marcuse (1964) discusses co-optation and explains the way in which ideas originally intended to challenge the dominant discourses at a particular time can be appropriated and incorporated into the 'established order' (Marcuse, 1964 p. 57). This pattern of co-optation can be seen in relation to discourses of self-care where both theorists including Illich (1976) and individuals make use of ideas relating to self-care to resist the unequal power relationships in institutionalised health care, the moralism of health, the rigidity and

harshness of discourses of control and objectifying advertising and media messages. For example, in *Medical Nemesis,* Illich (1976) argued against medicalization and in favour of coping when he put forth the idea that medicalization constitutes a form of cultural colonisation which treats natural processes like suffering, healing and dying as malfunctions and undermines patterns of self-care. However, discourses of self-care have in some ways been co-opted by capitalism and consumer culture and have been integrated into moral norms (Heyes, 2007). Heyes (2007) discusses this idea in relation to the discourse of self-care and how it has been '[appropriated and debased]' by dieting culture. Foucault, in his second volume of *The History of Sexuality,* discusses the idea of caring for the self as, 'a practice of freedom' (Heyes, 2007 p.64). However, Heyes, (2007) argues that common techniques of weight and health management through diet and exercise are considered less a practice of freedom and more a disciplinary technique functioning to produce docile subjects. For example, dieting programmes, such as Weight Watchers, have commodified the concept of self-care and exploit the moral implications of weight-loss (and weight gain) on subjectivity to continuously resell their product to women attempting to lose weight (Heyes, 2007). Illich (1995), in later work acknowledges how some of the ideas he expressed in earlier work have been coopted and resulted in the intensive micromanagement of individuals. 'As soon as you understand suffering as coping, you make the decisive step: From bearing with your flesh, you move towards managing emotions, perceptions, and states of a self conceived as a system.' (Illich, 1995 p.9). Other examples of the co-optation of self-care by consumer capitalism include the range of products and services marketed as facilitating the care of the self, such as gym memberships, superfoods and supplements. Self-care has also been incorporated into moralising health discourses as it has come to link poor health with being uncaring or unkind. This functions to further stigmatise those who are suffering from chronic illnesses, mental illnesses or who are disabled.

Conclusion

Although discourses of care can be powerful tools to enable individuals to contribute towards their own healing and to resist or challenge discourses promoting a sense of worthlessness and self-loathing, there is a danger in taking this so far that we begin to believe we are self-sufficient and that others should be too. Discourses of self-care can also be understood as a form of productive power in service of a neoliberal agenda, where individuals are made responsible for

meeting their own needs through the promotion of action and the facilitation of a certain kind of subject (who is kind and concerned for the wellbeing of the self as well as entrepreneurial and self-governing (Binkley, 2014; Cruikshank, 1999)) as opposed to the punishment of certain kinds of unwanted conduct (Brown, 2006; Godrej, 2016). Discourses of self-care could also play a role in facilitating the forgetting, ignoring or even becoming complicit in broader social and structural problems, for example inequality and poor access to health care services, that leave us in need of more urgent care. Caring for others and being taken care of functions in many socially, psychologically and politically beneficial ways and an awareness of the ways in which discourses of care can be co-opted to undermine these functions may facilitate the possibility of exploring ways of resisting these attempts.

Chapter 8: Balance

"A balanced diet goes hand in hand with a balanced mind, don't you think?"

The Vegetarian, Han Kang, 2015

"Something is always born of excess."

Anais Nin, 1945

"I don't know what living a balanced life feels like

When I am sad

I don't cry I pour

When I am happy

I don't smile I glow

When I am angry

I don't yell I burn

The good thing about feeling in extremes is

When I love I give them wings

But perhaps that isn't

Such a good thing 'cause

They always tend to leave

And you shouldn't see me

When my heart is broken

I don't grieve

I shatter"

Rupi Kaur, 2015

Balance is Key

A number of the participants discussed the idea of balance when constructing their understandings of health. Balance was seen both as an ideal to aspire towards as well as a signifier of health. Healthy was understood as the goldilocks zone of self-control and self-work. Individuals should take an interest in and strive towards a healthy lifestyle however they should avoid an obsessive investment (or at least the outward appearance of this) in health at all costs. They should try to improve themselves but this should not lead to any negative consequences relating to their personality or social presence in the world. Balance was also used to mean the successful management of all facets of one's life and an acknowledgement of the potential negative consequences that could arise as a result of prioritising one form of self-management over another. The sentiment that sums up the idea of balance relating to health specifically is the commonly used phrase *'everything in moderation'*. This was a phrase used by some participants and, along with many other comments and explanations about health and about themselves as health conscious beings, was often intended to resist discourses of perfect healthiness and obsessive self-control. However, when considering the phrase 'everything in moderation' in relation to the participants' speech and when considering how discourses of balance were linked to other discourses used to discuss health, it seemed to take on a different tone. Instead of illustrating a lack of excessive concern about health, in some cases it seemed to suggest exactly what it says: that everything should be moderated. This discourse legitimates a constant moderation of behaviour, thoughts and emotions. Participants would use phrases like: *'you can work on your body but you also need to work on your mind and your psychological wellbeing and all those things'*, *'health is a balance in ...your approach to nutrition and exercise as well ... as emotional aspects in your life'* and *'I can like exercise a little bit too much sometimes but I'm very conscious of it so I manage it quite well'*. These excerpts illustrate how all aspects of one's life should be carefully managed to ensure a balance is achieved. When viewed this way the discourse of balance becomes a mutation of the discourse of control which was usually exactly what participants were often explicitly challenging when they drew on this discourse. The balance discourses appear to arise at the intersection of the discourse of control and a context of neoliberal individualism; social pressures relating to what behaviours and personality traits are required to be a person worthy of being liked and included, and a desperate urge to retain a degree of self-acceptance and freedom from anxiety.

The following quotes illustrate the importance of the concept of balance in the conceptualization and assessment of individual health.

Jo: *It's important to be healthy, especially to keep it in balance… Oh gosh, I think really that it [health] means to be in balance. I don't think it's an excess of having this healthy food because that in itself is unhealthy you know, in having all that good food because then you don't have - for example, if you don't have carbs then that will be unhealthy in that case because then you don't have that source of nutrients.*

Lexi: *I always feel like everything's ok in moderation, so it's ok to have um a little treat every now and then, like if it's chocolate or something. But if you're going to eat chocolate every day, then it becomes an unhealthy lifestyle choice, it's almost like it's the moderation of it, but I'm not sure with things like smoking and drinking, it's like generally bad for you anyway though, so I don't know…*

Christina: *…have a balanced sort of lifestyle.*

Alex: *Ja like I feel like I'm at a point where nothings to an extreme or anything like that.*

Isobel: *They may have like some kind of hormonal; I think hormones are like really important. Like some people's hormones are in balance in themselves and others less so and sometimes I'm super grumpy and I don't really feel in balance so I'm probably not the best person to be around.*

The first three quotes show that health and balance are often seen as inextricable from one another, and are sometimes even synonymous. Jo discusses balance in relation to ideas about restrictiveness. She acknowledges that the pursuit of health could lead to an urge to cut out certain foods or to be excessively particular about what one is willing to eat, *'for example if you don't have carbs then that will be unhealthy'*. We see here the pervasiveness of health promotion discourses and the kinds of behaviours that it could facilitate. The moralism related to health and the pursuit of healthiness, as well as pressures from the beauty industry and consumer culture to attain a 'healthy' appearance, can motivate individuals to go to extreme lengths to situate themselves in socially acceptable positions. The acknowledgement of the tendency towards these kinds of behaviours among participants is an implicit acknowledgement that health could have negative associations with it. However, this is never explicitly mentioned and is rationalised by concluding that this would not be *true* health then and that the individual was simply misinterpreting the requirements for health or was acting in accordance with existing psychological problems (Dworkins & Wachs, 2009). Jo is resisting the pressure to adopt particularly restrictive health behaviours by making use of the balance discourse which challenges the idea that perfectly following the rules of health will make you healthy. The resistance to perfect healthiness is discussed in more depth later. Alex's quote also emphasises the point that *'extreme'* behaviours of any kind are not healthy and that they should be avoided in favour of a more relaxed, balanced approach to health.

Isobel mentions hormones specifically and the necessity (for women) to keep their *'hormones... in balance'* so as to avoid becoming unpleasant for others as she is, *'probably not the best person to be around'* when she is, *'grumpy'*. This idea also illustrates a significant aspect of the balance discourse: amiability. Being healthy should not impede an individual's likability and so pursuing health behaviours too enthusiastically or appearing too concerned with one's health is not an option. As a result, a notion of health which is amenable to smooth social interactions and minimal discomfort or conflict in social situations is preferred.

In the following interaction, Jo expresses a disapproval of an obsessive attitude towards health and favours one which is more light-hearted and care-free. However, she also hints at the idea that a failure to live up to health standards does need to be addressed and corrected as this is negatively valued.

Jo: *I think, well in my group of friends we eat healthy, and we'll have the occasional cake and cup cake and ... which is great and that's good 'cause you can't 'live'. But then there are the other friends who, when they eat something bad then they, "Oh I shouldn't have eaten that, I feel bad I feel guilty, it's bad for my body" you know like that kind of thing.*

Interviewer: *And then like, what will happen after that what do they do with that guilt?*

Jo: *Oh yes I have one friend...who because she's eaten like that meal or that bad meal she won't eat anything after that for the whole day or so. Really bad to skip meals at all in my opinion. I have others who are like "ah I shouldn't have eaten that oh well" (laughs) you know what I mean? That's like the one friend that I have.*

Interviewer: *Like the damage is done?*

Jo: *Exactly. Well not so wow but like it's already done so it's in the past - exactly. So I'm not like going to starve myself for the next four hours because of this one cheat you know. I'll go to gym tomorrow and try work it off - it's kind of like a balance. Ja, so I've only got like a few friends who are like when they starve themselves .... It's like only one or two.*

In the beginning of this interaction Jo describes eating something like a cupcake which is generally not considered a health promoting food as '*great*' and '*good*' because enjoying foods like that is part of 'living'. This suggests again that too much healthiness and perfect health rule following is not ideal as it is restrictive and boring. She then also critiques the corrective behaviour of her friend who '*skips meals*' if she has eaten something unhealthy as she argues that such behaviour is '*very bad*'. So it seems that unhealthy behaviours when engaged in for the sake of 'living' and enjoyment are acceptable but when they are engaged in out of anxiety or insecurity they become unhealthy. This idea relates to the confidence cult(ure), discussed by Gill and Orgad (2015) who argue that a lack of self-confidence has come to be viewed as unattractive and individuals (particularly women) are now expected to take responsibility for their self-esteem and, at the very least, act confident at all times if they want to be worthy of love and success and to effectively resist a culture intent on criticizing women. Acting in an

unhealthy way as a response to feelings of guilt or shame are valued negatively, possibly because they reveal an insecurity. The idea that Jo is discussing is also related to 'keep calm' culture where individuals are expected to moderate their emotions and avoid panic, anger and stress. This is associated with the popularity of mindfulness and meditation practices and apps aimed at assisting individuals with managing their stress (Cederström & Spicer, 2015). This calmness mandate may be viewed as a modern iteration of the perception of the hysterical, overly emotional women who needs to get her wild, disproportionate feelings under control.

Despite Jo's criticism of obsessive corrective health behaviours in response to simply enjoying oneself, she does describe a behaviour like eating a cupcake as a *'cheat'*. This is a very common term used in diet culture and illustrates the negative connotation given to the consumption of unhealthy, especially high calorie foods which could lead to weight gain. She then goes on to say that she would not do anything so radical and unhealthy as '*starve myself*' but she would need to go to the gym the next day and *'work it off'*. So although she describes the incident of eating the cupcake as '*in the past'* it stays with her for at least a day until she has corrected for and undone her *'cheat'*. We see Jo making use of the balance discourse to resist feelings of guilt and anxiety while at the same time using the discourse of control to illustrate that she can take responsibility for her actions, correct for unhealthy decisions and manage her emotions. Through the use of these discourses she can construct for herself a subject position of managed contradictions- the free, happy self who can enjoy her life without restriction; the self-controlled, disciplined self who makes rational choices and takes responsibility for her decisions and the emotionally restrained self who will not over-react to a small mistake but will instead behave calmly and reasonably.

As a result of these competing discourses a situation arises where one is prohibited from reacting emotionally to the experience of living with a tremendous pressure to become a self who embodies seemingly contradictory or inconsistent traits while still appearing congruent (so as not to appear crazy or inauthentic). This is because an expression of frustration, struggle, pain or anxiety is bad for one's health and should therefore be moderated. In this way, we see the disciplinary function of the discourse of balance where emotions are policed and tempered in order for them to become less threatening and more manageable. If strong feelings are

repressed and silenced through a constant self-management of emotions, resistance is made much more difficult and the status quo is allowed to persist.

In the following section the way the balance discourse has permeated a variety of aspects of our lives and has assisted in the promotion of the 'healthism' ideology will be discussed.

Balance and Holism

The following quotes illustrate the idea that health entails making sure that there is a balance between all the facets of a person's life. This means that physical health should not be prioritized at the expense of mental health and that it is important to make an effort to maintain your wellbeing more generally as opposed to focusing exclusively on one component of health. Here, we see a link between the balance discourse and the holism discourse which is often drawn on in relation to health. Holism in health requires successful management of all aspects of your life for the sake of your health (Crawford, 2006). At previous points in history holism encompassed a broader sense of connectedness and unity between individuals, communities and the environment (Shroff, 2011) and the more prevalent modern use of the word may have come about in opposition to more isolated, medicalized, treatment focused approaches to health which were sometimes deemed ineffective or even harmful. However, the neoliberal, individualized context in which the idea has recently become popular has fundamentally changed it's focus from a tendency towards community and support, to a tool to encourage the permeation of internalized disciplinary techniques and self-adjustments into all aspects of an individual's life.

> Alex: *It's like the balance between your psychological and your physical health I guess, so ja physically you benefitting but I mean no one wants to eat like only one thing and like be happy about it.*

April: *Okay so for me particularly, I think health is a balance in your understanding of nutrition and your approach to nutrition, and exercise as well, and um as well as emotional aspects in your life*

Adele: *Health I think means your overall wellbeing, not just your physical but also possibly your mental and spiritual, that's how I would define your health. Not just your physical…I think you know to be healthy is a holistic thing so you can be physically healthy but it doesn't mean that you're mentally or spiritually healthy. So I like to work on holistic things also at school we try to build them up to be like holistically educated. So I think you can work on your body but you also need to work on your mind and your psychological wellbeing and all those things.*

Adele: *I think exercise is important but sometimes that creates more stress because you creating time to go to the gym that you don't have, and that kind of thing. Ja and I think getting enough sleep and trying to eat well and just all round you know, I think it's an all round process. I don't think it's just going to the gym and then you know the rest of your life is falling apart. I don't think that works either. So it's a daily process I think keeping yourself healthy. Especially if like I said it's physical, emotional and psychological and all of those things.*

The holism discourse is often used in conversations around healthy lifestyles. The idea that health can become a lifestyle incorporates the hope that it will become easy and natural to be healthy and it will not feel like work. Understanding health as a lifestyle may be used to downplay the self-discipline usually required to abide by health rules. However, by broadening health to encompass one's whole life, the requirements for health become increasingly demanding.

When the balance discourse is used in this way to promote and idealise holism, Berlant (2011) might describe it as a cruel optimism as that which is perceived to be the avenue to the good life may in fact impede it. Individuals are required to put in a lot of time and effort to manage

their emotional, physical, mental and spiritual states. However, many factors determining their health status are out of an individual's control. As a result, this constant policing of the self may not prevent the failure to live up the demands of a healthy, holistic lifestyle. Instead, the constant self-management required of individuals may lead to more stress, disappointment and a rejection of some of the aspects of life which might lead to an experience of joy (Cederström & Spicer 2015).

The Rigidity of Balance

Jo mentions how, although a balance is ideal, this is not an easy thing to achieve. George also describes some of the challenges involved when trying to attain a level of balance.

Jo: *Generally, yes with obviously so you've got your general line and then you've got your little extremes. The good extremes and then the bad extremes. It's always going to be like that for me. Unless you're a really wonderful balanced person but I haven't been one of those yet.*

George: *Ah! (laughs) well hectic schedules for starters like uh being a student and all. Like for instance, there's this Afrikaans thing assignment that I have to do, I have to interview someone in Afrikaans, I have to practice it to make it sound good, and I also have to write a review you know. So your mind can be so fixed on those things, and I also have to study a reading for a [subject] assignment tomorrow, and study for a test, a [subject] test, so you know my mind is already fixed on those, and I have to do this [place] thing as well. So that'll take up most of my day so I have to do most of what I'd do now in the night. So ja you can imagine that and trying to squeeze it all in between eating healthy and exercising and having a meaningful conversation with a class mate or a friend or a call. So ja it's trying to find a balance... ja, I think that's what makes it difficult, that's the difficult part, balancing things out.*

Many of the participants make use of the discourse of balance to invoke a sense of flexibility and ease. The idea is that either of the '*extremes*'; the *'good extremes'* (healthy to the point of fixation) or *'bad extremes'* (to the point of gluttony or laziness), are restrictive and problematic. The extremes are associated with things like obsession and addiction whereas balance is associated with moderation, rationality and adaptability. In the above quotes, however, we see the participants struggling with the dedication and commitment required to live a balanced, healthy lifestyle. Cairns and Johnston's (2015) concept of 'calibration' may be useful when trying to understand the way ideas of balance, in relation to health, are experienced. They make use of this term when discussing middle class women's relationships to food and define it as, 'a practice wherein women actively manage their relationship to the extremes of self-control and consumer indulgence in an effort to perform acceptable middle-class femininities' (p.154). Although the balance discourse was used by both men and women from both working class and middle class backgrounds this notion could still be applicable and may illustrate the increasing reach of discourses which require a constant policing and moderating of behaviours and subjectivities. Individuals must constantly negotiate the tension between two opposing extremes in order to produce identities which are, demanding and elusive but also, socially pleasing. Individuals made sure to carefully, 'position themselves as conscientious, but not fanatical' (Cairns & Johnston, 2015 p.157) to avoid being pathologised as a 'health-fanatic' but also to avoid the opposite extreme of overindulgent or abject. This careful management of identity illustrates the sharp borders of acceptable performances of health and illustrates the connection between discourse and subjectivity (Cairns & Johnston, 2015).

This links back to the holism discourse where, because health has infiltrated into every aspect of our lives, in order to be healthy our entire lives need to be constantly policed and regimented. The discipline required to achieve a sense of balance could become an additional burden on individuals with already busy schedules and demanding lives. In this way trying to achieve a balance between all the necessary aspects of health may lead to stress and anxiety. Unfortunately, stress is often considered to be the enemy of health and is another thing that should be managed in order to achieve balance.

> Amelia: *I think stress is very unhealthy, it upsets your balance a lot. I think a balanced diet makes you feel healthy, feeling right, making sure your body gets all it need.*

If the pursuit of a balanced healthy lifestyle is experienced as difficult and sometimes stressful then an inescapable cycle of 'anxiety and control' (Crawford 2006) is likely to occur. The responsibility for ideal health is internalized and when this becomes challenging or impossible a sense of anxiety may result. Because stress is viewed as bad for one's health the responsibility for managing this is also internalized and so the cycle continues.

> Adele: *I'm not very good at it actually [managing stress], but I would say that probably exercising is the best way for me to control it, and just maybe socialising with friends, getting out of certain environments that maybe are stressful.*

In the above quote we see Adele internalising the responsibility for managing her stress by engaging in health promoting behaviours, for example, '*exercising*'. However, this can sometimes be a cause of stress when one feels that they are not living up to expected standards for sufficient health behaviours. As Adele says earlier, '*exercise is important but sometimes that creates more stress because you creating time to go to the gym that you don't have and that kind of thing*'. This illustrates the cycle of 'anxiety and control' which Crawford predicts as well as the pressure placed on individuals to live a holistically healthy life and how unattainable this goal has become.

Not Too Healthy

Within the balance discourse individuals emphasized the need to avoid an obsessive attachment to health behaviours and the pursuit of healthiness more generally. It was taken for granted that being too unhealthy was negative and should be avoided but participants felt the need to be explicit about the idea that being overly invested in health was also undesirable.

> Miranda: *…but at the same time I don't think I ever like starve myself, or I ever do completely you know- I'm not a robot, I don't have entire self-control, so you know there are nice cookies around I'm going to eat them, but I just try to make a point of*

not eating sugary things everyday. If I realize that I go a week or a weekend just eating a lot of junk then I go: "ok I sort of need to make up for that now" and then I make a point of not overindulging in sweet things or you know fatty fried, greasy things for a little while after that so… Try to maintain a balance.

Christina: *I do like healthy food but I don't really feel bad when I eat unhealthy food.*

George: *Well being the kind of person that I am, I would, I would kind of try to keep up with that level* [of a healthy partner] *unless it had gotten to a point where it was too ridiculous, like a bit extreme, then I'd say:" well look I'm comfortable with my level of health so I'm not going to try to bring you to it but I'm also, I also want you to be okay with it and be okay with this".*

Alex: *I don't know I'm not like super health focused or anything, just like normal level of healthy I think.*

George: *… there's you know there's this thing um I don't know if it's a philosophy or a saying or whatever, but it said that everything should be in moderation*

Owen*: I formed a very strong habit around it* [coffee] *and association around it and I think it just. So that's why I drink it. It's almost like that thing when you know that it creates issues. But it's not like I want to necessarily cut it out completely but I do need to bring it down to a certain level. Like from 3 a day to 1 a day. I can like exercise a little bit too much sometimes but I'm very conscious of it so I manage it quite well.*

Interviewer: *Ok, so do you think like your kind of enjoyment in that experience [doing something unhealthy] kind of outweighs the like negative impact*

Alex: *Ja 'cause I think the impact that that would have would impact my physical health, but like in turn it's like helping my mental health*

Within the discourse of balance individuals can protect themselves from societal expectations of perfection. In the quotes above, the participants describe themselves in behaviours which would not necessarily be considered perfectly healthy but that despite this they were allowed to be *'comfortable with my level of health'*. Miranda says, *'there are nice cookies around I'm going to eat them,'* Owen explains that he realises that his coffee consumption *'creates issues'* but he does not need to *'cut it out'* only to *'bring it down'*. Alex justifies behaviour that may be detrimental to his physical health could still be considered healthy in relation to his *'mental health'*. In this way, individuals can indulge in behaviours which may be generally believed to be unhealthy while discourses of balance allow them to maintain their conceptions of themselves as healthy. Perfection and competition are ideals promoted within mainstream media as well as in political rhetoric. Individuals are provided with messages that the perfect body, the perfect job and perfect life will lead to perfect happiness. Perfecting health is not only an unattainable goal for most people, it is impossible to sustain and oftentimes not within an individual's control. It is not likely a worthy use of time and resources, however, it is still idealised. In order to justify imperfect health, the balance discourse provides a legitimate reason not only to be satisfied with imperfect health but to actively avoid intensive or excessively demanding health practices. This allows individuals to ward off feelings of inadequacy, failure and shame. When making use of this discourse an individual is not lazy or lacking in self-discipline when they exercise less than is expected of them or if they consume foods they have been told are unhealthy. Instead, they are moderate, reasonable people who are making a conscious decision to temper their health related activities. If anything they could now be considered even more healthy and more self-controlled.

The balance discourse provides individuals with the option of distancing themselves from the overly enthusiastic, uncool, too invested and undignified self who would be too passionate about health. This individual would zealously pursue health and would be crushed by any setbacks. This temperance of emotions may also be related to dominant gender norms. Men are prohibited from expressing too much enthusiasm or investment in the pursuit of health ideals as this would contradict acceptable notions of masculinity as stoic and relatively

emotionally restrained (Norman, 2011). Women on the other hand are able to distance themselves from historical critiques of femininity as overly emotional, too sensitive and caring too much. Within the discourse of balance individuals can abide by the socially necessitated pursuit of health without compromising their personality ideals, while ensuring that they comply with socially rewarded gender norms. This discourse also serves to cement the facade of limited effort involved in these individual's health pursuits. Alex says that, *'I'm not like super health focused or anything just like normal level of healthy I think'*. Their good health status is likely to be more highly valued if they are believed to have achieved it without excessive effort or strain thereby maintaining their dignity and composure. Limited emotional affect especially in relation to anything that could be associated with vanity or narcissism is highly valued as it allows individuals to conceal insecurity (which is unattractive (Gill & Orgad, 2015)) and project self-confidence.

Life out of Balance

The quotes below illustrate the potential consequences of being unbalanced with regard to health. Being out of balance is described as leading to a range of unpleasant events from physically feeling unwell or contracting a disease, emotional pain and a lack of self-esteem or a life that was not adequately lived.

> Jo: *Because if things in your body aren't in balance, then things start going wrong and that's when you get infections and sickness and flu.*

> Jo: *with unhealthiness brings it brings sadness, it brings this kind of like guilt and loathing, self-loathing, which added on to the fact that for example, will add on like loss. Like it's not good for you. Like loss and self loathing not a good combination at all. It's more those kind of emotions.*

Jo describes some of the consequences of one's health and body *'aren't in balance'*. She talks about physical sickness and then also the impact on one's self-concept. She describes feelings

of *'self-loathing'* and *'loss'.* She may be referring to a loss of self-acceptance or self-esteem or a loss of a sense of autonomy over one's body and, related to this, one's life. This illustrates the belief in the fact that a healthy personality exists. Healthy is not only a physical state, it is a kind of person. This idea together with the holism discourse and the moralization of the healthy person means that maintaining a high self-esteem seems increasingly out of reach. If any problem in one's life is related back to one's health and is diagnosed as being due to an individual lack of hard work and self-control then feeling a sense of self-acceptance becomes temporary at best and at worst, impossible.

The following quotes illustrate the risks associated with being too healthy or being 'overly' concerned with one's health in relation to how others are likely to perceive you. These participants discuss how people that they know who are 'too' healthy are generally worse people and how it is their healthiness that is the cause of this unpleasantness.

Jo: *People who are obsessed with health and obsessive also, tend to be very negative because they always looking at that, always like "can't eat this because…" and are very restrictive in that way you know what I mean? So ja there are opposite ends of the scale.*

Jo: *If I have to say anything about health just that people should be really not too obsessed about it, because that often does just take over the life of your life and those of others, and you end up being very unapproachable because you only see like, "oh no that's not healthy I can't eat that …"…. So to be healthy but not to obsess about it to live at least. To give yourself some unrestriction that's the one thing I would say if anyone had to ask me about health*

Richard: *…the trend is ja the dominant one is that guys who are in top shape or girls who are in top shape are jerks ja, that's the trend.*

George: so I think I don't think there is such a thing as being too healthy, but it also I also associate that with, I think, when you're too healthy you start looking at other people differently, you know, so it does kind of like start having a negative impact in a way you know. I don't think there is such a thing as being too healthy, but if you are too healthy then you start seeing it, like people start making comments "oh so and so is too thin, they don't eat right. They're too, you know, because they're too healthy now" but you know for you it works because you are now in a very good um place in your life.

Interviewer: *okay so do you think, because you kind of feel like you're doing so well you might kind of judge other people a bit?*

George: *yeah that's what I've noticed with, you know with (laughs) I do have a friend, whose uh she's a lady, and she's kind of into body building and she's very healthy. You look at her she's very healthy, she does look like somebody who takes very good care of herself, but I noticed that uh when were in the train, like we're sitting in the train, 'cause we used to meet a lot um on our train rides. She's sitting there at one point, it got to a point where she actually took a picture of someone who was behind me. She was sitting with her phone she took a picture of someone who was behind me and she sent it via whatsapp to me like: "look at that person whose behind me, I mean behind you" and behind me was a lady who was standing- leaning on the post, on the central post and that lady was actually, she had you know she was a bit overweight- chubby. So I that kind of gave me an impression that she's kind of very healthy and stuff but see now, it's starting to have a negative impact on other people you know. And it's also starting to change the way she looks at other people, and the way other people are going to look at her, because of the way she looks at them yeah. So I think being too healthy, (sighs) it can come with some problems as well, unless you're that type of person who doesn't impose yourself on people then you can be as healthy as you want to be (laughs) yeah*

The above quotes address the social component to health practices. Jo explains that being too obsessed with health results in individuals becoming *'unapproachable'* and *'negative'*. George points out that people could be put off by his body-builder friend's critical attitude towards others and Richard expresses an observation that, in general, men and women who are very fit

are often *'jerks'*. The expectation to maintain a certain level of healthiness and to bear the signifiers of this health (an acceptable weight and a certain degree of attractiveness) exists alongside the social expectation to be sociable, easy-going, to participate in social customs and*, 'to live at least'*. These two expectations sometimes contradict one another and the restrictions or disciplinary techniques required to maintain an acceptable level of health prohibit individuals from engaging fully in certain social events for example the 'braai' or other family/social meals where food items that would not likely be permitted in most 'healthy' diet plans are offered and are expected to be enjoyed. In these situations, individuals need to choose between whether they will maintain their self-discipline and stick to their food rules or whether they will comply with the social expectations of the situation and consume foods that mean compromising their healthy lifestyle. If they choose the first option a degree of social tension is likely to occur. People close to the individual might feel offended that the food they have prepared is being snubbed, others who have chosen to consume these kinds of foods may feel judged or defensive about their decision or they may feel that their own lifestyle or even appearance is being criticized. This may also lead to assumptions about the individual who has chosen not to participate in the social ritual, he/she may be viewed as judgmental, uptight, difficult, stubborn, rigid or superior. Jo describes individuals like this who are *'like oh no that's not healthy I can't eat that'* as *'being very unapproachable'*. If the individual makes the choice to consume the off-limit foods, they may find the social situation a lot more bearable, however, they may also feel a lot of guilt for not being sufficiently self-controlled. In this case the balance discourse can provide a needed sense of relief about this choice as within this discourse one unhealthy meal occasionally is actually a requirement for being healthy as it proves an absence of '*obsession*', rigidity and stress. This allows the individual to enjoy social situations that do not abide by all the rules for a healthy lifestyle while at the same time maintaining their self-esteem and even pride in sustaining their healthfulness.

The term *'unapproachable'*, used by Jo, suggests that there is a concern that if one is too explicit or too rigid about one's health beliefs then others are likely to find you intimidating or just unpleasant. Other words that were used to describe individuals who are too healthy included: '*negative*' and *'jerks'* and the argument was made that people who are too healthy are judgmental and critical. In relation to this idea it is useful to consider the desired outcome of pursuing a healthy lifestyle. When asked about why they tried to stay healthy or why they believed health to be important a number of participants mentioned other things that being

healthy would enable them to do. Only a few participants explicitly addressed the emotional component of the desire for good health, most often relating to self-acceptance. The idea that health makes you more attractive to *others* was also prevalent in the participants' speech. Participants were generally reluctant to discuss physical attractiveness but they used other terms like '*confidence*', '*happiness*' and '*looking good*' to describe what healthy people were like and what the experience of being healthy was like. Being such an important social value too means that being healthy and being acknowledged by others as such is important in relation to how we are treated by others: whether or not we are accepted, respected and loved. If being healthy isolates us from others, as it appears to do when individuals are 'too' healthy or too vocal about their health, then it renders one of the desired outcomes of health practices (acceptance) improbable. The balance discourse seems to provide a loophole in this contradiction whereby individuals can pursue the socially acceptable health signifiers while maintaining, or ideally enhancing, their social status as opposed to hindering it. The use of the balance discourse to improve community belonging also illustrates a friction with discourses which individualise health. In many of the extracts health has been described as intensely personal and a project which only the individual can truly play a role in protecting and improving. However, while individuals are expected to take on the responsibility for their health on their own they also express a desire to be a part of a community and in some ways the individualisation of health appears to ensure that they are worthy of acceptance into a group.

The balance discourse and the concern around the perception of others that one could be *'too healthy'* also relates to the idea that being open about the sacrifices that are often made in the pursuit of healthiness is better avoided. This may be due to a number of different reasons but in a society that expects individuals to stay healthy and be good 'biocitizens' (Halse, 2009) it may feel uncomfortable to hear about what that requirement means practically in people's lives. It is more appealing to believe that being healthy does not require very much of a person because then individuals can feel reassured that they are putting in sufficient effort themselves and need not feel guilty that they are not doing more.

This contradiction between the expectation to work hard and to be committed and disciplined in relation to the pursuit of health and the criticism of those who put in too much effort or are viewed as *'obsessive'* could lead to a secretiveness around health practices and a silencing of

experiences which do not reinforce the idealization of health and the pursuit of perfect healthiness. Individuals may feel the need to publicly ascribe less value to their health practice or to downplay their commitment to ideal healthiness in order to appear balanced. This option would likely be more common among those who are very active in their health improvement practices and bear the symbols of ideal health- the positive personality traits of happiness and energy and a thin, toned body. It may also lead to a concealing of any negative emotions relating to health maintenance and improvement activities- in this way a person very invested in improving their health may express an enthusiasm around a chosen exercise or diet- implying that they engage in these things because they want to and they feel good doing it as opposed to out of a sense of '*obligation*' or anxiety as mentioned by Alex below.

> Alex: *I enjoy it but like if it gets to the point where it is an obligation then I would just eat something else. Like I'm not like super focused like if I'm in pinch like I'm not going to worry about the healthiest food.*

As a result, they can avoid seeming to be susceptible to social pressures- which could indicate a weak will or insufficient self-confidence, which may be embarrassing (as confidence has become an obligation (Gill & Orgad, 2015)) - and they can express other characteristics which are evidence of healthiness- happiness and positivity. This also results in the internalization of the responsibility for any pain or suffering that one experiences as a result of the pressure placed on individuals to maintain a certain level of health. If individuals are finding health too difficult a goal to achieve or are finding health pursuits and effectively meeting the prescribed health standards too stressful, then, within the discourse of balance, the response would be: well, you are simply doing health wrong. By constructing health as a balance, individuals who do not achieve this balance are not healthy, and have only themselves to blame for the suffering they experience.

Conclusion

The balance discourse was one of the most prominently used discourses in the participants' speech. John Stuart Mill's (1834 as cited in Phillips, 2011) statement that, 'there seems to be something singularly captivating in the word balance, as if, because anything is called a balance, it must, for that reason, be necessarily good,' seems to still hold true. Discussions around balance were often closely linked to discussions of control with participants often using the discourse of balance to alternately affirm and resist the demand for perfect self-control. By using the discourse of balance participants were able to construct a variety of sometimes, ideally, contradictory subject positions for themselves and to maintain a sense of social cohesion. This discourse is facilitated by ideologies of 'healthism' (Crawford, 2006), confidence cult(ure) (Gill & Orgad, 2015), and broader neoliberal discourses such as individual responsibility and competitiveness. The balance discourse was often used in attempts to challenge the pressure to conform to unattainable standards of health behaviour and commitment and resist negative emotions such as anxiety, stress, guilt and shame. However, it also functioned in ways that increased the requirements for health and therefore stress, prohibited emotional expression and silenced dissent, reinforcing the legitimacy of health as a *super-value* (Crawford, 2006).

Chapter 9: Goodness

'The best gift you can give your family and the world is a healthy you.'

Joyce Meyer, 2010

'In our culture, fat is evil. Eating it or wearing it, feeding it or bearing it is a sign of some moral deficiency. Aesthetically, physically and morally, fat is a badge of shame.'

Klein, 1996 p. 22

'Health is never simply 'health'; instead it can easily become a means of moralising of normalising and of regulating'

Parr 2002, p. 373 as cited in Evans, 2006

The discourses discussed previously all incorporate elements of morality to some extent. This section will focus on the idea of goodness more broadly, the sense that being healthy makes someone a good person and the reverse implication: being unhealthy makes them a bad one. In the following three sections, the way health was infused with morality and functioned to support dominant moral norms will be discussed. The first section focuses on the ways in which healthiness was equated with goodness. Then, the exceptions to this trend when healthiness was linked to arrogance or being judgmental is explored. Finally, the ways in which illness, or various conceptions of unhealthiness, was equated with being morally lacking or inferior will be discussed.

Healthiness is Goodness

Participants talked about healthiness as a state towards which individuals should aspire, as a means to social acceptance and as equivalent to having desirable personality traits. In Nathan's quote he illustrates the idealized nature of health by positioning it as something admirable and something to aspire to. His role models are individuals whose bodies are evidence of their superior health and therefore their worthiness of admiration.

> Nathan: *if you watching like maybe sport events, or you watching or you've got a hobby that you do, like dancing, and maybe you see someone that does it, and I think like seeing role models can motivate you. I know for me personally what motivates me is watching like a lot of sport on TV, and you get certain sports where you feeling inspired and ja and also like saying basically you want to be like that.*

This quote illustrates the aspirational tone which is sometimes used when discussing health. Healthy individuals, in comments such as the one above, are constructed as the apex of humanity, as examples of the potential humans have and as inspiring to others.

The example above touches on the idea of the possibility of individual achievement and greatness through health. Another way in which health was linked up with goodness was in statements and discussions about interpersonal relationships or the social roles of individuals. One of the common ways in which we see discourses of morality in discussions of health is related to sociability. Being socially accepted and positively regarded by others came up in many different instances in the participants' discussion of health. Health was often talked about as necessary in order to successfully interact with others and to prevent an individual from being unpleasant to be around, or devalued as unworthy of interpersonal relationships. Being sociable, *'friendly'* and having *'very good relationships with people'* was also seen as a sign of good health and healthy people were constructed as being more positive. In the quotes below, Jo and George discuss how healthy people are confident; sociable people who are well-liked.

Jo: *In other ways it ends up being that they more open that, they more friendly to other people. That's certainly in my friendship group anyway. Because they have that confidence they can always approach that other person they've never been able to approach before. And also I think because a person exercises, you do with other people you meet, other people- you like increasing your social. So it ends up being something that doesn't just work out your body but also works out your social skills so it ends up helping you in life.*

George: *I also try and keep good relationships with people. I think that also has a very positive impact on your health. So I also try to see people in a positive light because if you're the kind of person that's very negative about people then it shows you know. It shows in how you want to, want people to see you as well you know, and it's just never good, and I'm not the kind of person who says to people "don't do that it's unhealthy" you know but it just exposes you too much and it doesn't expose a very good side of you. So I try to keep very good relationships with people. It can be very tricky to balance it you know, um to try and eat healthy, exercise. They all sound so easy when I'm saying them: eat healthy, exercise, and at least what? Call three people a day that I very much get along with, you know, but that's my way of trying to stay healthy.*

In his quote, George discusses the importance of being a good, positive person who purposefully maintains *'very good relationships with people'* in supporting and ensuring that he stays healthy. This quote equates a healthy person with one who gets along well with people, is social and well liked. Similarly, Jo's quote describes healthy people as more *'friendly'* and warm, creating the impression that healthy people are simply better than unhealthy people. These ideas emphasize an understanding of healthy people as worthy of friendships and affection. The quote below by Adam Smith (1759 reprinted in 2002 p.100) touches on this desire to embody characteristics which we believe make us worthy of love and avoiding characteristics which might make us justified recipients of hatred or disgust:

Man naturally desires, not only to be loved, but to be lovely; or to be that thing which is the natural and proper object of love. He naturally dreads, not only to be hated, but

to be hateful; or to be that thing which is the natural and proper object of hatred. He desires, not only praise, but praiseworthiness; or to be that thing which, though it should be praised by nobody, is, however, the natural and proper object of praise. He dreads, not only blame, but blameworthiness; or to be that thing which, though it should be blamed by nobody, is, however, the natural and proper object of blame.

Health has come to be understood as evidence of an individual being a 'proper object of love'.

In George's quote above, he is also asserting his agency and control over his health. The message underlying these ideas is that health can be controlled through a range of different means, one of which involves ensuring that an individual has good social relationships. Skrabanek (1994) discusses 'lifestylism', the doctrine which constructs illness as mostly resulting from unhealthy and therefore 'immoral' behaviours. He argues that the validity of this doctrine is partly dependent on its mathematical language relating to risk. Behaviours are talked about in terms of the probability with which they will lead to disease. George seems to be applying the lifestyle doctrine in ways that both suggest an avoidance of risk and the promotion of aspirant healthiness. However, George is not referring to a risk of disease but instead a risk of not being well regarded by others or thought of as *'negative'*. The relationship between health and interpersonal relationships is complex. Health is constructed both as dependant of the cultivation of meaningful relationships, however, one becomes worthy of these kinds of relationships through being evaluated by others as healthy.

Previously in this research the concern has been mentioned that an increased individualization of the responsibility for health, a focus on behavioural change as the solution to all health problems as well as the status of health as a *super-value* may play a role in individualism and in disconnecting individuals from each other. In George's quote, we see the internalisation of the responsibility for health and of the disciplinary techniques understood as necessary for sustained health, when he applies his health related knowledge to his interpersonal relationships. He describes his health promoting practices as including the requirement to, *'Call three people a day that I very much get along with'*. In this context, his relationships may become objectified, they are a means through which he can improve his health. He also

describes an experience of feeling that the demands placed on him in order to remain healthy are high and are *'very tricky to balance'*. Viewing relationships in this way may make them seem like a burden that is necessary to maintain for the sake of individual health. Putnam (1995) has discussed the importance of strong social bonds, or social capital, for both individual and population health. However, White (2017), who sees the conceptualisation of a lack of social cohesion as a cause for health inequalities as an extension of individualisation, argues that this theory merely shifts from 'blaming the victim' to 'blaming the community' and continues to ignore the necessity of a reduction in income inequality in order to improve public health. From this perspective we may understand George's approach to interpersonal relationships as another disciplinary technique which reproduces dominant individualistic ideologies by placing the responsibility for strong, health promoting social bonds on the individual despite economic inequalities and structural barriers.

Whereas George emphasises the role he believes interpersonal relationships play in the promotion of good health, in the quote below Owen addresses the relationship between ideal healthiness and individualism. What it means to be a good person in neoliberal and individualistic societies intersects with what it means to be a good person within discourses of health. The result of this intersection is the emphasis on independence and autonomy as important characteristics of a good, healthy person.

> Owen: *health for me would mean, would involve self-sufficiency… So it's very much driving, being able to, in as many cases as you can, really remedy yourself without the reliance on the medical system.*

Owen's desire for '*self-sufficiency*' reveals the undesirability of dependency. Valentine and Harris (2013) discuss the association of dependency and moral failure. In their study, individuals tended to approach the topic of disabled people and access to social support services or other benefits with an emphasis on the need for such individuals to take responsibility for their lives and to avoid dependency where possible. Some also saw disabled people as getting 'special treatment' or as taking advantage of the system and shirking their duties instead of taking responsibility for themselves (Valentine & Harris, 2013). Attitudes such as this obscure

the social and economic structures which disadvantage those who do not occupy positions of power, in this case, those whose bodies do not function in accordance with ableist norms. Health distances individuals from dependency and as a result is valued as evidence of a moral superiority.

This association of healthiness and goodness with independence also further complicates the ways in which individuals relate to each other. There seems to be a push and pull towards and then away from connecting with others. Individuals are seen as needing relationships for the sake of good health and, at times, these relationships are positioned as a positive outcome of healthiness. However, individuals are not meant to need each other when they are unhealthy. Perhaps they must first prove themselves as worthy by attaining a degree of health where they are able to function relatively effectively and independently in society through their own efforts. Only once this is ascertained may they foster the close bonds necessary for the promotion of ideal or aspirant healthiness.

Another example of health being equated with goodness is illustrated below. This quote also draws on the aspirant aspect of constructions of healthiness.

> George: …*you know you don't know when your last day will come, but you do want to live longer. And for that period of time you do want people to see you as the person you'd like to be seen as, which is a healthy personality for everyone, ja so um I think that's pretty much the reason why people try to be- should be healthy and why people want to be healthy. They want to be seen as the person they like to be seen as you know*

In this quote George uses the term, *'a healthy personality'*. The *'healthy personality'* is the person you aspire to be and *'the person they like to be seen as'*. The opportunity for health to function as a status symbol, a form of conspicuous consumption, may be relevant in making sense of the prominence of moralising discourses of health amongst individuals from both middle-class and working-class backgrounds. The moralising of health is often understood as

serving the interest of the middle class and maintaining class distinctions. As Biltekoff (2013) describes the historical development of aspirant health and morality:

'The pursuit of health became a means for the professionalizing middle class of the late nineteenth and early twentieth centuries to know and identify itself and to stake claims to responsibility and authority. Health became a key marker of middle-class morality and identity, but its utility as such derived in large part from the way it could distinguish members of the responsible middle-class from those beneath them in the social hierarchy who failed to achieve the goal of health.'

The use of this discourse among individuals who would not be considered to be from middle-class backgrounds could be understood as aspirational. These individuals may be attempting to achieve middle-class status by aligning their values with those of the middle-class due to the social value and privilege assigned to wealth and class in capitalist societies. The appearance of health may be a more accessible symbol of high moral value or social status than some other consumer products which depend on high income levels. Resisting moralizing discourses of health may also function in ways that reinforce existing prejudices towards the poor as lazy or unmotivated, and so the burden of aspiring towards the appearance of good health may be placed more heavily on the shoulders of those who are not afforded access to moral value as a result of their income or lifestyles. Health can be viewed as not only an expression of middle class status but, because it is marketed as a signifier of class, also an avenue to achieving greater status within our society and avoiding the stigma associated with poor health and with poverty. As such 'healthiness' mutates from being a material lifestyle choice of the privileged to becoming a hegemonic ideological construct that is increasingly used by members of the society to understand themselves and their social and physical environment (Crawford, 1980).

The spread of healthism and the commonality of the morally laden beliefs and statements that are made about health is according to Skrabanek (1994) related to the filling of a vacuum left by religion in increasingly secular societies. Healthiness is constructed as the new path to salvation. If illness and death are caused by irresponsible, immoral behaviours then it is the sinners who suffer and die and the righteous that are saved (Skrabanek, 1994). Skrabanek

(1994) is highly critical of healthism and sees the elevation of health to the status of religion as problematic. However, Pelters and Wijma (2016) view the resemblance between health discourse and religion as a potentially positive perspective which could be harnessed to improve the outcomes of health interventions. They suggest that, 'Concerning medical and non-medical health interventions, being aware of and accepting the religious load of the health system may enhance their outcomes because hope and expectations of healing may be taken advantage of,' (145). This suggestion underestimates the psychological burden of moralizing health and stigmatizing illness and returns to the reliance on individual behaviour change as the key to improved health, completely ignoring systemic inequalities.

The Bad Healthy

Although being healthy was usually talked about as having positive implications for identity and how individuals interact with others, in some cases participants mentioned a tendency for individuals who are healthy to become arrogant or to be judgmental of those they believed to be less healthy than themselves. The importance of not being overly zealous in one's health pursuits was discussed in the previous chapter. We return to this topic to explore, in more depth, the moral consequences of this way of thinking.

> Richard: *People aren't the same, a lot of people, when they become fit. Like lets say a guy was fat, he works out he works hard uh within due time he's in the top shape. He's in great shape. There are guys who become jerks, and they treat other people like "no no no that's wrong, you're fat, that's bad blah blah blah" and there are girls who also become you know like "you're fat, I don't date fat guys" but she was fat also, but I feel like, so there is that trend in society. But then there are some people who are also like good 'cause, and then a friend of mine, okay I don't have Facebook now I was going to show you Liam. Liam is this well-built guy who is really, he's in top shape. He actually competes in body building ja. But Liam is the nicest person you'll meet. He's actually a very nice person. He's a welcoming person, he's a very engaging person, he actually makes you feel at home, and he's in top shape. So like there is, but the trend is ja the dominant one is that guys who are in top shape or girls who are in top shape are jerks, ja that's the trend.*

The idea that women or men in 'top shape' are judgmental or mean is related to the discussion of balance where being *too* healthy is a problem. However, the notion that those who attain a high level of health become prideful or look down on those who are less healthy than them illustrates the moral superiority attached to behaviours and bodies which appear to be healthy.

> Jo: *I think there is though, in some cases, it can lead more to arrogance. Because you are healthy and you see someone who is unhealthy you can say look- you can't actually do that and like it ends up being a judgment which I don't think that that's positive. It should never be done never be negative reinforcement it should be positively reinforced. .... have proven that with children that positive reinforcement is the way that you improve children's behaviour. So in that case how people can be a bit arrogant.*

Jo is also critical of people who are healthy and become judgmental of those who seem unhealthy, explaining that individuals should not be motivated towards health by shame or negativity. Instead they should be *'positively reinforced'*. This is also linked to discourses of happiness and health where individuals should be *'positive'* in order to be *really* healthy. In these quotes, we see the interactions of different moral norms: the high moral value attached to engaging in health practices successfully is diminished by the moral disapproval of being unkind or arrogant. By labelling these individuals who are very healthy as proud or critical, individuals may be able to protect themselves against any inferiority they may feel when the moralism around health and especially the immorality of unhealthiness is verbalized or otherwise suggested. However, Richard speaks fondly of Liam, who he evaluates as very fit but who makes the people he interacts with feel *'at home'*. This suggests that it is not necessarily being around healthy people that makes individuals feel defensive or uncomfortable but rather situations in which a negative evaluation and ranking of health may explicitly or subtly occur. Capitalism's encouragement of competition may make these hierarchical contexts more prevalent (Lury, 2011), thereby increasing insecurities. This culture may also play a role in fostering an environment where one's relative health in comparison to their peers becomes increasingly important as opposed to their experiences of health in relation

to other facets of their lives, for example, their ability to engage actively in their communities or be free from pain.

The Immorality of Poor Health

Whilst most of the discussion around health was oriented towards an aspiration to be good, to improve oneself and to be okay, there was a subtle judgment upon those who were not considered healthy. The reasons for the judgment or criticism ranged and although participants were reluctant to be explicitly critical of unhealthy people (healthy people are nice, remember?) they did seem to want to avoid poor health partly as a result of the implications that might have for their sense of self.

The differences between the healthy and the unhealthy.

George's quote below illustrates complex emotions around caring about health and eating fast food.

> George: *if you're an unhealthy person it's, for me, this is, those are the tell-tale signs you know like for instance, you try this out, you don't look like somebody who goes and queues at KFC for fried chicken right, but do try this out. I'm not saying go buy food there, but when you're walking past there, pay close attention at the people that are queueing there. You'll notice that it's people that have gained weight, and they're going about their phone, but at the same time they're looking to see if people are watching them, you know or people care, stuff like that. So it starts looking like it's, to you it looks like they already like, they can't help it anymore, and that's wrong. And it's unhealthy and it's wrong psychologically. So there is a difference, there is a huge difference you know, there is a huge difference. It just, ja it's sad but it's just one of those things. I don't think many people notice these things, but look, I do eat at these places so, I but I don't do it often okay you know. Because I'm not just that kind of person, I don't do it very often and it's not because I'm health conscious, but I don't care that much ja so I do take a look at the people there sometimes, and I say "okay, most of these people, they don't look very healthy you know" and they look like they*

really are kind of bothered, like if it were up to them, they would send someone to go get what they are trying to buy. So there is a difference, whereas healthy people they don't care you know, they don't care, you look at how they dress, how they embrace people you know. They look like the kind of people that don't hold back when it comes to socialising, so there is a difference, a huge difference.

The first sign of poor health that George mentions noticing is that the people he is observing have '*gained weight*'. The association between health and slimness can be understood within a broader context of 'fat panic' and the 'obesity epidemic'. Lebesco (2011) describes fat panic as a specific kind of moral panic. A moral panic is a 'condensed political struggle to control the means of cultural reproduction' (Cohn 2002 p. xxxv). Being considered overweight or obese is often strongly condemned both informally in social contexts as well as in the media, in political policy (Evans, 2006) and in medical discourses (Lebesco, 2011). The medicalization of fat as a health problem has allowed the judgment of individuals who do not fit narrowly defined beauty norms to gain legitimacy.

George also emphasizes the insecurity he observes amongst the individuals who frequent KFC. He describes them as looking uncomfortable and overly concerned with other people and whether or not they are being noticed. George describes this behaviour as '*wrong and it's unhealthy and it's wrong psychologically*'. In this sentence being unhealthy and doing something wrong are linked together further emphasizing the immorality attached to poor health and the negative evaluations of both the behaviours of individuals who are assessed to be unhealthy, and of those individuals themselves.

In the following statements George carefully distinguishes himself from the 'other' unhealthy people who eat at KFC. Although both he and those who he finds to be unhealthy appear to be engaging in the same behaviours, in this case it is the attitude with which the situation is approached which allows him to maintain his view of himself as healthy while the other individuals are viewed as unhealthy. He first identifies the frequency with which he attends fast food restaurants as being significant in asserting his healthiness. When he says he seldom eats there he explains that he is, '*just not that kind of person*', implying that a different, less

healthy, inferior *'type of person'* would eat there often. It is interesting to note that the assumption is made that the other people frequenting KFC are assumed to be 'the type of people' that would eat there often, based on their presence there. However, George resists the subjectifying implications his behaviour has by emphasising the perceived differences between him and the other individuals he observes. Through this discursive move he is able to distance himself from being classified as a certain kind of subject. He is able to extricate himself from being subjectified as a self who is less self-controlled, less healthy and more insecure than the kind of subject he believes he really is. He is also quick to distance himself from the perception that he would restrict his behaviour because he is health conscious. Throughout these statements he seems to want to ensure that he does not come across as insecure or ashamed of his behaviour. Here, healthiness is constructed as being confident, open and sociable. He also suspects that the kind of people that go to KFC often feel guilty or embarrassed about being there, he explains that *'they really are kind of bothered'* and *'like if it were up to them they would send someone to go get what they are trying to buy'*. He contrasts them with the healthy people, like himself, who *'don't care'* and who, *'look like the kind of people that don't hold back when it comes to socialising'*. Within this quote he constructs both healthiness and unhealthiness as well as his image of his own good health as dependent on this distinction between him and an unhealthy other, he insists that there is *a huge difference'* between them. This can be understood from a Goffmanian perspective where health can be considered a stigmatizing rhetoric. George's health depends on a continual noticing and construction of the poor health of others (Metzl, 2010).

The identity work done in this quote can also be understood through the notion of 'boundary work' (Lamont, Pendergrass & Pachuki, 2015 p. 850). This involves the constitution of the self and the cultivation of self-worth through the drawing of boundaries which include some and exclude others. George draws a boundary around himself which excludes the other individuals at KFC by identifying differences between him and them. This allows him to construct congruence between his belief about what constitutes healthy and unhealthy, good and bad behaviours while also maintaining his view of himself as healthy and good.

We may understand the defensiveness in George's quote within the context of consumer culture and the moral demands of discourses of balance. Malson (1998) notes the conflict that

exists, 'between the indulging 'consumer-self' and the controlled, abstinent 'producer-self' demanded by capitalism' (Malson, 1998 p.94; Bordo, 2004; Malson and Ussher, 1996). Competing demands to both restrain and deny desires as well as to continuously consume, place individuals in a difficult to negotiate position where they need to be an excessively conscious consumer, a consumer who is self-controlled and well-informed but never anxious or insecure. George's construction of his consumption experience, positions him as precariously balanced between these two discourses: he is consuming but not too much, he is knowledgeable and protective of his health but never obsessive or overly concerned. Cairns and Johnson's (2015) notion of *calibration,* 'draws attention to the dynamic process of discursive positioning' (p. 172). Individuals have to constantly make small alterations to their subject positions in order to distance themselves from constantly shifting identities that could incite judgments of failure or disapproval. In George's quote the moralism underpinning health discourses of balance interact with demands placed on individuals to be good consumers and in order to maintain his conception of himself as a good person he must find a safe middle ground between the two.

George's quote was concerned with the consumption of fast food and the resultant effects this has on his identity. In the quote below, Lexi explains her highly embodied moral experience of her consumption of cigarettes.

> Lexi: *we were doing a lot of like meditation and mindfulness practices and everything, and I just it's like a similar thing that happened with meat I couldn't like get away from what I was doing, so I couldn't just smoke and think about something else. I was so aware of what I was like, what I was actually doing, and it was like the same as meat. I just found I just couldn't, I felt like almost like sick when I was eating it 'cause I realised like this is like an animal, and then like then it's like really gross like going to the toilet afterwards as well, just the whole thought of it going like through my body and like ooh, it just like even now I remember having that weird like perception shift or something. I don't really know, it was quite bizarre but I told them at the Buddhist centre and they said they thought it was like maybe a good thing, maybe I was becoming like more aware or more mindful of what I was eating and how it was affecting me like mentally and physically or something. It was the same with the smoking, I just got to a*

point where I was just like aaah, I just don't want to do this anymore, like I don't want to do this, and then I just decided I'm just not going to smoke anymore, 'cause I couldn't, I couldn't smoke and enjoy it, because I was smoking knowing this is bad for me. It's actually killing me, like I'm breathing chemicals like into my lungs, like hot smoke (shudders). I don't know yeah, it's just like it's such a weird thing to do. And then I think as well I was more in touch with the the fact that like you know your heart is pumping and whatever to keep you alive, and by doing that you're actually just like, I don't know, it's almost like sticking a middle finger up to it or something it's just like it's trying so hard to keep you alive, and you're just like not appreciating that, or valuing that at all. And I just felt, I felt sad like I felt sad for my body as a sort of separate part of me. I know it's quite weird but that's probably as much as I can explain it...

Moral disapproval of smoking is especially strong. Cederstrom and Spicer (2015) discuss how smokers were one of the first groups to be sent to concentration camps in Nazi Germany and were regarded as 'second-class citizens'. More recently antismoking efforts by public health organisations, such as WHO, have explicitly employed a stigmatizing tactic to 'denormalise' and discourage smoking (Dean, 2014). The ways in which discourses about the immorality of smoking are internalised and embodied are illustrated in Lexi's quote above. She describes her engagement in smoking, a practice she understood to be *'killing'* her as, *'almost like sticking a middle finger'* up to her heart. She explains her smoking as showing contempt towards something that she describes as working hard for her and keeping her alive. Lexi's previous smoker self is constructed as ungrateful and unkind and as engaging in something which she now finds physically repulsive or abject (Kristeva, 1982). Her new understanding of the moral weight of her smoking made her identity as a smoker intolerable. This experience illustrates what Vander Schee and Gard (2014) describe as the 'the contemporary vision of a healthy, neoliberal subject/citizen [as] one who has the capacity to constantly examine and (re)construct him/herself' (p. 211) depending on the requirements of the context. There is an emphasis on continual self-work and self-improvement. In this context Lexi can repair any damage done to her identity as a result of engaging in the immoral practice of smoking by successfully working on and reinventing herself in a way that brings her closer to the dominant moral ideal.

Other behaviours relating to health which are constructed as immoral are discussed below.

Sloth and Gluttony.

 Nathan: *I think obviously you feel remorseful. I mean from being hung-over, obviously the overeating- I can tell you it's like I was taught it's a sin to eat such a lot. I remember a couple of years back, just before Christmas, so it was like two days we were in Durban, so we had like a buffet at the hotel and I felt like we were having basically the Christmas dinner I think, before the actual Christmas lunch, and I'm telling the guys it's not right to eat so much.*

Nathan describes his experience of being remorseful after eating too much and explains how he was told that over-eating is '*a sin*' and is *'not right'*. In this quote the link between the moral evaluations of health related practices and Christian biblical teachings are illustrated. Gluttony, according to the bible, is one of the seven deadly sins. Prose (2003) explains the way in which modern social and cultural norms have interacted with and altered current conceptualisations and experiences of gluttony:

'Most recently, our fixation on health, our quasi-obscene fascination with illness and death, and our fond, impossible hope that diet and exercise will enable us to live forever have demonised eating in general and overeating in particular. Health consciousness and a culture fixated on death have transformed gluttony from a sin that leads to other sins into an illness that leads to other illnesses,' (p.23).

However, in Nathan's quote we see that the immorality of overeating persists even in contemporary cultures. Therefore, although the reason for the disapproval of eating too much may have changed from concerns around idolatry to those of illness, fatness and death, the high moral value attached to *being* healthy leads to similar experiences of guilt and shame.

When discussing why some people are healthier or care about their health more than others Preston explained that:

> Preston: …*I think most people know that maintaining good health is important in life. But I think some people are just inherently lazy, and I think we do live in an age where the internet has made so many things so much easier. I can see it from a fundamental point of view, that because of our inherent laziness in this generation, because of how instant everything is, people don't have the motivation necessarily to do what's best for them, even though they know…*

In Preston's quote unhealthiness is attributed to '*inherent laziness*' and a lack of '*motivation*'. By constructing ill health in this way, Preston is able to position himself in a 'safe space' in relation to the morally hazardous topic of health. In his quote he initially refers to only '*some people*' as being '*inherently lazy*'- suggesting that some people are inherently better than others. However, later in his quote he makes use of the pronoun '*our*' when describing '*inherent laziness*' in this way including himself in the group that he is discussing. As a result, he is able to present himself as not only naturally imbuing morally ideal characteristics such as discipline and diligence, he is also able to view himself as one of few who are able to overcome the obstacle of an inherent character flaw in order to improve himself and support his health. His moral superiority is not as a result of some innate characteristics that he has no control over, instead it is as a result of his agency and sovereignty over his personality. By changing his presentation of what he believes to be the cause of individual poor health from the criticism of a problematic group of people to a cultural problem that he too is afflicted with, he is also able to avoid the appearance of being judgmental and arrogant which, as seen in the previous section, is not awarded the same social status as a healthy individual who is humble and kind towards the less healthy.

The two quotes above and the notion that ill health is the result of laziness and overeating seem to be specifically referencing obesity as the health problem of concern. The implication of the idea that it is wrong to exercise too little or to eat too much is that it is bad to become overweight. Evans (2006) explains the link between the moralism relating to insufficient

exercising and excessive eating and ill-health (and obesity specifically): 'Ill-health therefore represents the inability to 'correctly' control and manage the body to the standards required to ensure 'good' health; obesity the ultimate in failed 'body projects' (Shilling 1993) can therefore be read as 'the biomedical gloss for the moral failings of gluttony and sloth' (Ritenbaugh 1982, 352). This 'biomedical gloss' sanctions the negative moral evaluations of those who are considered unhealthy. By grounding criticisms in scientific and medical terms, moral judgments become validated and enable individuals to avoid the obligation to defend their moral prejudices.

Unhealthy and Unloved

The following quotes begin to illustrate some of the consequences of the moralism enacted through discourse of health in relation to subjectivity. Individuals usually did not speak about any current experiences of poor health. This may be because they all believed themselves to be incredibly healthy at the time of the interviews (which may have been why they agreed to participate in the interviews) or it may be too shameful to speak about one's self as unhealthy and unhappy about it. When a participant did discuss areas in which they would like to improve their health it was usually framed in a way in which they were positioned as relatively healthy at the time and aspiring towards greatness rather than in a way that positioned themselves as currently unhealthy and trying to remedy a disease. As a result, personal accounts of the subjective experiences of poor health at the time were seldom given. Participants were, however, able to discuss hypothetical experiences of ill health, the poor health experiences of others and those of themselves at previous points in time. Through these accounts we are able to explore the ways the moralizing functions of health discourses interact with experiences of the body and the self and facilitate certain constructions of identity.

Richard's quote illustrates the way in which identity is embodied. He shows the identity implications of having one's physical body to be found lacking or problematic in some way.

> Richard: *it's very possible to like inspire people without making people feel bad about who they are. 'Cause being fat or being out of shape, out of society you know, something*

like smoking or saying to people "oh that's bad you're smoking" you actually talking about the person now. When you're talking about the person, when you're saying smoking's bad for you, you're actually talking about cigarettes, you see? So when you're saying "hey, fatness is bad for you" that's the person's body, and- it's more personal- you see! So the person identifies his body as himself, this is Richard, that's how they identify people, this is Richard, this is me. So when you go about it like that, you're actually hurting people, then you're making them feel less of themselves. So ja, we do have a responsibility, but we also have a responsibility in how we convey the message.

Richard distinguishes between the criticism of certain health behaviours and certain health states. He believes it to be less personal to express a disapproval of a behaviour like smoking than of a person's body shape or their body composition. He constructs his identity and his physical presence and appearance in the world as inseparable, he explains, *'the person identifies his body as himself, this is Richard, that's how they identify people, this is Richard, this is me'.* As a result, negative evaluations of that appearance, *'fatness is bad for you'* makes him feel bad about *who he is.* His self is being criticized which is experienced as a lot more painful, *'you're actually hurting people then you're making them feel less of themselves,'* than a negative evaluation of a behaviour, *'smoking's bad for you'.* This quote illustrates some of the consequences for individuals' self-concept and identity of the moralization of health. The language used to describe certain things as detrimental to one's health are in terms of good and bad, right and wrong. When these evaluations are associated with identity, bad and wrong identities are constructed and internalized. There are potential negative psychological implications associated with constructing individuals who appear to diverge from ideal healthiness as bad and wrong. Stigmatising individuals who are mentally ill, chronically ill or disabled has been associated with issues including depression, PTSD (Whetton, Reif, Whetton & Murphy-MacMillan, 2008), low self-esteem and low self-efficacy (Watson & Larson, 2006). In addition to these problems, broader social and political institutions are also influenced by these dominant moral conceptions of individuals who may be experiencing the need for health care.

In this last quote, Christina discusses the way individuals who are not considered perfectly healthy internalize and introject the stigma and discriminatory attitudes towards bodies that are viewed as ill, fat or 'different' from the ideal.

> Christina: *I think sometimes, it's not so great but people look down on someone who is or isn't healthy, as they are not capable of doing things. You can have something as simple as someone who arrives in maybe a wheel chair. People sort of talk down to them, and even though they have lost one aspect of their legs, their legs aren't healthy, it sort of has an issue with their sort of like, society doesn't interact with them as well. But I think that also sometimes, because I have a friend who has cerebral palsy, and she, and although she interacts perfectly with people, she has sort of in her mind, she's obviously a very good friend, and we've dealt with a long road together, and she sort of feels like she doesn't deserve to have happy relationships because of her illness. And I think sometimes your illness, sometimes as an individual, you feel like your illness makes, can make you unworthy to do certain things. And for her it's been absolutely heart-breaking, but to see how she doesn't believe she deserves to have a boyfriend, because to get that love from someone else she would be a burden, because she's walking with crutches, and she needs a little bit of help in places. So I do think that our health has an impact sometimes on relationships, and the way we socialise and we deal with society.*

Christina illustrates clearly the cruelty of the moralism underpinning dominant health discourses. She describes how having an illness can make you feel *'unworthy'* of close relationships. She explains how her friend with cerebral palsy sees herself as a *'burden'* to others. This language is often used in discussions around state welfare provisions and individuals who make use of welfare services are viewed by some as a 'burden on the state'. We see again here, the demonizing of any kind of dependency (Valentine & Harris, 2013). Relying on others is strongly morally disapproved of in favour of a radical independence. The individualising of the responsibility for, not only the maintenance and promotion of one's health, but also for the protection of society from an ill self or a self in need of assistance leads to individuals who are already disadvantaged in our society feeling *'unworthy'* and undeserving of *'happy relationships'*.

The consequences of the reliance on health status for any positive sense of self are also illustrated in this quote. If self-esteem is made conditional and dependent on whether or not one's body is socially considered healthy, then poor health deprives people of feeling that they are acceptable and worthy of love. This is in addition to the difficulties they are currently facing as a result of their health concerns. These discourses revictimise those who have already been victimised and compounds their suffering. Additionally, in a context where needing people and asking for help is shameful, the anxiety which can accompany poor health (or the appearance of poor health) is constructed as deserved, positioning requests for support in dealing with these resultant issues as invalid.

Conclusion

Lebesco (2011) acknowledges that although it would not be useful to dismiss the realities of good health and suffering she warns against the construction of the pursuit of good health as a moral initiative. This, she argues, means that, 'health also becomes a sharp political stick with which much harm is ultimately done,' (Lebesco, 2011 p.78). Cederstrom and Spicer (2015) argue that the moralization of health actually functions in a way that depoliticizes political issues. So by understanding health as a moral obligation political concerns are 'played out in the moral register' (Mouffe, 2005 p.5). Differences in political opinions are not viewed in terms of alliances to certain political ideologies, parties or positions, but instead to moral standpoints (Mouffe 2005). In this way health becomes less about access to and quality of health support services, safe and healthy environments and workplaces, and is thought about more in terms of right and wrong, good and bad.

The moralization of political issues means that there is less of an assumption or expectation that health problems and inequalities should be addressed on a macro scale at the political level as they are understood to be the responsibility of individual moral actors. Additionally, the idealization of independence and the condemnation of dependence at the expense of reciprocity and community creates a context in which being taken care of becomes morally problematic. The moral value of individualism may also have an influence on the kinds of health policies

that are proposed and supported as in this context any health intervention that could be seen to be impinging on individual freedoms in anyway would be unjustifiable (Viens, 2016).

Biomedical and mathematical languages are used to situate discourses of health outside of the moral context, for examples discussions of weight, BMI, waist circumference, blood pressure and cholesterol measures are all used to discuss and define whether or not someone is healthy. The use of this kind of language and the discursive distance created between health and morality both legitimates and obscures the power dynamics and regulatory functions of discourses of health. When individuals in this study discuss their motivations for engaging in health improvement efforts they often discuss an experience of feeling better as a result of their health pursuits. They are not always referring to physically feeling more well. They are often talking about feeling better about *themselves,* having higher self-esteem and feeling more confident. The consequences of poor health are cautiously sketched out in their speech referring to past and other selves, illustrating a fear of shame and death. This understanding of poor health as well as good health is highly personal, focusing on intimate experiences of who they are and how they are treated in the world and shows a deep internalization of these techniques of discipline. Constructions of identity and experiences of self-worth are closely entwined with and in some cases dependent on these ideas about what it means to be a good, healthy citizen. As a result, the complicated and oftentimes unattainable demands of achieving sufficient healthiness make feeling secure or confident especially difficult and individuals must engage in constant 'calibration' to position themselves as morally acceptable.

Conclusion

The discourses of happiness, freedom, control, care, balance and goodness discussed in the previous sections interact and intersect with other dominant discourses to both reproduce and resist the status quo, while also facilitating certain constructions of the self and marginalising others.

Through most of the discourses mentioned, health is constructed as an obvious good and a legitimate ideal towards which all individuals should aspire. This occurs through the positive constructions of health as a means through which freedom and happiness can be attained, as well as through the negative ways in which unhealthy individuals are constructed as lazy, unhappy, and lacking self-control and self-respect.

The happiness, freedom, control, freedom, care, balance and goodness discourses also functioned in ways that consistently individualized the responsibility for health. The individual is expected to exercise their autonomy over their bodies, their minds and their environments, to ensure an avoidance of health risks and to ensure vibrant, productive healthiness.

The idealization and individualization of health constructs a reality in which individuals are responsible for successfully avoiding any threats to their health, and for engaging in the necessary activities to promote and sustain the appearance of good health. These disciplinary techniques usually involved consuming food and exercise in accordance with specific health rules, but were not limited to these activities. Outward symbols of healthiness were especially important to maintain if an individual was to be afforded both the social acknowledgement and approval of their health state and, related to that, their moral and social value and the resulting permission to accept and respect themselves. These symbols included a physical appearance that is in line with dominant beauty ideals, and an emotional temperance and avoidance of negative emotions including anxiety, anger, stress, sadness or obsessiveness.

Through all the discourses discussed, a strong sense of moralization around healthiness was noted. Healthy people were constructed as good, and unhealthy people were constructed as bad. These moral evaluations of people based on their health status is rooted in both religious traditions and understandings of sin and guilt, as well as in political efforts to produce good 'biocitizens' (Halse 2009) who are not a burden on the state and on others. These constructions support a culture of victim-blaming those who are suffering, and sanction an abdication of responsibility for support by the state and community. These discourses are facilitated and promoted by neoliberal ideals around what it means to be a good citizen, as well as gender norms (which function in various ways to stifle the expression and discussion of emotion, particularly negative ones as well as to promote *'nice'* women and *'practical'* men), religious doctrine (and constructions of hard-work, gluttony and sloth) and consumer culture (which facilitates an aspirational pursuit of ideal identities through the consumption of specific foods and exercise services). The association of healthiness and goodness, and unhealthiness and badness, is especially problematic when these associations are applied to the poor, the chronically ill, the mentally ill and the disabled. These populations which are already suffering are subject to the additional burden of societal assumptions about their inferior moral value and inadequate personality, as well as the notion that their health status is deserved.

The health discourses discussed are interwoven in ways which demand coherent yet contradictory selves who at once embody restraint, control and emotional moderation, as well as freedom, consumption and joy. These selves are responsible for constant self-awareness and calibration and their daily activities are subject to scrutiny based on how well they serve the goal of healthiness.

The pervasiveness and common sense aspects of discourses of health make the harm that is done through their use both invisible and taboo. Individuals are prevented from openly discussing any pain or emotional distress they may be feeling because of the way these discourses, particularly those relating to care, balance and happiness, inscribe negative emotions. This makes accessing support and connection more difficult in these situations, and makes resisting the oppression and inequality that is fostered through the use of these discourses especially difficult. On an individual level, those who do resist complying to health standards, or those who experience ill health in any of the range of ways this is conceived, are

potentially subject to an attack on their identity and their human value in society. This is because health has come to be constructed as a moral foundation of who a person is. On a broader more collective level, resistance to discourses which construct health as always positive and a matter of individual effort, may seem at least unnecessary and at worst detrimental to the moral value of society or to the economy. For example, efforts to question or critique the obvious goodness of health could be viewed as highly insensitive to the suffering of those with health problems. Arguments made against the individualisation of health could be viewed as fostering lazy, dependent and irresponsible citizens. If health was rather understood as dependent on systemic factors, this might require, for example: state support, improved work safety measures, or an overhaul of how industrial work is done. These ways in which these discourses of health function to impede both critical thinking and collective action, make ensuring equal access to good health more difficult and facilitate the reproduction of the status quo.

Certain silences of the participants are as important as the language that was used to construct health. The ways in which health problems were *not* constructed- as collective concerns or as a result of historical and structural inequalities- and the kinds of health related solutions which were *not* discussed- economic reform or political action- illustrate the boundaries within which health is constructed. An example of a hugely significant determinant of health which was not talked about is pollution. A recent study found that 16% of all deaths globally in 2015 were caused by pollution, and in the most affected areas this statistic rose to 25% (Landridgan et al. 2017). Pollution disproportionately effects the health of the poor, minorities and the marginalised. In this study health was often constructed as dependent on the consumption of healthy foods and consistent exercise practices. This means that not only are the poor more vulnerable to environmental health hazards, they are also excluded from popular health promoting practices. This example illustrates the silence around issues which have an impact on the most vulnerable populations in our societies and also contradicts the understanding of health as within an individual's control. The boundaries which determine how health is talked about and constructed, function to reproduce the status quo and ensure that the kinds of subject positions which are most readily available and rewarded are those which act in service of this reproduction.

This is not to say that resistance to or non-engagement with these dominant, and in many ways oppressive, discourses does not occur. In the speech of the participants there were also discourses that challenged constructions of health as only available to the exceptionally self-controlled, or of perfect health as the ultimate symbol of optimal morality. In some ways, other discourses present in society which constantly construct individuals as lacking, inferior or unworthy were effectively, if temporarily, resisted through the use of discourses of health. However, some of these discourses, for example that of Care, were also co-opted by neoliberal interests when they were previously intended to resist dominant and oppressive standards. Care discourses sometimes functioned to sustain the individualised and moralised norms surrounding health which serve to situate health problems within problematic individuals who are stigmatised for their perceived uncaring, irresponsible and dependent natures.

This thesis has discussed how the aspiration towards a very broad yet idealized healthiness has functioned in ways that may be victim-blaming and undermine wellbeing, the very goal that is pursued. The ways in which the discourses used to construct and experience health may impede progress towards ensuring that the basic health needs of all are met, were also considered. The argument has been made that perhaps it is not lazy, uneducated, gluttonous and overly-dependent citizens that lead to health problems, but instead some of the ways in which health is constructed, pursued and promoted which can be problematic. A critical stance towards the seemingly self-evident and incontrovertible goodness of health is necessary if power structures are to be challenged, individuals and communities are to be supported and alternate ways of approaching health problems are to be proposed and explored.

This thesis has contributed to the existing literature on this topic by providing a South African perspective on constructions of healthiness in the context of neoliberal influences. Future research could explore how the kinds of discourses discussed in this project are taken up and experienced by those who are from rural areas or from more collectivist communities as well as by those who are perhaps dealing with chronic illness, mental illness or disability.

Appendix 1: Informed Consent Form

My name is Michelle De Jong and I am a PhD student in the Journalism and Media Department at the University of Rhodes. As a part of my PhD I am required to conduct a research study which will be supervised by Prof. Anthony Collins, a professor at Rhodes University.

The study is entitled: *Exploring Constructions of Health in the Context of South African Consumer Culture* and aims to better understand how South Africans think about and understand health. I feel that health is an area that needs improvement in our country and I hope that if we understand health better it will equip us to work on finding solutions to our problems. I will be conducting semi structured interviews which will require you to answer questions about health in general, ideas about health depicted in the media and your experiences with health and trying to stay healthy.

Your participation in this study is completely voluntary and should you wish to withdraw at any time, you may without any negative consequences. All the information you give me during the research process will be kept confidential and your anonymity will be ensured by changing all identifying information such as your name and those of others mentioned as well as places and institutions.

If you would like to obtain more information on your rights as a participant as well as the details of the study please feel free to contact Prof. Anthony Collins by emailing A.Collins@ru.ac.za or calling 0466037108. If you would like to contact me personally my email address is michelletofts@gmail.com and my cell phone number is 0738313016.

I hereby confirm that I…………………………………………………………………………. (full name) understand fully the nature and purpose of the research project and voluntarily agree to be a participant in this study.

…………………………………..   ……………………
Signature of Participant   Signature of Researcher, Michelle De Jong

………………………...   …………………
Date   Date

Appendix 2: Interview Schedule

What do you think health means?

What do you think makes you healthy or unhealthy?

Would you say that you are healthy? Why?

Do you think it is important to be healthy? Why?

What does it feel like to be healthy?

What do you think it would be like to be unhealthy a lot of the time?

Do you engage in any health promoting behaviours?

    Why/ why not?

    What are they?

Do you do things that might be bad for your health sometimes?

    Why/ why not

    What are they?

What kinds of things do you think encourage people to be healthy/ unhealthy?

Do you think there is a link between being healthy and how we treat others?

Do you read or watch any health related media eg. magazines, TV shows? Which ones/ why not

Where do you get advice/ guidance on how to be healthy?/ who do you trust for your health information?

Do you think we have a responsibility towards other people's health?

What do you think would help to make South African citizens healthier?

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