CONSTITUTING THE HEALTHY EMPLOYEE?
Governing gendered subjects in workplace health promotion

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Abstract

With a post-structural approach and an analytical focus on processes of governmentality and bio-power, this study is concerned with how discourses of health are contextualized in educational practice and interaction between educators and participants in workplace health promotion (WHP) interventions. Of concern are issues of the discursive production, regulation and representation of power, knowledge and subjects as gendered beings in workplace health promotion interventions. The methods for generating data are participant observation, interviews and gathering of documentation pertaining to four different workplace health promotion interventions. Based on these data, the thesis offers an analysis of the health discourses drawn on in the interventions and the technologies of power and of the self by which the participants are governed and invited to govern themselves in the name of health. It also asks what practices and positions that thus come to be made available or not to the participants. Two health discourses are identified: the biomedical discourse and the wellness discourse. Both discourses are drawn on in all four studied interventions, the biomedical discourse being the dominating discourse drawn on. The biomedical discourse is informed by scientific ‘facts’ and statistics and is underpinned by a notion of risk. The wellness discourse is informed by an understanding of health as a subjective embodied experience and is underpinned by a notion of pleasure. Drawing on these discourses, the responsibility for health is placed with the participants and the healthy participant/employee is constituted as a rationally motivated risk-avoider and disciplined pleasure seeker who is both willing and able to actively make ‘good’ choices regarding their lifestyle. Furthermore, and informed by essentialist and heteronormative ideas about gender, the ideal healthy person is modelled on a male norm, representing women as the deviant Other.

Keywords: Workplace health promotion, health education, physical activity, diet, discourse, governmentality, bio-power, gender
ACKNOWLEDGEMENTS

So... I’m done. ... I’m done? ... Yes, I’m done!

Fantastic! Finally! At times I thought this day would never come. Now that it’s here, all I can feel is relief and gratitude and so it seems appropriate to share the gratitude around and give dues were dues are due:

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Erika Björklund

Gävle, 2008-08-02
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<tr>
<td>ALS</td>
<td>Amyotrophic Lateral Sclerosis</td>
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<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<td>BMR</td>
<td>Basic Metabolic Rate</td>
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<td>CHS</td>
<td>Corporate Health Services</td>
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<td>ENWHP</td>
<td>European Network for Workplace Health Promotion</td>
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<td>GI</td>
<td>Glycemic Index</td>
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<tr>
<td>HDL</td>
<td>High Density Lipoprotein</td>
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<td>HPA</td>
<td>Health Profile Assessment</td>
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<td>Kcal</td>
<td>Kilocalorie</td>
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<tr>
<td>LDL</td>
<td>Low Density Lipoprotein</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
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<tr>
<td>LO</td>
<td>the Employers’ Organization</td>
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<tr>
<td>MS</td>
<td>Multiple Sclerosis</td>
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<td>PMS</td>
<td>PreMenstrual Syndrome</td>
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<td>ROM</td>
<td>Range Of Movement</td>
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<td>SAF</td>
<td>the Labor Movement</td>
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<td>SOC</td>
<td>Sense Of Coherence</td>
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<td>VLDL</td>
<td>Very Low Density Lipoprotein</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WHP</td>
<td>Workplace Health Promotion</td>
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PART ONE
CHAPTER 1, INTRODUCING WORKPLACE HEALTH PROMOTION

Work sites are conceived as one of the most efficient settings for reaching adults with health promotion/education (ENWHP, 1997; SOU1998:43). The reason for this is that about 75 percent (in Sweden) of the workforce are in employment (SCB, 2007) and these people spend approximately one third of their waking time at the workplace. Furthermore, the workplace is conceived as an ideal place for health promotion because it is a place “where communication is organized and peers exert both support and pressure” (Reardon, 1998:118). Workplaces are thus conceived as supporting environments for behavior change.

The concern for workers’ health and consequent health work in the workplace has a long history. Generally, and much abbreviated, this history is described as beginning with a concern for employee safety, moving on to a concern for psychosocial issues to end in today’s concern with issues of wellness (Allender, Colquhoun, & Kelly, 2006b; Bjurvald, 2004; McGillivray, 2005). McGillivray (2005) points to another aspect of the history of health work in the workplace: even though the primary goal was not health enhancement but rather to offer more wholesome and enlightening leisure alternatives, the provision to workers of employer-sponsored recreational activities (what might today be referred to as workplace health promotion) dates back (in England) at least to the 17th century (McGillivray, 2005). However, even though this account along with the following outline may suggest a chronological and cause-consequence perspective, this should not be taken as representing my understanding of ‘development’ or history. Rather, it reflects my concession to conventions about writing history. Even though the following description of the ‘history’ of health work in the workplace offers a succinct and ‘evolving’ sense, my own conception is that the ‘progress’ of it was much more complex and contradictory than can be described in any detail here. From a poststructuralist understanding of history, the history of health work in the

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1 I use ‘employee’ and ‘worker’ as synonyms to improve variation and readability of the text. My use of the concept ‘worker’ should not be confused with a Marxist perspective.

2 Workplace health promotion is also referred to in the literature as ‘corporate wellness programs’ (McGillivray, 2005) and ‘worksite wellness programs’ (Reardon, 1998).
workplace (or of any other phenomenon) should not be expected to be one of progression toward ‘modern’ practices and ideas, but rather “a series of eras characterized by regressions and political struggles” (Lupton, 1995:17). This also means that any links between ‘causes’ and ‘effects’ described here are constructed for the purpose of telling this history, and this is how the following historical description should be read and understood.

Besides offering an overview of the history of workplace health promotion (WHP) in Sweden and a comparison of it to other countries, or rather to the USA, this chapter also suggests that specific changes in Swedish health politics form part of the backdrop for the recent proliferation of a specific aim and direction of WHP. I also situate workplace health promotion in relation to the wider concepts of public health, health promotion and health education, making the case that, despite the lack of educational theory in WHP, it is an educational public health effort. This is done by attempting to clarify the relation between health promotion and health education. I also address the issues of healthism and medicalization before I move on to describing current workplace health promotion research and the gaps that exist in that research. I then present some of the problems with WHP that have been identified, tying these in with a description of my research interests in health work in the workplace. Finally, I end this chapter with the general aim of this study.

History and future of workplace health promotion

Internationally, workers’ health protection programs were introduced during the Industrial Revolution and initially involved visits to mills by physicians, the guarding of machines and inspections of factories by the government (Allender, Colquhoun, & Kelly, 2006a). The primary concerns during this time were thus with occupational safety and issues of workers’ protection in the workplace, i.e. the work environment and employee safety. This is also how the concern for health in the workplace developed in Sweden. However, in contrast to other countries and on account of a growing labor movement the increasing concern regarding the miserable working conditions of that time resulted in the first legislation about workers’ protection being passed in Sweden in 1912 (Bjurvald, 2004) after more than 30 years of discussions and motions in the parliament (SOU 2004:113).

Already during the late 1800’s some industries had their own employed physicians or leased physicians from private practices, constituting a complement to the limited health care offered by society (SOU 2004:113). This arrangement, or tradition, continued in places well into the 1970’s and it was within this body of physicians that the principles for the modern day Corporate Health Services (Swedish: företagshälsovård) were established; a Corporate Health Services in which the key principle has always been that the
practice should be evidence based (SOU 2004:113). The first use of the concept ‘Corporate Health Services’ (CHS) was in a memorandum written by the Employers Organization (SAF) and taken by the labor movements (LO) in 1954 (SOU 2004:113). This memorandum set up guidelines for the voluntary organization of Corporate Health Services at corporations. Due to the successful efforts of the Employers Organization and the labor movement to reach mutual agreements, the first time CHS was regulated in any way in legislation was in 1984, during which time it was legislated that “If the working conditions call for it, the employer is to organize Corporate Health Services to an extent demanded by the work” (SOU 2004:113:52, translated from Swedish). The following table is based on Bjurvald (2004), who offers a brief historical exposé of the development and focus of health in the workplace or, more specifically, CHS in Sweden:

| 50’s – 60’s: | Technological workers protection, prevent accidents |
| 70’s: | Chemical workers protection |
| 80’s: | Chronic work-related myalgia and psychosocial problems |
| 90’s: | Adjusting to the EU, Systematic Work Environment work. Later: long term sick leave |
| 2000’s: | Long term sick leave, psychosocial problems (stress, depression, exhaustion and burn-out), health promotion and maybe wellness (Sw: friskvård) |

Table 1: CHS historical development and focus (adapted from Bjurvald, 2004:13)

As indicated in table 1 above, progressively companies came to offer their employees different services that went beyond the ‘traditional’ Corporate Health Services. Eventually, psychosocial issues thus came to be put on the agenda and CHS came to be complemented by other health oriented activities such as ‘corporate sports’ (the origin of ‘Korpen’). During the 1980’s, ‘wellbeing’ came to be an increasingly popular focus and some of the larger corporations hired health educators to their human resources departments as did some Corporate Health Services to engage with programs of health promotion (Bjurvald, 2004). This shift in health work in the workplace from a concern with occupational health and safety to an additional concern with individual health and wellbeing (health promotion) spawned a new field in health work in the workplace commonly referred to as workplace health promotion (Sw: hälsofrämjande på arbetsplatsen (Thomsson & Menckel, 1997)). The concept of corporate wellness programs, or workplace health promotion, thus saw its advent in Sweden in the early 1990’s (Källestål, 2004) as the CHS had to become more marketable.
However, not only CHS offered health promoting activities to corporations, but so increasingly did independent contractors, such as various types of therapists (e.g. masseuses, nutritionists and others) who were trying to establish themselves on the market. This emerging field of workplace health promotion can be related to, and was maybe even dependent on, a couple of significant shifts in health politics that were introduced in Sweden in the 1990’s.

Employees in Sweden are entitled to sick leave compensation (amounting to about 80 percent of full pay). This sickness benefit used to be paid by the Government through the Insurance Office. However, a law (Lag, 1991:1047) about ‘sick pay’ was passed in 1991, moving the responsibility for employee sick leave compensation for the first 14 days of sick leave from the Government to the employers. The employers were thus made financially responsible for 90 percent of the cases of sick leave (which, however, is much less than the actual amount of compensation days) (SOU 2006:86). Shifting the cost from the Government to the employers is not only a matter of finding new ways of covering the ever increasing costs for health care, but is also a conscious effort by the Government of making the employers take own action to improve and/or promote employee health (SOU 2006:86).

Concurrent with this new law on sick pay and aiding in this ambition of the Government to make employers take more responsibility for employee health, Corporate Health Services, which used to be corporate or Government owned and partly financed and regulated by the Government, were deregulated and privatized in 1992 and 1993 (SOU 2004:113). After public funding ceased, CHS was increasingly detached from, but dependent on, the corporations. With the Government as its client, the CHS had been independent from the employers and ‘free’ to look to the employees best interests in their working situation. They thus had something of a potential oppositional position in relation to the employer, standing up for the employees. However, after the deregulation and privatization of the CHS, they had to survive on the market and while the employees remained their ‘users’, their new clients became the employers of said employees. Maravelias (2006) suggests that the loyalties of the CHS thus have come to change and now lie with the employers rather than the employees or the union. From a concern with protecting the individual at work, the Corporate Health Services may now primarily be concerned to support the employer in finding the best way to make use of their human capital (Hansson, 2006).

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3 This period has shifted from two to three to four and back to two weeks.
4 In January of 2005 a law taken by the Social Democratic Government stated that employers also had to pay the equivalent of 15 percent of the sickness benefits, should the employee remain sick after 14 days (Lag, 2004:1237). Since January of 2007 the new Liberal Alliance Government has taken this law out and employers no longer have to pay this (Lag, 2006:1428).
This change, this marketization, necessarily came to influence what sort of portfolio of services the CHS could offer since the CHS now was dependent upon answering to the demands of corporations, rather than, as they had in the past, only offering that which was agreed upon in negotiations between the labor movement and the Employers’ Organization. Furthermore, as healthwork in the workplace was no longer the sole domain of the State, corporate health promotion became a growing market in its own right and was offered to companies by independent contractors as well as CHS.

The shifts in Swedish public health policy correspond to a similar but earlier shift in the USA in which the responsibility for health was moved from the Government to the employers and from the health care industry to its consumers (Reardon, 1998; SOU 2004:113). While differences exist between the two countries, a comparison can be made here with the United States. American health care benefits cover costs beyond those covered by Swedish sickness benefits or sick pay. Generally speaking, in Sweden, health care is paid for via taxes, while in the USA it is paid for by private insurance, employee health care benefits being one such insurance. This arrangement can be seen as a foundation for the development of workplace health promotion which emerged in the USA already in the 1970’s and was a constantly growing field in the 1980’s, although Conrad (1987) cautions that the numbers given by various studies to support this claim are difficult to interpret since there is no common agreement on what constitutes a WHP program: it may be a single intervention, such as a screening (e.g. for blood pressure), or it might be an extensive program covering several aspects such as screenings, health risk/profile assessments, aerobic exercise and fitness, nutrition, stress management, accident prevention, etc (Conrad, 1987). The growing costs to corporations of employee health care benefits prompted a development of WHP in a desire to contain or lower these costs. According to Reardon (1998), the development of WHP in the USA was, besides being due to cost-containment efforts, also a result of a worksite health promotion movement.

The main focus in Corporate Health Services in Sweden had hitherto been to offer an independent expert resource in the areas of work environment and rehabilitation. However, competing on a now open market, competing not only with other Corporate Health Services, but also with other independent contractors in the area of prevention and health promotion, and answering to the demands on the market, the CHS began to offer services directed more toward health promotion, such as Health Profile Assessments, massage,

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1 While in the Official Report (SOU 2004:113), it is questioned whether CHS should concern themselves with such activities as some of them have no evidence base, Bjurvald (2004) argues that the shift from preventive health care to health promotion in CHS is more of a discussion than a practically realized shift in perspective.
physical activity, etc; activities concerned with wellness and lifestyle issues (SOU 2004:113; SOU 2006:86), thus indicating that the Swedish corporate health market is increasingly following the development of WHP in the USA (Reardon, 1998), meaning an increasing focus on individual lifestyle and wellbeing.

Another development in the corporate health market is toward health care: in an Official Report (SOU 2006:86) the Swedish Government suggests a further expansion of the responsibilities of Corporate Health Services to also include primary health care and sick-listing. This suggestion would also mean that the conditions for Swedish employers may come to resemble those of the American employers, as they would come to carry some of the costs for actual health care, thus motivating employers to further guard against and attempt to lower such costs, possibly through WHP. However, a problem with this suggestion is that, after deregulating the CHS, there is no consensus on what constitutes it (SOU 2004:113), thus complicating a discussion about or a division of WHP actors into CHS-based and independent contractors. Despite this, the sitting Government supports such an expansion and has provided some guidelines for the implementation of this development in the budget bill for 2008 (SOU 2007/08:1 UO10).

In conclusion, Swedish politics in the area of health, and then specifically corporate health, might be expected to experience additional important changes, further expanding the private market for corporate health initiatives.

Workplace health promotion today

Today, as described above, workplace health promotion thus originates in both an occupational health movement and a health promotion movement (Reardon, 1998; SOU 2004:113; Thomsson & Menckel, 1997). However, today an integration of these two approaches is advocated (Chu, Driscoll, & Dwyer, 1997; Hanson, 2004; Reardon, 1998; Thomsson & Menckel, 1997; Yassi, 2005). Integrating these two approaches is also referred to as an ecological approach or perspective (Dooris, 2005; SOU 2004:113). In an effort to promote ‘good practice’ in WHP, a European Network for Workplace Health Promotion has, among other things, developed a definition of WHP (ENWHP, 1997:1) that serves to integrate these two strands:

> the combined efforts of employers, employees and society to improve the health and well-being of people at work. This can be achieved through a combination of:
> - improving the work organisation and the working environment
> - promoting active participation
> - encouraging personal development
Shain and Kramer (2004) likewise argue for the need of an integrated perspective on WHP. In line with the above quoted definition of WHP, they offer the following figure to explain how the two strands of work organization (related to occupational health and including both physical and psychosocial environmental aspects) and personal health practices (understood as personal development and related to health promotion) interrelate to cause consequences for worker health and productivity:

![Figure 1. Forces acting on health and productivity in the workplace](Shain & Kramer, 2004:644)

What Shain and Kramer are trying to illustrate here is that personal health practices and resources are interdependent with the organization of work and that these two together influence the health of employees as well as productivity. The model also illustrates that productivity is dependent on the health of the employees. Thus, responsibility for employee health is construed as shared between employees and employers and as productivity is linked with the health of the employees, an (economic) incentive is created for the employer to work actively to promote employee health. However, incentives for employees to participate in WHP are not as clearly stated, rather personal health seems to be conceived as an incentive in itself.

Concurring with the above and stressing the significance of the multitude of factors influencing health and the importance of workplace health promotion to address this, Thomsson and Menckel (1997) underline the importance of taking into consideration people’s entire life-situations and how these influence their capabilities to act in a healthy manner. With this approach, they want to broaden the scope of activities that are conceived as WHP activities and incorporate such activities as to introduce flexible working hours and working place, socially supportive working climate, etc, in that scope.
Despite all these calls for a more holistic and integrated approach, the notions of health as safety vs. health as lifestyle continue to permeate WHP initiatives and employers take an increasing interest in lifestyle issues among their employees (see e.g. Allender et al. 2006; Bjurvald, 2004). This concern among employers with the personal issues (such as dietary and physical activity habits) of their employees needs to be investigated and problematized. Hence, the focus for this study has been on WHP interventions building on the notion of health as lifestyle and, from now on, this is the type of workplace health promotion that I am referring to and writing about.

Workplace health promotion; an educational public health effort

Without any claim of offering ‘the complete and definitive’ picture, this section tries to situate workplace health promotion in relation to the wider concepts of public health, health promotion and health education, making the case that WHP is an educational public health effort. This is done by attempting to clarify the relation between health promotion and health education. In relation to workplace health promotion and public health the concept ‘health promotion’ is central. To me, the use of the concept has seemed erratic and it has sometimes seemed to be used interchangeably with ‘health education’ as if they are synonyms, and sometimes as though they are incompatible opposites. This inconsistency seems to also spill over into the Swedish translations of the concepts and both the English and Swedish versions have caused me, and others (see e.g. Korp, 2002; Medin & Alexandersson, 2000), some confusion and generated a need to explore how they relate to each other. Furthermore, because my first language is Swedish but I am writing in English, I also had to consider how I made use of the English concepts of health education and health promotion (and other concepts) and how they are related to their Swedish counterparts (‘hälsopedagogik’ and ‘hälsopromotion’). I am not trying to stipulate any definitive meanings of the concepts, nor will I comment on the Swedish conceptual translations or uses of them. Rather, what I want to do here is to explore the meanings with which the concept of health promotion and health education have been filled by others in order to become clearer regarding my own.

The practice and ideology of health promotion

The concept of health promotion has its beginnings in the late 1970’s (Parish, 1995), and by the 1990’s health promotion was described as an emerging discipline in its own right (Macdonald & Bunton, 2002). Although ‘health promotion’ may thus be regarded as a fairly new phenomenon, it seems already
to have come to be given two separate but related and sometimes confounding meanings. On the one hand it refers to the practice of promoting health in various ways and on the other hand it refers to an ideology (Tones & Green, 2004).

Health promotion as practice refers to the various activities through which health professionals and others strive to improve the health of populations, groups and individuals. One characteristic of health promotion as practice came to be its multi-focused approach (Bunton & Macdonald, 2002), as opposed to the atomistic approach to health in medicine (preventive health work). This multi-focused approach has resulted in a practice of health promotion which Seedhouse (2004) refers to as a ‘magpie profession’, referring to the tradition of looking to other disciplines for techniques, models and goals without any theory really of what health promotion is, should do and why. As mentioned previously, there are several ways of conducting health promotion, of which screenings for heart disease, lectures on nutrition or encouragement to participate in corporate sports are some examples of activities that, in this case, can be offered at the workplace, i.e. workplace health promotion.

Regarding health promotion as ideology: Macdonald and Bunton (2002:9) write that health promotion “sprang from dissatisfaction with … the biomedical model of health” which was conceived as limited and insufficient. This dissatisfaction is the foundation of an ideological division between the notions of health promotion and disease prevention, the latter being associated with the biomedical reductionist and static model of health as the opposite of illness, sickness or disease and focused on risk factors (Medin & Alexandersson, 2000) and the first being associated with a notion of health as wellbeing and focused on those factors concerned with increasing wellbeing, also referred to as ‘positive health’.

This distinction is evident also in the definition of public health work by The National Committee for Public Health in Sweden. They define public health work as “planned and systematic interventions to promote health and prevent disease” (Nationella Folkhälsokommittén, 2000b:97, translated from Swedish). Here, the notions of ‘health promotion’ and ‘disease prevention’ are implicitly construed as something different from and complementary to each other and as such they become distinguished as two different ideological approaches to public health work (see also Liss, 2001).

The ideology of health promotion is sometimes also distinguished from that of disease prevention by reference to the concepts of salutogenesis and pathogenesis (Antonovsky, 1991, 1996; Lindström & Eriksson, 2005; Mården, 6 For a deeper/different discussion about the ideology of health promotion, see Tones & Green (2004).
1999; Tones & Green, 2004), where salutogenesis is associated with health promotion and pathogenesis to disease prevention. Antonovsky (1996) furthermore advocates his salutogenic model as a theory for health promotion. Antonovsky's theory of salutogenesis is concerned with the determinants of health, as opposed to the bio-medical interest in the determinants of ill health. Drawing on this concept of salutogenesis, health is conceived as a dynamic, constantly shifting, and multidimensional state of being and focus is placed with the ability and capacity to manage and on problem-solving (Lindström & Eriksson, 2005).

The use of the concepts of health promotion or disease prevention as well as salutogenesis and pathogenesis has been contested on the grounds that what these concepts mean is not unambiguous – the distinctions are not clear in a practical day to day operation (Korp, 2002; Tones & Green, 2004). In a report on health promoting and creative workplaces, the leisure sciences researcher Olson (2004) comments that researchers and practitioners often talk about health promotion but do disease prevention and that they (start to) talk about wellness but only actually mean (end up talking about) physical health, excluding mental/psychological/spiritual health. He says: “In publications on health promotion a distinction is usually made between taking care of disease and promoting the healthy, but the discussion is often later reduced to questions about how we can prevent ill health” (Olson, 2004:10, translated from Swedish). This kind of critique has been directed at the entire concept and practice of health promotion (Seedhouse, 2004), as health promotion is often also used to describe such activities as may most often be associated with prevention, such as screening for heart disease. The activity of health promotion may thus be based on either an ideology of health promotion or disease prevention or both.

**Education in public health work**

Health education is defined by Tones and Green (2004:24) as “any planned activity designed to produce health- or illness-related learning”, while Olsson (2001) defines it as “a comprehensive concept for different sorts of processes for learning, communication and influence within public health work” (2001:7, translated from Swedish). To Tones and Green, the activity must thus be planned to produce learning to be perceived as health education. In contrast, I understand Olsson’s definition of health education to include any and all (health related) learning that may take place as the result of many different processes in public health work. Olsson’s definition is thus more inclusive, providing the possibility of perceiving of a screening for heart disease (for

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7 For more information and discussion about health education, see e.g. Green & Kreuter, 1999; Olsson, 2001; Tones & Green, 2004.
instance) as an opportunity for health related learning. Health education may thus be perceived as (an unplanned) part or consequence of health promoting activities that might not at first be thought of as health educational. Using this latter definition, health education may be perceived as a constant and unavoidable part of public health work. The presence of educational issues or aspects in public health work does not, however, mean that theories of education have been explicitly and consciously drawn on in public health work through its history of existence. Even today health interventions may or may not be explicitly based on pedagogic theories or theories of change (Thompson & Kinne, 1999), at least, according to Wijk (2002; 2003), not deliberately or in a carefully planned sense. Initially this was logical, since education as a distinct academic discipline has a shorter history in Sweden than does the practice of public health work or, for that matter, school education. Furthermore, as explained by both Tones and Green (2004) and Olsson (1997), this history of health education in public health work began rather as propaganda than as education. Also, research in education in Sweden initially had difficulty gaining recognition as a distinct discipline (see e.g. Dahllöf, 1986; Englund, 1992; Lindberg, 1992; Lindberg & Berge, 1988), and research in the area of education has been dominated by psychological research. Education was conceived as inseparable from psychology and education as a distinct discipline seemed unimaginable. Several professorships where even named accordingly as “psychology and education” or “education and educational psychology” (Lindberg & Berge, 1988). This is further made clear in the inaugural speeches made by professors of education in Sweden as they were appointed (Lindberg & Berge, 1988); appointments made with the expressed aim of developing an education discipline/science. These speeches are dominated by psychology, with the exception of the inaugural speech made by the first professor of education in Sweden – Professor Hammer (Lindberg & Berge, 1988). Hammer’s speech in the year 1910 had a solid educational focus and expressed an educational agenda for the future of the discipline of education.

While in education the issue has long been how to describe and delimit the discipline in relation to other (close) disciplines such as psychology and sociology, in health education the issue has been with struggling to legitimize education theory in public health work. Even as education became a distinct discipline, public health workers did not turn to education for theories on how to educate and influence the public, but rather turned to theories of marketing and advertising (see Mården, 1999; Olsson, 1997; Palmblad & Eriksson, 1995).

The explanations as to why education even up until the present day has led a modest existence within public health and workplace health promotion may be numerous. One possible explanation may be found in a statement by (the first woman) professor of education Franke-Wikberg (1988) in her inaugural speech
in 1982. She comments that the educational object of study more than in any other discipline is “‘public property’ in the sense that nurturing and education are part of everyone’s experience and concern. If you are not a ‘nurturer’ you are at least ‘nurtured’, if you are not a ‘teacher’ you are at least ‘taught’. This does not just mean that there is a great interest in educational issues but also that everyone has their own values and make their own judgments of how nurturing and education should be done” (Franke-Wikberg, 1988:215, translated from Swedish). Thereby and in this sense everyone may consider themselves to be an educationalist with the consequence that they see no need for a ‘specialist’ educationalist.

Recently, however, educational aspects of public health work (and workplace health promotion) have become recognized. For instance, the national public health work has moved from a clinical approach, via a biopidemiological and a socio-epidemiological approach, to the policy and environmentally targeted approach of today. With this change, the importance of “information – education – communication for health” (Nationella Folkhälsokommittén, 2000a:8) has come to be emphasized. Further, according to Olsson (2001), talk about health information has ever since the 1980’s become more and more nuanced: due to a dawning realization among public health workers about the complexities in the relationship between information and behavior change, notions of how to educate and influence people toward better health have become more complex.

Health education has thus come to be regarded as important to the theory of health promotion (Macdonald & Bunton, 2002; Tones, Tilford, & Robinson, 1990). Health education is even, in the view of Tones and Green (2004), together with healthy public policy conceived as constitutive of health promotion.

Healthism and medicalization

There is a conception in today’s public health work that health is related to one’s lifestyle and as such an individual responsibility. Writing in 1997 on the issue of the increasing requirement on individuals to take personal responsibility for their health, Nettleton suggests that health promoters would “balk at the very suggestion that it is their place to ‘tell’ others how to behave to ensure their future health. Rather they would prefer to provide ‘consumers’, ‘user’ or whoever with information and a range of options so that they themselves can decide what is best for them” (Nettleton, 1997:220). Already in 1980, Crawford coined the concept ‘healthism’ to direct attention to this conception, defining it as:
the preoccupation with personal health as a primary – often the primary – focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of life styles, with or without therapeutic help. The etiology of disease may be seen as complex, but healthism treats individual behavior, attitudes, and emotions as the relevant symptoms needing attention. ... solutions are seen to lie within the realm of individual choice. Hence, they require above all else the assumption of individual responsibility. For the healthist, solution rests within the individual's determination to resist culture, advertising, institutional and environmental constraints, disease agents, or, simply, lazy or poor personal habits. In essence, then, cause becomes proximate and solution is constructed within the same narrow space. (Crawford, 1980:368, emphasis in original)

This focus on the individual and the individual's lifestyle is characteristic of public health work today (Crawford, 1980; Palmblad & Eriksson, 1995). According to Crawford (1980) this is due to a “medical perception [which] pushes causal understanding toward the immediate and local, and solution toward the elimination of symptoms and the restoration of normal signs” (Crawford, 1980:371). This means that, informed by a medical perception, health comes to be perceived as the result of individual choices and behaviors. Hence, the problem comes to be located at the level of the individual and because of this, the individual is also looked to for explanations, ignoring or obscuring any structural conditions. The individual thus comes to constitute the boundary for causation and becomes the locus of intervention. In this manner, the responsibility for health is placed with the individual.

Placing responsibility for health with the individual is based on the idea that given the opportunity and the knowledge, people would do what is healthy for them because it is rational; that knowledge of causality will lead to rational action based on this knowledge (Gard & Wright, 2001; Palmblad & Eriksson, 1995). The ‘rational individual’ who immediately starts behaving according to what is good for them as soon as they learn what this behavior is, is a common idea (Burrows, Wright, & Jungersen-Smith, 2000) and has been the basis for Swedish public health work since the 1930’s and 1940’s (Palmblad & Eriksson, 1995). This conception “turns on certain presuppositions of the notion of self as autonomous, capable and free thinking which have been evident in a range of settings, such as the workplace” (Nettleton, 1997:213). It constitutes these ‘rational’ people as individuals who are able to and willingly exercise ‘free’ “choice within a free market and moral economy” (Fullagar, 2002:72). Not only do the individual responsibilities for health include a demand for the individual to increase their knowledge, act rationally and exercise ‘free choice’, but the notion of individual responsibility also creates expectations about self-regulating individuals (Kjellström, 2005). These expectations include, among other things, demands for increased self-knowledge, reflection and personal
development. In this healthist understanding, then, focusing on one’s lifestyle choices “has become an alternative to prayer and righteous living in providing a means of making sense of life and death. ‘Healthiness’ has replaced ‘Godliness’ as a yardstick of accomplishment and proper living” (Lupton, 1995:4).

Perhaps as a consequence, there is an increase in the range of social phenomena that has become linked to health and the institution or practice of medicine. Such ‘spreading’ of health is referred to as ‘medicalization’. Medicalization is criticized by feminist researchers on the grounds that it serves to pathologize women’s bodies and construe the male body as the ideal (Hubbard, 1979/1990; Johannisson, 1994; Kapsalis, 1997; Martin, 1987). As women and men during the 19th century came to be conceived as essentially different, this construction also influenced notions about health: the male body was conceived as strong while the female body was conceived as weak (Johannisson, 1996). For instance, a medicalized view of the healthy body entails an unchanging and stable body, which thus excludes the typical changes that occur in all people’s lives due, for example, to aging, but, particularly in women’s lives, due to monthly variations in hormone levels (Young, 2002). Hence health has come to be conceived as the norm for the male body while the female body is associated with periodicity, lability and constitutional weakness (Johannisson, 1996). Because this view is dominant in our society, all changes which are not toward a younger and more stable (in diverse senses) body, come to be seen as deviations from the norm. This turns the question of the medicalized healthy body into a question of gender issues, since the female body will most often be the most unstable body, thus also constituted as the deviant, the Other. Johannisson (1996) points out that this medicalization (and de-medicalization) of the female body has continued and followed the needs of the labor market. She says that “it is primarily the female body that has been reconstructed, adapted and biologized. The ideals have shifted from weak and fragile (1880’s), strong and child-rearing (1910’s), slim and capable (1930’s), sound and housewife-adapted (1950’s), strong and equal (1970’s) to the 21st century’s reconstitution of a feminized women’s body and strengthened gender dichotomy” (Johannisson, 1996:125, translated from Swedish). Hence, notions about health serve to reproduce gendered bodies that are conceived as essentially and unavoidably different, constructing two different bodies: a woman’s and a man’s (Harding, 1997; Hubbard, 1979/1990; Olofsson, 2005). Health research and advice on health related behavior are generally based on this division, suggesting a difference in needs between women and men. For example, there is a societal norm that suggests that women are and should be concerned with issues of personal health and their bodies whereas men are not and should not be (Lupton, 1996). In constructing and reproducing distinctions between women and men, notions about health thus work to maintain current
power/gender orders by maintaining and reproducing boundaries between women/femininity and men/masculinity.

Research for and on workplace health promotion

Research in the area of workplace health promotion can be distinguished into two groups: research for WHP and research on WHP, of which research for WHP seems to be more common than the other (Allender et al., 2006b). By ‘research for workplace health promotion’ I mean research that focuses on refining and developing the practice of WHP. By ‘research on workplace health promotion’ I refer to research with a critical perspective on WHP. I realize that all research on WHP could be said to, in the end, be of benefit to the refinement or development of the practice of workplace health promotion and in that sense could be argued to be research for WHP. However, to further clarify the distinction, research on WHP is here conceived as critical research that does not explicitly express ideas or advice on how to improve WHP but rather leaves that judgment up to each reader. Based on such a distinction, Zoller’s (2004) article “Manufacturing Health: Employee Perspectives on Problematic Outcomes in a Workplace Health Promotion Initiative” may for instance be described as research for WHP. In this article, although assumptions made in WHP are problematized from a critical perspective, the article is concluded in the spirit of a ‘best practice’ as explicit ideas and advice on how to improve the practice of WHP are given (see also Zoller, 2003). Below, I will begin by attempting to outline the research for WHP, then moving on to a brief review of research on WHP. This review will then come to an end as I delineate the gaps in knowledge that this study sets out to address.

To my understanding, research for WHP is primarily engaged with one of two (related) problems: 1. establishing ‘best practice’ and evidence based WHP, and/or; 2. evaluating the efficiency and effects of WHP, in relation to financial and/or health (beliefs/behavior) outcomes. In McGillivray’s (2005) words, this type of research is mostly based on positivist and functionalist analyses.

Improving intervention programs and approaches and developing ‘best practice’ is a major preoccupation in WHP research (see e.g. Eakin et al., 2001; Shain & Kramer, 2004; Zoller, 2004). This type of research is concerned with determining how best to intervene in order to achieve the best results regarding employee compliance with a WHP intervention and subsequent increase in loyalty, followed by increased productivity, followed by increased corporate profits. Calls for evidence based health promotion have resulted in evaluations with both what McGillivray (2005) calls ‘positivist’ approaches (see e.g. Brand et al., 2006; Dishman et al., 1998) and approaches taking on the challenge of considering the complexities of health promotion and public health (Dooris, 2005). However, as of yet there is no consensus on what constitutes ‘best
practice’ in health promotion or workplace health promotion and gaps and contradictions in the ‘evidence’ are rather expected (Green, 2001). This may, at least in part, be due to the variations and width in range of what may be conceived as a WHP intervention. This variation and width has in turn been described as the result of a lack of consensus regarding what workplace health promotion is (Conrad, 1987) as well as due to the multiplicity of professionals with a vested interest in workplace health, promoting specific understandings of what it is as opposed to others (Allender et al., 2006a).

What according to my readings of the research for WHP seems to be the ‘cutting edge’ in WHP best practice at the moment is, as described above, an integrated perspective (Chu et al., 1997; Dooris, 2005; ENWHP, 1997:1; Hanson, 2004; Reardon, 1998; SOU 2004:113; Thomsson & Menckel, 1997; Yassi, 2005). With an integrated perspective the orientation is more toward the employee than the employer. For example, such issues as employee voice come to be taken into consideration in planning and implementing interventions (Zoller, 2004) or issues of employees social locations such as gender, sexuality, class, ethnicity, etc (Campbell et al., 2002; Hunt et al., 2007; Zoller, 2003).

Another effort at building ‘best practice’ is to (critically) review a host of evaluations and make conclusions based on this accumulation of experience (Kallestål, 2004; Harden et al., 1999). However, despite these efforts and despite the calls from various actors for integrated approaches to WHP “few studies have examined integrated, comprehensive strategies as a whole, focusing instead on the individual components” of workplace health promotion initiatives (Dooris, 2005:57).

The evaluation research focusing WHP has been concerned with evaluating the effects on costs for health care benefits and absenteeism (see e.g. Aldana, Merrill, Price, Hardy, & Hager, 2005; Schultz et al., 2002). Health care benefits and absenteeism are in turn associated with both productivity (Shain & Kramer, 2004) and employee morale and loyalty (Conrad, 1987; Zoller, 2003). Conrad (1987) suggests that improving loyalty and productivity may be at least as important to employers as containing or lowering health care costs.

In research focusing on evaluating the effects of WHP on employee health, health is variously defined. For instance, health may be conceived of as social health (Farrell & Geist-Martin, 2005) or as quality of life (Brand, Schlicht, Grossmann, & Duhnsen, 2006). Or the focus may be on effects on employee lifestyle behaviors, such as changed diet and level of the physical activity (Campbell et al., 2002; Dishman, Oldenburg, O’Neal, & Shephard, 1998). Or effects on employee health may be measured as changes in employees’ risk of

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8 For further discussions, comments and critical perspectives on these issues, see e.g. Allender et al (2006b), Conrad (1987), Holmqvist and Maravelias (2006), or Zoller (2003, 2004).
Introducing Workplace Health Promotion

Cancer (Hunt et al., 2007) or experienced level of stress (Eakin, Cava, & Smith, 2001). This is just to mention a few examples of the diversification of perceptions in the field of how to evaluate effects on health. This diversification may help explain why there is no consensus on ‘best practice’ or why studies to evaluate efficiency of programs have difficulty asserting whether they have had (the desired) effect or not (Harden, Peersman, Oliver, Mauthner, & Oakley, 1999).

Turning then to the critical research on workplace health promotion, I begin in the more general field of public health. Although this situation may be changing, conceiving of health and health work from critical and interpretive perspectives are not yet common in the general field of public health internationally (Lupton, 1995) and possibly even less common in Sweden, as Olsson’s (2001) call for such research might indicate. In Sweden, this could be due to public health work being developed and heavily influenced by a medical paradigm (Hammarström & Ripper, 1999) which, as Lupton (1995) points out, is not a tradition in which ‘softer’ perspectives are highly valued:

_The tendency has been to accept the prevailing orthodoxies of public health and health promotion, focusing upon statistical measures, cost effectiveness and the evaluation of measurable effects, but devoting comparatively little attention to the critical analysis of the political implications of such endeavours._ (Lupton, 1995:1)

This development in Sweden can be compared to the development of public health in other countries such as Australia in which public health grew out of the social sciences, enabling (an earlier) development of critical perspectives (Hammarström & Ripper, 1999). These days, however, as Kjellström (2005) points out, notions of health are moving or have moved beyond medicine also in Sweden, and a social perspective on health is becoming more and more prevalent. Although variously with or without a critical perspective, this development is resulting in an increasing production of theses in the social sciences focusing on health and specifically health promotion (see e.g. Kjellström, 2005; Korp, 2002; Mården, 1999; Olsson, 1997; Wijk, 2003).

Critical research on health promotion tends to examine issues of choice and free will and to be critical of the general lack of theory and reflexivity in health promotion research (see e.g. Kickbusch, 2001; Seedhouse, 2004; Sharrock & Idema, 2004; Wijk, 2003). Related to these, the spreading medicalization and healthism in health promotion efforts is of interest as is how health promotion serves to regulate populations and govern subjects (see e.g. Coveney, 1998; Fullagar, 2002, 2003; Galvin, 2002; Greco, 1995; Lupton, 1995).

Although critical research on health is not common in the greater field of health research, research on the regulation of populations through health in
health promotion (see e.g. Bunton & Macdonald, 2002; Lupton, 1995; Petersen & Bunton, 1997; Sharrock & Idema, 2004) is more common than research on the regulation of populations in the intersection between health and work. However, there are some, such as Allender et al (2006a) who problematize the discourses drawn on in WHP and, in a second article (Allender et al., 2006b), investigate how such discourses serve to regulate employees. McGillivray (2005) also investigates the regulating effects on employees of discourses drawn on in workplace health promotion initiatives. The present study may likewise be situated as research on WHP, as it is concerned with examining and problematizing issues of medicalization and heathism in WHP.

**General Aim of the Study**

People spend a considerable amount of their time at work and hence this becomes an important social arena for people to play out their individuality. The workplace is also an important arena for health promotion efforts in which health is inexorably regarded as something ‘good’, as something that has a value in and of itself. Health promotion initiatives are even perceived as part of employers’ social responsibilities (Holmqvist & Maravelias, 2006). However, “‘[h]ealth’ and ‘healthy’ are merely words human beings use to describe states and behaviours we value positively. Different human beings value different things. Consequently we do not always agree which states and behaviours to label ‘healthy’” (Seedhouse, 2004:xiv). However, what is perceived as healthy is not as interesting as what these conceptions do: the consequences of valuing something positively or negatively, of calling something healthy or unhealthy. Today, little is known about how health imperatives are negotiated in the interaction between educators and participants in corporate health promotion programs (although see Zoller, 2003 and 2004), or with what consequences for social (re)production and regulation of employees as gendered subjects. As the number of WHP interventions is increasing, reaching an ever expanding quantity and variation of people, and due to the amount of time people spend at the workplace, it becomes important to investigate what limitations and imperatives are imposed on people in these WHP initiatives. Hence, the present study will be concerned with exploring how health imperatives are taken up and re-contextualized in workplace health promotion initiatives and with what consequences for how participants’ are invited to make sense of themselves as gendered healthy subjects.
CHAPTER 2,
UNDERSTANDING WORKPLACE HEALTH PROMOTION

Whenever we observe the world and try to understand that which we observe, we use theory. Theory tells us what to focus on: what is important of all of the things that we (could) observe around us. As such, theory directs our gaze and suggests how to make sense of that toward which our gaze has been directed (Maton, 2006). Theory may also be perceived as “a vehicle for ‘thinking otherwise’” about something (Ball, 1995:266). It may be a means to “defamiliarise present practices and categories, to make them seem less self-evident and necessary, and to open up spaces for the invention of new forms of experience” (Ball, 1995:266), i.e. to challenge what we may take for granted. To make explicit the theory on which one bases one’s observation and understanding is to invite another to observe that which one is observing and to agree, dispute or critique the understanding of the observed from the perspective of this theory. Consequently, this chapter is an invitation (or, if you will, a request) to you to observe and make sense of the objects of this study from a specific perspective, with the aid of the specific theoretical framework presented here.

The theory that I draw on to observe and understand the objects of this study is a theory to defamiliarize practices and categories, a theory to help in “thinking otherwise” and challenge what may be taken for granted, namely post-structuralism. Attempts at defining post-structuralism will always to some degree fail and may be perceived as contradictory to the idea of post-structuralism (Davis, 2004). Despite this, Weedon (1997:19) ‘defines’ post-structuralism as “a way of conceptualizing the relationship between language, social institutions and individual consciousness which focuses on how power is exercised and on the possibilities of change”. Another reason for objecting against attempts at defining post-structuralism is that it is not just one single theoretical position but many. However, according to Weedon (1997:20) all of these positions share “certain fundamental assumptions about language, meaning and subjectivity”. In this chapter, then, my aim is to elaborate on what these assumptions may be and their consequences for my study. In elaborating on this, I will describe the specifics of how I understand and make use of post-structuralist theory. I will also describe the analytical instruments that I have drawn on. The main analytical tool that I am inspired by and have used in my
analysis is Foucault’s notion of governmentality which, however, is not actually one tool but many, as will be elaborated on further below. I will describe how these work to direct my gaze, on what they tell me to focus. In order to make these tools comprehensible I will first address matters of language, meaning, knowledge, power and discourse because how these are conceptualized forms the building blocks for understanding the notion of governmentality. I have organized this presentation such that I will begin to discuss the relations between language, meaning and knowledge, and then the triplet of knowledge, power and discourse. With these concepts I try to describe the ontological and epistemological underpinnings of this study: how the ‘subject’ and our ability/capacity to know anything about it and the rest of the world are perceived in this study. Following this, I try to describe how I draw on and how my analytical gaze is influenced by Foucault’s notion of ‘governmentality’. Ending this chapter on theory is a specified aim, expressed with the help of the theoretical tools elaborated in this chapter.

This organization may suggest linearity in the relations between these concepts, as if the first concept relates to the second, which relates to the third, etc. However, even though this line of thought might be of help in grasping their relations, this is not how they should be understood. All of these concepts are intimately related to each other in a way that might best be described as a contingent network and the present organization should only be taken as my way of building toward an understanding of governmentality.

Language, meaning and knowledge: Constituting the world of health promotion

One founding assumption made in post-structuralism is that meaning is constituted in language and does not exist prior to that articulation. Furthermore, building on Derrida (1997), meaning is conceived as produced via difference (from other signs) and deferral (in the difference to other words, of which meaning is always deferred). The consequences of these assumptions are that knowledge (as construed in/through language) is conceived as socially and culturally situated, produced in discursive relations and social practices that are historically specific, and consequently that how we make sense of the world (i.e. produce knowledge about the world) is likewise contingent (Hekman, 1990; Weedon, 1997; Winther-Jorgensen & Phillips, 2000). Social activities are also interpreted and understood by social actors in various and contradictory ways, making "social activities … repositories of multiple meanings" (Gilbert & Mulkay, 1984:9) which may at times represent competing or even conflicting interests (Weedon, 1997). However, even though language and its meaning are in themselves contingent and filled with multiple and potentially contradictory meaning, meaning that no description is ever definitive, this does not mean that
meaning and knowledge are relative: since meaning and knowledge are created in social interaction they remain quite stable. Temporary fixings of words depend, as mentioned, on the discursive context in which they are located. Thus, the meaning of, for instance, health is produced socially and is also “variable between different forms of discourses” (Weedon, 1997:22). This means, for instance, that drawing on a biomedical discourse health may be perceived as the absence of disease (such as cardiovascular disease), while drawing on a wellness discourse the meaning of health will shift and health may be perceived as the subjective experience of happiness.

Another poststructuralist assumption is that “[l]anguage is not transparent … it is not expressive and does not label a ‘real’ world” but that language rather constitutes social reality (Weedon, 1997:40). Accordingly, knowledge about ‘reality’ cannot be regarded merely as a reflection of an already existing reality, but must rather also be conceived as constitutive of the social world (Richardson, 2001; Winther-Jorgensen & Phillips, 2000). Depending on how we conceive of health and what our conception of a healthy body is, then, various actions will be regarded as more or less ‘natural’ and ‘normal’ and hence promoted (or not) in health education interventions. For instance, if a healthy body is conceived as a muscular body, practices of weight lifting or other practices which serve to build muscle will be conceived as ‘normal’ and healthy.

Building on poststructuralist theory, my position in this thesis is, in other words, that ‘reality’ is only available to us via language, via the signs and categories that we use to signify and structure it (see e.g. Winther-Jorgensen & Phillips, 2000). I do not question that there is a physical, material world but would argue that this world only becomes meaningful through language. The only way we can understand the world is by naming, categorizing and classifying it, and by doing this, we produce meaning and knowledge about the world through language. Consequently, there is no knowledge or meaning outside language. Since language and knowledge are thus perceived as constitutive of the world, from this perspective, ideas about ‘objectivity’, ‘rationality’ and ‘truth’ (knowledge) must be questioned, and totalizing, essentialist and fundamentalist perceptions of the world rejected. Instead, reality is conceived of as constituted in relations and ‘talk’. Furthermore, as suggested above and as I will elaborate more on further down, how in this case health is conceptualized and defined is perceived to have consequences for social action (Seedhouse, 2004).

To further understand how language, meaning and knowledge about, in this case health and pedagogy, work to produce subjects as un/healthy, I turn

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9 By ‘talk’ I do not only mean the act of speaking but refer also to all of the ways we have of communicating, with others and with ourselves.
primarily to Foucault. Throughout his entire work, as he describes it (Foucault, 1982/2003), Foucault has been concerned with the subjectification of humans. Even though his earlier works were more concerned with the objectivizing (by power-knowledge) of the speaking, productive and living subject, and the objectivizing of subjects by ‘dividing practices’, he later became increasingly interested in the subjectification of subjects by themselves through the power-knowledge of discourses. This is why I turn to his work now, as I think that his conception of power-knowledge and discourse, as I will expound on next, will be helpful to me in my own work. However, even though this study is informed and inspired by Foucault’s work and even though I let his theoretical concepts guide my theoretical understanding and analytical gaze, I do not make any claims to be a Foucault scholar or ‘foucauldian’ and this is not a foucauldian study. Rather, I take Foucault at his word when he said that “[w]hat I say ought to be taken as ‘propositions’, ‘game openings’ where those who may be interested are invited to join in – they are not meant as dogmatic assertions that have to be taken or left en bloc” (Foucault, 1980/2003:246). He also said that “If one or two of these ‘gadgets’ of approach or method that I’ve tried to employ with psychiatry, the penal system or natural history can be of service to you, then I shall be delighted” (Foucault, quoted in Gore, 1993:50). I understand these quotes as invitations to make use of his work in ways that make the most sense to my own study and to make of the tools what I can. Taking him at his word, I make use of some of his concepts as ‘tools’ for making sense of my empirical material (compare with Gore, 1993), but I might not necessarily use his concepts as some might think of as appropriate or ‘true’ to his intent.

Knowledge, power and discourse: Constituting the gendered, healthy subject

Drawing on Foucault’s conception of power-knowledge to understand the production of subjects and subjectivities, power, knowledge and discourse are here conceived as inseparable from but not identical with each other: power is productive of knowledge, which is productive of power, and this relationship between power and knowledge (power-knowledge) is captured in the term discourse (Foucault, 1984/1991). I’ll explain a bit closer, beginning with power and connecting these notions of power, knowledge and discourse to notions of the subject, body and gender.

Power, which may generally be associated with repression and prohibition, is differently conceived by Foucault. In an interview on the issue Foucault had the following to say:
If power were never anything but repressive, if it never did anything but to say no, do you really think one would be brought to obey it? What makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no; it also traverses and produces things, it induces pleasure, forms knowledge, produces discourses. It needs to be considered as a productive network that runs through the whole social body, much more than as a negative instance whose function is repression (Foucault, 1984/1991:61).

Foucault’s analysis of power suggests instead, then, that power is relational, constantly circulating between individuals, and productive, constituting the social world so as to both enable and disallow certain ways of describing and conceiving of the world around us (Winther-Jorgensen & Phillips, 2000). Power is thus perceived as “productive of knowledges, meanings and values, and of certain practices as opposed to others” (Hollway, 2001:278). Consequently, power is conceived as inseparable from knowledge as it in fact produces knowledge and as knowledge produces power (Foucault, 1984/1991). Or, in his own words: “It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power” (Foucault, 1980:52, quoted in Barker, 1998:28). For instance, how we conceive and make sense of gender (our knowledge about gender), is constituted in/through power relations which in turn produces (enables or disallows) specific ways of doing femininity and masculinity. From this perspective, gender is thus conceived as a contextually variable social construction and performance rather than as a material essence. How femininity and masculinity may be performed and understood in a certain situation can thus be conceived as an expression of available discourses and subject positions (i.e. relations of power-knowledge) at the specific point in time and space. This understanding of gender is representative of a feminist poststructuralist perspective. Lenz-Taguchi (2004) refers to feminist post-structuralism as the “third wave feminism”, comparing it to liberal feminism (first wave) and radical feminism (second wave). Liberal feminism seeks access to the male dominated sphere while radical feminism seeks a re-valuation of the female difference. In contrast, feminist poststructuralism conceives of women and men as multiple and fragmented constructions. “This means that femininity and masculinity do not have to be conceived as opposites, but rather as inclusive of the other, although not in terms of being similar but as multiple ways of being” (Lenz-Taguchi, 2004:81, translated from Swedish). According to Davies (2000:66), “the male/female dualism is fundamental to all discourses”, meaning that gender always matters. Further, in taking up as their own the discourses constituting gender, women and men are simultaneously both acting subjects and subjected or determined by those discourses. “That subjection is generally invisible because it appears not only to be natural, as Butler points out, but also to be what women [and
men want, a result of free choice” (Davies, 2000:72, emphasis in original). The point with feminist post-structuralism is “to make visible how language operates to produce very real, material, and damaging structures in the world” (Adams St. Pierre, 2000:481) such as constructing women as inferior to men.

As mentioned, in Foucault’s understanding, power is not possible without knowledge and vice versa. Knowledge does not pre-exist power or control power. Foucault would not agree with the notion that “knowledge is power”. Knowledge, or truth, is by Foucault conceived as an effect of power relations and produced within a general politics of truth (Barker, 1998). “Truth” is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extends it” (Foucault, 1984/1991:74). For instance, Winther-Jorgensen and Phillips (2000) point to how the modern prison system cannot be thought without psychiatry and criminology. Likewise, contemporary health education cannot be thought without medicine and education. Foucault (1984/1991) also says that: “truth isn’t outside power or lacking in power”, rather truth produces power and power is immanent in knowledge relationships in the sense that there is knowledge that is conceived as more or less important, and more or less legitimate. For instance, in contemporary Western medicine, scientifically based knowledge is perceived as more important and legitimate than knowledge based on religious ideas or personal hunches. Moreover, in medicine, scientific knowledge from the natural sciences takes precedence over social scientific understanding/knowledge which is why knowledge about differences (or similarities) between women and men that is based on scientific research comes to take precedence over other attempts by, for example, the social sciences to explain such differences (or similarities).

Knowledge is thus, as mentioned previously, not an ‘objective’ representation of what is ‘out there’. Rather, certain knowledge, or a certain perception of the world, makes certain actions ‘natural’ and others ‘unnatural’, hence language comes to produce meaning, produce ‘reality’ (or realities). This social construction of knowledge and ‘truth’ creates concrete social consequences and instead of studying truth claims for their assumed reflection of reality then, Søndergaard (2002:188) suggests, with Foucault, to study them, “for their production of social and cultural effects and thereby for their inductions of regular effects of power.”

The term ‘discourse’ may generally be associated with linguistics and conceived as “passages of connected writing or speech” (Hall, 2001:72), but Foucault gives the term another meaning and another use. Drawing on Foucault, discourse may be described as being “about what can be said, and thought, but also who can speak, when, where and with what authority” (Ball, 2006:48). According to Foucault (1984/1990:100), “it is in discourse that power and knowledge are joined together” in the sense that power and
knowledge are both the constituents and the effects of discourse. Or, in Carabine’s (2001:275) words: “To understand discourse we have to see it as intermeshed with power/knowledge where knowledge both constitutes and is constituted through discourse as an effect of power.”

Discourse thus “defines and produces the objects of our knowledge. It governs the way that a topic can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others” (Hall, 2001:72), and it does this by virtue of being “designed to be persuasive, to win hearts and minds” (Wetherell, 2001:17), thus convincing us to make them part of who we are. “[I]n this sense discourse is not a question of meaning or of method but a description of function” (Gore, 1993:1-2) and discourses and practices function to construct certain subjectivities (Lupton, 1995). For instance, discourses of public health and health promotion construct subjects as fit/unfit, good/bad, moral/morally, etc. In this sense, subjects “emerge through and within discursive power” (Søndergaard, 2002:189) and are “realized in the material practices of everyday life which are also discursive practices” (Weedon, 1997:175). In the practice of forming and constituting the objects and subjects of which they speak, discourses also function to conceal this very practice. However, individuals’ choices in language points to the discourses drawn on and also to the positions accorded to themselves and others (Wright, 2006).

Thus, not only has the “shift toward a constructionist conception of language and representation [done] a great deal to displace the subject from a privileged position in relation to [discourse, power,] knowledge and meaning” (Hall, 2001:79) but these have come to be conceived to produce the subject. The subject “must submit to its [the discourse’s] rules and conventions, to its dispositions of power/knowledge. The subject can become the bearer of the kind of knowledge which discourse produces. It can become the object through which power is relayed. But it cannot stand outside power/knowledge as its source and author” (Hall, 2001:79-80).

From this perspective, the notion of a coherent and fixed subject with an unchanging ‘identity’ or a ‘core’ is inconceivable. Rather, notions of ‘identity’ are regarded as “discursively produced, [politically] necessary but always contingent and strategic” (Weedon, 1997:176). Consequently, subjects are expected to be contradictory and paradoxical due to being constituted continually through simultaneously available multiple and contradictory discourses constituting multiple subjectivities. Thus, the subject comes to be perceived as a verb, meaning that the subject is always in process, always ‘becoming’, rather than as a noun, meaning stable and relatively fixed (Davies, 2000).

Conceiving of the subject and of the availability of multiple discourses in this manner also enables for attributing the subject with agency: “The
possibility of choice in a situation in which there are contradictory requirements
provides people with the possibility of acting agentically” (Davies & Harré,
2001:270), and “in feminist appropriations of Foucault, Derrida and
Kristeva... agency is seen as discursively produced in the social interactions
between [these] culturally produced, contradictory subjects” (Weedon,
1997:176). Thus, even though poststructuralist theory recognizes the
constitutive force of discourse and discursive practices, it also “recognizes that
people are capable of exercising choice in relation to those practices.” (Davies &
Harré, 2001:262):

The individual subject thinks and acts from within the culturally and
socially construed and given meanings which are formed in discourses and
practices. The subject is produced/constituted by discursive meanings but also
produces her/himself through them; by drawing on them, resisting them and
reconstituting their meaning, individually as well as collectively. (Lenz
Taguchi, 2004:83, translated from Swedish)

These choices regarding what discourses to draw on, resist or reconstitute
are, however, limited by the discourses that are available to the subject at the
specific time and place. Furthermore, as mentioned above, the power of the
discourse is seductive and is such that it not only forces us to be and behave in
specific ways but even make specific ways of being and behaving so attractive
and desirable as to make us actively strive toward them and make them a part of
who we are: “It [power] is a set of actions on possible actions; it incites, it
induces, it makes easier or more difficult; it releases or contrives,
more probable or less; in the extreme, it constrains or forbids absolutely,
but it is always a way of acting upon one or more acting subjects by virtue of
their action or being capable of action” (Foucault, 1982/2003:138). “Agency,
then, does not entail an escape from power but a specific exercise of it”
(Edwards & Nicoll, 2004:162). For instance, resistance to a discourse or
discursive position by invoking another discourse or by positioning oneself in
unexpected ways in relation to a discourse are examples of ways of exercising
agency. An example of such resistance would be if a patient in a doctor’s office,
in response to the doctor’s recommendation that the patient take anti-
depressants, the patient suggests instead that maybe what is needed is healing
(e.g. reiki healing). In this case, the patient is resisting both the position of a
submissive patient and the medical discourse of prescription medication by
instead drawing on a discourse of alternative health.

Thus, I do not mean to say that the educators and participants of the
present study in any essential sort of way are the way they may appear or are
described in this study. Rather, their acting represents the various discourses
that they at the given point of time and space have been invited and/or chosen
(consciously or unconsciously) to draw on. In this study, agency is perceived as the possibility and imperative for subjects to (consciously or unconsciously) choose between discourses and subject-positions which in turn enables for different ways of thinking, feeling and acting, i.e. choice. Furthermore, post-structuralism and the notion of discourse as presented here allows me to ask other questions to my data than whether my informants are telling the ‘truth’ or are being ‘objective’ or ‘neutral’. Instead of focusing on “the real nature of events, people’s real experiences, their views about what is going on” (Wetherell, 2001:16), it allows me to ask questions about how reality is construed and what this reality is like, “how truths emerge, how social realities and identities are built and the consequences of these” (Wetherell, 2001:16). Instead, I can concentrate on questions such as what discourses about health that educators and participants draw on in workplace health interventions and what their functions and social effects may be in terms of the subjectivities they produce.

The body and bio-power

Conceptions about health also shape how it is possible to think about the body (Foucault, 1975/2003) and vice versa. The privileged subject of contemporary times is characterized by a mind/body dualism, separating body and mind and constructing the mind as “transcendent over the body, ideally having the power to control the urges and emotions of the potentially recalcitrant flesh” (Lupton, 1995:7). This construction has served to render the body invisible in research and feminists “have tended to remain wary of any attempts to link women’s subjectivities and social positions to the specificities of their bodies” (Grosz, 1994:x). However, that feminists have been reluctant to focus more on issues of the body is hardly surprising, says Grosz, given the idealistic (in humanism) or materialistic (in natural and social sciences) conceptions of the body on which “unreflective presumptions regarding the sexes and their different social, sexual, and biological roles” (Grosz, 1994:x) are projected. Despite such reservations and concerns, however, feminists came to draw on social constructionist theories to ‘bring the body back in’ in order to reject and critique the binary opposition created between body and mind, meaning that there is a feminist critique concerned with the invisibility of the corporeal in notions of subjects and subjectivities (see e.g. Bordo, 2003). There is also a sociological critique from which an entire field concerned with the sociology of the body has sprung (see e.g. Featherstone, Hepworth, & Turner, 1991; Shilling, 2003). Second wave feminism helped put the body on the political agenda as well as in research: “feminist analyses of women’s oppression brought the body into academic conceptualizations of patriarchy” and “systems of domination and subordination” (Shilling, 2003:28). However, “[i]n the face of social constructionism, the body’s tangibility, its matter, its (quasi) nature may be
invoked; but in opposition to essentialism, biologism, and naturalism, it is the body as cultural product that must be stressed” (Grosz, 1994:23-24).

According to Foucault, power relations can penetrate the body materially and after Foucault the body has become recognized as the site of power struggles and the site of the realization of power: “For Foucault, power does not exist independently of the body, is not external to the self, but acts to construct the body in certain ways” (Lupton, 1995:5). This exercise of power in and through the body Foucault has termed ‘bio-power’ (Foucault, 1976/1990) thus offering an approach to analyzing how power works in relation to the human body.

However, Grosz (1994) is critical of the ‘neutrality’ of Foucault’s notion of the body (which apparently, she says, is a male and not, as is suggested in his writings, a neutral body) because it underscores the binary of body and mind in which the body is that which must be changed, altered, bettered and which is associated with the feminine. Grosz says that:

> in feminist terms at least, it is problematic to see the body as a bland, passive page, a neutral ‘medium’ or signifier for the inscription of a text. If the writing or inscription metaphor is to be of any use for feminism – and I believe it can be extremely useful – the specific modes of materiality of the ‘page/body must be taken into account: one and the same message, inscribed on a male or a female body, does not always or even usually mean the same thing or result in the same text. (Grosz, 1994:156)

What Grosz is arguing for here is thus that a gender perspective be drawn on when discussing how discourses construct bodies (and subjects). Even though Foucault in his analysis of for instance punishment may be blind to, or at least ignores, the difference in the kinds of treatment women and men receive, Grosz (1994) concedes that his analytical tools may well be used to investigate these things provided one takes on a gender perspective in the analysis and perceive of gender as constructed in power relations. Thus, I turn to Foucault’s notion of bio-power in order to further be able to understand the mechanisms of how power works in relation to the body, of how it produces, regulates and represents bodies, of how the material body is produced in and productive of social and power relations.

The body has not always been conceived in the manner in which it is today: the body was not focused upon as an individual entity (rather than as a collective entity – a population) until the seventeenth century (Foucault, 1984/1991). From a social constructionist approach, this was when the

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10 Besides Grosz, see also Butler (1990/1999) for further critique of this binary construction.
individual body was ‘invented’ (Gastaldo, 1997). In his book The Birth of the Clinic, Foucault (1975/2003) shows how a specific discourse about the body, heavily influenced by a medical perception of it, grew during the 19th century, and how this discourse shaped the way that the body was seen, described and acted upon, objectifying the body and subjecting it to new techniques of power. Foucault’s notion of ‘bio-power’ has created a way “to understand ourselves as living beings whose very vitality, longevity, morbidity, and mortality can be managed, administered, reformed, improved, transformed, and has a political value” (Rabinow & Rose, 2003:xii). Bio-power is a “modern form of regulation of the bodies of individuals and groups” (Grosz, 1994:153) that regulates “the minute details of daily life and behavior in both individuals and populations” (Grosz, 1994:152) and that “characteristically entails a relation between ‘letting die’ (laissez mourir) and making live (faire vivre)—that is to say strategies for the governing of life” (Rabinow & Rose, 2006:195). However, bio-power is not “a general system of domination of a group that permeates the whole social body. It is also not a set of mechanisms that guarantee control of citizens by the state ... Rather, bio-power is a subtle, constant and ubiquitous power over life. It is exercised through a set of power techniques, but two basic forms can be identified as the poles of this ‘line of power’. In Foucault’s terminology, they are the ‘bio-politics of the population’ and the ‘anatomo-politics of the human body” (Gastaldo, 1997:115).

Bio-politics, also referred to as the ‘macro’ or ‘molar’ pole (see Rabinow & Rose, 2006), is concerned with the population; with body politics and the disciplining of populations/bodies by employing regulatory controls and interventions (Foucault, 1976/1990). There are both more visible and more invisible power techniques for this kind of regulation. An example of an invisible technique may be “the expansion of the domain of the health system into private life, [which serves] to establish what is considered normal and pathological” (Gastaldo, 1997:116), i.e. medicalization. Thus, bio-politics in this study refers to the medicalization going on in the interventions studied and the normative practices that aims to produce behavior changes.

Anatomo-politics, also referred to as the ‘micro’ or ‘molecular’ pole (see Rabinow & Rose, 2006), is concerned with constituting the individual body in medical encounters between individuals (Foucault, 1976/1990). Anatomo-politics “focuses on the body as a machine … Focusing on individual bodies or on the social body, health professionals are entitled by scientific knowledge/power to examine, interview and prescribe ‘healthy’ lifestyles. The clinical gaze is omnipresent and acceptable because its objective is to promote health” (Gastaldo, 1997:116). Anatomo-politics thus refers to the management of individual bodies.

However, these two ‘poles of power’ should not be conceived as operating separately from each other. Rabinow and Rose (2006:204) suggest that
although the macro pole may have been privileged before, today the macro and micro are more closely related to each other.

According to Gastaldo (1997), health education contributes “to the exercise of bio-power because it deals with norms of healthy behaviours and promotes discipline for the achievement of good health”. Health education and workplace health promotion (WHP) are not only concerned with training and shaping minds but is also very concerned with schooling bodies; to manage and discipline bodies, e.g. concerning the acquisition of specific dispositions, tastes and abilities such as, in the case of the studied WHP interventions, being inclined to do physical activity and having a taste for and knowledge about healthy food. As such, health education plays “an increasingly important role in the exercise of ‘bio-power’ through its association with illness prevention and health promotion” (Bunton & Petersen, 1997:5). WHP may be conceived as a site “in which experiments about how to produce and regulate ways of maximizing the capacities of both the population [workforce] and the individual as a target of power” is being carried out (Rabinow & Rose, 2006:199). From this perspective, health education, including WHP, may be conceived as a site for cultural (re)production of bodies in specific ways and the question that arises is: how are bodies (subjects/subjectivities) produced, regulated and represented in these contexts?

Governmentality:
Governing subjects toward health

Out of this notion of bio-power and as an instrument through which to analyze the production, regulation and representation of bodies and subjects Foucault developed his concept of governmentality (Rabinow & Rose, 2006). From a perspective of governmentality, power relations are perceived “as diffuse, as emerging not necessarily from the state but from all areas of social life” (Lupton, 1995:9). As I understand it, and in relation to my study, governmentality is a perspective on power for the purpose of shedding light on how subjects become subjects. It is “a framework for thinking about the linkages between questions of government, authority and politics, and questions of identity, self and person” (Dean, 1999:13). It “incorporates an analysis of both the coercive and the non-coercive strategies” and it “provides a means of understanding the social and political role of public health and health promotion discourses and practices” (Lupton, 1995:9). In health promotion, the issue is often about how the subject/s should choose or how to guide the subject/s to choose. However, as Coveney (1998) points out, how the choosing subject is produced is left unproblematized but with Foucault “we can see health promotion as a form of government which is productive in the sense that it produces modern subjects: it defines empirically what it is to be healthy (in
ever expanding ways) and it 'supervises' the proper routes to health through a
discipline which establishes for us a rapport de soi [meaning ethics for self-
regulation]" (Coveney, 1998:462, emphasis in original). Governmentality is
concerned with the shaping, guiding or direction (the governing) of conduct,
i.e. with the constitution of the self (Foucault, 1988), including bodily practices
(Lupton, 1995), i.e. the exercise of bio-power. However, this shaping, guiding
or direction is not perceived as being about domination or manipulation but
rather about recognizing individuals’ capacities for action and adjustment. “To
govern is to act upon action. … To govern humans is not to crush their
capacity to act, but to acknowledge it and to utilize it for one’s own objectives”
(Rose, 1999:4), and, in this manner, “structure the possible field of action of
others” (Foucault, 1983:221 quoted in Gore, 1993:52). According to Rose
(1999:21), “[g]overning … is neither a concept nor a theory, but a perspective.”
From this perspective, attention is drawn to the multitude of ways in which
conduct is governed (Rose, 1999).

As government is about disposing, arranging things in a specific way so as to
achieve certain ends (Foucault, 1978/2003), the analysis of “mentalities of
government is to analyse thought made practical and technical” (Dean,
1999:18), i.e. to analyze “what authorities of various sorts wanted to happen, in
relation to problems defined how, in pursuit of what objectives, through what
strategies and techniques” (Rose, 1999:20). Educational situations or meetings,
such as schools (Davies, 2000; Foucault, 1978/2003; Rose, 1999) as well as
practices of public health and health promotion (Lupton, 1995) or, more
specifically to this case, workplace health promotion, are examples of sites of
technologies for the government of capacities and habits and as such lend
themselves very well to an analytics of government. For instance, the point of
public health and (workplace) health promotion is to shape and normalize
human behavior in specific ways: “Public health and health promotion may …
be viewed as contributing to the moral regulation of society, focusing as they do
upon ethical and moral practices of the self” (Lupton, 1995:4). As such, health
education may be conceived of as a governmental apparatus:

While the institutions of public health and health promotion [or WHP] often
display very overt signs of the state's [employers'] attempts to shape the
behaviour of its citizens [employees], where this attempt at control becomes
invisible is in the justification used. In the interests of health, one is largely
self-policing and no force is necessary. Individuals are rarely incarcerated or
fined for their failure to conform; however they are punished through the
mechanisms of self-surveillance, evoking feelings of guilt, anxiety and
repulsion toward the self, as well as the admonitions of their nearest and
dearest for 'letting themselves go' or inviting illness. Therefore it is not the
ways in which such discourses and practices seek overtly to constrain
individuals’ freedom of action that are the most interesting and important to examine, but the ways in which they invite individuals voluntarily to conform to their objectives, to discipline themselves, to turn the gaze upon themselves in the interests of their health (Lupton, 1995:10-11).

Thus, “[w]herever the learning takes place … individual learners are required to bring forth their subjectivities for disciplining, to become a particular type of person” (Edwards & Nicoll, 2004:163). Drawing on this notion of governmentality, my interest in this study lies with the ‘voluntary’ participation (Lupton, 1999) by the participants in a project concerned with their improved health, and the regulating consequences of the health discourses drawn on in the studied workplace health promotion interventions.

What the perspective of governmentality does, then, is to point to where to look for and investigate relations of power-knowledge. But how is an analytics of governmentality to be performed? Dean (1999:4) points out that “[t]here is no one governmentality paradigm. There is no one common way of using the intellectual tools being produced by workers in this area”. However, Foucault (1988) describes four different aspects of governmentality: technologies of production; technologies of sign systems; technologies of power, and; technologies of the self. Of these four, he mainly concerns himself with the two latter aspects. Technologies of power, also referred to as ‘disciplinary power’, are concerned with the governing of others, while technologies of the self, also referred to as ‘ethics of the self’, are concerned with the governing of the self. Below, I will describe these in more detail, together with ideas on how I intend to use these ‘tools’.

Technologies of power
Technologies of power determine conduct and submit individuals to domination. In Discipline and Punish, Foucault (1977/1995) gives the examples of normalization, surveillance, classification, hierarchization, distribution of rank, individualization and examination as instruments of power. Partly these instruments seem to fold into each other. For example, Foucault describes examination as consisting of a normalizing gaze and surveillance which both serve to differentiate and judge individuals. Thus, it would be a mistake to think of these techniques as completely separate from each other. Instead, they should be understood as weaving into one another.

From a close reading of Foucault’s Discipline and Punish, Gore (1998) developed coding categories for different types of technologies of power with which to analyze her data. The categories or technologies of power that she identified were surveillance, normalization, exclusion, classification, distribution, individualization, totalization, and regulation. Gore (1998:234) found that "the techniques of power that Foucault elaborated in prisons [were]
applicable to contemporary pedagogical practice”, regardless of site (her study was of four different sites of adult education). Thus, I have made use of these categories too, using them as tools in my own analysis. In a later paper, Gore (2002:4) developed her thoughts on these categories further in an outline to a general theory of power relations in pedagogy and it is from this paper, together with an article by Wright (2000), that I have put together the following description of these technologies of power:

<table>
<thead>
<tr>
<th>Classification</th>
<th>Differentiating individuals and/or groups from one another, divides the world into groups and linking particular ways of being and behaving with a specific group, use of binaries (good/bad, strong/weak) or attributive statements of how/what something is like</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribution</td>
<td>Dividing into parts, arranging, ranking bodies in space</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Tracing the limits that will define difference, boundary, zone, defining the pathological, something is explained in terms of problems (opposite of normalizing)</td>
</tr>
<tr>
<td>Individualization</td>
<td>Giving individual character to, specifying an individual</td>
</tr>
<tr>
<td>Normalization</td>
<td>Invoking, requiring, setting or conforming to a standard, defining the normal, suggests the correct and proper way of doing something, often in comparison to another way of being and acting, includes statements such as ‘usually’, ‘normally’, ‘the best/better/right way’ of being or performing an action</td>
</tr>
<tr>
<td>Regulation</td>
<td>Controlling by rule, subject to restrictions; adapt to requirements; act of invoking a rule, including sanction, reward, punishment; statements including ‘must’, ‘should’, ‘need to’, ‘have to’</td>
</tr>
<tr>
<td>Surveillance</td>
<td>Supervising, closely observing, watching, threatening to watch, avoiding being watched, including evaluative statements and statements such as ‘I’m watching you’, or ‘let’s see’</td>
</tr>
<tr>
<td>Totalisation</td>
<td>Giving collective character to, specifying a collectivity/total, will to conform</td>
</tr>
</tbody>
</table>

Table 3, Technologies of power

I have made use of these categories as tools for identifying instances where technologies of power have operated. According to Gore (1998), none of the educational sites that she studied ‘escaped’ the use of techniques of power. On this basis, it becomes interesting in this study to investigate whether these techniques are used also in health education. As mentioned previously,
“[d]isciplinary techniques may be embodied in an external regime of structured times, spaces, gazes and hierarchies. But discipline seeks to reshape the ways in which each individual, at some future point, will conduct him- or herself in a space of regulated freedom” (Rose, 1999:22). Disciplinary techniques thus seek to produce practices of self-government, which takes us to Foucault’s notion of technologies of the self.

Technologies of the self

Through his first 25 years of historical inquiry, Foucault concerned himself with techniques of power and domination and during the last years before his death his interest turned toward the self, toward how “a human being turns him- or herself into a subject” (Foucault, quoted in Martin, Gutman, & Hutton, 1988:3; see also Foucault, 1988). The tool for analysis of this type of self-government Foucault (1988) called ‘technologies of the self’. Technologies of the self ‘permits’ individuals to effect “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” (Foucault, 1988:18). Technologies of the self, Foucault says, is something one does to/with oneself, possibly with the help of others. However, “[t]he technologies or practices of self are, of course, not something that individuals invent in any original sense. Rather, they are patterns found in culture which are proposed, suggested, and imposed upon individuals by their culture, their society, and their social group” (Gore, 1993:53). As the governed are free actors, they may behave ‘unpredictably’, and practices of the self can also be a “means of resistance to other forms of government” (Dean, 1999:13).

Some of the techniques of the self that Foucault (1988) describes are, as I have tried to summarize them, self-disclosure, self-examination and self-mastery. These may be described as follows (adapted from Foucault, 1988):

<table>
<thead>
<tr>
<th>Self-disclosure</th>
<th>Introspection and publicizing one’s findings, confessing.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Descriptive</td>
</tr>
<tr>
<td>Self-examination</td>
<td>Taking stock, reviewing what’s done, what should have been done, comparing these. Evaluative and not necessarily publicized</td>
</tr>
<tr>
<td>Self-mastery</td>
<td>Acceptance and acknowledgement of ‘truths’ and converting ‘truths’ to rules of conduct for oneself</td>
</tr>
</tbody>
</table>

Table 4, Technologies of the self

Technologies of self-disclosure are about introspection and to publicize one’s findings – a sort of confession but descriptive rather than evaluative. Technologies of self-examination are concerned with taking stock and include “a review of what was done, of what should have been done, and comparison of
the two” (Foucault, 1988:35). Results of one’s self-examination are not necessarily publicized, nor is the act of doing it. Self-mastery concerns an acceptance and acknowledgement of the ‘truth’ of teachings (for instance about what is healthy or not) and a conversion of these ‘truths’ into rules of conduct for oneself; a subjectivization of ‘truth’. As with the technologies of power, these technologies also fold into one another with no definitive lines between them.

I have made use of these categories as tools for identifying instances where technologies of the self have been employed. My aim has then been to explore the ways in which the participants monitored and managed themselves and the means by which the educators invited the participants to work on themselves; to assess and act on themselves.

**Specified aim**

With an analytical focus on processes of governmentality, this study is concerned with issues of the discursive production, regulation and representation of power, knowledge and subjects in workplace health promotion interventions as these come to be expressed in the interaction between educators and participants. These issues will be investigated by asking the following questions:

1. What health discourses do educators and participants engage with?
2. By what technologies of power are the participants’ conduct governed?
3. By what technologies of the self are the participants invited to govern themselves?
4. How do these practices intersect and contribute to the reproduction of gender?
CHAPTER 3, 
EXPLORING WORKPLACE HEALTH PROMOTION

The purpose of this chapter is to outline the practical decisions taken regarding data collection and data analysis. The methods of data collection and analysis are, as indicated in the previous chapter, informed by post-structural theories on discourse and subject formation which have in turn informed my research questions. In my research questions, I place the focus of attention on the interaction between the educators and the participants. The focus on interaction is motivated by the conception that subjects are constituted (as gendered, healthy, etc) and governed through and in their experience and social interaction (as explored and described in the previous chapter on theory). Social interaction and subjectification are here conceived as processes taking place across both time and space, processes which are informed by the context in which they take place. Thus, how health (for instance) is defined, discussed, negotiated and promoted determines how it comes to subjectify individuals to specific ways of being and behaving. In order to be able to study contextualized social interaction across time and space I turned to ethnography, which “is probably the only methodology that is able to take into account the multifaceted ways in which subjects are produced through the historical categories and context in which they are placed and which they precariously inhabit” (Skeggs, 2002:433).

There are different notions of what constitutes ‘ethnography’ (compare e.g. Fetterman, 1989 and Skeggs, 2002) and how ethnographies are finally shaped is in the end decided by the theoretical position of the researcher and the subsequent questions asked, as well as the researcher’s disciplinary location and political aims (Skeggs, 2002). Skeggs defines ethnography in general terms as “a theory of the research process – an idea about how we should do research” (2002:426). She goes on to specify this general definition by describing commonly combined features in ethnography:

It usually combines certain features in specific ways: fieldwork that will be conducted over a prolonged period of time; utilizing different research techniques; conducted within the settings of the participants, with an understanding of how the context informs the action; involving the researcher in participation and observation; involving an account of the development of relationships between the researcher and the researched and
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focusing on how experience and practice are part of wider processes. (Skeggs, 2002:426, emphasis in original)

In relation to these features, my own fieldwork took place in the contexts of four different workplace health promotion (WHP) interventions. During this fieldwork, the different research techniques I used were to do participant observations which I supplemented with interviews and various documents from the interventions. The purpose of the remainder of this chapter is to elaborate on the procedure for selection of and access to the interventions as well as the processes of data collection and analysis. Finishing this chapter, I give a brief comparative description of the interventions studied. But first, let me say a few words about my position as a researcher, working in the field.

Thoughts on the researcher’s position

Turning a reflexive gaze at one’s work, position and the discourses informing these, risk being conceived of as an attempt at ‘better’ objectivity, or reflexivity can be regarded as a form of confession and a hope for absolution (Pillow, 2003:186). However, for the sake of clarity and transparency regarding the possible consequences of my position and preconceptions as these may be expected to have influenced the research, reflecting over and reporting on one’s position in relation to the discourses investigated is conceived as essential to maintaining “the theoretical consistency of discourse analysis” (Winther Jørgensen & Phillips, 2000:29) and is as such my motivation for doing so here. This section offers some general reflections on ethics while most of my reflexive work is done throughout the rest of the chapter. For instance, as a researcher, I became the main producer of knowledge since it was I who decided which problem(s) to study, which data was most useful, which type of analysis was the most reasonable and what conclusions could be made from this work (Widding, 2006). The various positions and approaches I took in relation to what I researched partly determined what I was able to see and what I came to present as the results of my research. For instance, having completed undergraduate studies in health education, I came as a researcher in the field of WHP with an investment in health discourses. I was therefore to some extent part of the culture I was studying, at least in the sense that I shared some of the same for granted taken assumptions that I was trying to uncover. This could be expected to make it more difficult for me to uncover the sought after discourses and their effects. This was dealt with by extensively reading and re-reading the data as well as related research literature until I could somewhat distance myself from my own investment in the discourses enough to be able to ‘see’ them.

Considering the ethical aspects is important in all research, especially when people are involved as ‘informants’ (RESPECT, 2004; Vetenskapsrådet). By
reflecting on my position and approach to the observations and interviews I have also been forced to consider whether my research can be considered to stand up to the ethical aspects of research. For example, due to some of the explicitness in details or specificities in some quoted comments or episodes, it cannot be disregarded that some people may be able to recognize themselves in the text and in so doing, may also recognize some of the other people described or referred to in a specific example; they may also not agree with my interpretations. As Widerberg (2002:176) puts it:

First of all, it is nearly impossible to avoid that the person in question recognizes her/himself. Secondly, having one's statements scrutinized, examined and categorized in terms of contradictory discourses or discourse positions may be upsetting. Thirdly, the interpretations may not at all concur with the [informant's] own perception.

As far as possible I have sought to protect the individuals involved in the study and their workplaces by not using the names of the interventions, the workplaces or the city in which they were located, and by changing the names of the people in the interventions to fictitious names. In my research, my ambition has always been to meet and treat the subjects of my research with respect and compassion.

The influence on this study of my position as a researcher and of my preconceptions does not end with these comments but stretches out over the entire process. Although it is impossible to consider all of the ways in which one’s position and preconceptions have influenced one’s research, I continue this reflexive work in the ensuing descriptions below of the empirical material and the analysis procedure, beginning with how I went about selecting workplace health interventions to study.

Selecting workplace health promotion interventions

Regarding ethnographic work, Delamont (1992) says that “[w]hat is crucial about sampling is honesty and reflexivity. The most important things are to record how the sample was drawn, and to think carefully about how the selection/recruitment has affected the data collected from them” (Delamont, 1992:70). I'll start by describing my thoughts on what type of WHP I was looking for, then move on to a discussion about my thoughts on how this selection has affected the type of data collected.

The scope of my search for interventions to include in my study was shaped by the discourses available to me and my knowledge about health education interventions/workplace health promotion at the time. These discourses and
this knowledge decided what it was possible for me to think of as likely and appropriate candidates for my research. As discussed earlier (in the Introduction) there is no fixed consensus on what workplace health promotion is. Thus, in order to locate suitable interventions and to make a purposeful selection, I needed to state a clear set of criteria that I wanted the interventions to meet. These were the criteria I decided on:

1. Since I was interested in the interaction between educators and participants, it was important to me that the interventions were based on a meeting between educators and participants (thus excluding interventions of a mere informational style, such as posters on billboards or e-mails).

2. Because I was interested in the social effects of educators’ and participants’ engagements with various discourses about health it was important that the intervention spanned over some time, preferably several sessions, allowing for more opportunities for engagement in diverse ways with various health discourses.

3. To somewhat limit the scope of interventions, I focused on interventions concerned with the issues of diet and physical activity (they may also include other issues or subjects such as stress, but diet and physical activity were absolute preconditions). I decided on these activities because of my interest in imperatives concerned with the conscious shaping of bodies, and diet and physical activity are intimately related to such management.

In finding and selecting interventions for this study I turned to my network of connections in the field of health work to search for possible interventions (network sampling, see Merriam, 1994). The interventions I was to study had to be implemented during the fall of 2003 and/or the spring of 2004, which of course posed a limitation on what interventions I could include in the study. Through my networks I was able to locate and gain access to two interventions. I received an unsolicited invitation to participate in another intervention and so was able to locate and gain access to a third intervention (opportunity sampling, see Delamont, 1992). I found the final intervention by calling around to different Corporate Health Services asking about health projects that they offered to their clients. This method could probably not be categorized as either network or opportunity sampling, unless you would agree to regard creating an opportunity as part of an opportunity sampling method.

By these methods of sampling I thus ended up with four workplace health promotion projects. Because I found most of the interventions through my own contacts it was uncomplicated to gain permission from the commissioners and

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11 By ‘commissioner’ I mean the person in the corporation who commissioned the intervention in
educators to participate and to include the interventions as part of my study. The educators who didn’t know me beforehand accepted me because of my contact with the commissioner and (all but one) even welcomed me because they found my research project intriguing and important. And because the educators accepted and welcomed me, I was easily accepted by the participants as well. In one of the interventions, however, my participation in the intervention was quite unknown to most of the participants. This was due to the large number of participants in that particular intervention (900 employees). In that case, I let it suffice to ask permission of the human resources manager, the corporate health team, the educator and the participants that I interviewed or came in contact with in other ways.

Being well received by most allowed for a relaxed atmosphere despite my role and position as a researcher. Although I was introduced to the participants by the educators and perhaps aided by my conscious efforts to be so, I was soon perceived as ‘one of the gang’, meaning one of the participants and even at times as an ally against the educators, rather than as an outsider/stranger or educator (controller). Gaining the participants’ trust also facilitated my building rapport with them. The generated data reflects this relationship that I had with educators and participants alike, as it also includes participants’ occasional comments about the educators, just as the data from the educators includes their comments about the participants. I was thus perceived by the educators as one of their ‘gang’, and by the participants as one of their ‘gang’, as I will discuss more below.

Empirical material

The empirical material resulting from ethnographic fieldwork is generally varied and extensive, as is the case in this study (see table 4 below for a summary). In accordance with the notion touched on above of situated and contextually specific knowledge, the empirical material should be conceived as “contextually grounded and jointly constructed” between me, the educators and the participants (Fontana & Frey, 2000:663). As such, the data generated here should be understood, not as ‘true reflections’ of ‘reality’ but rather as the result of the specific context and relations as well as my interpretation of actions and events at the moment I recorded them, i.e. as further constructions of meaning and preliminary first analyses. In the following, I describe the materials and discuss the processes of generating these in more detail, the processes being participant observation, interviews and gathering of documentations. Of these, the observations may be described as my main source of data, through which I
was able to observe and record the actual interactions between the educators and the participants. The interviews and documentations may be described as supplementary to these observations, offering opportunities to both widen and deepen my understanding of the interaction in the interventions and the social consequences of this interaction, and thus provide me with a stronger basis for analysis of the discourses, technologies och constructions of gender that were made available and drawn on in the interventions.

Participant observations
My main means of generating data was, as mentioned, through participant observation which enabled me to see and record the interaction between educators and participants. Some of the advantages of using participant observations, besides giving me access to the interaction between educators and WHP participants, was that it gave me access to informal information and to what Ambjörnsson describes as (2003:40-41) “sensitive and fleeting information that characterize questions about gender /…/ [and] difficult to grasp processes of normalization”. Although participant observations are readily used in educational research in schools (see e.g. Forsberg, 2002; Gustafson, 2006), the same method is rarely used in research on WHP (although, see Zoller, 2003, 2004), and I have been unable to find research in which participant observation in WHP has been used to interrogate the educational aspects of interventions. In light of this, my use of participant observations in this study and the particular knowledge thus generated is one of the scientific contributions of this work.

It may seem unnecessary to point out that my observations were participatory since, according to Angrosino and Mays de Pérez (2000), there is no non-participant observation because the presence of a researcher always has bearing on the observed interaction. However, by ‘participant observation’ I refer to my active participation in the interventions, in activities and conversations, rather than standing off to the side as a passive observer, taking notes all of the time.

My participation was not undertaken in order to make my own experiences of participating in an intervention part of my research, part of my data, but rather as a strategy to get closer to both educators and participants and, if possible, be perceived as ‘one of the gang’ and to avoid being perceived as an ‘other’, an outsider. However, although I strove to be as active as possible in my participation, I was inevitably more of a ‘witness’ (Pillow, 2003) than an active participant, due to being busy taking field notes which inevitably put me apart from the rest of the intervention participants (I was able to tape-record the sessions for two of the interventions, which then freed me up a little to make notes of other things that went on in the room. In the other two interventions I could only take field notes). This was the most obvious difference between me
and the rest of the participants, the difference that constantly revealed and reinforced my position as ‘the researcher/observer’.

Because I had the notebook with me all the time, it earned many a comment. Although the comments were in good humor, it cannot be excluded that it might to some degree have been due to it generating some discomfort and/or self-consciousness on the part of the intervention participants. This may well be expected to have influenced how educators and participants talked and acted with and around me. I'll give an example: At one occasion, early on in my participation in one of the interventions, I sat in the gym with my notebook, waiting for everyone to come in to begin the class, meanwhile taking notes about the room we were in. Participants entered, deep in a discussion that took an abrupt end as they saw me sitting there taking notes. They commented on my note-taking, asking if I was writing down everything they were saying. I was glad to be able to say, at that time, that I was only taking notes about the environment, which seemed to soothe them because they picked up their discussion again.

In order to offset reactions such as this and to help the participants feel more at ease with my note-taking, whenever participants and educators asked what I was writing or glanced over my shoulder to look at my notes, as sometimes happened, I made a point of not making a big deal of it. I thought that not being protective of my notes may have served to appease any anxieties they might be experiencing and thus I let them look or, because my handwriting is pretty much unintelligible to anyone but me, at times I described what I had written. This seemed to have the desired effect: people would nod, say “Uhu”, and then continue on with whatever they were doing. Also, the tension that I experienced at the beginning of the interventions eased off as time went by and the participants became used to, and perhaps comfortable with, me and my note-taking. Once, my note-taking was even used in a disagreement about something that had been said, as they asked me to refer to my notes to find out what had actually been said.

Besides participating and observing during intervention sessions, where I was able, I also observed during educators’ meetings and Health Profile Assessment consultations (see table 4 and 5 below for details).

Interviews
Besides observations, I did more ‘formal’ interviews (as opposed to the more informal conversations we had during the interventions) with both educators and participants, both in groups and individually. Each interview lasted between half an hour to three hours. All but two interviews were tape-recorded. The interviews where I was not allowed to tape-record the lectures, I was also not allowed to tape-record the interviews with the educators. The reasons they
gave were confidentiality – either for the protection of the participants or for the protection of business secrets.

All interviews were made after the interventions were finished, except one interview with one of the educators that for practical reasons took place between sessions. Although my initial reason for doing the loosely structured interviews with the educators was to gain more contextual information about the background of the educators as well as the interventions, I found that I was able to use the material from these interviews also to analyze the discourses that the educators drew on.

As I wanted a chance to grasp the participants’ uptake of the discourses drawn on in the interventions, I chose to do group interviews with them after the interventions were over (except for one intervention in which I did the interview between sessions due to practical reasons). Although as a participant observer I was among the participants during the interventions I chose also to interview them at the end of the interventions because I wanted to see what notions and imperatives about health had stayed with the participants post-intervention, as well as how the participants had come to draw on them. To achieve this, my questions to the participants were primarily concerned with asking them to talk about their notions of health in relation to diet, physical activity and gender.

The participants were chosen for interviewing on the basis that they wanted to participate, which meant that I asked for volunteers. Agreeing to do an interview with a researcher may have been somewhat daunting and intimidating so to make the interview situation more comfortable to the participants, I conducted the interviews in groups (of three), so that participants could feel that they had each other for support. Fontala and Frey (2000:652) suggest that group interviews may also offer the advantage of being stimulating for the participants, aiding recall, being flexible and producing “rich data that are cumulative and elaborative”. For the majority of the interviews, the volunteer interviewees knew each other. Either they had become friends during the intervention or they were friends already from before. This was likely to further aid in their ease and comfort during the interview. However, in a couple of instances, an interviewee in a group might best be described as acquainted with the others in the group. Although these interviewees seemed to position themselves/came to be positioned in opposition to the rest of the group, this did, however, not seem to make them any less talkative during the interview. The opposing ‘sides’ thus constituted did rather add depth to the material as the dividing line, or object of contest, came to be centered on the issue of what constituted a healthy lifestyle and who conceived of themselves as ‘good’ at it or not.

In total, I interviewed eight educators, variously individually and in groups, depending on how many educators were involved in each intervention: a total
of four interviews. I also interviewed a total of fifteen participants in group interviews (due to practical reasons, one interview came to be an individual interview), three participants from each intervention except for one intervention from which I interviewed six participants (in two groups – one group of women and one group of men): a total of six interviews. Besides these interviews, I also did ‘introductory’ interviews with the commissioners in two of the interventions to familiarize myself with the interventions beforehand. In one intervention I also did an ‘ad hoc’ interview with one of the consultants (see table 4 below).

Documents

Finally, I also collected documents pertaining to the interventions as they became available to me. These could be schedules, books, assignments, questionnaires, etc. I was interested in and collected any and all documents that were related to the interventions and that I could get access to. Thus, I also sought out, where available, documentations about participants’ Health Profile Assessments (with the approval of the participants), documentations of the planning and evaluations of interventions, advertisements of interventions, documentation clippings about the interventions from personnel magazines and more. I was thus rather non-discriminatory in my selection of which documents to include in the study, thinking that as long as the text was, in one way or another, related to and/or produced because of the specific intervention, and it was available to me, I would include it.

Gaining access to all of these documents was not always easy, due to primarily two reasons: medical confidentiality and business secrecy. One intervention was construed as a ‘rehabilitation program’, with the consequence that my access to certain documents was restricted based on medical confidentiality. In another instance, the intervention was commissioned to an entrepreneur who initially referred to business secrecy. However, this secrecy came to result only in the restriction of my use of a tape-recorder, while I came to be given access to the documentation that I asked for.
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Empirical material

<table>
<thead>
<tr>
<th>Empirical material</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Observations</td>
<td>10 hours</td>
</tr>
<tr>
<td>Interviews with educators</td>
<td>1 group interview</td>
</tr>
<tr>
<td>Interviews with participants</td>
<td>1 group interview</td>
</tr>
<tr>
<td>Other material</td>
<td>Interview with commissioner, schedule, invitation, hand-outs, evaluation, overheads</td>
</tr>
</tbody>
</table>

Table 4, Empirical material

Analyzing the data

Working from a poststructuralist position, knowledge is conceived as situated socially, historically, geographically and contextually, i.e. as a discursive construction. This means that the knowledge drawn on and produced in the interventions is not taken as reflecting the ‘truth’ (about health) or as representing a space in which competing discourses (about health) have ‘settled’ (Berglund, 2008, referring to Nicoll, 2003). Rather, I understand the discourses drawn on as exemplifying the discourses available to the educators and the participants to draw on. However, health education in workplace health promotion with the aim to influence behavior and lifestyles are not ‘innocently’

12 This includes observations of two educators’ meetings and two sign-out consultations.
13 This includes observations of two Health Profile Assessment consultations.
reproducing knowledge but rather work to persuade. Hence, which discourses are drawn on in the interventions, how and with what effects are conceived as political and active in shaping how it is possible to think about health and to conceive of healthy lifestyles. The focus in the analysis has thus been on the discourses rather than on the interventions per se or the people in them.

Wright (2006:61) points out that “[k]ey to most forms of poststructuralist analysis … is the notion that all forms of meaning production, including ‘lived experience’, can be treated as texts.” This includes ethnographic material which “can be systematically analysed as texts … as they are constituted in and by specific social and cultural contexts” (Wright, 2006:61). The easiest way to begin to do this is to first transpose the data, consisting of fieldnotes and tape-recordings, into clean copies of texts (the documents collected were already in a text-format and these I simply compiled for easy access). I transcribed all of the fieldnotes myself. Regarding the tape-recordings I started out transcribing these but ended up sending it out for transcription. However, as the transcribed copies were of a less than ideal quality (quite a few places where words had been left out or misheard/misunderstood), I stopped doing so. This means that at places in the results I refer to pages – these are the clean copies of fieldnotes and tape-recordings – and at other places I refer to minutes – these are the tape-recordings that have not been transcribed. I find that not having transcribed all of the material (myself), did not present me with any problems: I had conducted both observations and interviews and had first-hand experience with what was recorded. Furthermore, all texts were read and re-read, or where appropriate, listened to and listened to again, to such an extent that had there been any disadvantage from not transcribing (all of) the material, this would have been overcome in that process.

In transferring quotes from the transcriptions/audio-tapes into the thesis, I have edited these to increase readability, since spoken language is not easy to read. When comments by one and the same individual have been excluded in a quote I use the marking … and when comments made by other people have been excluded from the quote I use the marking /.…/. Underlining is used for when the quoted person has emphasized something.

In analyzing the data I was guided by analytical questions that I have derived from Foucault’s notions of governmentality and bio-power as well as feminist theories on gender in relation to my area and specific object of study. In the analytical work, I focused on describing the discourses that were drawn on in the interventions and the consequences of these for the ways the participants in the study constituted themselves as subjects and the techniques they used in doing so. I also focused the analysis on how these practices (re)produced gender, as well as how constructions of gender served to produce specific practices. This work was a long and tedious process, in which I went about reading and re-reading the material I had, and sorting and re-sorting it until
sensible and reasonable descriptions of the discourses and their work in the interventions became clear to me. Although the process was long, I found that this was an advantage as it gave me the time to gain a distanced perspective on the material and also served to ‘distil’ the impressions I had of what I thought the material was saying.

I searched the material to find the health related discourses in order to build my understanding of what these discourses ‘looked like’ in these specific interventions. I started by sorting and re-sorting all of the ways that the educators and the participants talked about health in the interventions, the concepts and figures of thought that they drew on, including how they talked about the body and gender. After doing this, I began to see patterns and began to be able to discern discourses. This was when I turned to the wider research literature in the field to compare my findings with what was ‘out there’. Having come this far, I began to be able to identify processes of subjectification, the technologies of power and of the self and constructions of gender operating in the interventions. These findings are detailed in part II below, which starts off with a Prologue in which I describe the health discourse that I found in the material. After this, part II presents one intervention per chapter, with an overarching comparison, analysis and discussion following in part III. Furthermore, in part II, I have chosen to present each technology one at a time although the technologies, as discussed in the previous chapter, weave into each other. However, this outline serves to clarify which technologies are drawn on and to facilitate comparison of these between the interventions. But before moving on to part II, it has become time to give an initial brief orientation of the studied interventions.

**Brief description and comparison of the studied interventions**

I will here describe the studied workplace health promotion interventions with a brief comparative summary in the form of a table. The table addresses issues such as specifics about the settings for the interventions and facts about the educators and the participants. Further the interventions are compared regarding program characteristics, time-span and content as well as my own participation in the interventions – the time actually spent observing in each intervention. Fuller descriptions of each intervention are provided in the results-part of the thesis, following immediately on this summary.

A couple of points in the table may require some explanation. At all of the worksites, the employees were allowed one hour of physical activity or other health related activity during working time, and thus, the program characteristic on whether or not the intervention is “part of more extensive WHP initiative” does not refer to this but rather refers to whether or not the employer was doing
anything else in relation to the specific intervention studied. In intervention 3, for example, the employer had taken the opportunity of making several additional efforts to improve employee health in conjunction with and relating to the intervention, such as upgrading the company gym, getting the lunch cafeteria to offer a healthy alternative, etc. This can be compared to intervention 1, in which the employer also offered other activities and did other efforts to improve employee health. These efforts were however not connected to the intervention under study.

Regarding the “weight control” category in the table, this refers to whether or not the participants were weighed, other than during the Health Profile Assessment (HPA). Regarding the program content and the issue of the lectures: the subject areas mentioned in the table are the different foci that the lectures had, but other subject areas may have been touched on. Regarding the private consultations, these were offered to the participants of intervention 3 as part of the HPAs, which was also the case for intervention 2. However, in intervention 2, the participants could also ask for additional private consultations beyond what was offered as part of the Health Profile Assessments. Regarding the time span of intervention 4, these figures relate to the intervention as it was implemented, not as it was planned: one session was cancelled during the first half of the intervention, which means that the actual time span planned for was twenty hours over a total of ten sessions.

Finally, some clarification and explanation regarding my participation is merited: in intervention 3, the table shows that the intervention spanned over a total of about seven or eight hours, while my participation was eleven hours. This was possible due to the lecture being repeated several times to accommodate for all of the employees to participate, and I was thus able to participate several times in the ‘same’ session as it was repeated. In intervention 2, my participation was limited to the latter part of the intervention, while in intervention 4, I participated in the first half of the intervention. Some may argue that not participating in the whole interventions is a flaw in the study, making it inadequate because I thus lack knowledge about those parts of the interventions. However, based on my experience from the other two interventions I would argue that my findings would not have changed, had I participated longer in interventions 2 and 4. Interventions 1 and 3 show that the same basic features of each intervention continued through from beginning to end like a red thread, the educators maintaining a steady course through the interventions. This steadiness could be distinguished in interventions 2 and 4 too. Furthermore, I still had the schedules, and for intervention 4 I also had a

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14 The numbering of the interventions reflects the order in which I participated in them. Due to reasons of confidentiality, the actual names of the interventions (whether in Swedish or translated into English) will not be used.
course book, from which I was able to gain an insight (albeit limited) into those parts of the interventions too. Finally, epistemologically, it was never necessary for me to participate from beginning to end in any intervention. Rather, the important thing was to participate in interventions in which the educators and the participants had an ongoing relationship (see the selection criteria further above).

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Program content

| Lecture nutrition               | Yes | Yes | Yes | Yes |
| Lecture physiology              | Yes | Yes | Yes | No  |
| Lecture stress                  | Yes | Yes | No  | No  |
| Lecture other                   | No  | Yes | No  | Yes |
| Cooking                         | No  | Yes | No  | No  |
| Physical activity               | No  | Yes | No  | Yes |
| Health Profile Assessment (HPA) | No  | Yes | Yes | No  |
| Weight control                  | No  | Yes | No  | No  |
| Private consultations           | No  | Yes | No  | No  |

Program time-span

| Number of sessions              | 8 (weekly) | 25 (weekly) + 2 HPAs | 3 lectures + 3 HPAs | 9 (fortnightly, with summer break half-way through) |
| Duration of each session        | 1-2 hours | 8 hours (full day sessions) | 1-3 h lectures, ~45 min consult | 2 hours |
| Total program time              | 10 hours | 200 hours | ~7-8 hours | 18 hours |
| Program time spanned over       | 9 weeks  | 9 months | 1.5 years | 8 months |
| Practical training              | None | Exercising and cooking ~45 hours | None | Exercising ~6.5 hours |
| My participation                | 10 hours | Last 50 hours | 11 hours | 6 first hours |

Table 5. Brief summarizing overview and comparison of the four WHP interventions
PART TWO
As an introduction to the findings of this study, it seems necessary to say a few words about the health discourses that were drawn on in the interventions. This is only to give a brief introduction, and, apart from in the rest of part II, the discourses will be further discussed and examined in part III. Before moving on to describing my findings from the interventions I will also say a few words about the outline of part II. But first, I start with the discourses.

All four studied interventions drew on a number of discourses about health. The health discourses that I have focused on in presenting my findings here are two discourses that were reproduced in all four interventions and that may be described as the most prominent health discourses in the study. I refer to these as the biomedical discourse and the wellness discourse. As discussed in Chapter 2, the meanings and contents of these discourses should not be perceived as set in stone and defined once and for all but rather as constituted by constant internal struggle regarding meanings and contents. Besides internal struggle within each discourse, the discourses also fold into and struggle against each other, constantly (re)constituting one another. The biomedical and the wellness discourses are furthermore reflected in the discussions about health promotion/disease prevention presented in the Introduction to this thesis. They also correspond to discourses that have in one way or another been described by others in previous research (see e.g. Sointu, 2005; Fullagar, 2002). The following text offers a brief description of the discourses as I have come to understand them based on how they were reproduced in the interventions.

In the biomedical discourse health is understood in reductionist terms as quantifiable and described in negative terms as the absence or opposite of illness, sickness or disease (Medin & Alexandersson, 2000). The discourse is underpinned by a notion of risk, constituting undesirable bodies and behaviors as risky. Drawing on the biomedical discourse, risk is to be reduced and/or avoided. Fullagar (2002:73) is critical that, in this risk reduction discourse, “the non-rational, affective and symbolic dimensions of everyday life and leisure” are ignored, values such as the joy and pleasure of physical activity. Such values and dimensions are the concern of the wellness discourse. The wellness discourse may perhaps be conceived as having been constituted in the so called “new health consciousness movements” (Crawford, 1980:365) which grew out of a critique against medical conceptions and practices and as such may be perceived as a reaction against the primacy and doctrine of the biomedical discourse. Despite this, however, the discourses should not be perceived as in opposition to each other but perhaps rather as complementary to each other although in
constant competition over the right of interpretation. The wellness discourse is further characterized by a salutogenic framework, in contrast to the pathogenic framework of the biomedical discourse. However, the salutogenic framework may be perceived to complement, rather than oppose, the pathogenic framework. The concept ‘salutogenic’ was coined by Antonovsky (1991) in 1979 and refers to a concern with issues of how come there is health instead of ill health – what causes good health? A salutogenic approach to health thus focuses on “the factors associated with successful coping” (Tones & Green, 2004) and on the origin of health. The wellness discourse is underpinned by a notion of pleasure, constituting desirable (healthy) behavior as pleasurable. Both of these discourses appear in all four studied interventions, but in varying degrees and with different consequences for how health is conceived, and hence what are considered healthy practices and healthy subjects, which is what will be further elaborated on in the following.

My interest in this study regarding these discourses, and that will be described in more detail here in part II, is how they have been drawn on to produce different understandings of health, as well as the practices and subjectivities that these understandings of health then came to produce in the interventions. Each of the following four chapters describes one of the interventions studied. Each chapter follows the same outline: it begins with a presentation of the intervention, followed by a segment concerned with the health discourses and how these were drawn on in the intervention. A third segment is concerned with describing the technologies of power and of the self by which the participants were governed toward becoming healthy subjects, followed by a section in which I take a closer look at how gender was reproduced, before finishing each chapter with a summary.
CHAPTER 4, INTERVENTION 1

Introducing the intervention

Intervention 1 was set at a university-college with about 600 employees in a mid-sized town in Sweden. The institution had an active employees’ health interest group which regularly arranged activities for the employees such as various physical activities, massage, courses to quit smoking, etc. Some employees petitioned the health interest group to provide a course in weight-loss, preferably they wanted the Weight-Watchers. However, due to the health interest group’s limited funding, they could not afford to retain their services. Instead, the question of organizing a course in nutrition and lifestyle for the employees went to the students at the health education program at the university-college. Two female students in their last year of education took the commission. They were in their twenties, physically active (running, volleyball, gym training, etc) and they were at the time enrolled in a course on food habits and nutrition and considered the intervention a good opportunity to use their new knowledge. This would be their first time planning, organizing and implementing an intervention.

The intervention was offered to all employees and advertised via e-mail. The target group was not explicitly formulated but the invitation/advert for the intervention said:

For health, new-thinking and joy of food
[The intervention] wants to give you
- knowledge about what your body needs based on [a computerized diet registration program]
- basic knowledge about carbohydrates, protein, fats, vitamins and minerals
- you will also get knowledge about the connections between dietary composition, physical activity and stress
- the chance to comment on tv-shows on food, tv-dinners, fastfood, food

15 Intervention 1, Interview with commissioner (secretary of the health interest group).
16 Intervention 1, Group interview with the educators.
Although they were responsible for deciding on the contents, the fourth point was never addressed because the educators did not feel that they were knowledgeable enough or that they had “any scientific ground to stand on” to do it and hence “could not quite stand for it”. However, based on the above, the intervention may be said to have targeted employees with an interest to know more about nutrition and nutritional needs of the body. Application was made to the secretary of the health interest group and although the advertisement stated a maximum admission of 12 participants, all 16 applicants were accepted.

Although the entire work-force at the workplace was targeted and informed about the intervention, the participants were all Caucasian women, aged between early 30 to late 50, working as administrative personnel. They participated out of work hours or, if their manager so approved, during working time.

The intervention was set at the workplace in a couple of different rooms (classrooms and a conference room) appropriate for their needs. With a couple of exceptions, the arrangement of the furniture followed a traditional classroom setting in which the participants sat at desks, facing up to the educators who stood up front, by the whiteboard. One exception to this arrangement was during the second session, another during the last session. For the last session, everyone sat at desks facing each other, like a U. During the second session, everyone was in a computer room, in which all participants sat facing outwards, toward their computer screens.

The intervention consisted of eight sessions for a total of ten hours (the second and last sessions were two hours long) and was organized around the nutrients. The first session was a general introduction, focusing on the question of why humans eat. This session was followed by a session focusing on the participants’ current dietary habits, with individual diet registration and subsequent feedback with the help of a diet registration software. Sessions three through to seven focused on a specific nutrient: carbohydrate, protein, fat, vitamins, and minerals, while the last session focused on diet in connection with physical activity and stress. These sessions presented the participants with facts about how the body functions regarding metabolism, facts about the chemical composition of nutrients and where various nutrients can be found, and facts about the quantities of the nutrients that the body needs.

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17 Intervention 1, Invitation to the course, e-mail to all personnel.
18 Intervention 1, Interview with educator Jeanette, p3.
Primarily the sessions were built around the educators lecturing on the topic of the day, with some group exercises to get discussion going. Despite this, however, the educators came to dominate the ‘spoken room’. When the educators directed questions toward the participants, these were primarily in reference to the current session or previous sessions, and seemed to be concerned with checking whether the participants had paid attention, as this quote from one of the educators’ questions may illustrate: “what was it that we should eat to receive vitamin D?” As such, these types of questions were primarily of the kind to which the participants were expected to give the correct answer regarding nutritional details.

The second session differed somewhat from the rest: it was more of a diet registration work-shop than a lecture. The only ‘homework’ given was in preparation for this second session in which the participants were asked to write down everything they ate for two days – one work day and one day off. These notes were then used during the second session to calculate the participants’ energy intake in relation to their metabolism, using a computer diet registration software.

The intervention was evaluated by the educators as part of the course in food habits and nutrition that they themselves were taking as part of their own education. Their evaluation focused on the participants’ expectations and opinions of the contents of the intervention.

Constructing truths about health

Health as a goal, a state of being, was conceived in terms of ‘balance’, as was the guiding principle for how to reach this goal:

[Health is all] about balance, moderation, about not exaggerating in any direction.\textsuperscript{20}

Balance was conceived as that point at which ‘one feels well’:

So, balance becomes a sort of a word for that which is in the middle or what should you call it, then. That one feels well.”

Drawing on a biomedical discourse, ‘balance’ was furthermore conceived in relation to dietary habits in calculable terms of nutrition and energy intake as

\textsuperscript{19} Intervention 1, Session 7, p3.
\textsuperscript{20} Intervention 1, Interview with educator Jeanette, p4.
\textsuperscript{21} Intervention 1, Group interview with the educators, p1.
exemplified in this quote in which the need for the nutrient carbohydrates is given in terms of energy percentage:

*There is a recommendation called the Swedish Nutrition Recommendations … it varies a bit but between fiftyfive and sixty percent [of the energy intake] should come from carbohydrates*

That which needed to be balanced in order for the participants to achieve health was thus their diet and what was conceived to constitute a balanced diet was dictated by the national nutrition recommendations, and the notions of energy percentages and energy balance. These dictates served to make judgements about participants’ dietary and physical activity habits and behaviors by setting up boundaries for what could be conceived as healthy or not. Energy balance was conceived as that (calculable) point at which the energy intake equaled the energy expenditure. Energy expenditure was calculated based on basic energy expenditure, level of physical activity, thermogenesis and growth, constituting physical activity as the variable alongside energy consumption (i.e. eating) that it is possible to change.

It was assumed by the educators that within the boundaries of the nutrition recommendations and the notion of energy balance, the calculable point of balance varied and was different for everyone and dependent on an unspecified number of variables:

*You can’t set a fixed point that this is good. It is a bit different from person to person too, you know. You can’t say … this is how you should eat … and that’s how everyone should eat. It can be a whole bunch of different things. It depends on how physically active you are, you can be allergic to something and it can be a whole bunch of things that make one thing [unhealthy and] the other healthy.*

Again drawing on biomedical discourse, the notion of health as balance which set up boundaries for what could be conceived of as a healthy diet and physical activity also served to constitute these as potentially risky: too much or too little was a health risk with possibly severe consequences, as exemplified in this quote on physical activity:

*It’s unhealthy to not be physically active at all but also to have a way too extreme, well exercising … Health promoting [physical activity] is when*
you are physically active so that you feel, feel good. Get, get this extra energy, well, yes, feel that you become, catch this positive feeling from training, you feel that, yes, that the body feels good from it. That’s what’s healthy, I guess.”

As this quote shows, a discourse of wellness was also drawn on in the intervention, here to construct balance as that point at which ‘you feel good’, and a healthy (i.e. balanced) amount of physical activity as a source of pleasure. The wellness discourse was drawn on to legitimize behavior that from a biomedical perspective could not be defended, because “even if you are aware and careful about your diet it mustn’t be boring, you have to be able to indulge yourself if you were to want pizza and kebab and that which maybe isn’t so very nutritious”.

Constructing dietary and physical activity habits as vital determinants of individual health as was done in this intervention, served to locate the responsibility for health with the individuals themselves. This was a point that the educator conceived as important for the participants to learn:

…it was one’s own choice, that [the responsibility] lay with oneself, that’s what it felt like. We came back to that several times so it felt like, the last time, that this was what had stuck with them.

To summarize, drawing on a biomedical discourse, health was constituted as balance which was conceived in calculable terms in relation to national nutrition recommendations on nutrition intake and energy balance. This notion of health served to constitute all dietary and physical activity habits that did not conform to scientifically motivated recommendations as risky. Drawing on a wellness discourse, the notion of balance was conceived as a point of pleasure and well-being. Finally, the responsibility for health was placed with the individual.

How to improve health
As mentioned above, the main point made in the intervention was that the way to improving health was to achieve and maintain a balanced diet with no exaggerations in either way. Although on a more general level the importance of a regular meal order with breakfast, lunch, dinner and two snacks in accordance with the (Swedish) food plate model was mentioned as important for improving health, the main thrust lay on a more detailed level. To make their point clear, the educators chose to saturate their lectures with detailed nutritional facts and

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Intervention 1, Interview with educator Jeanette, p6.
Intervention 1, Interview with educator Lotta, p8.
Intervention 1, Interview with educator Jeanette, p2.
information which stressed the negative consequences of eating too much or too little of any nutrient. This excess in details was based in the notion that although the participants would not remember the details, the structuring point of the sessions (i.e. the importance of balance) would make a lasting impression28. Each ‘fact’ about the consequences of an unbalanced diet indicated what the ‘good’ and balanced behavior was and hence indicated the changes that the participants should be making. For instance, switch to oil instead of butter for frying29, or switch to food low in GI instead of high in GI30.

Besides nutrition, the other focus was on energy and specifically on how to achieve energy balance. In addition to adjusting one’s energy intake, suggestions were also made regarding physical activity for regulating one’s energy expenditure. The proposed physical activities were primarily concerned with small changes and adjustments in the participants’ lives, such as taking the stairs instead of the elevator31 and not so much with regular exercise per se. The focus was thus on making the participants take advantage of the opportunities for physical movement in their everyday lives.

However, despite all of the detailed information about nutrition and energy offered in the intervention but fully in line with the notion of exaggerations as detrimental, the solution for how to live up to all of the imperatives was construed to be to have variety in one’s diet. The message was that because different nutrients exist in different foods and are variously taken up by our bodies depending on how they are combined, rather than try to find the ‘optimal combination’, you should have a variety of foods in your diet. Varying one’s diet would assure that one got all of the nutrients that were needed to achieve a balanced, and hence healthy, diet. For instance:

If you just eat a varied diet you’ll get all of the vitamins you need32

To further impress this upon the participants, they drew on the authority of research: “… so researchers say that we can count on receiving it [in this case, vitamin B’s] if we just eat a varied diet”33. Eating vitamin supplements was construed as ‘exaggerated behavior’, construing the ‘normal’ and healthy behavior and the solution to improving one’s health as eating a varied, balanced diet and taking advantage of everyday opportunities for physical movement.

28 Intervention 1, Group interview with the educators, p1.
29 Intervention 1, Session 5.
30 Intervention 1, Session 3.
31 Intervention 1, Handout: “Ideas on sneak-exercise” (Sw: “Tips till smyg-motion”).
32 Intervention 1, Session 6, p2.
33 Intervention 1, Session 6, p8.
Constructing the healthy person

In the intervention, a healthy person was conceived as a balanced person, which entailed more than just eating a sound diet. This notion covered multiple aspects of a person’s being – physical, mental, emotional, behavioral – and was also individualized, meaning that it was based on a notion that what could be conceived as ‘balanced’ depended on the individual, and that what might be conceived by some as unhealthy may very well be healthy to someone else. In this manner, the notion of what a healthy person is was troubled and a notion of difference was privileged. For instance, a thin person was not necessarily healthy:

*Participant*: I’ve been under the impression that it was just big, fat [male] geezers that got it [high cholesterol], but that’s completely wrong.
*Educator*: You can be really thin and have it too, it has nothing to do with that.

However, overweight was always conceived, if not as a state of ill health, then at least as a risk factor that needed to be taken into account when determining what could be conceived as healthy behavior or not for that person. Taking into account one’s physiology was in general conceived as important and the participants were regularly encouraged to ‘listen to their bodies’ because:

*The body is rather clever if you listen to the signals*.35

Bodies were conceived as a source of constant signaling regarding its condition, signals in the form of various symptoms. Listening to these corporeal signals, such as poor sleep, anxiety, stomach problems and mood shifts (to give a few examples), and reflecting over one’s dietary and physical activity habits and connecting these with each other were construed as sign-posts of a healthy person or as the road to improved health for the rest of them. A healthy person was thus someone who was able and willing to read off the signals from the body and adapt her/his behavior in accordance with what these were saying. A healthy person was thus conceived as a person with self-restraint and control. For instance, this person who listened to her/his corporeal signals would be eating every four hours (no snacking in between) since this was construed as the physiologically determined cycle at which point in time one’s corporeal signals should be calling for food:

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34 Intervention 1, Session 5, p4.
35 Intervention 1, Session 1, p2.
We become hungry at about four hour intervals, which is the time it takes for the stomach to empty and the nutrients to be absorbed. Although the notion of difference, as mentioned earlier, was privileged in this intervention, the above quote exemplifies an instance in which the notion of difference gave way to a notion of universality, constituting everyone as similar, namely as regards physiology and in this specific case regarding the periodicity of hunger.

Although the healthy person was construed as disciplined, a healthy person was also conceived as someone who was able to enjoy life and enjoying life entailed to be able to (know when to) allow oneself occasional indulgences: You have to be able to indulge yourself too.

These indulgences, or at least the need or craving for them, were construed as natural in the sense that they were a consequence of a biological predisposition dating back to pre-historic times:

We often choose the sweet and fatty foods. It's not because of bad character but because of a predilection for chocolate, snickers-bars, and stuff like that. The sweets signals carbohydrates and [that it is] non-poisonous.

And:

Humans have … a predilection for combined fat and sweet food. This behavior is still with us since the pre-historic times during which time we had to eat fat nuts for energy and sweet fruits which signaled that they contained carbohydrates and were non-poisonous.

However, a healthy person would not be overpowered by these cravings but would exercise self-control and indulge in a moderate fashion. In order to be able to accurately navigate between when to abstain and when to indulge, the healthy person also needed to be knowledgeable and skilled at distinguishing and interpreting corporeal signals.

In relation to this notion of a healthy person, the participants were positioned as at risk of poor health due to a lack of knowledge: a lack of knowledge of the importance of a balanced diet and of what constitutes a

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36 Intervention 1, Handout: "Metabolism of the body" (Sw: "Kroppens metabolism").
37 Intervention 1, Session 3, p6.
38 Intervention 1, Session 1, p2.
39 Intervention 1, Handout: "Metabolism of the body".
balanced diet. The computerized diet registration exercise in which the participants’ diet was compared to a healthy ideal based on the national nutrition recommendations served to establish that the participants’ diet was inadequate and in poor balance, thereby demonstrating to them that they were at risk and in need of knowledge on the subject. The participants were furthermore positioned as sedentary and when talking about physical activity, the educators did not suggest to the participants that they should perform more vigorous physical activity but rather let it suffice to advice the participants to increase everyday mobility, for example by taking the stairs instead of the elevator or stepping off the bus a stop or two earlier than their usual stop. Thus, implicitly, the participants were also construed as either unable or resistant to vigorous physical activity.

In summary, the ‘normalized’ healthy person was someone who adapted dietary and physical activity practices to individual needs as expressed by corporeal signals. This person exercised self-restraint but was still able to indulge occasionally, enjoying life in the process. In relation to this healthy ideal, the participants were positioned as deficient, as reluctant exercisers in need of accurate and precise nutritional knowledge and also in need of listening to the signals from their bodies.

Technologies of power

The educators assumed that the participants’ health would be better off if they were more knowledgeable and aware about the possible consequences of the dietary choices they made and of the importance of a balanced and varied diet. This was where the intervention fitted in: it would provide the participants with information and facts on nutrition and metabolism, aiding them in making conscious dietary choices.

Based on this knowledge and awareness, the participants were expected to make what was perceived as minor behavioral changes. The willingness and ability to make these changes and to make the ‘right’ dietary choices was perceived to follow more or less automatically upon increased knowledge and awareness:

Erika: What … do you hope that they [the participants] take with them [after the intervention]?
Lotta (educator): Well, the primary is that it’s their, it’s their choice, that they have a choice and that by becoming more aware about how it [diet]
influences and, well, you know, that [they] will become more aware and in that manner, well, change their dietary habits."

However, although the educators may have perceived of their work in the intervention as one of providing the participants with mere information and facts and the ability to make informed choices, the point of this analysis is, besides highlighting what these ‘right’ choices were, to show the means by which the participants were governed toward wanting to do the ‘right’ thing. The primary technologies of power drawn on to guide and direct the participants in this direction were normalization, regulation, exclusion, and surveillance.

Normalization and regulation

Drawing on a notion of health and a balanced diet as calculable, the computerized diet registration program served to evaluate the participants’ diet in relation to a biomedically set standard (the national nutrition recommendations) that was construed as the ideal diet – the ‘normal’ diet. The assessment was made for each nutrient and in relation to the person’s energy requirements as estimated by the software based on the participants’ answers to questions about sex, age and level of physical activity. The comparison showed the divergence between the participants’ diet and the ideal, normal diet in figures, percentages, diagrams and charts. Deviations from this norm were construed as problematic and the possible sources of illness, disease or even death: deviations were construed as risks. In this manner, the software exercise served to point the participants in the direction they should take: what nutrients they needed more or less of and whether they needed to increase or decrease their energy intake/expenditure in order to achieve a more ‘balanced’ diet and to avoid risk.

The diet registration program evaluated the participants’ intake of carbohydrates, protein and fat in relation to the biomedical norm. However, to achieve a balanced diet, it was conceived as important that the participants were knowledgeable about nutrients on a more detailed level – a micro-nutrient level, if you will. This meant that the nutrients were described and discussed on a chemical level, dividing each of them into groups: carbohydrates was divided into three groups (sugar, starch, and fiber), proteins were broken down into two groups of amino acids (essential and non-essential), fats were broken down into four groups of lipoproteins (HDL, LDL, VLDL and chylomicrons), vitamins into two groups of solubility (water soluble and fat soluble), and minerals into two groups of size (macro and micro elements). Each nutrient and each group was further detailed and discussed regarding their absorption and metabolism.

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40 Intervention 1, Interview with educator Lotta, p4.
This detailing served to warn the participants about, and underline the risks of, eating too much or too little of any of the nutrients and to refine the notion of what constituted a balanced diet. For instance, it was not enough to eat a healthy amount of fat in terms of energy percentage, one also needed to consider the type of fat one ate:

… if one eats too much fat, that is, the polyunsaturated fat, that’s a really tough balancing act, to find this balance … one needs all three parts [saturated, unsaturated and polyunsaturated fat] equally much, even though not in equal parts…"  

And although all foods were allowed and conceived as necessary, specific foods were construed as both potentially healthy and potentially risky:

… one tries to achieve a balance … as I said, liver is really good for you with iron and everything but by being aware that it contains these things [cholesterol] too maybe one won’t, well, overdose on it  

This complexity caused one of the participants to react with frustration that apparently all of the foods that she previously had perceived as healthy (such as liver) could be conceived as a potential health risk:

No matter which way you turn, you’ll still have your ass behind you!  

So, no food could be conceived as unequivocally healthy: it depended on the amount, combination and variation, which brings us to the next point made in the intervention; that of the importance of variation. Along with all of this detailed information, the participants were also told that they should not exaggerate their concerns about what they ate. An exaggerated interest or fixation was conceived as unhealthy in itself. Rather, the key to achieving a healthy and balanced diet was construed as varying one’s diet. For instance:

All of these vitamins, they actually exist in the food we eat. So if you just eat a varied diet, you’ll receive all of the vitamins that you need."  

Since knowing when one achieves a balanced diet was considered to be difficult, varying what one ate was conceived as the key to achieving a balanced diet. By suggesting that failure to eat a varied diet would result in symptoms
that would require a visit to the doctor, the importance of a varied diet was underlined at the same time as the participants’ attention was once more directed toward their bodies:

See, that’s what’s really difficult [knowing when one achieves balance], so that’s why you, you have to see to it that you eat a varied, but if you feel well and don’t have any symptoms, then probably you’re eating what you should. If you should experience symptoms, anything, then you’ll go to a doctor if that’s so, so it’s really difficult to know for yourself. The only thing you can know is that if you do not eat a varied diet, then, but you’ll have to see to that, make sure you eat all of these components. So, it’s difficult.⁴⁵

Along with the notion that being healthy shouldn’t be boring and shouldn’t be about fixation or exaggeration, that it is about finding this elusive point of balance in nutrients by maintaining a ‘relaxed attitude’ and eating a varied diet, a notion of the necessity for balanced energy consumption and expenditure for health served to draw the attention back to the details, in this case of calories and a model of energy in/out. This energy in/out model also served to individualize all recommendations:

The recommendations are stated in relation to energy consumption so it’s different from person to person [how much one needs of a specific nutrient].⁴⁶

Drawing on this model of energy balance, diet comes to be conceived in terms of calories, or energy, and to maintain health the energy consumed should equal the amount of energy expended, constituting an energy balance. Too much energy consumed in relation to energy expended was conceived to lead to overweight, i.e. risk. However, consuming too little energy in relation to what one expended was also conceived to lead to weight gain:

If you eat too little you will also gain weight. You store energy in the form of fat since your metabolism decreases.⁴⁷

To maintain one’s weight, and health, it was conceived as important to be physically active. Doing so, one could even allow for indulgences in candy and snacks from time to time, as explained in this quote in which the moralistic underpinnings of this notion is well illustrated:

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⁴⁵ Intervention 1, Session 6, p5.
⁴⁶ Intervention 1, Session 6, p5.
⁴⁷ Intervention 1, Session 2, p1.
If you are physically active then you can allow yourself to eat that which maybe, isn’t the best, but something that you have a craving for, because then you’ve been good, or at least you have done your body something good. And then you can eat that."

So, after the participants have “been good” then they may allow themselves something ‘extra’.

Exclusion

Besides normalizing ‘moderate’ dietary and physical activity practices by drawing on a notion of an ideal (person/practice), this was also achieved by setting a boundary between what could be conceived as healthy and balanced or not. This boundary was set up by marginalizing ‘other’ positions and practices and constructing these as exaggerated, risky and wrong, such as inactivity/indifference and fixation. Healthy and balanced practices were thus construed and defined in relation to what was conceived as their opposites, as in this example where a healthy diet was conceived in opposition to a boring or exaggerated diet and a healthy interest in diet was conceived as the opposite of both fixation and indifference:

It mustn’t be boring either. You have to … find a, good level without sort of exaggerating in either direction. It’s not, it’s not healthy with a real, if you have a real fixation on diet. On the other hand, just totally not caring about what you eat also isn’t good. It’s this, balance again that is, really difficult to find. I think so too."

In another example, healthy physical activity was also conceived as the opposite of indifference and fixation, constructing the healthy level of physical activity as something in the middle, a balance between indifference and fixation:

I think it is unhealthy to not be physically active at all, but also too extreme, well, exercising, so to speak, whether one has a fixation that one has to train all of the time, then it’s unhealthy."

By marginalizing certain positions and practices, other positions and practices were construed as ‘normal’ and desirable, thus guiding the participants in the ‘right’ direction, in this case toward finding and choosing a ‘middle way’.

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48 Intervention 1, Session 5, p7.
49 Intervention 1, Session 5, p7.
50 Intervention 1, Interview with educator Jeanette, p6.
For example, in one exercise concerning protein, vegans and bodybuilders were positioned as extreme and marginalized because they professed a physiological need for protein that was very low (vegans) or very high (bodybuilder)\(^5\). In this construction, taking the position between these two extremes was construed as healthy, balanced and desirable. In this manner, the national nutrition recommendations for protein could be perceived as the ‘normal’ and balanced intake and therefore constitute the desired practices.

**Surveillance**

The construction in the intervention of the body as giving off ‘signals’, more or less constantly revealing the participants’ state of health to others around them, served to condition the participants toward conceiving of themselves as constantly being watched or at least potentially so.

The participants also expressed their own ideas regarding what physically visible signals that could be conceived as indicative of a healthy person, thus extending the scope of aspects about themselves that they expected to be watched and scrutinized and that thus needed to be controlled. For instance, a fresh-looking person, with a straight posture and a ‘presence’ was conceived as healthy, while a person with hunched over shoulders, gazing at the ground was not perceived as healthy. Being in the outdoors was conceived by one of the participants as particularly important to achieve a healthy body and her contention was that it is indeed obvious from a person’s face if they are or not, even though, as she says, it is difficult to express exactly how this is visible:

… a person [who is rarely outdoors], that person becomes very pale and, what should I say, a bit flabby in some way. It’s some sort of, well, it, it’s hard to express. But don’t you think one looks different if one is outdoors a lot, if you think about these farmers and lumberjacks, you know? The face, it has a different color when you’re outdoors all year around all the time than if you’re sitting indoors.\(^6\)

Her contention was, then, that appropriate physical activity practices (in this case meaning that one were out in the fresh air) would be visible to others on one’s body. Linking behavior to looks in this manner functioned to suggest that you might expect others to judge your behavior based on your looks. Since being in the outdoors was conceived as the healthy way to exercise and since being in the outdoors was conceived to be physically visible for others to see, this served to regulate this particular participant in the direction of being physically active in the outdoors.

\(^5\) Intervention 1, Session 4, pp 5-7.

\(^6\) Intervention 1, Group interview with participants, p5-6.
Technologies of the self

In this section I will show how the educators set up the means for the participants to start to assess and act on themselves; to self-govern. I will demonstrate how the ‘truths’ constructed in this intervention about the imperative of balance in its different variations served to guide the participants toward examining and constructing their own behavior and lifestyle choices as normal and healthy (self-examination) and to practices of self-disclosure regarding their dietary habits. However, in relation to this I will also show that the same ‘truths’ also served to give them a bad conscience about their own behavior and drove them to reveal things about their own behaviors and habits to each other. I will also describe how the participants came to accept and acknowledge the ‘truths’ constructed in this intervention, and how they converted these into rules of conduct for themselves and how they drew on them to position themselves as ‘good’ and healthy (self-mastery).

Self-disclosure

Self-disclosure or setting up the means for participants to divulge details about their own habits and practices was not high on the agenda in this intervention. However, one assignment did serve to condition the participants in this type of practice, namely the diet registration during the second session. The software was presented as an aid in regulating one’s diet to manage to achieve a balance in one’s energy intake in relation to one’s energy expenditure. The software for the diet registration program provided that the participants accurately, conscientiously and in detail described their diet, which demanded of them to keep a diet journal, in this case during one or two days. In this journal they were asked to write what they ate and when, and to be very specific about the details – what sort of pasta (ordinary or whole grain), what amount, did they use oil in the pasta, what kind, how much, etc. Hence, the diet registration served to make the participants divulge details about their dietary habits and practices in order to make them aware of these.

Self-examination

Conceiving of ‘deviant’ conditions such as fatigue, irritation, or a poor mood but also overweight, high blood pressure or gallstones as signs of a poor lifestyle, as symptoms indicating that the body is off balance, served to direct participants’ gaze toward themselves and their body. The notion of health as balance and balance as indicated by various corporeal symptoms (or lack thereof) demanded of the participants that they be(come) constantly vigilant

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53 Intervention 1, Handout: “Diet, physical activity and stress” (Sw: “Kost, motion och stress”), and; Session 5, pp 2 and 4.
and aware of any symptoms and to connect these with details of their lifestyle. In this manner, participants’ bodies also became their disciplinarians, regulating their behavior and schooling them into practices of self-awareness and self-reflexivity. As symptoms manifested, the participants were expected to take these as cues to take stock of and review their lifestyle related practices and compare what they had done with what they knew (from the intervention) they should have done.

The notion of balance continued to be the participants’ guiding light as they were to take stock of their practices in terms of energy balance (the energy in/out model) and a balanced nutrition intake. The energy in/out model directed the participants to review their dietary practices in relation to their physical activity practices and to consider whether they were balancing these and what changes they perhaps ought to make on one or both of these aspects of their lifestyle. The imperative of a balanced nutrition intake directed the participants’ attention toward their diet on a more detailed level. Besides their own corporeal signals, the participants were given one more instrument for self-examination in this respect: the diet registration program. The computer program gave detailed information about the nutritional status of their current diet and how close to or far from the ideal they were and served as such to make the participants become not just aware of their dietary habits on a detailed level, but also to judge and evaluate them for the purpose of doing better. Each detail that the participants gave regarding their diet in the program represented a choice that the participants could make, a possibility for change, and thus each detail needed to be evaluated regarding whether or not it was responsible and defensible to maintain it, should the program – or their corporeal signals – suggest that changes needed to be made.

However, although corporeal symptoms on the one hand were construed as vital to guide the participants toward a more balanced life and the participants were exhorted to pay attention and ‘listen to their bodies’, they were also warned against doing so. Complicating the imperative to listen to their bodies and heed corporeal signals, the participants were also told that their body’s signals may be less easily detected, read or interpreted or even be false:

*Appetite doesn’t always follow the physiological hunger, but is influenced by psychological factors*.

Another problem, the participants were told, was absence of signals that should be there: “The signals [in this case, signals of satiation] may be disrupted, by habit, stress…” Or the signals they could read might not be the

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54 Intervention 1, Handout: “Metabolism of the body”.
55 Intervention 1, Session 1, p2.
most important ones: high lipoproteins or low bone density is not easily identified by you yourself but can only be detected by a physician. Hence, self-examination of dietary and physical activity practices relying on corporeal signals was also construed as uncertain and inadequate.

**Self-mastery**

Having accepted the imperative of balance to achieve and maintain health, the participants translated the advanced detailing of foods and nutrition in the intervention into rules of conduct that they could live by. A healthy diet and regular physical activity were conceived as important aspects of health, and the absence of these would always indicate poor health, whether that person felt well or not:

> I mean, if you naturally have that in you, that you exercise, you are physically active, you know, ... then you can eat chips maybe sometimes and you can eat a pastry, you can eat and feel well, but if you don't have it in you [being physically active] and still maybe ... eat all that, and you still feel like, you feel well, then that isn't a healthy body, I don't think.

However, and in line with what they had been instructed in the intervention, although negligence of these aspects were considered unhealthy, fixation with a healthy diet and the 'correct' body weight were also conceived as a health risk in itself:

> [I]f you fixate too much on, eh, ... eating right and chasing kilos and such, then that can become mentally very hard and can then result in other manifestations in the body.

Instead of trying to live up to all of the detailed imperatives presented in the intervention, and since the educators had conceded that knowing when one achieved balance was impossible, the participants picked up on the notions of variation and a relaxed attitude and the importance of these to achieve a balanced diet and a balanced approach to one's diet. In sum, to the participants this meant that:

> ... by and large, one should eat a healthy diet, so to speak, think about what one eats. Ok, one may digress occasionally, but the everyday and most of the

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56 Intervention 1, Group interview with participants, p2.
57 Intervention 1, Group interview with participants, p2.
time, then, sort of, one has to consider a little bit what one eats. That’s what I think.\footnote{Intervention 1, Group interview with participants, p2.}

Although this imperative of maintaining a healthy diet had been converted into a rule of conduct for all of the participants, the employment of this rule differed regarding what was conceived as a healthy diet and when it was conceived as acceptable to indulge and what was cause for a bad conscience or not. For one individual, this general rule of conduct was specified at a more detailed level by drawing on both the model of energy in/out and the notion of the importance of a relaxed attitude, in this case manifested in allowing indulgences at regular intervals:

\begin{quote}
I think that, during the weeks you can be more tenacious about refraining from cookies and pastries and such, you can skip butter on your bread and things like that, you know, and then, when it’s the weekend, then you can, then you can maybe allow yourself something of these parts, like pastries and such. Because it mustn’t, it’s like you’re saying, you need to feel well too, you know, and don’t you feel well when you eat a cinnamon roll? I think so, sometimes, you know. It can’t go to extremes either. … Sure you can tell the difference. You can tell the difference when you change it a little, … You feel better when you abstain that roll in the evening and things like that. You feel better from taking, when you take a whole grain cracker or a rusk or something like that. You do actually feel better from it, I think.\footnote{Intervention 1, Group interview with participants, p2-3.}
\end{quote}

Drawing on the energy in/out model it was conceived that by being strict during the week this left more room during the weekend for indulgences and still being able to maintain energy balance. Here, indulging was conceived as something that you had earned by keeping to a healthy regiment all through the week by maintaining a balanced diet (and level of physical activity). However, this approach seemed to set participants up for feelings of anxiety and guilt if they were not able to keep to the healthy regiment during the week before indulging during the weekend, positioning them as out of control and giving them a bad conscience that was described in vivid images of physical sensations:

\begin{quote}
when I eat … a cinnamon roll or something [during the week] … then I think that, now it feels, oh, now, now I’ve eaten that roll and now it lies there, splashing around. Wasn’t that unnecessary? I don’t need that roll, it would have been better if I’d taken some crackers or a fruit or something like that. … because I know, I know that it’s important still to try to abstain from this. It feels important to me, you know. /…/ during the weekend, then
\end{quote}
I can eat a cinnamon bun or I can even eat a pastry without bad conscience /…/ there are weekends when I don’t eat any buns or cakes too, you see, but I can eat, I can eat a pastry and think that oh yummy, oh lovely, like that, but during the weeks then I think it’s, then I think it’s unnecessary.

Another approach was to conceive of occasional indulgences independently of when they occurred as okay, as an occasional departure from the everyday (healthy) eating provided one went back to ‘normal’ and healthy habits right after. For these participants, such departures did not result in any bad conscience:

No, I don’t get a bad conscience ‘cause, sure, I eat a pastry and stuff, I like it very much but I don’t always take one, no. … [but when I do] I then go back to living like before.

Instead of getting a bad conscience from these digressions, one of these participants described how she did not always eat all of the meals that she (now) knew that she ought to eat:

It’s very easy for me to skip lunch, for instance, and, no, I don’t notice any difference, it works very well but it’s not healthy, really, to do so. Rather it is important to eat, well, like every four hours, you know, to maintain a balanced [blood sugar level].

Thus, although she herself did not experience her habits as problematic, the biomedical imperative to eat every four hours to maintain a balanced blood sugar level construed her tendency to skip meals as problematic, thus giving her something of a bad conscience over this instead.

Besides setting up rules of conduct for their dietary habits, as far as exercise went the participants had accepted the ‘truth’ that exaggerated exercising or exaggerated concern with exercise could be detrimental to one’s health:

It can become exaggerated, that you have to exercise. You know if you get a bad conscience if you’re not out exercising every evening or, that can go [wrong] too. Instead, it should be … so that you feel well.

The participants expressed acceptance of the notion that small changes in the everyday life were appropriate and adequate, referring to it in medical terms
as a ‘dose’, and that once you had started to exercise you would begin to feel a need, an urge to be physically active:

*It’s more important to take these smaller steps in order to get continuity … because exercise to me it can be to take a walk home from work for instance, then you get a dose … I think that when you start to exercise in any way then you get some sort of need for it.*

One of the participants also described how she had, as a consequence of participating in the intervention, changed her physical activity practices by adding a brief walk to her daily routines:

**Participant:** Yes, exercising I think became more of an issue maybe. I get off the bus one stop earlier.  
**E:** Do you still do this?  
**Participant:** Yes, but not every day I can’t say. It depends on how much in a hurry I am but I try to do it as often as possible anyway.

In this case, the participant had adhered to the advice about stepping off the bus a stop early to get a bit of a walk on her way home, thus increasing her everyday level of physical activity.

**Gender**

Drawing on a biomedical discourse, the intervention was informed by essentialist notions of women and men, constituting them as different from each other. Since all participants were women the educators decided to emphasize the nutrition recommendations as they were given for women, including the discussions about the consequences of an unbalanced diet. For instance, women were described as having a greater inclination for iron deficiency due to menstruation which in turn “may decrease or weaken the immune system and decrease the mental and physical abilities to perform”\(^6^6\), and as having a greater inclination for osteoporosis with increased age due to a deficiency in estrogen levels which in turn were due to menopause\(^6^7\).

These descriptions were clearly, however tacitly, made in comparison to a norm. The norm that women were compared to, that didn’t suffer from iron deficiency or osteoporosis due to menstruation or menopause, was conceived as naturally healthier than women who menstruated or were menopausal (i.e. most

\(^{64}\) Intervention 1, Group interview with participants, p4.  
\(^{65}\) Intervention 1, Group interview with participants, p10.  
\(^{66}\) Intervention 1, Session 7, p8.  
\(^{67}\) Intervention 1, Session 7, p4.
women). By implication, this norm was thus a man. As a result, women were construed as deviating from a male norm. Further, women were pathologized as this comparison and these ‘deviances’ served to construe women as constitutionally weak.

While the educators drew quite unproblematically on these essentialist notions of biological difference, the participants identified problems related to the different expectations placed on women and men. The participants talked about the issue of the general intolerance in society for overweight women; that overweight women were perceived as ugly and that there was an expectation placed on them to be slim. In their discussion, besides expressing frustration over this state of affairs, the participants drew on three different perceptions of how to understand especially women’s overweight: as a biological predisposition; as a consequence of different dietary habits (compared to men); and as a delusion among women:

Participant 1: [maybe] women have a greater tendency to become round than men and maybe they choose different things [to eat]?
Participant 2: Maybe women have a greater pressure not to be round, well, that women are more inclined to think that they are round and that men have a greater … that they can tolerate a greater weight before they think that, ouch now I’m beginning to fill out a little.
Participant 1: It’s a bit authoritative [for men] to have a belly, you mean, but it’s ugly when we grow a belly.

The male scope of variation for ‘good’ physical attributes was conceived as greater than the female scope, allowing for a bit of overweight to be perceived as ‘authoritative’. In contrast, women’s scope of variation for what could be conceived of as ‘good’ physical attributes was conceived along a narrower scale, allowing for more ‘unhealthy positions’: a woman with a belly could not be expected to be appreciated for her looks or (implicitly) conceived as healthy and she probably should reconsider what she was eating. Further, her belly would make her morally reproachable, because it indicated that she lacked in self-control. Alternatively, women could also be conceived of as delusional regarding their weight and in need of getting a grip on reality again.

While touching on the notion that what constitutes a ‘good’ body is conceived as different for women and men, they reiterated a perceived need for women to improve their self-control and self-awareness (to get a ‘true’ perception of themselves and their bodies) and a tendency to blame women for their lack thereof. In so doing, the participants also reproduced gender

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44 Intervention 1, Group interview with participants, p7.
differences, constituting women and men as different in their approach to their bodies and to weight.

Gender differences were also construed in relation to women’s and men’s perceived approach to food and eating as women were conceived as more concerned with the meal as a social event than men were:

*for women [eating] is a very social affair*\(^69\)

...and women were perceived to prioritize setting a nice table for dinner while men were perceived to...

*have a greater tendency to eat straight out of the pots and pans.*\(^70\)

This construction served to construe women as emotional and men as rational and to place the responsibility for the social and the meal with women, and freed men from the very same responsibility.

**Summary and comments**

In intervention 1, health was primarily conceived as a state of balance and balance was the notion around which the entire intervention revolved. The specific notions of balance drawn on in this intervention were primarily informed by the biomedical discourse and these notions influenced the participants’ conceptions of health and dictated what could be conceived as the right lifestyle practices. Furthermore, it also affected the subject positions made available.

Drawing on a biomedical discourse, the notion of balance was conceived in terms of energy percentages and energy balance that were individually variable. The biomedical discourse thus served to set up quantifiable boundaries for what could be conceived as healthy or risky. Transgressing these boundaries was conceived as constituting a health risk. As the intervention placed the focus on dietary (and physical activity) practices, i.e. lifestyle practices, the responsibility for health and for avoiding risk was placed with the individual and the participants were conceived as transgressing the boundaries, positioning them as at risk of ill health, disease and/or possibly even death.

Another conception of health as balance was constituted by drawing on the wellness discourse. By drawing on the wellness discourse, balance came to be perceived in subjective terms as that point at which ‘you feel good’. It also

\(^69\) Intervention 1, Session 5, s8.
\(^70\) Intervention 1, Session 1, p2.
construed physical activity (and diet) as a source of pleasure and legitimized indulgent behavior for the sake of pleasure that from a biomedical perspective could not be defended, as an aspect of health.

In the intervention it was conceived that health could be achieved by the means of small changes in dietary and physical activity practices. These changes were concerned with varying one’s diet and taking advantage of opportunities for physical movement in one’s everyday life.

A healthy person was conceived as someone who took an active interest in their diet without obsessing over it; someone who ate moderately without limiting themselves too much; someone who occasionally indulged her/himself but without losing control over it; someone who “understands that a healthy diet is about balance”\(^{71}\). The healthy person was thus conceived as one who pays attention to what they eat, eat a sensible diet and behaves in a sensible manner: a ‘balanced’ individual. This person was furthermore someone who listened to her/his body. Physically, what constituted a healthy person varied from individual to individual and could not be judged from one’s looks alone. However, some physical attributes were clear signals that something needed to be done, signals such as overweight, or, as pointed out by one of the participants, a ‘pale and flabby’ look.

Continuing to draw on the biomedical discourse, a healthy diet was conceived as objectively calculable in accordance with the energy in/energy out model which suggested a balanced energy intake and physical activity as the way to maintain (a healthy) weight and thus health. However, risk was omnipresent around dietary issues. By presenting the participants with facts about the risks associated with eating too much or too little of anything, the participants were coached by fear toward compliance. However, the participants also were not supposed to develop an obsession with nutrition and composing good meals, nor to be indifferent. Therefore the importance of finding a balance was repeatedly stressed. ‘Balance’ was presented by the educators as the ‘cure’ or ‘insurance’ against risk.

When talking about intake the participants rarely, if ever, touched on the issues of specific nutrients, but kept a more general approach to their diet, and their conception of a balanced intake seemed more to agree with the educators’ notion of balance as moderation than as the calculable equilibrium that the educators had been concerned with during the intervention. Further, the educators’ emphasis on the importance of listening to the body seemed to have paid off, at least in the sense that the participants knew that they were supposed to do so and, according to their own understanding of it, were doing so.

\(^{71}\) Intervention 1, Interview with educator Jeanette, p4.
In their conceptions of what is healthy or unhealthy the participants clearly echoed the educators’ conception of health as balance. They did this by pointing to the importance of maintaining a ‘middle way’, by not exaggerating in either direction. The participants construed their own bodies and behaviors as ‘normal’ and ‘healthy’ (balanced). They did this by construing others’ behavior and bodies as abject, as more at risk than, their own and also by individualizing what health is, conceiving of it as that point at which one feels well.

In this intervention, essentialist notions of women and men construed women as pathological and constitutionally weaker than the norm (men), as lacking in self-control and self-awareness and as emotional rather than rational in their dietary practices.
CHAPTER 5,
INTERVENTION 2

Introducing the intervention

Intervention 2, which was being offered to company employees for the third time, was set at a large, male dominated industrial steel corporation. It was initiated and designed by a team of four people: three female nurses from the Corporate Health Services and a male physical therapist from a private health clinic. This team of four was the core team of educators in the intervention. Two of the nurses had taken courses in health education. All of the educators in the core team were avid exercisers and enjoyed many different activities both on and off work. Besides these four people of the core team, others were engaged for longer or shorter periods of time (‘external lecturers’), for instance a Qi Gong-instructor, a psychologist, a priest, and an outdoor life enthusiast active in the Association for the Development of Skiing and Outdoor Life in Sweden (Sw: Friluftsfrämjandet).

The intervention specifically targeted employees judged by the team to be at risk of various lifestyle related diseases such as cardiovascular disease, stress related disease, overweight or chronic pain syndrome and the goal was to reduce participants’ risk factors for such disease by improving, among other things, their diet and level of physical activity.

The intervention was advertised to managers in leaflets and to individual employees during health check ups with the corporate health team. Sometimes employees turned to the Corporate Health Services (CHS) team, in general asking for help with losing weight, or changing their lifestyle and being recommended then to participate in the program. Because the intervention was on its third round, it had also happened that employees knew about the existence of the intervention and asked the team specifically to participate in it. All interested employees had to apply to the CHS team and to their manager who had to consent to the employee’s participation because depending on what type of shift they were working, they might have to miss work to participate.

Applicants were evaluated by the CHS team during a health check up (including a Health Profile Assessment and a lengthy and exhaustive questionnaire) and their motivation for change was assessed as part of the

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72 Intervention 2, Program contents (and target group)
admission procedure. However, due to the (low) number of applicants, all applicant employees fitting the target group description were considered eligible for admission and admitted.

Each year, the numbers of participants was limited to a maximum of 14 employees. During the time for my study, admissions had been rolling, meaning that the intervention did not have one starting point but rather, participants started as the need arose. However, the educators didn’t feel that the rolling enrollment was working in favor of the participants. Rather, the coming and going of participants was quite a disturbance because each change in the composition of the group meant a disruption of the group dynamics. The rolling enrollment had thus been terminated, which meant that no new participants were entering the course and that this course would end at one point, whereupon a new course would start with a new group of participants that would start at the same time and follow each other through the intervention.

The intervention had already started when I entered it. At this time, there were five female and seven male participants. Due to the rolling enrollment, four of these women completed their participation during my observations and one woman and seven men remained until the end of the intervention. They were all industrial workers between 30 to 55 years old, working ‘on the floor’, except for one man who worked with computers. They were of various shapes and sizes, admitted for differing reasons which fitted in with the categories for the target group.

The intervention consisted of 25 whole-day sessions, once a week over a period of six months. Each session was structured in a similar way, with approximately two physical activity classes and two lectures each day and occasional collective cooking. When there was no collective cooking, lunch was served at a lunch-cafeteria nearby at no cost for the participants. During the first eight weeks, the morning physical activity was aerobics, after that it was swimming for eight weeks after which they did team cycling (spinning) for the last nine weeks. The afternoon physical activities included walks and a couple of times it was cross country skiing but the main afternoon physical activity was gym training. During the last third of the intervention, a pre-lunch exercise was also added in the form of Qi Gong. Besides the physical activity during each session, the participants were also expected to be physically active at home/off hours and were in effect given home-work assignments in this respect. Physical activity levels were monitored by way of an exercise diary that the participants were expected to keep. The educators also at times asked the participants to report to the group about their physical activities during the week. The core team of educators also had regular meetings by themselves to discuss the progress of the participants as well as possible changes to the plan and curricula of the intervention.
The specific physical activities offered in the intervention were, according to the educators\(^7\), chosen based on season and based on a perceived ease for the participants to continue doing them as they finished the intervention, as the activities existed in society already, such as aerobics classes, or were feasible for the participants with no dependence on anyone else, such as taking walks. Furthermore, it was to allow the participants an opportunity to try to find an activity that they liked and to become enough acquainted with the activity so as to feel comfortable doing it elsewhere too, without the comforting environment of the intervention or presence of well-known educators.

The contents of the lectures varied but included topics such as nutrition, stress management, exercise physiology, and personal development.

The location for the intervention was primarily an old manor hall that they leased. The manor hall had a kitchen in which they did the occasional collective cooking. The kitchen had been remodeled and modernized into an elaborate kitchen with four stoves and ovens, two microwave ovens, a sink and a couple of basins, plenty of work-benches, cupboards, drawers and large fridge and freezer. All lectures were held in one of the rooms in the building. In this room there was a whiteboard on wheels at one end and in front of this whiteboard several smaller tables had been placed together to form a large square table with chairs around three sides of it. Besides the manor hall, a local gym and another, bigger facility a bit further away were used for the physical activities.

Starting and ending the intervention, each participant had two meetings: one with the physical therapist and a physician (from a private clinic, not the CHS) and one with one of the health educators. The beginning meetings were for initial (base-line) assessment. The purpose of the meetings at the end of the intervention appeared to be not only follow-up but also a sort of planning-meeting in which the participants were asked to describe their plans for how to maintain changes in lifestyle that they had achieved during the intervention. They also talked about what, if any, additional changes they were contemplating as well as the achieved changes in the participant’s health. Sometimes, an additional meeting was set up to further follow up on some changes the participant said they would do or for some other similar reason.

**Constructing truths about health**

The notion of health underpinning this intervention drew on a biomedical discourse, where health was conceived as a physiological condition constituted in relation to the notion of risk. This was exemplified in the constitution of the target group. The target group was, as mentioned previously, defined as

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\(^7\) Intervention 2, Group interview with the educators, p4.
“Persons with risk factors for cardio-vascular disease, overweight, chronic pain syndrome or stress related disease.” Employees admitted to the intervention were thus conceived as at risk of possibly quite severe conditions with the possible consequences of death. In relation to the notion of risk participants’ health status was determined in Health Profile Assessments (HPAs) by biological markers such as weight, condition, blood pressure, glucose, etc. Health was thus conceived in measurable and calculable terms in accordance with a biomedical model of health.

However, drawing on a wellness discourse, the educators also proposed that health was an attitude. More specifically, health was to have a positive attitude and “a positive outlook on life”. Being positive meant to be able to see that others have it worse than you, and to be able to accept the situation you are in, which in turn would demand a certain degree of self-awareness. However, accepting the situation did not mean to give up, but was perhaps rather conceived as a precondition to be able to “be the commander of the situation”. Being positive thus also entailed taking charge of the situation by deciding not to be hindered by one’s health condition, whatever it might be.

Health, both as measured by the biological markers and as an attitude, was furthermore construed as the result of individual (lifestyle) choices, which placed the responsibility for health firmly with the participants themselves. The design and contents of the intervention in which lifestyle and lifestyle choices such as dietary and physical activity habits were focused illustrate this. However, although the intervention was designed to promote participants taking responsibility for their own health, and although the educators agreed on its importance, some of the educators also conveyed a bit of confusion in the matter, expressing an urge to take on responsibility for the participants:

Stefan: I have counseled and what they do with that afterwards, I have no possibility of thinking about, because if I do I’d break apart I have so many participants in different projects. It may sound bad but that’s how I have to work.

Sandra: We cannot take responsibility for them.

Sofia: Sometimes you feel that you have to call them up and see if they are doing it [maintaining new habits]. /…/ I’m thinking that it will be a bit of follow up. They talked about that [during a study visit to another intervention], that it’s important.

Stefan: But what effect does it have, and what will happen to me, having to follow up on it. I have 3-4000 cases in a year.

75 Intervention 2, Group interview with the educators, p5.
76 Intervention 2, Group interview with the educators, p6.
In this quote, the educators disagreed regarding what approach to take in relation to the participants and their responsibility for their own success or failure in the intervention. One of the educators expressed difficulty in distancing herself from the participants, claiming that taking an interest in their progress could be conceived as a follow up. However, struggling to renounce responsibility and place it firmly with each participant (or ‘patient’), Stefan tries to convince her (and perhaps himself) of the benefit and necessity of his approach. Expressing doubts that taking on the responsibility for the participants would have any effect on the success of the participants’ behavior change, he argued that it was a matter of coping for them as educators. The discussion was an ongoing dispute throughout the intervention and was reflected in various discussions about changes to the intervention for the next implementation. The solution that the educators agreed on during one of their planning meetings was to extend the intervention for next time and maintain contact with the participants for a longer period of time.

In summary, health was conceived both as a physiological state of being, construed in relation to risks such as disease, injury and death, and as an attitude of optimism related to the ability to take charge of one’s life. Both of these notions placed the responsibility for health on the individual and related it to lifestyle choices and practices.

**How to improve health**

In order to achieve health as described above, it was assumed to be necessary for the participants to start a regime of healthy physical activities and diet. For the participants to be able to start this new regime it was conceived as necessary that they took the situation and condition that they were in right now as their starting point, meaning that it was conceived as necessary to begin by assessing their current situation and condition. This was done in numerous ways throughout the intervention, beginning with the first HPA and continuing on with various exercises for the purpose of self-assessment of (among other things) dietary and physical activity habits and practices as well as personal attitudes.

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77 Intervention 2, Group interview with the educators, p.3.
One key to achieving and maintaining health was conceived to be physical strength. For instance, physical strength would help in keeping musculoskeletal disorders in check or at bay:

*If one is weak in these muscles [in this case, the shoulder] it is easy to bring about injuries from exhaustion of the muscles.*

To become physically stronger, physical activity was necessary. Besides improving strength, physical activity was also conceived as good for health in so far as it would improve the participants’ condition, balance, coordination, proprioception, and body awareness:

*Stefan:* It’s good for the body to be active /…/
*Stina:* Their condition, /…/ they need to become stronger muscually.
*Stefan:* Balance, coordination, proprioception /…/
*Stina:* Body awareness is important.79

To improve health, it was understood that physical activity should be performed and maintained on a regular basis and should get the participants' pulse up. To achieve this it was conceived as important to choose activities that were appropriate for each individual according to their unique needs and capacities and according to their preferences and desires. To choose appropriate physical activities, then, the participants would need to be clear about what their needs, capacities, preferences and desires were. To become aware of what these were, this required of the participants both self-reflection and submission to probes, tests and experimentation with various physical activities, i.e. active participation in any and all (physical) activities offered in the intervention.

Healthy dietary habits were also understood as important to improve health. A healthy dietary regiment was conceived to consist of regular habits without unnecessary snacking. Furthermore, meal composition in terms of both types of foods chosen (or abstained from) and the amount of these in relation to the other types of foods chosen was perceived to be important. Ideas about what constituted a healthy meal composition were based on the (Swedish) food plate model and the Keyhole symbol80 which in turn are based on the National Nutrition Recommendations. In line with this, the ‘good foods’ were those low in (saturated) fat and rich in fiber81.

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78 Intervention 2, Session 18, p12.
79 Intervention 2, Group interview with the educators, p4.
80 Intervention 2, Session 17, p8 and p9.
To be able to regulate their dietary practices and to achieve a healthy diet, the participants were assumed to need to begin by contemplating their current dietary practices regarding what, when, how and why they ate. At a more practical level and to help them become more aware of their own eating patterns and to take command of these, various exercises were suggested. For instance, they should look at what they’re eating, make sure they taste the food and eat slowly:

*A few ideas are not to eat so fast, look, taste the food and eat slowly.*

However, their healthy practices needed to begin already in the grocery store, where they needed to make the “right” choices in accordance with what they learned during the intervention.

**Constructing the healthy person**

A healthy person was understood as someone who conformed to biomedically set standards. In subjecting the participants to two HPAs (one upon entering and one upon finishing the intervention) and irregular weighing during the course of the intervention, a norm for what constituted a healthy person was construed that drew on a biomedical discourse. This norm referred not only to a set of corporeal standards concerned with weight, blood-pressure, glucose, cholesterol and the like, but also to mental and behavioral standards concerned with drugs and alcohol habits and general lifestyle. Healthy drug and alcohol practices as well as other lifestyle practices were conceived in calculable terms: for example, the number of times in a month, week, or day that something was practiced was measured or the participants were asked to judge their own practices by grading them on a scale between one and five.

In accordance with these norms, and as implicated by the above presented notions of how to improve health, the healthy person was conceived as someone who was physically active on a regular basis and who ate a healthy and wholesome diet. Furthermore and, as also briefly mentioned above about how to improve health, a healthy person was conceived as someone with a positive attitude and who put an effort into mastering the situation they were in. The importance that the educators put into this may be exemplified by one of the women educators’ (Sandra) anecdotes of her own experiences: at times Sandra had stress fractures in her lower leg which had stopped her from running as she usually did. However, this did not stop her from exercising. Instead she went team cycling (spinning) and she held classes in gymnastics for strengthening the neck and back.*

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* Intervention 2, Session 17, p12.
* Intervention 2, Session 25, p1.
educators’ position on the issue, which was that no matter your condition you could, and should, always be engaged in some kind of purposive physical activity, no matter how sick or injured you were. Sandra told me that, according to her, the only valid reasons for not doing any physical activity at all were “if you have a fever or if you’re paralyzed from the neck down”.

In line with this, the educators’ notion of a healthy person was furthermore construed in relation to people living with serious conditions and handicaps, such as Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS) and sitting in a wheelchair. In talking about what constituted health, the educators used these people as good examples and representatives of health: they were conceived as happy and conveying an optimistic outlook on life in spite of their situations and in spite of living with pain:

It’s interesting with pain and health. I saw part of the program [on a person suffering from ALS]. She was looking for positive environments and answers to her disease. There was never any problem. That’s important to health. If one searches for [symptoms], we all have terribly many [symptoms], but it is a part of health to have a positive outlook on life.

Here, the educators construed the healthy person as someone who, despite any shortcomings or difficulties, was happy and optimistic with a positive outlook on life. This was thus the attitude that the participants were expected to adopt. However, happiness and optimism could also be questioned by the educators. In the following quote, the educators were discussing one of the male participants who was one of the ‘jokesters’ in the group and who gave the impression of being ‘happy and frisky’. His weight loss had stagnated and he was perceived to be unable to incorporate the recommended changes into his lifestyle. According to the educators, he had however not yet experienced any of the negative consequences of being obese. Besides considering this as a problem (rather than as a good thing) which was actually causing his inability to change,

his happiness and otherwise general optimism was questioned and construed as a façade:

Stina: But I conceive of Andreas as happy and frisky.
Sofia: But is he? /…/ Maybe he is a bit down and sad but doesn’t want to show it. /…/ The condition in itself can cause feelings, I am this big … I don’t think anybody wants that. And when you see that you have this future, and you don’t want to die /…/ It can depress you. Cause you to strip yourself

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84 Intervention 2, Session 25, p1.
85 Intervention 2, Group interview with the educators, p5.
86 Intervention 2, Observation of educators’ meeting, 2004-01-19, p2.
of self-value. ‘I still have to be happy, even though I’m this big’. 
Stefan: Many overweight people have that image [of being happy].

Here, the participant’s behavior was interpreted through his physical constitution, and being overweight was not conceived as conducive with truly being positive and happy (i.e. healthy). That a fat person like Andreas could truly be a happy person with a positive attitude was construed, if not as inconceivable, then at least as improbable.

The ideal notion of a healthy person, which all of the participants were thus positioned and assessed in relation to, and to which they were expected to aspire served to pathologize the participants and position them as unable to measure up to standard. As such, the participants were positioned as in need of help, a positioning that all of the participants seemed to accept, as this quote exemplifies:

_The first HPA I did, granted, I had been on sick-leave for two months, but I tell you, if I had been a trotter then I would have already run my last race. They would have taken me to the vet or something like that. No, but really I was in a miserable condition._

All of the participants considered that they needed help to find a new lifestyle. Besides acknowledging physical shortcomings, they also positioned themselves as in need of help by problematizing their behavior relating to diet and physical activity. For instance, one of the women participants was quite small and thin and might not have been immediately picked out from a crowd of people as someone who needed help with her lifestyle. She was there for stress related problems. However, during an exercise to raise self-awareness regarding dietary patterns of behavior by identifying and naming personal so called dietary ‘pitfalls’, meaning situations in which one was at risk of eating too much, she was one of the first to say that all of the situations suggested by the educator were pitfalls for her:

_Annika: All of the pitfalls concern me. /…/ The gas station is a death trap. I used to go to unmanned gas stations with automatic gas pumps, but these days I go to those where they have a store too. And then I buy something to eat.
Börje: You don’t look like you suffer from it.
/…/
Annika: Sometimes I buy a hotdog and then I buy chocolates to have_

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87 Intervention 2, Observation of educators’ meeting, 2004-01-19, p3.
88 Intervention 2, Group interview with men participants, p1.
afterwards. [Personnel development] courses are terrible! Usually, we take the complimentary candy into our room just so that no one else will be able to eat from our candy. /…/ I take both fruits and candy. And in the afternoon I linger to see what sorts of cakes or cookies they will treat us with. I’m terrible!

As she started to tell everyone about her pitfalls, she received a comment that she did not seem to “suffer from it”, to which she answered by continuing to list problematic situations, clearly positioning herself as in need of help in this area and as belonging in this group of people, of participants.

To summarize, the healthy person was construed as someone fitting with biomedically set standards for healthy physique and behavior, who was willing to work hard to maintain and improve health, who enjoyed being physically active with whatever physical activity s/he had found that s/he liked, and who ate healthy food in accordance with national recommendations. The healthy person was furthermore a genuinely happy person with a positive attitude and an optimistic outlook on life, who took difficult circumstances and adversity in stride. In relation to this ideal, the participants were positioned as in dire need of help.

Technologies of power

Changing lifestyle related behaviors and becoming a positive and healthy person was construed by the educators as quite difficult. Two factors were conceived to complicate and obstruct the participants’ change of lifestyle: human nature which was conceived to be unchanging and the participants’ drive for instant gratification which in turn was conceived as all the more serious in the light of the stability of human nature:

Change is difficult. The human is at its core stable. … Our brain makes sure that we are stable, that we will tread in the same tracks. That’s why it can be difficult to quit bad behaviors. Old behaviors are well ingrained if you’ve had them for 20 or 30 years. They may give positive consequences at the moment. Positive consequences due to a new lifestyle come much later."

Thus, although the participants were all there voluntarily, drawing on this notion of a stable and unchanging human nature allowed the educators to construe the participants as constrained by this very nature in their ability to change by their own will and as such in dire need of the help that the educators could offer them. Consequently, making the necessary changes was perceived by the educators to take hard work and plenty of motivation on the part of the
participants. In fact, it was perceived to take total indoctrination for the participants to see what they needed to do and to make the necessary changes:

Stefan: …they have to understand that they have to, that diet and exercise influences so terribly much of our body and this they have to understand, try to understand. In five weeks it’s impossible, but in six months we’ll have time to indoctrinate them.

Stina: To get them to understand that it requires of them to do this work. It will take a toll on them along the way, but they will get it all back later.

Sandra: They will get nothing for free.\textsuperscript{90}

According to the educators then, the most important aspect to be able to achieve behavior change was time; time to “indoctrinate” the participants into understanding the importance of a healthy diet and physical activity level so as to maintain health. The educators strove to ‘indoctrinate’ the participants in three areas: self-awareness, knowledge and skills. In ‘indoctrinating’ the participants, all manners of technologies of power were drawn on to guide, shape and direct the conduct of the participants in the interest of health: normalization, exclusion, regulation, individualization, classification, distribution, and surveillance.

Normalization and exclusion

In using the HPA to evaluate the participants’ current level of health, a biomedically set standard was the goal toward which the participants should strive. This standard was defined as the normal to which the participants should conform. This normalization served to define the participants’ bodies as inadequate and in need of adjustment in order to fit in with that norm or to at least approach that norm. To be able to reach this goal, the participants were told that they would need to change several of their current lifestyle practices and habits, to ‘normalize’ these too.

‘Normal’ dietary and physical activity practices were conceived in accordance with national recommendations regarding nutrition and energy consumption. For instance, the educators referred to statistics regarding Swedes dietary practices which showed that at the top of the list of what types of food that Swedes eat and spend their money on was sweets and snacks:

\textit{The most amount of money is spent on things that aren’t food.}\textsuperscript{91}

\textsuperscript{90} Intervention 2, Group interview with the educators, p1-2.
\textsuperscript{91} Intervention 2, Session 17, p7.
Spending a lot of money on sweets and snacks was thus conceived as common and as such in a sense ‘normal’. However, as she went on to describe these foods as “things that aren’t food”, this common/normal behavior was also constituted as misguided and undesirable, suggesting that the participants should avoid this kind of behavior.

**Classification**

Classification was used to guide the participants toward a desired behavior and attitude, as exemplified in this quote:

> **Andreas:** I started exercising in May and then it’s been less and less.  
> **Camilla:** Sounds like helplessness. You don’t run your life, the car, yourself. You are not the actor of your own life. You are a helpless victim with no will of your own. Or?

In this quote, the participant described his declining ability to do what he knew he should be doing. In response to this, the educator called him “a helpless victim”, classifying him as an undesirable Other who was unable to take command over his own life, to maintain his exercise regime and to take responsibility for his own actions. However, her question in the end, the “Or?”, served to try to make him change this approach, to prove that he was indeed the actor of his own life, that he was willing to take command and to take responsibility for his own actions.

In relation to this idea about individual responsibility, the educators were contemplating extending the battery of medical testing performed in the HPA to be able to evaluate the participants’ ‘actual’ ability for it, to be able to medically and physiologically categorize the participants as able or unable to take command of their own lives. The test was concerned with dysfunctions of the thyroid gland, such as a medical predisposition for sedentariness due to hypothyroidism:

> **Sofia:** I think we should amplify the [HPA] testing ... Just so we can establish that they don’t have any medical reasons for lacking in energy.

The tests would thus be used to classify participants as medically able or unable to participate successfully in the intervention. In this manner, not only sedentariness but also the general ability to take command of one’s life was constituted as a matter of biologically predisposed energy levels.

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82 Intervention 2, Session 19, p4.
83 Intervention 2, Observation of educators’ meeting, 2003-12-08, p4.
Regulation

Both implicitly and explicitly, prescriptions and imperatives regarding what the participants were expected to do, what they should or needed to do, in order to improve their health, were plentiful in the intervention. Since human nature was conceived as stable and the participants were conceived as driven by instant gratification, changing lifestyle to become physically active and switching to healthy food was, as mentioned previously, conceived as quite difficult for the participants. In line with this conception, any relapse or failure was due the stability of human nature and as such pretty much expected. The only way to overcome this problem was to exercise one’s will and make a conscious effort to apply this will toward working hard by repeating the new and healthier behaviors time and time again until it stuck as a new habit:

Camilla: You have to change it [your behavior/habits] by will and do it actively. Again and again and again. Then you’ll get a new habit."

And in answer to the question of how one was supposed to manage to do this, Camilla answered:

Become conscious, make up your mind. Actively make your choices. You have to buy the risk of heart attack for every extra thing you eat."

Here, to make the participants understand the gravity of the choices they made every day, each choice was constituted as the potentially lethal one. Thus, participants were regulated toward compliance with the dietary (and physical activity) regimes proposed in the intervention and toward always making active and conscious choices by way of threats to their life. Although it was perceived to take hard work and an ability to ‘get back in the game’ after having had to give in to their human nature, the participants were assured that they would be able to be(come) the masters of their own situation and do the right thing. Basically, all it took was to ‘just do it’. Repeatedly.

In order to be able to ‘indoctrinate’ the participants and help them become aware of their destructive habits, regular attendance and participation in all activities in the intervention was considered to be central. Participants also came to incorporate this attitude although from another perspective. Some of them conceived of invalid absences as disrespectful of the opportunity they had been given to participate in the intervention. Their position was that they

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Intervention 2, Session 19, p4.
Intervention 2, Session 19, p5.
should be grateful and take the opportunity to get as much as possible out of this experience, which did not allow for any absences.

Consequently, absence from any activities was frowned upon and punished by both educators and participants alike. At one level, punishment consisted in withdrawal of the monetary compensation that the participants received for participating in the intervention – compensation to cover for the loss of income they accrued from being absent from work. However, at another level there were more or less subtle means of punishment, such as comments and questions about the absences or giving the latecomer a ‘crooked look’ or ‘the silent treatment’ by ignoring the person. For instance, in this example, the latecomer saunters in about fifteen minutes after a session of spinning had begun and was in a sense reprimanded by way of public shaming, as the educator asked for all to hear:

*Stina: Were you about to abandon the group? Did you find something better to do?*

And at another instance, when another participant was a few minutes late, a fellow participant commented:

*Kennet: Perhaps this is a ‘drop in’ class?*

Such comments served to regulate participants’ behavior and to convince these ‘problematic’ persons to fall back in line and follow the program.

**Individualization**

In accordance with the imperative of active and absolute participation and in line with the idea of making the participants masters of their situation, difficulties performing certain activities were addressed by individualization of (the performance of) the activity in question. Thus, if a participant had trouble performing for instance sit-ups because of pain somewhere or because her/his belly was “in the way”, they were given alternative exercises in which they could avoid the pain or in which their belly would not be in the way and that would still strengthen their abdomen:

*Stefan: …it may be difficult sometimes to do sit-ups. This may be due to weakness or because it [the belly] is in the way. At the same time, Maria who is sitting on the floor illustrates by holding her hand with her fingers spread out a decimeter or so before her belly, trying to*

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96 Intervention 2, Session 18, p2.
97 Intervention 2, Session 21, p2.
lean forward but her belly gets caught on her legs. At the same time as Stefan says it, she says: It’s in the way. /…/ Stefan: You can also stand on your hands [as if prepared for a push-up] and exercise the abdomen.”

The alternative exercise suggested here was the ‘plank’ (or ‘hover’) exercise standing on hands. Thus, even though they might not be able, for some reason, to do a specific exercise, it was repeatedly impressed upon the participants that there were alternatives to each exercise and that they must plan their workouts based on their own abilities:

Stefan: How do you easily train these [shoulder muscles]?
Annika: Push ups.
Stefan: Yes. But according to your own ability. We can do them in different ways. Work out based on your own status in the muscles and joints.”

Individualized work outs was emphasized and construed as the solution to all problems related to performing physical activities. Exercising was also conceived as something that you should be enjoying doing and to do this, the participants needed to find out what activities they liked doing. Hence, in this manner yet again was it conceived as important to adapt the type of physical activity you did to who you were:

Stina: You must also find out what exactly it is that makes you feel good. It's different for everyone. Find suitable forms [of exercise] precisely for you.100

The reason for why it was important to find activities that they liked and that made them “feel good” was a conception that to be able to maintain a physical activity over an extended period of time, as the participants were expected to do, it demanded that the activity was something that they enjoyed doing. Furthermore, individualizing physical activity also served to invalidate any excuse for not participating, for not being physically active.

Surveillance
In the intervention, participants’ bodies, behavior, emotions and thoughts were monitored. Besides submitting to the medical testing in the HPAs, the participants were subjected to weighing every now and then throughout the

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100 Intervention 2, Session 20, p3.
intervention and they were subjected to questionnaires about their behaviors, thoughts and emotional state. In the interest of encouraging participation at all times and of making sure that the participants were doing the work, the educators also registered their attendance each day and for each activity. However, the participants were not only expected to participate and be active during the one day a week that the intervention had a session. They were also expected to continue at home what they had learned there:

The educator goes on to point out that these afternoons [with physical activity in the gym] are to be regarded as opportunities to try this out. Stefan goes on to say that they [the participants] receive training here so that they will know how to do it when they are at home. The afternoon physical activity is thus a bonus and they are expected to do their exercises at home later on.  

The educators also checked whether the participants had performed the recommended physical activity, whether it was taking a walk, doing push-ups, or doing something else, between sessions. This was done both verbally, by asking the participants in group what they had done, how often and for how long, and with an exercise diary that each participant kept or was expected to keep.

Finally, the first HPA together with the HPA performed at the end of the intervention served to allow for assessment and evaluation of the participants’ progress in terms of an improved overall physical, mental and behavioral constitution.

Technologies of the self

Besides being monitored by the educators and fellow participants, the participants were also expected to turn an assessing gaze at themselves. This assessment was primarily concerned with the participants’ physical constitution, mental attitude and with their behavioral patterns. In this section, I will describe some of the devices by which the participants were invited to do work on themselves so as to transform themselves in the direction suggested by the intervention and by the results of their self-assessments.

The means used to turn the participants’ gaze were numerous, and included the HPA and weighing which served to make the participants look at themselves with the eyes of the biomedical standard for what a healthy body is. The physical activity diary and other exercises directed the participants’ attention at their own behavior and served to suggest changes that they could make:

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Sandra: For next week I want you to draw your apartment and mark the places where you eat and then eliminate one of these.\textsuperscript{102}

This request served to direct the participants’ attention toward their dietary practices in their own home and to reflect, not over what or when but where they ate. In this manner, the participants’ homes and their private dietary practices in these homes were constituted as potentially problematic and as such, the participants needed to become aware of this and take command by eliminating at least one eating place.

Besides constituting the participants’ bodies and behaviors as problematic and in need of revision, the participants’ mental attitude was also a target toward which the participants’ attention was turned. For instance, an entire lecture was devoted to the issue of the importance of being optimistic and to look at one’s experiences as something positive\textsuperscript{103}. The lecturer said:

\begin{quote}
We all carry experiences that we value as positive or negative. These experiences define us. … The only thing you can do is to make changes [in one’s approach/attitude] from here, where you stand today.\textsuperscript{104}
\end{quote}

By implication, then, how one valued one’s experiences defined who you were, meaning that valuing one’s experiences negatively meant that you were a negative person. In this lecture, being a negative or pessimistic person was connotated as undesirable and boring. Thus, if the participants currently were prone to valuing their experiences in negative terms, they should change this and learn to look at their experiences from a positive perspective and thus become positive and optimistic persons.

In these manners, and as will be further elucidated on below, the participants were guided toward self-assessment of their own bodies, practices and attitudes and invited to engage in practices of transformation of themselves in relation to these aspects.

**Self-examination**

All lectures may be said to, in an indirect way, have functioned to direct the participants’ attention toward their own being and behaviors, by giving examples of how they should (or should not) be and behave. As such, the lectures offered the participants opportunities to assess themselves against other ways of being and behaving which were construed as the norm. For instance, were they eating the right things, did they exercise enough and in the right way
and were they progressing adequately? Besides the HPAs and the occasional surprise weighings that the participants were subjected to and that served to direct the participants’ attention toward self-assessment of their bodies, the means of inviting the participants to self-examination were the various exercises that the participants were asked to do during lectures and as homework; exercises with the explicit purpose of making the participants take stock and review what they had done and compare this with what they should have done.

One example of such an exercise was when a female priest came in to lead the participants in an exercise in self-awareness and mindfulness. The notion in her lecture of changing attitudes by thinking positively, in this case by shifting focus from troubling to happy memories, tied in well with a previous lecture on optimism as she came in to talk about joy of life and listlessness:

*The moments in life are what we can keep. We can hold on to the images of the happy moments when we’re going through a rough and difficult time. … I have some assignments with me that you, we will be working with. … First, let’s think about what’s meaningful [in our lives] … Then, what makes life difficult. Balance is good but it doesn’t have to be [balanced]. But do [name] at least one positive [thing].* 105

The priest here made the assumption that the participants were preoccupied with ‘difficult moments’ in their lives and the idea behind the exercise was that by making them focus on and identify at least one ‘happy memory’ the participants could be made to change this. The exercise thus served to guide the participants toward becoming aware of and examining the types of memories that they carried with them and that they allowed to influence their outlook on life and thus their general attitude. In examining the memories, the participants were expected to assess whether these were good (‘happy’) or bad (‘difficult’) memories. The purpose of this assessment was to identify and learn to hold on to the good and happy memories – to improve their mindfulness – which would then hopefully come to improve their general attitude too.

The exercise diary that the participants were expected to keep during the intervention was another of these more direct devices for coaching the participants. The participants were given a schedule with proposed physical activities, next to which they were expected to fill in the activities they performed, when, and how many minutes they had performed that activity. This diary served as a tool for the educators to keep track of the participants’ compliance with the exercise regime. However, the diary also functioned as a tool for self-examination. Each time the participants revisited their diary to fill

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105 Intervention 2, Session 20, p8.
it out, the act of filling it out served to reassure the participants that they were indeed following the program and doing what they should be doing – exercising. But it was also an occasion for assessment of that exercise – of the current entry in comparison to the previous entries and in comparison to an implicit or explicit idea of what should have been done and thus of what should be entered in terms of type, duration and frequency of activity. As such, the diary had the dual function of serving as the participants’ bad conscience if it showed that they had not exercised ‘enough’ and of serving as a reward by giving participants a sense of accomplishment if they had been able to fill it out satisfactorily. As such, the diary was a tool for both control and encouragement to get the participants to do the physical activity that it was perceived to take to strengthen their bodies, to produce healthier bodies. Furthermore, it served as a tool for self-monitoring and as grounds for self-assessment and evaluation.

These assignments, along with the other tasks in the intervention, construed specific situations and behaviors as potentially problematic and therefore worthy of scrutiny and assessment and thus served to invite the participants to self-assessment and self-monitoring. The assignments directed their attention to their automated behaviors in problematic situations: they were encouraged to identify these situations and to analyze when they occurred, how they had dealt with the situations previously and to suggest new, and healthier ways of dealing with them. They furthermore served to constitute self-awareness as important to the project of becoming healthy and also served the additional purpose of summoning the participants to self-assess on a more general level by giving them (new) tools to do so.

**Self-disclosure**

Most assignments in the intervention had an element of confession on the part of the participants in them. The participants were expected not only to consider and assess their own behavior, or as in the example above about joy of life, their attitude, but to publicize their findings about themselves to the rest of the group. One such example was when the educators would quiz them in front of the rest of the group about the physical activities they had been doing during the week and the participants were expected to give a full and detailed account of what, when and how long they had been exercising. In answering these questions the participants subjected themselves to publicly confessing to what degree they were adhering to the program or not.

In another assignment, called ‘Pitfalls’, the idea was for the participants to list and discuss risky situations, or the “Pitfalls/situations that may lead you to eat more, or unhealthy food”. A ‘situation’ or a ‘pitfall’ could be a mood, a

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106 Intervention 2, Handout: exercise Pitfalls.
place, a time, or a social situation. The purpose was to collectively come up with ideas and strategies for how to manage these situations, or in the words of the educators, "what you can do to avoid 'lapses'." In this exercise the participants shared examples with each other of situations they found difficult. For example:

Andreas: When you’re away at a conference it’s all about eating. You eat breakfast, coffee, lunch, coffee, dinner, beer in the sauna, and then it’s time for evening coffee.

Rita: Being alone, because then nobody sees anything [of what you’re doing].

And:

Andreas: I get cravings when I’m drunk. Ah, the pizzeria
Annika: The day after is even worse. First you eat nothing at all and then you want everything.
Göran: And it must be greasy.
Annika: Yeah, just goo.

In this manner, as the participants went on describing various situations that they felt were problematic to them, the exercise took on the character of a confessional where each member of the congregation was expected to share their sins, to consider their problems and then to publicize these and share them with the rest of the participants and the educators.

Self-mastery

During the intervention and based on what they learned and came to accept as 'true', the participants came to make up (new) rules of conduct for themselves regarding their lifestyle, especially in relation to their physical activity and dietary practices. In line with these rules of conduct that they set up for themselves, they also made or attempted to make changes to their lifestyle. These changes included adding physical activities or increasing the level of physical activity they were already doing and/or making changes to their dietary practices. Walking was the most popular form of exercise and weight lifting came in as a close second, followed by spinning, swimming and with running as a goal for some. Some chose at times to switch the car for the bicycle when

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107 Intervention 2, Handout: exercise Pitfalls.
108 Intervention 2, Session 17, p10.
109 Intervention 2, Session 17, p11.
going places. However, contrary to the educators’ position on the matter, the participants were of the opinion that there was a limit as to how much one should exercise, because life was not all about exercising:

Göran: Now we’re supposed to do forty sit-ups a day plus push-ups, walks, and so on. Fifteen minutes here and fifteen minutes there and then you won’t have time for anything else.116

Nevertheless, it was not doing physical activity that they opposed, but the amount of physical activity that they were expected to fit into their daily routine. It was thus conceived as acceptable to do less than what the educators advocated. Physical activity was rather conceived to guarantee to make everyday life easier as they became stronger and this was the boon they were reaching for:

Göran: But the ambition with all of it is that it will be, that everything around me will be easier, when I do things, [that] it won’t be hard.117

Regarding their dietary practices, there seemed to be a couple of different uptakes among the participants as to what approach to take. Some were of the opinion that you shouldn’t punish yourself for buying the occasional hamburger and fries and that such food could also be necessary for the purpose of ‘satisfying the brain’:

Göran: You shouldn’t go and punish yourself for buying a hamburger and fries either. I don’t think so. Or at least I will never punish myself for it. I mean, of course, if that’s what I want that day then instead of going around with a damned craving for something. Then it’s better to have it… Niklas: Then it’s about satisfying the brain too. With the food. Often times. Erika: How do you mean? Niklas: No, but maybe you feel really like being extravagant and eat something, or eat something really delicious and then you should sort of, then you should do so because you, feel good from getting to do so too.118

In contrast and in parallel with this more relaxed approach with a broadened sense of how to conceive of healthy behavior, there was also a more ‘frugal’ or strict approach to how and what one should allow oneself to eat:

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116 Intervention 2, Session 16, p16.
117 Intervention 2, Group interview with participants, p7.
118 Intervention 2, Group interview with participants, p20-21.
Rita: I don’t binge in candy or cakes. But I shouldn’t eat anything [like that] at all.

Annika: Because it can’t be about bingeing, right, because if I take one then I take one.\textsuperscript{113}

Here, the participants construed a strictly candy-and-sweets free diet as the only healthy dietary regiment, a notion that served to construe them as failures at self-restraint whenever they ate anything between meals or anything unhealthy. Self-restraint was thus one of the rules of conduct that the participants set up for themselves, and acceptable dietary behavior was thus behavior in line with this notion. The following quote from a discussion about how to deal with various problematic situations (‘pitfalls’), such as in this case the temptations offered when on a conference, is an example in which Niklas from the quote above also positions himself as a good participant in terms of being able to exercise self-restraint:

Niklas: The last three times I’ve been at a conference I haven’t taken any [candy]. I’ve taken fruit instead.\textsuperscript{114}

The following quote, from a discussion about motivation for change, may serve to illustrate the import that the participants placed in finding a way to master their dietary and physical activity practices – their lifestyle – in accordance with the advice given in the intervention and the consequences that some of them perceived could be the result if they failed:

Camilla (external lecturer/therapist): We must motivate ourselves. It is you who have the responsibility. \textit{All} of the time. So, how important is this for you?

Andreas: Superimportant.

Camilla: What will the consequences be for you?

Andreas: I’ll \textit{die}, I guess. I’ll never be a grandfather; I won’t make it long enough.\textsuperscript{115}

For this man, the stakes were perceived as high and death seemed to be looming over his head as a definite possibility around the corner unless he managed to change his lifestyle. In relation to this notion of his it may also be interesting to note that according to the educators:

\textsuperscript{113} Intervention 2, Session 17, p 10.
\textsuperscript{114} Intervention 2, Session 17, p 10.
\textsuperscript{115} Intervention 2, Session 19, p4.
His [Andreas'] overweight hasn’t given him any consequences yet … he doesn’t have elevated levels of cholesterol, pains in his joints, or anything like that.117

Thus, despite being basically healthy (albeit grossly overweight) this man was convinced enough by the risk discourse associated with overweight and obesity that he felt that he was at the verge of dying unless he managed to change his lifestyle.

Gender

In this intervention, gender was generally disguised in neutral, non-gendered notions of ‘people’ and ‘humans’. However, there were a few instances of more explicit gender constructions generally made in sweeping statements about ‘all’ women or men, or about women or men ‘in general’. In these constructions, women were generally construed as the weaker sex, both physically and mentally. One such example was in a discussion among the educators about what approach that was necessary in regards to the participants:

Stefan: The participants are predominantly male. It’s not possible for flibbertygibbets to come and do it [lead an intervention]. You [aimed at the women educators] aren’t like that, and that’s good. But then it might be good that I’m here too. I can tell you of an episode. It was street cleaners with a lot of back problems. They started wearing kidney-belts and two physiotherapists came to teach them. Two flibbertygibbets, then. The guys just laughed and considered it ridiculous that they came.

Stina: You can feel this when you meet these men and also the women, who have a bit of tough skin.118

Here it was conceived as important to treat men participants with a firm hand and not ‘mollycoddle’118 them and it was conceived to be potentially detrimental to the male participants’ confidence and trust in the educators if they were not able to do so. Shining through in the statement that the participants – both women and men – “have a bit of tough skin” are perhaps also prejudices about the participants as ‘workers’, as of working class, and a notion that working class women are equally in need of a firm hand. Thus, in this quote, the participants were classed and gendered in such a way as to be

117 Intervention 2, Group interview with the educators, p1.
118 After conversation with English speaking people, ‘mollycoddle’ (as verb) and ‘flibbertygibbet’ (as noun) appears to be the best translation of the Swedish word ‘tuttinutta’ (used both as verb and noun).
perceived to need a special kind of educator, most often found among men. The male educator also implied that ‘mollycoddling’, meaning in this case a lack of a firm hand, was predominantly a problem among women educators, who thus came to be construed as weaker or softer than men educators. However, he also quickly retracted that statement by assuring his women colleagues that they were not “like that”, and as the present women educators showed no inclination of being ‘flibbertygibbets’, they would probably do as well as he himself would in getting the participants’ confidence and trust.

Women and men participants were also construed as essentially different from each other, but then primarily on a physiological level. For instance, men were conceived as innately stiffer in their joints and muscles, while women were conceived as more limber. Being stiff was construed as a problem to men only when they hunker down, but it was also conceived as a good thing for their posture. Meanwhile, women’s limberness was not conceived as positive in any respect, but was rather construed as resulting in problematic behavior, such as women not using their muscles appropriately:

Stefan: … girls overextend in their knees and hips, which results in them not using their muscles to maintain an upright position, rather, they are ‘hanging in their ligaments.’
Maria: But why is it mostly women who do this?
Stefan: Because it’s easy. You are softer and hence can do it. Guys are stiffer and can’t even do it. /…/ You should be as if arthrodesized [in your back], with a book on the head.

Women were thus construed as limber and this limberness was furthermore construed as problematic because a good posture was conceived as important and this meant to carry yourself correctly, something that limber women had a propensity not to do. This perceived difference between women and men were conceived as determining what types of physical activities that could be considered to be appropriate for women. Even though exercise was consistently construed as very important to achieve and maintain health, another aspect of exercise that was also addressed was injuries, primarily due to lack of enough exercise but at times also as the result of exercise. Although the educator in the quote below acknowledged that men also become injured due to sports, what was focused on and what was discouraged against was women doing specific sports:

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118 Intervention 2, Session 18, p15.
120 Intervention 2, Session 18, p14.
Stefan: Collarbone injuries are inflicted in contact sports. For men it’s wrestling, women when they play handball or soccer. Women shouldn’t train in these sports, is what I say.

Stefan: Of course women should do what they find to be fun, but women are softer, muscles and tendons become exhausted. If they play many matches they will get many injuries. This goes above all for women.

Women were thus constituted as innately weaker, softer and more easily exhausted than men. The educator thus constructed limits to what women could and should do physically and also positioned women as at greater risks due to their fundamentally weak physical constitution. Thus, women were construed to have greater obstacles to overcome in order to achieve and maintain health.

While weakness was primarily attributed to women, it was not discarded as a possibility for men. However, while weak women were conceived and discussed as a problem needing a solution (in this case abstaining from ‘dangerous’ physical activities), weak men were conceived and discussed in terms of ridicule.

In the following quote, the educators had a meeting in which they were discussing the participants’ progress. Here, they were discussing one of the male participants. This participant had been successful in that he had lost quite a great deal of weight. However, according to the educators he had not been successful at gaining a strong enough body. Among the educators, this was cause for making a joke about the participant:

Stefan: … Walks just aren’t enough, it won’t give him any muscles.
Stina: He has no muscles. Only fat.
Sofia: He is so doughy.
Stefan: If he can get started exercising he’ll also get an improved locomotor system.
Sofia: Maybe all inner muscles become limp (she gestures with her hand, indicating a limp penis and all educators laugh and address me, telling me to write that down, that Sofia was talking about his penis).

These constructions served to position the participants (as classed and gendered beings) as in need of a firm hand and to construe women and men as physically different, meaning that women were conceived as innately weaker than men. In these examples, the problem for both women and men had to do with physical strength. For women, the problem was that they were not strong

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121 Intervention 2, Session 18, p11.
122 Intervention 2, Observation of educators’ meeting, 2004-01-18, p5.
C O N S T I T U T I N G  T H E  H E A L T H Y  E M P L O Y E E? 

enough and thus in need of help to become stronger. For men, the problem was rather that they were expected to be strong and when they were not, this was cause for ridicule.

Summary and comments

In summary, drawing on both a biomedical and a wellness discourse, in intervention 2, health was conceived as a state of being to which everyone was assumed to aspire; a state of being that was related to lifestyle choices and practices and that, as such, placed the responsibility for health with the individual.

Informed by a biomedical discourse, health was construed in relation to the risk of disease, injury and/or death and was conceived as a physiological state of being, conceptualized in calculable terms as a specific weight, level of cholesterol or the like. This conceptualization further served to atomize and pathologize the participants’ bodies as the body was conceived as the medicalized object of health which was to be measured, improved upon and evaluated, as exemplified in the measuring taking place in the intervention through such activities as HPA.

Informed, on the other hand, by a wellness discourse, health was conceived as a psychological state of being construed in relation to the attainment of specific positively formulated characteristics and abilities, in this case a positive attitude. And this attitude was in turn associated with the ability to master one’s life. Thus, drawing on a wellness discourse, the notion of what constituted health was expanded upon as optimism was medicalized.

Which-ever discourse was drawn on to define health, a dualistic perception of body and mind was reiterated in which the body was conceived as the recalcitrant vessel over which the mind needed to take command. Thus, the way to improve health was through continuous assessment and monitoring of one’s physical condition, dietary and physical activity practices and habits. Such close self-monitoring would in turn enable the participants to change these practices in accordance with biomedically set standards.

The goal, i.e. the type of healthy person that the participants were supposed to aspire to reach was conceived as someone fitting with biomedically set standards, who enjoyed being physically active with whatever physical activity s/he had found that s/he liked, and who ate healthy food in accordance with national recommendations. The healthy person was furthermore a genuinely happy person with an optimistic outlook on life, who took difficult circumstances and adversity in stride. However, a happy person could only be conceived as healthy if that happiness was expressed by someone with a physiology that fitted with the biomedically set standards for what was
conceived as a healthy body. If this was not the case, the happy person could expect to be perceived as putting up a façade.

The participants were conceived to need to overcome their human nature as essentially stable beings stuck in a destructive pattern of practices and a desire for instant gratification. This was considered achievable by way of indoctrination which would improve their knowledge base, skills and self-awareness. By way of the techniques of normalization, exclusion, regulation, individualization, classification and surveillance participants’ bodies, behaviors, attitudes, thoughts, emotions and progress were governed. The participants were invited to self-govern the same aspects of themselves by way of the techniques of self-examination, self-disclosure and self-mastery.

The effect that the educators were talking about and that they expected as a result of the intervention was for the participants to come to understand the appropriate behavior. In this statement lies an assumption of a direct relationship between understanding and practice. The participants’ unhealthy behavior was thus conceived as a result of their being unaware that their lifestyle was unhealthy, that their lifestyle placed them at risk of disease and illnesses, or how it was affecting their health negatively. From this assumption it followed that education and enlightenment, i.e. understanding, was expected to carry with it changes in lifestyle-related behaviors: that if only the participants understood what the correct, meaning the healthy, behavior was they would do it.

Under a veil of a primarily gender neutral language, women’s physique was problematized while men’s physique was normalized. Women were construed as weak and fragile and subjected to a restricted scope of what could be perceived as appropriate and suitable physical activity, while men were construed as strong and subject to ridicule if they were not.
CHAPTER 6, INTERVENTION 3

Introducing the intervention

The third intervention was set at a large, male dominated lumber/pulp industry with about 1300 employees. The intervention was part of the corporation’s vision and efforts to create a “health promoting workplace”. Besides the intervention, the corporation also offered its employees aerobics and weight-lifting in facilities owned by the corporation as well as membership cards at various gyms in the city, among other things. As part of this effort, a “policy for wellness” (Sw: friskvårdspolicy) had been produced with the goals to improve employee health and decrease employee absence due to sickness. Further goals stated in the policy for wellness were to “increase physical activity levels and improve dietary habits”. The intervention studied here was part of the efforts to achieve these goals.

The intervention was initiated by the Corporate Health Services (CHS) who in turn commissioned it to a commercial actor with extensive experience in the field of WHP. The personnel from this commercial agency engaged in the intervention were educators and a number of consultants. The educator who was engaged during the time of my study was also part-owner of the company. He was a man of young middle age with a background as a physical therapist. The consultants, some with previous education in the field at various levels, had received training by their employer in how to perform the consultations and also expressed a general personal interest in health and fitness.

The intervention was set at the workplace in various company premises appropriate for, on the one hand, seminars and, on the other, individual consultation sessions. It consisted of two lectures one year apart and three individual consultations with a consultant – one consultation following each seminar and one consultation as a follow up three months after the first consultation. The employees were also offered individual health check-ups and an individual consultation, after which the consultant together with the participant formulated an individual action plan. So called “relatives' seminars”

123 Intervention 3, Interview with commissioner (CHS team member), p2.
124 Intervention 3, Interview with commissioner (CHS team member), p1.
125 Intervention 3, Interview with commissioner (CHS team member), p 1.
were also arranged as part of the intervention to allow interested family members to take part in the program, because: “Experience shows that it is difficult to make lifestyle changes if one’s partner isn’t also in on it.”

### Design of the intervention

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
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<tbody>
<tr>
<td>1  Seminar 1:</td>
<td>Seminar 2:</td>
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<tr>
<td>“Your personal health”</td>
<td>Follow up (1 hour)</td>
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<td>(3 hours, obligatory)</td>
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<tr>
<td>2  Individual health check up</td>
<td>Individual health check up</td>
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<tr>
<td>3  Individual consultation 1:</td>
<td>Individual consultation 3:</td>
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<tr>
<td>Goals</td>
<td>Follow up</td>
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<td>(Including HPA + ROM)</td>
<td>(Including HPA + ROM)</td>
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<td>4  Individual action plan</td>
<td>Individual action plan</td>
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<tr>
<td>5  Individual consultation 2:</td>
<td>Follow up</td>
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<td></td>
<td></td>
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<tr>
<td>6  Relatives’ seminar</td>
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Table 6, Design of intervention 3.

All employees at the work-site were targeted and of those who participated in the first seminar, about 90% were reported to have continued in the subsequent activities to some degree. Participation took place on or in conjunction with company time. The first, three hour long, seminar was obligatory for all employees and focused on motivating the employees to change. Due to their large number (1300), employees were divided into several groups and the seminar was repeated enough times to accommodate all employees. At the end of the seminar a list was sent out among the audience for people to sign up to participate in the individual consultation. I learned from one of the participants that I met as I was given a tour of the lunch cafeteria, that there was considerable peer pressure to sign up – he saw hardly anybody who did not sign up. He told me that even he, who really was not very keen on the idea of participating in the intervention, signed up simply because everyone else was doing it. However, at this point in time (about one year later) he was quite pleased that he had because he had lost 12 kilos due to his participation in the intervention. A total of about 900 employees signed up.

Included in the individual consultation was a Health Profile Assessment (HPA) including testing of cardio-fitness and body-fat percentage and, where needed (i.e. if the participant experienced any kind of aches or pains), a Range Of Movement-test (ROM). Based on the consultation, the HPA and the ROM, the participant and the consultant together formulated an individual action

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126 Intervention 3, Personnel magazine, 1st article.
127 Intervention 3, Interview with commissioner (CHS team member), p 1.
plan for the participant. Following the consultation, the consultant sent the participant her/his individual action plan along with information about issues they had discussed; information such as about cravings, stress, fatigue, etc, and how problems such as these could be addressed and dealt with through diet. Between consultation 1 and 2, letters of encouragement were also sent out to the participants.

One year after the first seminar, a follow-up voluntary “reminder seminar” of one hour (repeated nine times to enable all employees to participate) was offered to the employees, also followed by individual consultation. These are the seminars and consultations that I was able to attend and observe. I also observed during a couple of individual consultations with two male participants. The consultations were held a few days after the seminars and in a different building (still in the facilities of the workplace) in small rooms that used to be offices but were at the time empty except for a table and a couple of chairs in each room. The consultants, both women and men, were in their twenties or early thirties. The seminar seemed to have two purposes: on the one hand, to incite and encourage the participants in their (work toward) lifestyle changes and, on the other, the seminar also was something of a ‘sales pitch’ to make participants proceed to the subsequent individual consultations. In the following quote from the follow up seminar in year 2, the educator recited statistics on the changes that the participants had achieved and he encouraged them to continue on the path they had now embarked upon:

After three months, 7-8 % were still at a poor diet, 70 % were at a good diet. This is an incredible change. The average increase in condition was at 15 % at [this industry]. It was obvious at the [previous] follow up that things had happened even if not all of you had quite reached their targets. When you’ve set a goal, perhaps to become less tired, you will get advice, that maybe will be about going to Friskis & Svettis [“a keep-fit organization”], make dietary changes. This increases the energy, water and the physical activity. … There still remain things that aren’t good, but a lot is good. This is why we’re back now, to see what it looks like now. What long-term goal did you set? Was it the same or have you changed it? We take stock according to the list [a list of symptoms] and check to see if anything has changed. We can see that 70-75 % of the new habits, between 60-80 % better blood sugar and condition remain, without us having been there, poking around. So, it’s exciting to see what you need now. If it’s a kick in the butt or if you just want to know what the Futrex [a body-fat measurer] looks like now. Take the chance and come now, based on your needs. About 50 % became better in

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128 [http://web.friskisvettis.se/theidea___189.aspx](http://web.friskisvettis.se/theidea___189.aspx)
The educator drew the employees in with reports of how well they did during the first half of the intervention, constructing the intervention as a solid success regarding helping the participants change their lifestyle. The educator was of the opinion that in order to achieve change, one first needs the knowledge and then the tools for change. Judging from the design and content of the intervention, the knowledge was concerned with metabolism, nutrition and the connection between diet/physical activity and various symptoms, while the ‘tools’ were ideas about how often we need to eat, and how to compose healthy meals. The main thrust of the intervention seemed to lay with providing the participants with information, thus improving their knowledge base, and only provisionally with providing ‘tools for change’.

The intervention was evaluated in progress reports on the development of workforce health status and the status of their lifestyle concerning diet and physical activity (the reports did not have details about individual employees’ health or behavior).

**Constructing truths about health**

In this intervention, the biomedical discourse which construed health as measurable against a standard was again pre-eminent. This was exemplified in the practice of subjecting the participants to Health Profile Assessments and Range Of Movement analysis. This ‘standard’ served to constitute the boundaries between the ‘normal’, meaning the healthy, and the ‘ab-normal’ or ‘abject’, meaning the ill or at risk, body. In this manner, health was constituted in relation to risk, as further exemplified by the “Symptom inventory”. This inventory was a list of symptoms that the educator wrote on the whiteboard before each lecture and then referred to during the lecture. The list consisted of conditions that were construed as indicators of poor health or of being at risk of poor health: Weight gain or loss; cravings for sweets; cardio-vascular disorders; sensitivity to infection; sleep disorders; musculoskeletal disorders; allergies; PMS/menopausal disorders; low threshold for stress; decreased general condition.

Constituted as a goal, an end state, health was also understood as something that could be evaluated once one had reached the age of retirement. Drawing on a medical discourse, health as an end state was understood as successfully

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achieved if you were free of medications. Drawing on a wellness discourse, the goal was understood as achieved if you were able to enjoy life and still enjoy being physically active:

_Educator: I have one goal: To die healthy. I mean, without medications and preferably in action. I don’t want to die in an old people’s home … In order to be able to enjoy being 70 and be able to play golf … I have to take care of myself._

The guiding principle for reaching this goal was conceived as ‘energy’: Energy balance was construed as the source of health and energy imbalance as the cause of ill health, while energy level (stamina) was construed as the result of one’s lifestyle. Energy balance was understood as dependent both on the ratio between energy consumption and energy expenditure, and on the quality, the type, of foods that supplied the energy. This meant that the participants would need to consider on the one hand the amount of energy they ate and expended and on the other the quality of energy they ate.

Energy balance and level were conceived to determine one’s ability to perform both at work and in the private life and although both were discussed, attention was directed toward the private life and how much energy the participants had left for leisure-time activities after a full day at work:

_You must have energy left for after work._

Energy was thus equaled to health in the sense that being energetic and having the energy to deal with everyday situations was conceived as being indicative of a good health.

Energy balance and energy level were related to individual lifestyle choices regarding primarily diet but also physical activity, constituting dietary choices (and to a lesser degree physical activity) as the primary determinant of a person’s health. By constituting diet as the primary determinant of health, the responsibility for health comes to be located with the individuals.

Making the employees take responsibility for their health was an explicitly stated goal of the intervention: “[The intervention] was implemented partly to survey the unknown number of cases with musculoskeletal disorders at the company and to make the employee take responsibility for their own health”.

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132 Intervention 3, Session 3:4, p3.
133 Intervention 3, Session 3:1, p3.
As such, an energy imbalance was construed as the direct cause behind weight gain or loss, cravings for sweets, sensitivity to infection, sleep disorders, low stress threshold and decreased general condition. It was also the reason for physiological conditions such as allergies, PMS/menopausal disorders and musculoskeletal disorders, as in this following quote in which musculoskeletal disorders and ROM inhibition were construed as caused by unbalanced energy intake:

*After a longer period of low energy consumption, the risk for these [musculoskeletal] disorders increases. When the intake of good energy is low and the body expends more energy than what is supplied, the energy deficit must be replenished from reserves somewhere in the body. When the consumption of carbohydrates is low, the body gets its energy from the protein, i.e. the “building-blocks” in the musculature. When the musculature is weakened and strained with monotone movements this also means a greater risk of injury.*

Here, monotone movements and the work environment were disregarded as potential causes for health problems and the problem behind these conditions was rather conceived to be related to individual dietary habits. An inadequate energy balance was construed as destroying the body, as weakening the body, which would then be the reason behind musculoskeletal problems and disorders.

Drawing on a biomedical discourse, health was thus conceived in relation to risks of various undesirable conditions as a physiological condition dependent on the energy balance and manifested in energy level. Energy balance and level were furthermore conceived as the result of individual dietary habits, placing the responsibility for health with the individual.

**How to improve health**

Although the educator acknowledged that behavior change “takes time and is difficult,” the principle for how to improve health was construed as quite simple in the sense that it was constituted in a general principle with very few details for regulating individual behaviors and differences. As described above, the problem behind why people suffered from health related issues was considered to be related to energy levels and energy balance. Energy level and energy balance were defined as dependent on blood sugar levels which in turn was dependent on eating regimes: “A good diet is about achieving a stable blood
A stable blood sugar was described as dependent on both the quality of the foods chosen and on the meal order. However, the educator’s main concern in the intervention was with the participants’ meal order, rather than with discussing the quality of specific foods. Hence, reconstituting the meaning of a ‘bad diet’, the way to achieve and maintain a regular blood sugar level was conceived to be by maintaining a regular meal order:

*We don’t talk about bad food, but about bad energy. A bad diet is to not have breakfast, then have lunch and later a small dinner. A good diet is to eat three main meals a day and possibly snacks.*

Improving health was thus construed as a simple effect of improving one’s meal order which would ensure the participants ‘good energy’. Specifically, the changes that needed to be done were to begin eating breakfast, lunch, dinner and one to three healthy snacks plus enough water – every day. Resulting from these changes in dietary intake regime, participants’ cardio-fitness would improve as would their ability to counteract musculoskeletal problems. The participants were told that further and/or more pronounced effects could be achieved if they also made some concrete changes to how they composed their meals, i.e. the specific foods they chose to eat, but the emphasis was on the meal order.

In the intervention, the focus was clearly on dietary changes. Still, the issue of physical activity also came up and it was variously construed as an optional activity that they could add on in order to assure (faster) results, as an alternative to changing one’s dietary habits, or as key to preventing so called ‘system diseases’. Should a participant, for some reason, not (want to) change their diet they were told that: “then you need to walk 10,000 steps a day and so you won’t have to go to the doctor. This way you will keep most of the system diseases: diabetes, high blood pressure, etc [at bay]”. So, 10,000 steps a day was here promoted as the minimum amount of physical activity needed to stay healthy. Additional effects of physical activity were related to long term effects:

*The best pensions insurance. To walk is a way to be able to use the pension insurance. To have the stamina, I’m not saying that it’s a demand, but you’ll get a healthier skeleton, heart, vessels and the brain. Are there many of you feeling pre-dementia? Consider the oxygen supply to the brain. Physical*
activity influences endorphines, which in turn repre braincells and the nervous system. The waste-products are transported away as we move.  

As such, physical activity was promoted as the ticket to a healthy and active old age.

Constructing the healthy person

In light of the above described notion of health, the practices related to it and to how to improve it, the healthy person was assumed to be someone who conformed to the biomedical standards for a healthy physique, meaning ‘normal’ weight, blood pressure, glucose, cholesterol etc with a full range of movement and no musculoskeletal problems. Furthermore, this person was someone who had a level and balance of energy adequate to performing satisfactorily both at work and during spare-time and who thus was able to lead an enjoyable and full life:

When does one have the most fun? If one is about to faint during one’s spare time? One has to have the energy to be at leisure.

To achieve these things, the healthy person ate three full meals a day plus snacks, drank enough water and was ideally physically active on a regular basis. What’s more, this healthy person realized that she/he had the power to make changes in their own life, set aside time for doing that which must be done and as a consequence was an alert and happy person with whom it was nice to be:

Realize that it is only you yourself who has the power to make changes in your life. Take a positive attitude and prioritize that which really is important to you. The time you set aside for yourself is an investment for increased wellbeing. This to the pleasure of both yourself and the ones closest to you since you will be a more alert, happier and a nicer person to be with.

Moreover, and as a consequence of the notion of a healthy person being a ‘nice person to be with’ and the imperative of being able to enjoy oneself, this person should also be rather ‘mellow’ and relaxed about their (newfound) lifestyle or life philosophy. This meant that they should allow themselves to eat the occasional sweet things, maybe bake cinnamon buns and have one every now and then, “Because life isn’t supposed to be dull” and what could be duller than a fanatic:

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You cannot be a fanatic because then you will become dull. Maybe not to yourself, but to others. I will never become a fanatic.144

Based on an accumulated analysis of several previous interventions, the educator made generalized assumptions about people in general and the participants in particular. These generalized assumptions were concerned with dietary habits and enabled for the educator to describe the participants as suffering from energy imbalance and fluctuating blood sugar:

Many [of you] ate only once a day. One main meal a day. No breakfast, then lunch or dinner. […] At the beginning [of the intervention], fifteen, twenty, twenty-five percent are at an inadequate diet with breakfast, lunch and a small dinner consisting perhaps of sandwiches. Five, ten, twenty, say ten percent are at a good diet. This means that we’re out of gas in the cottages, that is to say, there is an energy deficit.145

Besides leaving the participants lethargic and inactive and causing them to be tired at work and even more tired during their sparetime, the energy imbalance was considered to be manifested in the various symptoms and conditions that the participants had displayed during the HPAs at which “many tested high on blood pressure, blood sugar, cholesterol”146. Other symptoms that may or may not have manifested themselves during the HPAs but that the educator construed as caused by an energy imbalance were weight gain/loss, cravings for sweets, sensitivity to infections, cardiovascular conditions, sleeping disorders, musculoskeletal disorders, allergies, PMS/menopausal disorders, low stress tolerance and a lowered general condition147. As such, these conditions were described as “symptoms” indicating that the participants were suffering from energy imbalance and that they needed to do something to get rid of the symptoms and/or stop the symptoms from manifesting in even worse conditions. This positioned them as in need of help to correct this imbalance.

Initially, there had been comments among some participants on the intervention being a means for brainwashing, for the company to be able to squeeze a little bit more work out of its workers. However, this response diminished rather quickly once they experienced the promised results from following the program.148 Furthermore, as exemplified in the quote below, other participants described knowing they needed to do something, mixed with a
sense of general skepticism toward health imperatives and curiosity about the intervention. Although they might not have perceived of themselves as ‘unfit’, these notions together with the ‘truths’ about the need for continuous self-improvement promoted in the seminar finally persuaded the participants to accept the educator’s proposition that they were in need of the help that the intervention offered them:

Well, it was curiosity I think. Since one’s always been a notorious skeptic of this sort of, of, well, what should you call it, ideas or concepts and wellness and diet. I mean there is a mountain of these things, but they arose a certain degree of curiosity so that, and I think that it has been an incredibly positive surprise, this, the seminar. Uh, I felt that I tended to buy it. What they said. Above all that which concerned dietary issues, woke my interest. So, well, I guess that’s how it is. It’s via the seminar that I at all came to feel that this is something that I can imagine going along with. Sure. And then it’s a little bit like Robert [other participant] said too. I mean certainly one feels that one is neglecting the diet and the exercise. That’s how it was, you know. Even though I also didn’t think that I was particularly overweight or had a poor condition, but, one’s, have passed 40, and one has been working the shift for a long time and, for sure the body has, of course, been more active than what it is now. So that, but, I guess it was time, it felt like, to do something. but this felt good. 149

To summarize, the healthy person was construed as someone fitting with biomedically set standards, who was able to lead a fun and enjoyable life due to sticking to a regular diet, but who was still a nice person to be around because s/he was not a fanatic about it, but was able to maintain a relaxed attitude to her/his diet, eating the occasional ‘non-orthodox’ foods. In comparison to this ideal, the participants were positioned as suffering from energy imbalances which negatively influenced not only their energy levels but also their health, and as such in need of the help that the intervention would offer.

Technologies of power

One fundamental principle of the intervention that the educator promoted was free choice. Subsequent principles were the employees’ voluntary participation in the intervention and voluntary behavior change, as illustrated by this slogan:

Not because you have to but because you want to. 150

149 Intervention 3, Group interview with men participants, p2.
150 Intervention 3, Interview with commissioner (CHS team member), p3.
The slogan was developed and used by the educator and borrowed by the employer who used this on roll-ups during the seminars\textsuperscript{151}. The educator continued to emphasize this sentiment during the seminars:

\textit{You should choose what you want to do.}\textsuperscript{152}

From the educator’s and the employer’s point of view, actions to convince employees to participate, such as making the first seminar obligatory for all employees, were not perceived to detract from the principle of free choice or the employees’ voluntariness regarding participation or behavior change. Instead, the intervention was promoted as an opportunity for the employees, and the participants were promised that it would only take a small effort on their part but that this small effort would pay off in making a big change in their energy level.

An analysis of the intervention suggests that the logics of normalization, regulation and surveillance were the primary technologies of power deployed to guide, shape and direct the conduct of the participants in the interest of health.

\textbf{Normalization}

In the Health Profile Assessments (HPAs), a body that fitted with biomedically set standards and parameters was conceived as healthy and as such normalized. By constituting all deviance from this standard as a health risk, this normalization served to produce a desire among the participants to make changes in their lives in order to be physically able to approximate this standard. The main means to do this, promoted by the educator, was to ‘normalize’ their diet. The ‘normal’ diet, the standard of which the participants were expected to emulate was a regular dietary regime with three full meals plus snacks a day. All other regimes were construed as detrimental to health in one way or another. The idea of the necessity for three full meals a day plus snacks was normalized by drawing on a biomedical discourse by which health could be constituted as the result of a balanced blood sugar.

\textbf{Regulation}

In the intervention, behavior was regulated by invoking the participants’ desire for a fulfilling life and then telling them what they needed to do in order to achieve this type of life. However, explicit ‘finger-pointing’ was an unimaginable practice to the educator who stated that he and the consultants would never tell anybody what they had to do, should do or look like:

\begin{itemize}
  \item \textsuperscript{151} Intervention 3, Personnel magazine, 2002:4 p3.
  \item \textsuperscript{152} Intervention 3, Session 3:1, p2.
\end{itemize}
I hope you did not get a consultant who said that ‘you have to, you must, yuck look at what you look like?’

Despite this declaration, an important part of the intervention was to do just that. The educator told the participants what they had to do or should do regarding their diet – if they wanted to get more energy and become healthier. The participants were regulated toward eating according to the dietary regime prescribed for them by way of invoking the participants desire to have a satisfying life and spare time:

When do you have the most fun? If you’re about to faint during your spare time? You have to have the energy to be at leisure.

The educator promised that adherence to the dietary regime that he proposed would result in the participants experiencing increased energy levels and a better health and, by consequence, a more fulfilling working and private life. Implicit in the above quote was also the threat that noncompliance would result in, in this case, fainting.

Furthermore, they were promised that they would live longer lives which they could fill with enjoyable activities, because they would have the energy for that too, provided they took care of themselves, which meant to eat in accordance with the recommended dietary regime:

You only live once. In order to be able to enjoy being 70, and be able to play golf… then I have to take care of myself, too.

Moreover, and perhaps to an even greater degree, the participants were regulated by way of invoking the participants’ fear of failing physical, mental and social capacities if the participants did not follow the prescribed route:

You need to eat about every three hours. If you get to a point in which you’re out of fuel, what happens then? What does the body do then? It uses the muscles for energy. Then you get tense muscles, you become tense in the shoulders, back, thighs, stop breathing. How many of you look like this [the educator has tightened all of the muscles he has just mentioned and is now supposed to look something like a 70-year old man with a badly bent back]. If you’re on a cruise to Finland, on bad terms with three people and become drunk, then the wallop is right there. You might not have experienced it, but

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153 Intervention 3, Session 3:5, p1.
154 Intervention 3, Session 3:1, p3.
155 Intervention 3, Session 3:4, p3.
with a low blood sugar you become easily irritated. How many of you had the flu over Christmas? /.../ What should we eat in order not to turn sour within, to not corrode into pieces?²⁰

In this manner the educator (and the consultants) spent both time and energy on regulating the participants’ behavior by telling them what they should (want to) do (invoking rules to live by), why it was a good idea to do as suggested (rewards/promises) and why it was a bad idea not to do so (punishments/threats). These promises and threats then served to coach the participants toward making the voluntary and own choice to adopt the recommended dietary regime.

**Surveillance**

The technique of surveillance played an important part in this intervention, as it was used in several ways and to cover several aspects of the participants’ lives. The participants’ bodies, behaviors, thoughts and emotions were monitored and assessed to a degree in the seminars but primarily in the individual consultations in conjunction with the HPAs. The seminars served as a device for surveillance to the extent that it was a place where the participants could expect to be watched by both the educator and each other. As such, it was an opportunity for the educator to survey all of the participants and assess their bodies, individually and in group. As the educator told them, they (the educator and the consultants) were there to “see what’s happened since last – dietary habits, condition status, how you feel, where you are today”²⁰. The participants also felt that they were monitored and assessed by both the educator and each other, as exemplified by a comment made by one of the (male) participants as he entered the room with a pear in his hand: "I took the smallest one so as not to draw any attention”²⁰. As this quote indicates, the seminar was furthermore an opportunity for the participants to gaze at each other, perhaps more in terms of their bodies and assess their achievements than their behavior during the seminar as such. Participants’ gazing at each other was, however, not limited to the seminars but had been ongoing during the time span of the intervention. Participants kept an eye on each other and weight changes were conceived as tell-tale signs of whether or not a colleague had adopted and kept up this new lifestyle²⁰. In at least one unit, the employees had even started something of a competition amongst themselves about who could lose the most weight. This

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²⁰ Intervention 3, Session 3:3, p2-3.
²¹ Intervention 3, Session 3:5, p1.
²² Intervention 3, Session 3:8, p1.
²³ Intervention 3, Group interview with men participants, p4.
activity was referred to in the personnel magazine in positive terms as a “spontaneous activity” resulting from the intervention:

One such activity is the ‘weigh-in’ performed each week at the x-shift in the y-unit - The boys have started to use the scales that are available in the company and then fill in their weight on a sheet of paper on the notice board. /…/ You might say that we have an internal competition going on that results in some jibe here at work. It is of course a bit humiliating for the personnel that it is the boss who has the best results.160

Furthermore, following the first seminar, the focus on diet among the participants had been huge, and participants had kept an eye on what colleagues chose to eat for snacks during breaks and ‘healthy’ sandwiches had been dubbed “[intervention]-sandwiches”. Eating an “[intervention]-sandwich” during a coffee break was perceived as something good, as a sign that the person in question was on the right track. Consequently, eating cookies and other sweets had been made quite difficult:

Oftentimes we had one of those boxes of cookies put away and we took it out for, for coffee breaks. But I’ve begun to /…/ bring with me a lot of fruit, and then some Finn Crisps or some of those Norwegian or flatbreads or yeah, something of that kind is what we all have now. It’s the whole, the whole unit or the four of us who sit in the same room, that do this and so we go shopping every other week or something like that. So this is both for the morning and the afternoon coffee break161.

This collegial surveillance had been one of the purposes of the seminars:

The idea is that all of the employees will hear the same things and that this will create a group pressure and a shared language.162

Besides the seminars, and perhaps more importantly from the perspective of techniques of surveillance, the intervention also included three individual consultations and in each of these consultations the participants underwent an HPA and an optional ROM-analysis. These consultations were as such a major device for surveillance as they were opportunities to measure and assess the participants’ bodies in accordance with parameters as set up by biomedical ideas about health, parameters which included but were not limited to cardio-fitness,

161 Intervention 3, Group interview with men participants, p22-23.
162 Intervention 3, First meeting with commissioner, p1.
weight, body-fat percentage, blood pressure, glucose and cholesterol. The assessment was also concerned with possible changes in the markers for each participant from one consultation to the next, and biometric changes were taken as signs of behavioral changes (or the lack thereof) and used as devices to further query the participants about their goals, habits, behavioral changes, thoughts and emotions and to assess these in terms of their conduciveness for a healthy lifestyle. In so doing, the consultations (as did the intervention in its entirety) also served as a device to direct the participants’ gaze toward themselves, as will be further elaborated on below.

Technologies of the self

In the following quote, the educator stated that the intervention was not about admonitions, about telling anybody what they should or should not do or to comment on participants’ looks; that it was up to them to decide what they wanted to look like and to make behavioral choices conducive to this decision. In accordance with this approach, the participants were asked to reflect over how they felt, how their bodies felt. However, the examples given by the educator still began to suggest what was considered ‘acceptable’ or not:

*When we met a year ago, someone was anxious, someone felt tense, was irritated, felt ‘loose in the flesh’. I don’t know about you, but maybe you experienced some of this. Perhaps someone experienced it all. But what would have happened if our attitude had been that ‘Oh my god, look at you! At your age?!’ What would you have said then? Our pedagogy is based on the idea that you should choose for yourself. It should come from you. Does it [the fat] wobble as much as last year?*

In this manner, participants were suggested to take a look at themselves, compare what they see with what they wanted to see and consider whether their behavior and (perceived) lifestyle could be conceived of as conducive with what they wanted to look like. In the intervention, devices such as this type of self-assessment were used to invite the participants to engage in practices so as to transform themselves in suggested directions, as will be described in more detail below.

Self-disclosure

The set-up of the intervention depended on the collaboration of the participants. They were expected to actively involve themselves and contribute to the process by submitting to Health Profile Assessments (HPA) in individual

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137 Intervention 3, Session 3:6, p2.
consultation sessions. In these assessments/consultations, they were expected to reflect on their own practices, desires and goals and to share these with the consultants to assist the participants in setting up realistic goals and planning the work necessary for the participants to achieve their desired goals. To do this, the participants were expected to confess to all of their practices and habits, good or bad:

Alfred (consultant): Do you weigh about the same as last year?
Olle: A bit less, I think. About 71. I think that’s my ideal weight.
Alfred: What about your diet. You don’t eat so many snacks?
Olle: No. Yes, I eat every third hour. I’ve always done that, haven’t I written that? I only take a fruit in the afternoon and a sandwich in the morning.
Alfred: A tip is to do it the other way around during the days when you train.
Olle: I finish each evening with a sandwich and a fruit. For a while I ate yoghurt, but that’s a sugar bomb, isn’t it?
Alfred: Yes, fruit-yoghurt is. But regular yoghurt or soured milk are ok.
Olle: I guess you should steer clear of sugar and salt.

Here, the participant, Olle, is willingly disclosing and discussing his physical constitution and dietary habits without the consultant needing to explain what or why he wants to know more about. Instead, the participant readily offers the information to the consultant, even making some evaluative comments, showing that he has not only noted but also reflected over his practices. To this end, the seminars had served to prepare the participants and teach them a language with which to talk about their lifestyle, shortcomings and desires related to health. However, should a participant not want to “open up”, the measurements, such as weight, body-fat percentage, etc, from the HPA would do the talking:

[The intervention] gets through on a good level. People get it. They [the participants] come very well prepared to the consultations thanks to the seminars. In the consultations we talk about your health. [...] Everyone doesn’t want to open up, and then they don’t have to. If I can see that they have weight issues I won’t say it. This [the body-fat measurer] is for motivation, not for saying that you’re fat or not. Then you get advice depending on what you want. It’s based on the individuals’ own goals.

Together with the seminar, these consultations/HPAs were the tools used to enable for the participants to start doing the work on themselves, and this work

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164 Intervention 3, Consultation 1, p1.
165 Intervention 3, Interview with consultant, p1.
began and was to a certain extent upheld with their self-disclosure in the consultations.

Self-examination

In the intervention, the participants were guided toward the practices of self-examination and self-assessment for the purpose of achieving and maintaining health. For instance, the educator directed each participant’s gaze toward themselves, in this case their corporeality, by asking them if their fat “wobbled” and by reminding them of how they had felt a year ago. This evaluation helped to establish a connection between what was perceived to be the cause and effect. He also suggested that they should review, take stock of their actions over the past year and compare what they had done with what they should have done:

> When we met a year ago, some of you were worried, felt tense, were irritated, felt loose in the flesh. /…/ Does it [the fat] wobble as much as it did a year ago if you do this [the educator jumps up and down]? What have you done?

Continuing to direct the participants’ gaze toward their bodies, the educator talked about posture, clothes sizes, and the position of their belts (were they able to wear it ‘correctly’ or did they have to but it below the belly), thereby suggesting these as further devices for examining, assessing and judging their health and lifestyle by. Further devices to turn the participants’ gaze toward their corporeal bodies were self-assessments concerned with considering the presence and extent of various symptoms as indicators of a problematic diet; symptoms such as sensitivity to infection, PMS, and allergies.

Another important marker in this intervention, which the participants were expected to examine and assess in order to evaluate their progress and maintenance of a healthy lifestyle, was their levels of energy and stamina and their levels of alertness during their work and during spare time. In the following quote, a participant in a consultation session, in an act of self-examination, was reviewing what he had done, comparing this to what he knew (had learned in the intervention) that he should have done, thereby assessing and judging his own behavior:

> Pernilla (consultant): You were here about a year ago. How has it worked out for you?
> Tor: I guess it’s wrong to say so, but it’s been a lot in life and I haven’t had the energy to think about me. I’m active in the union. I don’t have time to think and so I’ve fallen back into old patterns. It worked the first month.
ate oatmeal for breakfast, but then I wanted to sleep longer in the mornings and started to eat breakfast at work instead. /…/ I eat lunch, but not always dinner, it hasn’t worked out. We’ve had dismissals this summer so a lot of the energy has gone into work. I take walks, however, and do some swimming. I started doing it, but there’s so much work. I feel that I feel better when I exercise. But I don’t have the time. /…/
Pernilla: Do you feel tired in the afternoon? /…/
Tor: Right after lunch, yeah, then I’m alert again by four or five.\textsuperscript{167}

This quote shows how the notion of individual responsibility functioned to give the participant a bad conscience about blaming his circumstances for his current situation (feeling tired) and lifestyle. What the man was saying here was, first, that he knew that it was wrong to blame his circumstances rather than taking responsibility for his own actions. The quote also exemplifies a process of self-examination in which the participant described his failure in maintaining new dietary and physical activity behaviors. The consultant picked up on this, asking the participant if he “feels tired in the afternoon”, directing the participant’s attention toward his energy levels and reminding him to evaluate these in relation to his dietary and physical activity habits. In this manner, she confirms his initial notion, that he was wrong to blame his circumstances for his behavior and reaffirms the connection between dietary and physical activity behaviors and energy levels, thus reiterating the need for him to be more self-disciplined.

Self-mastery

According to the participants, even before the intervention, they had accepted the ‘truths’ of the public health imperatives concerned with dietary and physical activity habits and were already quite aware of ‘good’ and ‘bad’ practices and of when they were doing the ‘wrong’ thing: “You have it in the back of your head, that this, this is wrong and this is right and this maybe you, this is wrong so maybe you don’t have to gorge on so much of that.”\textsuperscript{168} The intervention then was considered to be a nudge in the right direction, a nudge toward starting to behave in the way that you, in the back of your head, already knew that you ought to be behaving:

\begin{quote}
Astrid: I think it [the intervention/seminar] gives you a little, boost from it, you know, that you get, a little something to think about to get started.
Mona: A small nudge that now you have to do something, that is needed, then. Because you have it in your head that you should do something. But it
\end{quote}

\textsuperscript{167} Intervention 3, Consultation 2, p1.
\textsuperscript{168} Intervention 3, Group interview with men participants, p3.
is, like I said, it doesn’t get done. But when doing this, all the way from the start, because we are in the second round [second year] now, then, sort of; then, yeah you got that extra nudge that now, now I will get started.

Acknowledging the ‘truths’ of ‘good’ and ‘bad’ dietary and physical activity practices and habits and converting these ‘truths’ to rules of conduct, the participants came not only to eat according to the dietary regimen put forth in the intervention, but also to adapt their foods when wholesome alternatives came on the market: “…you become more and more aware, so to speak, of what you, there are actually alternatives, there is a supply now too. There didn’t use to be before. There is enough now that you can choose.” These rules of conduct also included the occasional allowance of transgressions, allowances that may be perceived as adaptations of the educator’s admonitions not to become a fanatic and being able to have a cinnamon bun every now and then:

On the weekends you want to eat that which is tasty and unhealthy. You have to eat it; you have to feel good too. It shouldn’t, you know, be exaggerated in either direction really, you know.

And:

Robert: You have to be able to do that. No but, you have to, you have to feel good and live and have, feel that you can allow yourself something, so to speak. Not just like, have a tunnel vision and look and count calories, count, I mean, if you have a reasonable so to speak balance, well, then it works. Are you supposed to become a fanatic, well, but

…

One: Yes, if you have everything under, but say if you keep it within a reasonable level then its, common sense and balance.

In relation to these ‘truths’ and the further ‘truth’ of health as energy, the participants were guided to set up personal goals during the individual consultations. These goals were intended to guide the participants’ conduct and reaffirmed the ‘truths’ as presented to them by the educator and the consultants: “[m]any employees state that their overarching goal is to become more alert and efficient, both during and after the work-day.” The participants converted the ‘truths’ of the discourses not only to rules for their

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170 Intervention 3, Group interview with women participants, min 0-1.
170 Intervention 3, Group interview with men participants, p28.
171 Intervention 3, Group interview with men participants, p21.
172 Intervention 3, Group interview with men participants, p29.
own conduct, but also to ‘truths’ about how they evaluated their daily living practices. For example, they reported that, owing to their now eating breakfast, or better breakfasts than they used to, and snacks in the form of fruits, they now felt much more alert in the mornings and during the day than they used to:\footnote{Intervention 3, Group interview with men participants, p21+22.}:

*And then you noticed after a while that it worked much better both physically and mentally. Definitely mentally, I’d like to say. Much more alert and more energetic. And then you noticed that quite a great deal happened with the body [weight-loss], once you had appropriated this.*\footnote{Intervention 3, Group interview with men participants, p24.}

However, as this next quote will show, some participants also found other reasons for maintaining new behavioral patterns, constituting their own ‘truths’ and converting these into rules of conduct for themselves: One of the male participants, for example, described how he started walking home after work. Although he suggested that he started doing it in response to the intervention, his explanation to why he continued to do this one year later did not refer to increased energy levels or decreased symptoms as the educator had been talking about. Rather, he had found his own reasons for keeping this habit up, which, drawing on a wellness discourse, had to do with a sense of wellbeing and of clearing his head after work:

*…in the beginning when you started to walk, then it was more for, you know, weight-maintenance maybe. To get started and to feel better, so, but what I’ve noticed is this mental wellbeing when, like this morning, for instance [a sunny and warm morning] when you’re walking to work, that’s unbeatable. And also that you, well, ponder, walk in your own world. And the same thing then, when walking home, above all, because the girlfriend notices immediately when, when I haven’t had this 40-minute walk, if she comes and gets me or if I take the bike or something, because then you’re still in work and you sort of haven’t finished. Because it can be a lot in a day if you have very much going on. But walking, if you’re walking home then that’s, the pieces fall into place and then you can put it to the side, so it’s really good actually.*\footnote{Intervention 3, Group interview with men participants, p10.}

In this manner, it was possible to find personal reasons and motives for continued self-mastery.
Gender

According to the educator, feedback received from previous implementations of the intervention at other workplaces had been critical of the intervention on the grounds that it was perceived as “too macho.” The educators interpreted or construed this as a consequence of their (the educators’) failure to address the biological differences between women and men: “Because there is a difference /…/ Women’s bodies and systems are more fragile and demand greater care.”

On this precept, the intervention seminars were adapted and now explicitly drew on essentialist notions of women and men, meaning that women and men were understood and described in the intervention as essentially different from, but complementary to, each other. In the intervention, this construction of gender differences served at least two functions: 1) to explain, motivate and perpetuate perceived psychological, physical and behavioral differences with biological arguments, and; 2) to explain why women did not achieve as good results as men did in the intervention. The means through which the educator sought to convince the participants to accept his understanding of gender differences was by aiming to make the information “simple, clear, positive, and captivating” and through using humor as the seminars were “based on laughter and affinity among the participants.” Much of the ‘laughter and affinity’ was sought through the essentialist descriptions of women and men. However, presenting these gender constructions as comic relief served as a cover for misogynist conceptions of women as the ‘problem’ when constructions of gender were used to explain participants’ success or failure in the program.

Weight and weight loss were prioritized issues during the seminars and often used as examples. In these examples, women were construed as at a disadvantage in loosing weight due both to biological and social reasons although the social reasons were conceived as derived from, that is caused by, the biological. The two primary biological reasons for why women were construed as being at a disadvantage and men at an advantage were because of fat distribution and hormones. While men were described as basically made to loose weight, women were described as made to function as fat-gatherers, which was furthermore considered to be a problem:

*Women’s bodies are programmed to collect fat, men’s to burn fat.*

And:

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177 Intervention 3, Interview with educator, p1.
178 Intervention 3, Interview with educator, p1-2.
179 Intervention 3, Interview with educator, p5.
180 Intervention 3, First meeting with commissioner, p1.
181 Intervention 3, Session 3:3, p1.
Men have their fat distributed in the muscles, so when they introduce carbohydrates, water and oxygen they burn this fat away. ... If you, as a man, have too much fat, then you should eat protein to activate the emission of fat. ... What about women? They have less muscles and the fat sits under the skin. Like a lifesaver-ring around the waist and a spool-shaped part here [educator indicates hips and bum]. We [men] have a hormone called testosterone that burns a lot of fat. Women have estrogen – they also have testosterone, but mainly it’s estrogen. What does estrogen do? It collects fat. She needs to eat good fats. Estrogen is a problem, then...

So, how fat is distributed physiologically was construed as different between women and men, to men’s advantage for weight loss. According to the educator, men’s fat deposits are disseminated within their muscles, while women’s fat deposits are gathered in discrete deposits under the skin in specific places in the body. To illustrate his point, he compared women to pork chops and men to loins of pork:

Guys have a greater muscle mass. Men have their fat disseminated in the muscles, like a loin of pork. ... Women have a smaller muscle mass and more stuffing. It’s under the skin and must be transported before it can begin to be burned. If you imagine a pork chop.

The consequence of this distribution was conceived to be that men are able to burn fat faster and better than women because their fat is already in the muscles, where it should burn, while women’s fat have a longer way to go before it can be burned. Although described as natural, women’s propensity to gather their fat deposits strategically over the hips and thighs was thus considered a problem. The educator professed that the only instance when women had an advantage in weight loss was during pregnancy and especially during breast-feeding. These times were described as opportunities to get “wickedly into shape,” provided she also continued to eat right, which meant:

If a woman has difficulty losing weight, then she should decrease the carbohydrates, increase the good fat and increase protein, preferably lentils, beans and sprouts, because you are gatherers from the beginning. Women don’t feel as well [as men do] from meat and a cream-sauce.

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182 Intervention 3, Session 3:5, p3.
183 Intervention 3, Session 3:1, p4.
184 Intervention 3, Session 3:3, p1.
185 Intervention 3, Session 3:6, p3.
Here, the educator promotes the notion that women should eat vegetable protein rather than animal protein, which is described as better for men, thereby perpetuating the notion of women as vegetable eaters and men as meat eaters.

In the following quote, this is developed with the physical norm for men being constituted in opposition to undesirable ‘feminine shapes’, which are in turn represented as breasts and belly:

*Men who drink beer get more feminine shapes. They don’t become feminine, but they collect fat where women collect it, in the breasts, the belly. There’s nothing wrong with drinking beer, but not every day, maybe.*

Besides constituting the male body as an ideal and the femal body as abject, comments such as these also served to instruct the participants to engage in assessing themselves and others using a naturalized set of assumptions about women and men. They were thus invited to position themselves and others as adequately or inadequately feminine or masculine. This furthermore served to constitute successful corporeal femininity/masculinity as a result of one’s lifestyle.

Besides their biological makeup constituting a problem for women, their social habits as inherited and determined by their historical legacy from the Stone Ages, was proposed by the educator as another problem. Men were described as having an easier time making changes and following the program, and this was considered to be ‘only natural’:

*Education: Who do you think have an easier time following our program? You get a program*

*Male participant: Men.*

*Education: Why?*

*Male participant: It’s only natural.*

*Education: Because if you [as a man] think that it sounds fair, then you’ll do it. You will drop that which sounds bad.*

This difference was explained as a result of women and men being essentially the same as they were during the Stone Ages. Specifically, women, as gatherers with a propensity to “try different things”, were fickle and indecisive (i.e. emotionally driven) while men, as hunters with a propensity to do “one thing at a time”, were single-minded and resolute (i.e. rational):

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145 Intervention 3, Session 3:8, p1.
146 Intervention 3, Session 3:2, p1-2.
What is the difference between men and women in almost everything? Women try different things. Why do they do this? They are gatherers. Men hunted and were supposed to defend the women and the silver-male [sic] took care of the home and lived the good life. If a man wants an elk, then he sits on the lookout and he shoots the elk – one thing at a time. How many women are like that? … If a guy decides to loose weight, then he does it. Women have a harder time at it, they have more things to do, they have more of a bad conscience. Women have greater cravings for sweets.\textsuperscript{188}

And furthermore:

\textit{Men have a tendency to do one thing at a time. Have you thought about that? They don’t knit, iron, plan lunch-boxes … Women often tire of doing things in one way all of the time. We’ve seen that this is a problem in [this program], because in it one has to do it in one way.}\textsuperscript{189}

So, not only were women and men construed as essentially different, these differences were also construed as the innate reason for how the intervention was received and for the success rate of women and men in the program, exempting the educator from any responsibility for women’s (or men’s) potential failure. Rather, the responsibility for women’s failure was placed on themselves while a responsibility and expectancy for success was placed on men.

Summary and comments

In intervention 3, the idea of health was constituted in terms of energy, in the sense that being energetic and having the energy to deal with everyday situations was understood as being indicative of good health. Energy balance and energy level were described as the result of individual lifestyle choices regarding primarily diet but also physical activity. In this manner, the responsibility for health came to be located with the individuals.

Drawing on a biomedical discourse, health was explained in relation to risks of various undesirable conditions as a physiological condition dependent on one’s energy balance and manifested in one’s energy level.

A wellness discourse was drawn on when defining the goal that the participants should strive to reach in the positive terms of enjoying life. Hence, the degree to which one was enjoying life was promoted as a measure of health. In this manner, the wellness discourse once again served to expand the scope of

\textsuperscript{188} Intervention 3, Session 3:3, p1.
\textsuperscript{189} Intervention 3, Session 3:7, p2.
what could be conceived to be constitutive of health as joy of life came to be medicalized.

The way to achieve these forms of health was assumed to be through a diet regime primarily consisting of a regular meal order but that could be further fortified by making conscious food choices and by being physically active. The superior physical activity was walks, more specifically 10,000 steps a day.

The healthy person was defined as someone fitting with biomedically set standards, who was able to lead a fun and enjoyable life due to sticking to a regular diet, but who was still a nice person to be around because s/he was not a fanatic about it, but was able to maintain a relaxed attitude to her/his diet, eating the occasional ‘non-orthodox’ foods. In comparison to this ideal, the participants were positioned as suffering from energy imbalances which negatively influenced their health.

Participation in the intervention was promoted as voluntary and the changes participants were expected to make were described as small changes with potentially big effects. All the participants needed to do was make a conscious choice about making this small dietary (and perhaps physical activity) change. By way of the techniques of normalization, regulation, and surveillance participants’ bodies, behaviors, thoughts, and emotions were governed. The participants were invited to self-govern the same aspects of themselves by way of the techniques of self-disclosure, self-examination, and self-mastery.

The intervention was informed by essentialist notions of gender which was used to describe men as superior regarding losing weight and women as inferior in this respect. This was understood to be the consequence of both differing (masculine and feminine) physiology and behavior, both of which were described as underpinned by biological predispositions inherited from the Stone Ages. Even though both women and men were assumed to be capable of change men were conceived as better at behavior change due to their mentality which made them able to focus, while women were more likely to be ‘scatter-brains’. Furthermore, men’s bodies were explained as being superior to women’s because, due to evolution, men’s bodies were made to loose weight while women’s bodies were made to gain weight. Women’s physiology was thus conceived as an innate problem and overweight was constituted as natural and to be expected on a female body but also as undesirable and unhealthy. On a male body, overweight was constituted as unexpected but it was also constituted as undesirable by describing it as ‘feminine’. By constituting a successful corporeal masculinity as a matter of weight and weight as a matter of lifestyle choices, successful corporeal masculinity was constituted as the result of one’s lifestyle.
CHAPTER 7, INTERVENTION 4

Introducing the intervention

The fourth intervention targeted local government employees in a small municipality in mid-Sweden. It was initiated by an employee health interest group as a response to a request from employees. The project was commissioned to a local female entrepreneur in health education. Her background was originally in daycare management and she still retained a part-time position in that capacity. She had also, however, taken courses in health education and maintained a business on the side in this field. The educator was in her early 60s and was a well known health educator in the region. Most of the participants had encountered her during one or another health and fitness activity in the area as she was also an aerobics instructor, and some of them also knew of her in her capacity as a daycare manager.

The intervention was advertised on posters on billboards and via mail directly to the employees. All employees of the local government with an interest in “Getting motivated to: Get started exercising, Loose weight, Become conscious of Your stress-signals”, were targeted. Employees submitted their applications for participation to their employer, the local government. For some of the participants, the educator’s name on the poster had been an important or even the determining factor because they knew of her and felt convinced that they would receive a quality course with her as the educator:

Lisa: First of all, we know Tina [the educator] a little bit. She’s a strong person who gives you a lot.
Agne and Maud: Mm.
Lisa: I trust that, if she had a course, then it would be a good course.
...
Lisa: And Tina has been over instructing us in back-gymnastics before. And Agne [other participant] took aquarobics with her.

190 Intervention 4, Poster advertisement/invitation.
191 Intervention 4, Group interview with participants, min 6.
192 Intervention 4, Poster advertisement/invitation.
Agnes: Mm.
Lisa: You know, that she has something to give you. You feel safe knowing that it’s her.\textsuperscript{159}

In total, there were twelve applicants, all women, and they were all accepted and enrolled in the intervention. Participation in the intervention was partly financed by the employer and partly by the participant herself. I learned of the intervention from a contact I have in the local government and was granted permission by both educators and participants to participate and to record the sessions.

The participants were aged between late twenties to early sixties. Most of them worked at various pre-schools and daycare centers run by the local government\textsuperscript{194} and one person worked at the social services department. A final participant did not work for the local government at all but ‘tagged along’ with one of the other women anyway. During the first session, for which eight people showed up, five of them described themselves as quite physically active and enjoying it. Two were less active, and one of these individuals thought exercise was rather boring.

The intervention took place in facilities arranged for by the educator, and it took place during the evening, meaning off working hours and in the employees own time. It was designed as a study circle, because, the educator said, she wanted all of the participants to be part of shaping and planning the course while she herself would rather be there as a coach, helping the participants along:

\textit{The idea is that we together will plan the course, discuss, and give each other tips and ideas. I’m here to coach you and help you.}\textsuperscript{195}

The only set criteria for the intervention, the educator said, were that the intervention would consist of ten sessions, two hours each. However, the educator also brought a course book\textsuperscript{196} which she suggested would be good for the intervention. As they all agreed that the book would be fine as course material, the book also came to decide most of the content of the intervention and the educator frequently referred to the book during sessions and everything

\textsuperscript{159} Intervention 4. Group interview with participants, min 5-6.
\textsuperscript{194} However, although some of the participants knew of the educator in her capacity as a daycare manager, the educator was not also their supervisor at work.
\textsuperscript{195} Intervention 4. Session 1, p3.
\textsuperscript{196} Kihlman, Iris (2003) \textit{Life is yours! – about diet and exercise, stress and motivation} (Livet är dit! – om kost och motion, stress och motivation), ABF’s Health School, Workers’ Educational Association of Sweden.
she said during the intervention was in line with the contents of the book. Thus, the course book came to play a significant role in the intervention.

During the first session, the design of the intervention was discussed and negotiated. As per the participants' request, it was decided that the ten sessions would take place fortnightly and be spread out over two semesters, with five sessions during the spring and five sessions during the fall. On the educator's suggestion it was furthermore decided that everyone would go out together for a walk or do some other physical activity for the last half hour of each of the ten sessions. The educator also decided that, between each session, the participants would be given homework and these assignments were taken from the course book.

As it happened, the main focus through the spring came to be on physical activity, while through the fall the focus was on diet. During the first session, the educator gave an introduction on the concept of health and ideas on how to achieve (better) health. The participants were also asked to set up a personal goal toward which they would strive throughout the course. The second session (which I did not participate in) focused on physical activity, the third on mental training, the fourth was cancelled and the fifth was an introduction or 'try out' yoga class. Besides regular walking at the end of each session we also tried stick-walking once.

**Constructing truths about health**

Health was constituted drawing on discourses of both biomedicine and wellness, as in this example where the educator used the WHO definition of health when introducing a discussion about what health is:

> Health is not merely the absence of disease but also the presence of physical, mental and social well-being.\(^{197}\)

Health was also defined in relation to the health coordinate\(^{198}\) which served to illustrate a relationship between wellbeing (positive health) and ill health (negative health) on two continua in a coordinate axis (see diagram below). By constituting health and wellbeing in this manner, in relation to disease, illness, infirmity or death, the risk of falling ill or dying comes to be ever present in its very definition and thus health is construed in relation to notions of risk.

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\(^{197}\) Intervention 4, Session 1, min 28-29.

\(^{198}\) Intervention 4, Session 1, min 50.
Diagram. The relationship between well-being and ill health (the health coordinate), adapted from Downie, Tannahill and Tannahill (1996) as reproduced in Medin and Alexandersson (2000).

Drawing on biomedical ideas, health was conceived as measurable in terms of BMI, condition and resting pulse. With these as markers, it was thus conceived as possible to measure health status and improvements in health for the participants. Stabilizing certain biological markers (e.g. BMI) at ‘normal’ values, or to constantly improve other markers (e.g. resting pulse/condition) were thus construed as key to achieving and maintaining health. However, one’s level of physical activity was also conceived as an important indicator of one’s health status:

*It is better for your health to have a higher BMI and be physically active than it is to have a low BMI and be sedentary.*

Specific behaviors related to physical activity (and diet) were thus construed as indicative and constitutive of health. In the course material, “the fit body” was achieved through diet and physical activity and “the most important step toward a better health and greater wellbeing” was construed, besides exercising in the right way, as “*‘the right food at the right time’*”. Physical activity was also described as the best medicine of all times, and as something that makes you feel good and happy.

However, health was also constituted in relation to Antonovsky’s notion of Sense of Coherence (SOC):

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199 Intervention 4, Course book, p.7.
200 Intervention 4, Course information material, p.3.
201 SOC is “a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one’s internal and external environments in the course of living are structured, predictable and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement.” (Antonovsky, Aaron. Studying Health vs. Studying Disease, Lecture at the Congress for Clinical Psychology and
Educator: There is, a concept called … SOC. It is coined by, Aaron Antonovsky, is his name, [he] is one of these, health prophets. [This concept] means that it [life] should be comprehensible, that life must be manageable, and meaningful.

This notion of health was mirrored and expanded on in the course book (although Antonovsky was not explicitly mentioned), and served to constitute health more in terms of quality of life:

*Zest for life and quality of life is not just about physical health. It also has to do with self-reliance and inner balance. Having something meaningful to do and being able to influence one’s situation. Having good relations, people that are close to you. Being a thinking and feeling person with the capacity to handle problems and plan for the future, but also with the ability to live in the now; with a positive attitude and curious about life.*

Here, health was conceived more in psychological terms as qualities of personal characteristics, attributes and capacities. Consequently, although during the first session all sorts of factors that were considered to influence health were mentioned, such as social circumstances and standing, heredity, age, environment, etc, the focus in the intervention was nevertheless on lifestyle issues, meaning, for example, what the participants themselves could do to improve their health through diet and physical activity. Thus, the responsibility for their health was placed with the participants themselves.

To summarize, health was conceived as both a physiological, measurable state associated with risks of illness or decreased wellbeing as a result of deficient physical activity and dietary habits and a psychological, qualitative state associated with mental capacities. Both notions constituted health as an individual responsibility.

**How to improve health**

To achieve health as described above, it was assumed in this intervention, as it was in all of the others, that the participants would need to change their diet and physical activity levels. Thus, ideas about how and what they should eat and exercise were provided to them from the educator and via the coursebook. These ideas about how and what they should eat and exercise were described as a more ‘natural’ way of living by, among other things, making comparisons to notions of how we lived during the Stone Ages:
We have forgotten that we pretty much are the same biological creatures today as when we ran around hunting with a stone-ax 10,000 years ago. Back then, we lived a mobile and active life out in nature; the body is meant for it. Sometimes there was an abundance of food, long periods of time food was scarce. That is why we have the ability to gather fat in our tissues, a sort of built in reserve cupboard to use when times are tough. Today, most of us have sedentary jobs. The food is neatly and easily captured on the shelves in the store; French fries and other half-fabricates, soda, chips and other stuff with way too much fat or sugar and too few nutrients in them. The fat cells hoard up, but the period of starvation never comes. We simply have to plan for a more natural life. Regular exercise, pleasurable enough that it actually gets done. Better food, so fresh and tasty that it will become a pleasure to eat right.

The ‘natural’ diet was thus construed as fresh and tasty, a pleasure to eat. Despite this emphasis on the need for fresh and tasty food to make it pleasurable to eat right, this focus and construction of a healthy diet as something pleasurable was not picked up on in further recommendations for healthy eating. Rather, the right food was related to one’s level of physical activity, calculated in terms of calories, described in terms of nutrients that it should provide, and conceived of in accordance with recommendations from the National Food Administration. This suggested a notion of the right and healthy food as something objectively calculable, instead of the subjective measurement and embodied experience of ‘tastiness’.

The participants were also told that they should become more physically active, which was also construed as a more natural state of being. Even at a low intensity, physical activity was described as having desirable effects. The healthy minimum dosage of physical activity was described as being in accordance with experts’ recommendations as 30 minutes of brisk walking a day. However, both the educator and the coursebook material proposed that the physical activity chosen must be pleasurable, meaning that the type and amount of physical activity that one did should be adjusted to one’s own condition and capacity. If it were not, it would be difficult to maintain. Pleasurable physical activity was thus not necessarily related to hard physical training: “you do not have to work out hard enough to bust a gut, [because] you get a good effect also from low intensity training”. Hard physical training was construed as, if not a foreign idea, then not particularly pleasurable to the participants. Instead, and referring to “the latest recommendations”, the participants were suggested to

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204 Intervention 4, Course book, p4.
205 Intervention 4, Course book, p8.
207 Intervention 4, Course book, p8.
do low intensity training which, they were told, may very well consist of a brisk walk, preferably half an hour to an hour every day. Walking was thus defined as pleasurable.

On the other hand (and without reference to it being pleasurable), the coursebook also told the participants that being physically active should be done by taking advantage of all of the “natural” opportunities for movement that appear in one’s everyday life:

*Remember to take advantage of all natural opportunities to activate yourself in your everyday life. Walk the stairs instead of taking the elevator. Take the bicycle to work if it is possible, or step off the bus a couple of stops earlier and walk the rest of the way. If you go by car, park the car a ten minute walk from work. Take a walk during lunch. Rake your garden or shovel snow, depending on the season.*

Being sufficiently physically active was here construed as easy and uncomplicated, rendering any excuse for staying or becoming sedentary obsolete.

**Constructing the healthy person**

The norms established by the practices of measuring BMI and aerobic capacity (as measured by taking one’s pulse during rest) were promoted in the course material and by the educator. By these, a healthy woman was considered to be someone with a BMI between 18.6 and 23.8, with a low resting pulse, and who exercised to improve aerobic capacity, strength and agility. These were the physical ideals that the participants had to contend with. Of these, the biomedical notion of BMI offered something of an absolute ideal in which one would either fit or not, while the less finite notions of improved aerobic capacity, strength and agility suggested the need for an ongoing improvement, possibly everlasting.

In accordance with these norms, and as implied by the above presented notions of how to improve health, the healthy person was conceived as someone who was physically active on a regular basis and who ate good and healthy food. Furthermore, as having fun exercising was considered as integral to maintaining a healthy level of physical activity, the healthy person was also someone who enjoyed exercising, and enjoyed life in general:

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208 Intervention 4, Course book, p8.
209 Intervention 4, Course book, p 6-7.
It should be ‘fun’ to exercise, it should be ‘fun’ to make changes overall, it should feel ‘fun’ to go to work.\(^{211}\)

During the first session, the participants positioned themselves, as did the educator, as quite knowledgeable about healthy behavior both as regards dietary and physical activity habits. Most, but not all of the participants, also described themselves as already quite physically active. This was done during the first session when they presented themselves to each other and answered the question of what quality of life was to them. During this round of presentation, the question of how physically active one was, came to be part of the presentations without the educator having explicitly asked them to include this information in their presentations. However, before the presentations started, the educator said a few introductory words about the contents of the intervention: “motivation, maybe exercise, weight loss, stress. Some will be about diet and exercise, or physical activity as we call it really. But several of you are physically active, right?”\(^{212}\) She had thus asked the participants this question just before she asked them to do a round of presentations. As the participants described their level of and interest in doing physical activity, most of the participants said that they took their bicycle to work each day, some did aerobics or aquarobics a couple of times a week. The more active and interested participants were positioned by themselves, the educator and the other participants as more successful than the others by comments they made. For example, one participant was a bit more active than the rest, which prompted some despairing comments from her listeners:

_Elin_: I exercise, what is it, four, I take aerobics-classes four to five times a week.

_Agnes_: Oh, my!

(Everyone laughs)

_Lisa-Marie_: I can go home now.

_Britta_ (the educator): She should share a bit of that [energy among the rest of us].

_Lisa-Marie_: Yes exactly.

_Elin_: Very much physically active.\(^{213}\)

Although all participants were positioned as ‘good’ participants since they were here, after all, moving in the right direction, the less successful participants, those who were less physically active, were visibly and audibly daunted by this very active participant’s account. For example, there was one

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\(^{211}\) Intervention 4, Summary evaluation, p2.

\(^{212}\) Intervention 4, Session 1, p3.

\(^{213}\) Intervention 4, Session 1, min 5.
participant who was more daunted than the others by the level of physical activity that the group as a whole represented (Lisa-Marie in the quote above). As she explained in an interview later on, she enrolled in the course because she felt she needed a group of likewise inadequately physically active and overweight people with the common goal of doing something about that, and this was what she thought she had signed up for:

Lisa-Marie: I need to exercise more. That's why I'm here. /…/ And that's something I'm thinking about this group then, that maybe ..., since it said [on the poster/invitation] about, it was also about overweight [people] it said something like that. And then all these [people who] run, almost, then you feel, you can also get to feel, a bit bad in that context too, you know. So that's what I think was, a bit wrong, that, it could have been [a group with] those who really have a need for it and then they could have had another group that, are elite exercisers.\(^{214}\)

Her own comment on physical activity during the participants’ presentations was: “I find physical activity to be boring, but I try to do stick-walking. It’s fun being outdoors.”\(^{215}\) In this quote, although she started by stating that she found it boring, it is clear that she was well aware of what was expected of a healthy person: to be physically active and to enjoy it! And the quote also shows that she, as well as the other participants, were successfully, albeit with a bit of resistance, conforming to the health imperative of being physically active or at least feeling guilty about not being so. In this group of participants, however, she came to be positioned as less successful at this in comparison with the high level of activity displayed by the other participants.

Being physically active was thus construed as a telltale sign of a successful and healthy person, and all of the participants explained that they were physically active to some degree. This should have meant that the participants were to be conceived of as 1) healthy (at least in terms of being physically active) and 2) as capable of coming to action, of doing what it takes. However, as a collective, the participants were still classified, both by the educator and by themselves, as unable to come to action and this was understood by all of them to be the grounds for their participation. The participants themselves, in accordance with what the educator told them, came to conceive of themselves as knowledgeable about what constitutes good and healthy food but unable to come to action, in this case in regards to actually eating the right things:

\(^{214}\) Intervention 4, Group interview with participants, min 14 and 24-25.
\(^{215}\) Intervention 4, Session 1, p5.
Britta (the educator): It is like this, that you have a lot of knowledge about how, what you should eat, how, how you should eat, but to, maybe, do it then
Participants: Yes. Exactly. That’s the worst thing.
Britta: That’s the problem
Astrid: It’s terribly difficult.
Lotta: That which is so difficult. You go, ‘I’ll just cheat now’.
Britta: Yes exactly. It’s that you have a little bit of a poor self-discipline.
Maybe you do it for a week or two.
Lotta: Or you will start tomorrow.
(Everyone laughs)
Britta: Yes, right.216

And, at the end of the first session:

Britta: You are all so wise. You know so much. I knew it!
Susan: But then, to do it, that’s a whole other thing.
Britta: Yes. But that’s why you, why you, why we can cheer each other on a bit here, push on.217

Although the participants in their initial presentations of themselves described themselves as capable of doing what it takes, they later came to adjust their self-conception according to the educator’s positioning of them as in need of help to become more of an achiever in regards to a healthy lifestyle. The educator also told them that what they were lacking was the ability to control their thoughts, emotions and practices, thus constituting self-control as a vital psychological characteristic of a healthy person, as in this passage from the course book:

*The difference between those who succeed in appropriating new positive habits and those that fail is primarily a difference in thinking.*218

To summarize, the healthy person was construed as someone fitting with biomedically set standards, who enjoyed being physically active on a regular basis and eating good and healthy food, and was in control of her thoughts, emotions and behavior. The healthy person was construed as a ‘doer’. In comparison with this ideal, the participants were construed as knowledgeable about healthy behavior regarding physical activity and diet but nonetheless also positioned as at risk of ill health or death. They were taught that despite their

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216 Intervention 4, Session 1, min 23.
217 Intervention 4, Session 1, min 69.
218 Intervention 4, Course book, p10-11.
knowledge, they lacked in behavioral control, meaning that they were not able to realize their knowledge into action and that what they needed to do in order to improve their health was to become better at disciplining their minds. Disciplining their minds would help them with making the right choices regarding their diet and physical activity level, which would be directly beneficial to their physiological health status. Disciplining their minds would also be good in getting them to be more positive about their lives and actions. Being able to think positively would help them to reach their (health) goals and to enjoy themselves in the process, which in itself was perceived to aid their coming to action. The way to do this was through mental training, setting up realistic goals and to make the decision to work toward that goal.

Technologies of power

Taking control of one’s life, becoming disciplined and changing dietary and physical activity practices was perceived to take time and perseverance, motivation, knowledge and determination and was conceptualized as a journey. The intervention was explicitly described as the first step on a long journey toward a healthier lifestyle as the educator started off her first lecture by displaying an overhead image of a cartoon boy taking a big step with a text saying: “Even a thousand-mile journey begins with one step.” With this image, the educator characterized the work ahead of the participants as quite vast and long-lasting, and as such difficult. However, this road to behavior change was broken down into steps, which would each take a bit of effort for the participants, but as each step was conceived as small and easy in itself, behavior change was construed as achievable. What was more, the first step had, according to the educator, already been taken by their being there:

You have to start somewhere. And it’s now that we all begin.

To guide participants to continue on this journey toward improved self-control and health, the primary technologies of power deployed in the intervention were normalization, regulation and surveillance.

Normalization

In relation to the above described healthy practices, certain bodies were normalized by drawing on a biomedical discourse and the notion of BMI, which served to define healthy bodies in terms of weight:

219 Intervention 4, Course book, p2.
220 Intervention 4, Session 1, overhead-image.
221 Intervention 4, Session 1, min 28.
Britta: [BMI] is height times height divided by weight.

Susan: right, and then you get a figure.

Britta: Then [when calculating your BMI] you’ll see whether you are underweight or overweight or normal.

Susan: Underweight, normal weight, overweight and grossly overweight is what there are different, numbers for, you know. /…/ And as I said, you’ll get to set up goals.222

What was conceived as a ‘normal’ and healthy body was thus construed in contrast to underweight and overweight bodies. This served to set up boundaries for ‘normal’ weight goals and ideas about ‘normal’ or abject bodies and also set up boundaries for what could be conceived of as reasonable and legitimate goals to set for oneself in the intervention. Acceptable goals were goals that would follow and reproduce the norm. Unacceptable goals were goals that constituted a break with the norm.

By constituting this healthy body, and a healthy lifestyle, as the result of individual choices and free will, an idea of the necessity for a disciplined mind was enforced. Mental training was promoted as the answer to the problem: only with mental training and by setting clear goals was it possible to become self-disciplined enough to be able to apply one’s mind and will, to condition and improve one’s will, toward achieving or maintaining health:

Each of your actions is preceded by a thought – an inner image of what you will do. Often these mental images are unconscious, they work automatically. It is as if you had an autopilot running your actions. When you yourself have a clear image of a goal and integrate it into your subconscious with mental training, then you have taken command. You run your own life. Your psyche will adjust to the positive goal that you consciously have decided on.223

Mental training, of which goal-setting was regarded as a vital part, was thus conceived as a means to multiple ends, of which some were to build a positive self-image, self-confidence, motivation, and constructive emotions, thoughts and attitude, all of which were construed as vital to becoming self-disciplined and reaching one’s (health) goals:

[Mental training is useful] to prevent stress, to set up goals in life so to speak and then to work with it … You work with different aspects, you might say.

222 Intervention 4, Session 1, min 19.
223 Intervention 4, Course book, p12.
That which you will train then ... is your self-image, then. ... Self-confidence, you know. ... Motivation. Eh, and then attitude, what attitude I have in regards to things and in regards to myself, then. And then it's this about communication and, and a lot is about this thing with emotion too of course.

By describing it as an elite approach that was first developed for athletes, and that had now evolved into something suitable for the 'ordinary' person, mental training was construed as something bound to provide success:

Britta: [Lars-Eric Unestål] was the father of mental training, at least here in Sweden. He started working with this in the 70s somewhere, and then he's developed this enormously. When he started with this, it was in sports. You know, an athlete who does not work with mental training, setting up goals, doesn't become a really good athlete.

And:

Britta: Lars-Eric Unestål has developed very many [mental training] programs for just this, the ordinary person, anybody at all, basically. So you know, you don't have to be an athlete to do it, these days.

Regulation

In order to become the type of person described above, who fits with the biomedical standards for weight and resting pulse and who is self-disciplined, various practices were understood as important, such as building a positive self-image:

The important thing is really to build a positive image about oneself. Because many a times you walk around with very many negative thoughts about yourself, right? And think, negatively about yourself. And others, perhaps. Too much. Right?

The way to achieve this positive self-image was by practicing mental training. To do mental training (successfully) it was considered important to do it in a quite specific way that allowed the participant to be relaxed, mentally and physically:

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224 Intervention 4, Session 3, min 13-14.
225 Intervention 4, Session 3, min 8.
226 Intervention 4, Session 3, min 17-18.
227 Intervention 4, Session 3, min 18-19.
Britta: When you do things like this you should be quite relaxed. … you should try to wind down and be calm and relaxed because most often this is when, the thoughts come to you, these good thoughts, that we have. You know how it feels when you’re out on a walk, how good you think, really. That is really actually mental training. And this, this we practice actually every day without thinking about it.

And:

Britta: The foundation is that one works with this, with relaxation. Basic relaxation, I mean, learn to relax, muscarily, learn to relax mentally

Furthermore, mental training was conceived as a skill that was likened with “perishable goods”, requiring a specific frequency of execution to be upheld and, consequently, for the successful achievement of one’s goals:

Britta: …when training mentally, this is just like when training your condition, it’s perishable goods. You have to keep it up, every week. Preferably every day, at the beginning, before you get more into it. Especially when training your basic relaxation, so to speak, this muscular relaxation.

Goal-setting was described as an integral part of mental training. Besides setting reasonable and acceptable goals that complied with the norms for what constituted a healthy person, ‘good’ goals also needed to be articulated in a specific way: they needed to be concrete, daring, exciting, positive, possible to evaluate, achievable, and limited in time:

Britta: What is a goal, then? What does it need to contain? Yes. A goal needs to be /…/ concrete. It needs to be, well, daring. /…/ It also can’t be too soft, you know. Because I have to have something to, to take aim toward. That I feel that, it needs to be exciting, this. That’s what it needs to be. /…/ the goal needs to be set by you yourself, too. /…/ It needs to be positive. /…/ It needs to be possible to evaluate it. And it needs to be achievable. It can’t be so daring that I can’t, that I can’t reach this goal that I’m setting up. /…/ One more thing, it also needs to be limited in time. Preferably. It simplifies it a bit, then, to see that when this time has gone by I need to have reached this goal.
Trying to meet all of these expectations and counting on physical activity being part of the intervention, the participants set goals for their participation concerned with weight loss, learning more about diet, preferably in order to lose weight and learning stress-management. However, reacting to the regulatory nature of the health imperatives drawn on in the intervention and in society in general, which seemed to require a constantly active and somewhat ‘multi-tasking’ individual as the following quote also shows, some resistance coupled with a sense of inadequacy and frustration could be detected among at least one of the participants:

Britta: It is recommended that to get as well-rounded exercise as possible, for the body, you know /…/ they say that you should try to get in this about flexibility, condition, and strength. Those are the three parts that, are important, so that you know that you get all those parts to get an all-round training for the body.

Lisa-Marie: I also feel that when you read all this about what you should do, you should eat well and exercise this many times, that alone is stressful. /…/ That you should have time to do a strength-[class], take walks every day and you should get your pulse up a couple of times a week. I mean, that also feels, when you have been working a whole day, like you said, Susan, when you come home and are tired and sit down. You don’t have the energy to go off. And then you feel, shucks, now I haven’t done anything this week. /…/ But when you read all this about what you should do to, to, to feel good, then, this can become a stressor for many too, that ‘I don’t do that’ and ‘How will I be able to find the time to do that’ and /…/ Some people when they talk about what they are doing, I don’t think they are quite sane, you know. [laughs around the table] No, but I mean, it’s walk, and walk, and walk and then they want their men to go out and walk and they are to eat and I mean it’s insane. I mean, if you feel stressed out, then it can’t be that you should set up a bunch of musts. Perhaps you have to eliminate some musts first and then rebuild yourself. I mean and then they are so tense that they almost tremble instead. How much fun is that on a scale from one to ten?232

In response to her frustration, the solution according to the educator and the other participants was conceived to be to individualize the activity and to be disciplined at the same time as one does something that one finds to be fun:

Participants: It [exercise] mustn’t be a compulsion /…/ I think that you must find that which suits you. But it’s the own goals, isn’t it? /…/ That you start from your own goals. Yes, that’s what you’ll have to do.

Britta: But that’s how it should be.

232 Intervention 4, Session 1, min 76-78.
Lisa-Maria: Maybe start by, going once a week. Now I’ve made up my mind. I’ll take a walk once a week.

Britta: Of course, you have to start based on who you are. You can’t be looking at what other people are doing. /.../ Then you have to feel that I think this is fun, this is what I want to do.

Lotta: Yes, it has to be fun.

The participant’s resistance was thus approached by stating that what could be understood as a reasonable level of physical activity “of course” had to be based on each individual’s preconditions.

**Surveillance**

The educator gave the participants homework in the form of setting up goals, assignments from the course book, and being physically active between sessions. In each session, she then quizzed the participants about whether they had done the homework and asked them to share their experiences from it. The quizzes thus functioned as a basis for discussions during the sessions. By quizzing the participants, the educator was also able to keep a watch on their progress toward becoming more disciplined and healthier individuals. The quizzing furthermore served to make the participants publicize their ability for self-discipline and level of adherence to the program, possibly serving as a means to improve their self-discipline because of it, at least for the duration of the intervention.

To initiate and promote the participants’ change from the undisciplined individuals they had been established to be (see section Constructing the healthy person) to the disciplined and active individuals they wanted to be, they were given homework. However, this idea was not met with enthusiasm by everyone:

Britta: You’ll get homework assignments too. That’s good, right? Homework.

It was a while since you had that, right?

[scattered laughs around the table]

Lisa-Marie: I’ll surely not do it. [laughs]

Britta: No? [laughs] I see.

This resistance and lack of enthusiasm was read by the educator as an indication of their need for this type of intervention, as a leftover of the passive lifestyle that they, judging from their participation in the intervention, wanted to leave behind. Addressing this passivity and lethargy, the educator promised to quiz them on their homework:

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233 Intervention 4, Session 1, min 77-79.
234 Intervention 4, Session 1, min 20.
Britta: We’ll start with a small goal, then, until next time. And then you’ll be quizzed about it next time, too.

Astrid (really quiet): Then I don’t dare come.

Britta: That’ll be fun.\(^{235}\)

Supervision and monitoring of what the participants did or did not do was thus conceived as necessary to get them to do the work required of them to reach their own goals. Although Astrid’s comment in the quote above indicated that she did not find quizzing to be particularly enjoyable, the educator tried to present it as fun.

During the subsequent sessions, the educator followed up on her promise to quiz them about their homework assignments, in this case regarding being physically active:

Britta: Have you been out walking at all?

Participants: Yes. A bit.

Britta: You have. That’s good. Has it been regularly or?

Lisa-Marie: Yes.

[snickering]

Astrid: Depends on what is meant by regularly.

Britta: Yes, what was it that we said? We talked about exercise, namely, the last time. Regularly is that I do something, every week. If I do it one time or twice a week, for instance. But that I repeat it so that it comes to be, every week. That’s the, important thing, then. So this you have done?\(^{236}\)

And on writing their goals in the course book:

Britta: About goals. You’ve all set a small goal. Has anybody written anything in, on this page [in the course book on setting a goal]?\(^{237}\)

Kajsa (only person answering): Yes.

Britta: GOOD Kajsa! [laughs around the table] That honors you.

In summary, it would seem the participants did not feel confident that they would be able to meet the educator’s (or their own) expectations on them, as indicated by their resistance to being monitored.

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\(^{235}\) Intervention 4, Session 1, min 28.

\(^{236}\) Intervention 4, Session 3, min 4-5.

\(^{237}\) Intervention 4, Session 3, min 5.
Technologies of the self

Besides having the educator monitor their work and practices, the participants were also expected to turn an assessing gaze on themselves. This assessment was to a degree concerned with the participants’ physical constitution but primarily with their thoughts and thought patterns. So as well as asking themselves if their bodies fit the norms as decided by the biomedical notion of BMI, they were also encouraged to ask themselves if their thoughts and emotions were constructive and conducive to behavior change or to maintaining a healthy lifestyle, and what they could do to achieve this:

Emotions and thoughts, you all. What I feel and think. You know, the thoughts I have. What thoughts am I walking around thinking, really? What have I, is it something that, eh, what thoughts get repeated in my head? Is it positive thoughts, is it a lot of negative thoughts? These are things we will touch on quite a bit too. That maybe you can understand, if, now, you have very many negative thoughts, that you turn these to become positive thoughts. Because it can be done. It really can.238

These destructive thought patterns and emotions were interpreted as the underlying cause of the participants’ current situation (such as failing to maintain a healthy diet and level of physical activity) because of their negative influence on the participants’ self-image and good intentions:

The primary reason to why we so often fail our intentions is because our subconscious trips us up. With our mouth we say that we will change our lives. But innermost we don’t believe that we will be able to do it. /…/ You feed yourself all these negative expectations and they control the result. Then, when you fail, this comes as a confirmation that you are exactly as useless as you thought.239

However, the way to remedy this problem was to make an internal ‘make-over’ by way of disciplining their minds with mental training, because:

The good news is that it is possible to be reprogrammed.240

In this manner, the participants were directed to turn their gaze inwards, toward their own practices, thoughts and emotions, and invited to govern

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238 Intervention 4, Session 1, min 42-43.
239 Intervention 4, Course book, p11.
240 Intervention 4, Course book, p11.
themselves with the help of the techniques of self-disclosure, self-examination and self-mastery.

Self-disclosure
During the intervention, the participants were asked to make ‘confessions’ regarding what type of physical activity they did and how often, as well as what their goals were with attending the intervention. As mentioned previously, the participants’ confessions about their level of physical activity served to position the participants as variously successful or not. This type of self-disclosure also had a self-regulating effect as it allowed the participants to learn of (monitor) the others’ physical activities, and to enable (force) them to compare their own level of physical activity with these in order to judge it as adequate or not.

Regarding the goals, although the participants wrote these by and for themselves and although it was explicitly stated that they did not need to share their goals if they did not want to, they still came to be coached to do so as the educator claimed that publicizing one’s goal would help to make it bear more power in their lives, make it more real:

Britta: I mean, if you say the goal out loud too, then it becomes all the more fortified.  

Sharing their goals with the rest of the participants and the educator was conceived to strengthen their resolve to reach it, to build up their will and self-discipline.

Self-examination
The notion of BMI served as a device to turn the participants’ gaze on their bodies and to instruct them in how to scrutinize and assess their own bodies by calculating the degree to which they fit with the healthy ‘norm’. However, the main focus of the intervention lay with mental training, which provided the participants with the means to become aware of and monitor their own thoughts and feelings and compare these with the ones they ‘should’ be thinking and feeling:

Emotions and thoughts, you all. What I feel and think. You know, the thoughts I have. What thoughts am I walking around thinking, really? What

\[241\] Intervention 4, Session 1, min 67.
Constituting the Healthy Employee?

have I, is it something that, eh, what thoughts get repeated in my head? Is it positive thoughts, is it a lot of negative thoughts?242

As part of mental training, the practice of goal-setting was an additional device to set the participants up for self-examination. The purpose of setting goals was not only to point participants’ actions in a specific direction but also to allow for evaluation; for the participants to be able to take stock of what had been done, review this and compare with what should have been done as stated in one’s goal. In this manner, setting goals also served to set the participants up for further self-scrutiny.

In an act of self-examination, a participant described positive corporeal sensations that she experienced from being physically active:

Susan: I think, you feel, I feel immediately when I begin to be more physically active, then you feel much more wholesome and healthy. You also feel it in your clothes, I think, right away, although maybe I don’t eat any different. But as to sitting in the couch after you get home, it’s a real difference, you know. You think you are plenty active, but you don’t do it enough when you have children, you think you are active, but you’re not active enough. Not in the correct way, you know. And you also have to have the time and energy when you work and, and stuff.243

In her evaluation of her level of physical activity, she judged it as inadequate.

Self-mastery

Heeding the notion of mind over matter and the exhortation to take control of one’s life, the participants tried to set up some new rules of conduct for themselves, such as taking daily walks:

Astrid: I take walks, now, actually, which I used to think was so boring, I try at least a couple of nights [a week] to walk.244

The participants accepted the idea that one should be physically active (in the ways described in the intervention) as a truth. This meant that just lying around on a couch, doing nothing really ‘useful’, was not really thought of as an acceptable behavior. Still, as this participant admits, this ‘unacceptable’ behavior was also practiced at times, and this practice was defended by constructing it as vital for one’s wellbeing:

242 Intervention 4, Session 1, min 42-43.
243 Intervention 4, Session 1, min 71.
244 Intervention 4, Group interview with participants, min 11.
Kajsa: if life is spinning fast, it can spin too fast also, and then you must have the ability to, wind down too. /…/ Then I use music and the couch. Or a book. But then I’m the kind of person too who likes the music and the book a great deal so that sometimes it comes to take over before that other stuff [physical activity], I admit that. But at least I know that.

Gender

Although the participants were all women and gender was concealed behind a seemingly neutral language, the intervention was underpinned by essentialist notions of women and men, constituting them as different in at least a couple of respects. For instance, women were conceived as smaller than men, as exemplified in the notion of BMI, in which women of ‘normal weight’ were indicated by those having a BMI between 18.6 and 23.8, while men of ‘normal weight’ were those with a BMI between 20 and 25. This differentiation between women and men was continued in a subsequent construction of energy expenditure. A person’s energy expenditure was calculated based on age, basic metabolic rate (BMR), level of physical activity and gender. As a consequence, dietary recommendations on the basis of the recommended consumption of calories a day, suggested that women should eat less than men. The point here is that this is essentialist because it classifies all women and all men in the same way. All women are therefore expected to fall within the norms or not be appropriately female, and likewise for men.

Furthermore, how to calculate one’s energy expenditure was presented in a table. However, when exemplifying what BMR may be for a woman or a man, this example simplifies the figures in a manner which may well be in line with common rounding off, but it may also be interpreted as forming an imperative as to how women and men should think and what they should do. The example says:

A grown man that weighs 70 kilos has a BMR of about 1700 kcal a day, while a woman of 60 kilos needs 1300 kcal.

However, when using the table to make the calculations, the exact figures come to:

Women: 60 x 22.5 = 1350 kcal
Men: 70 x 24 = 1680 kcal
Thus, women should round off down meaning eat less than recommended, while men may round off up meaning that they may eat a bit more than recommended. Furthermore, giving an example in which women are conceived to be smaller than men, weighing less than men, does at least two things: 1) It reproduces a heterosexual norm in which the ‘normal’ woman is conceived to be smaller in size than men, and 2) It makes the difference between what women and men should eat seem greater than it is. If the example is changed and the woman’s weight is altered to 70, her BMR comes up to 1575 kcal, which means that the difference between women’s and men’s BMR would be construed as a difference of a mere 105 calories a day as compared to the difference of 330 kcal construed in my example, or even 400 kcal construed in the example given in the intervention. So, the difference between women and men in this matter has been enlarged by a factor of 4 in the intervention.

Turning the attention to the physical activities promoted in the intervention, judging from the activities promoted, there were certain activities that were deemed appropriate for women and others that were not. Appropriate activities were primarily walking, stick walking, and yoga. These types of activities are at no risk of challenging the norm for what women’s bodies should look like, but rather comply to this norm, reproducing women’s bodies as they are expected to look and behave. Other physical activities were mentioned, too, and although weight training was mentioned in the course book, nobody was encouraged to start body-building or doing some other activity that would shape their bodies contrary to the norm. Nor were any norm-breaking activities suggested or discussed during the intervention. Instead, all activities that were suggested functioned to shape the participants bodies to fit better with the norm for what a healthy woman should look like. The participants were positioned as ‘typical’ women, as they were only expected to want to adopt less strenuous physical activities: no norm-breaking activities were promoted.

This notion was reinforced by the pictures used in the course book. There were ten pictures with people in them in the book. Of these, it was not possible to determine the sex of the people in two of the pictures (one was of someone hiking in the far distance, and the other of a pair of dirt-covered hands holding newly dug-up potatoes, although these hands might have been male, judging from the look of the hands). Most of the rest of the pictures were of women, with a ratio of fifteen women to two men and the two men were in two separate pictures, one with another woman, both of them out for a jog, while the second man was in a picture with two women, all of them preparing food together. The pictures of women were either of women being physically active together or of lone women. The lone women were doing yard-work, holding apples and looking serene, or standing in a field looking blissful, stretching her arms up and out in the air. In all of the pictures everyone was looking sound, healthy and happy, with a BMI that might have been in the lower ‘normal’ range.
These pictures thus served to reinforce an image of health as primarily a women’s interest and healthy women as thin, happy, social and physically active. These notions were further reproduced in the intervention as women were described in ways that suggested they were more concerned with their health, more social and more active in taking courses than men:

\[\text{Lotta: Are any men enrolled?} \]
\[\text{Britta: No, no men. /.../ I think it’s because women care more [about their health]. I also think it’s because women are more social and take more courses in general than men do.}^{247}\]

By constructing women as more concerned with their health, more social and more prone to taking courses, women’s participation was legitimized and the absence of men was explained. Still, although women were described as more concerned with health, women’s issues or problems with changing dietary and physical activity habits that may be associated with women’s specific situation and responsibilities in the family were not specifically addressed in the intervention: not by the educator, not by the course book and not by the participants. As mentioned previously, difficulty changing one’s lifestyle was described as a consequence of destructive thoughts, rather than possibly being related to the realities of women’s (and men’s) lives and responsibilities or any other factors.

Women were furthermore construed as better at grasping the whole picture, of maintaining a holistic perspective, as in this quote from a male yoga instructor:

\[\text{…we have a masculine and a feminine brain half. The feminine brain half sees the entirety and that is why it is more women who practice yoga which is about holism.}^{248}\]

However, despite this proclamation that women were more concerned about health issues, men were prolifically referred to as health experts. In the course, all of the experts referred to both verbally and in the course book were men, except for two women referred to on two pages of the course book. Men were the experts of mental training, physical training and stress. Not until the participants went deeper into the issue of stress, further back in the book, were two women experts referred to.\(^{249}\) Furthermore, although the course book most

\(^{247}\) Intervention 4, Session 1, p1.
\(^{248}\) Intervention 4, Session 5, p1-2.
\(^{249}\) Intervention 4, Course book, p61 (Marianne Frankenheuser) and p62 (Lena Nevander-Fristöm)
of the time maintained a ‘neutral language’, talking about “one” or “you” rather than “he” or “she”, at times, men were still used as the example. For instance, when making an example out of the Stone Ages, it was about the Stone Age man (emphasis added):

…for the Stone Age man at that moment in time it was about using all resources to survive. When he was safe, or after having slain the tiger, he could relax again.\(^\text{250}\)

At another time, when describing the process of change, the neutral language suddenly slipped into a gendered form where male is the norm (emphasis added):

…so that he realizes that he can make lasting lifestyle changes. He can also start out slow and carefully with an activity that he likes, so that he can feel that physical activity is something positive, something from which he stands to gain, instead of a ‘must’.\(^\text{251}\)

Judging from the rest of the book and the obvious attempts at keeping the language ‘neutral’, these “slip-ups” were most likely mistakes in the progress of writing which slipped through the editorial corrections. However, that the slips resulted in the example persons being men and not women, could also be conceived as significant as it suggests a notion of this ‘neutral’ person still being gendered, and gendered male. The example of the Stone Age man could also be criticized for the stereotypical and essentialist portrayal of men that it gives.

To sum up, although a seemingly gender neutral language was used for most of the time, gender was still (re)produced in the language and practices associated with the intervention. Gender was constructed in accordance with norms and ideas of women and men as essentially different. These norms and ideas functioned as determinants for the types of behaviors deemed normal and acceptable or not for the participants. In this manner, gender discourses determined what could be conceived of as a healthy lifestyle for women and for men.

Summary and comments
In intervention 4, health was conceived as a measurable state in terms of biomedical standards and ideals but also as a qualitative psychological state of being, conceived as self-reliance and a capacity to be happy. In relation to this,

\(^{250}\) Intervention 4, Course book, p26, emphasis added.
\(^{251}\) Intervention 4, Course book, p19.
someone who enjoys living healthy and that was a ‘doer’ in control of
themselves was conceived to be a healthy person. The way to achieve and maintain health and to become a healthy person with healthy habits and a healthy lifestyle was, in this intervention, considered to require a disciplining of the participants minds which could be achieved through mental training.

In this manner, health was constituted by drawing on both a biomedical and a wellness discourse of health, which in turn classified the participants variously as physically fit or unfit depending on their BMI, and all of the participants as in need of improving their self-control regarding their own thinking and behavior. Drawing on healthist notions, behavior change was conceived to be the result of free will and individual choice, placing the responsibility for change firmly with the participants. As the participants accepted the notion of health as an individual responsibility, the only explanation for failing to become healthier was that one had not worked hard enough, had not done what it took. Underpinning these ideas about behavior change was a classic split between body and mind where the mind is construed as superior to and in charge of the body and the body is nothing more than a recalcitrant vessel for the mind.

The participants were considered to be knowledgeable about what constituted a healthy lifestyle, but unable to live according to what they knew and thus as in need of help to discipline their minds (and thereby their bodies). Change was conceived as a long and difficult journey that could be made easier by dividing it up into smaller steps. By way of the techniques of normalization and surveillance the participants’ bodies and behaviors, but primarily their thoughts and emotions were governed. The participants were also invited to self-govern the same aspects of themselves by way of the techniques of self-disclosure, self-examination, and self-mastery.

The intervention was informed by radical essentialist notions of women and men and these notions constituted women’s and men’s bodies as different in terms of size and thus energy need. As such, these ideas set the boundaries for what could be conceived as a reasonable amount of food for women (and men). Furthermore, the types of physical activities recommended in the intervention also served to reproduce rather than challenge the essentialist ideas about women’s and men’s bodies.
PART THREE
In the previous chapters (in part II) I have taken apart and described the interactions between the educators and the participants in the studied interventions. I have given detailed descriptions regarding how the biomedical and the wellness discourses operated in the interventions and of how health and healthy behavior were thus conceived both in relation to quantifiable measurements and a sense of wellbeing. I have also detailed the different technologies of power and of the self operating in the interventions, showing that normalization, surveillance and regulation were the most prominent technologies of power and showing how the educators set up the means for the participants to self-govern. Furthermore, I have described the ideas about gender that were reproduced in the interventions, demonstrating that these were derived from essentialist ideas. In this chapter I assemble back together what has been taken apart or, in other words, weave back together the threads that have been laid bare in the previous chapters. In this reconstructed ‘weave’ I want to describe the common ideas about what was perceived to constitute a ‘good’ participant and a healthy employee but without losing the nuances regarding the differences and similarities in the interventions.

As described in the prologue to part II, I have identified two health discourses that run parallel through all of the four studied interventions. Just as the notion of ‘health’ is produced by and productive of a notion of ‘ill health’ by way of their difference and perceived oppositionality (compare with Derrida, 1997), the biomedical and the wellness discourses are mutually dependent and constitute each other. It is not surprising, then, to find that both discourses inform all four interventions. Overall, I would say that the most prominent discourse was the biomedical discourse, which may be considered unsurprising in light of the biomedical tradition in Swedish public health work (Hammarström & Ripper, 1999) and hence also in health education. These discourses constitute health on the one hand as a sense of wellbeing, underpinned by a notion of pleasure, and on the other as biomedically quantifiable, underpinned by a notion of risk. However, discursive production and reproduction is contextually variable, meaning that although both the biomedical and the wellness discourses inform all four interventions, how and to what extent the discourses operated in the interventions differed somewhat.
On a detailed level, so did also notions about how to ‘do’ health as a gendered employee. Below, I will elaborate on how the notions of risk and pleasure respectively informed perceptions about the ideal healthy employee and hence served to govern the participants. I will also describe how essentialist and heteronormative ideas about gender permeating the interventions served to produce a norm that constituted the healthy employee as a heterosexual man characterized by physical strength and rationality. Before moving on to this, though, I will begin with the issue of how the ‘good’ participant/employee was constituted as willing and able to change lifestyle in accordance with health imperatives.

**Willing and able?**

As is common in health interventions (see Thompson & Kinne, 1999; Wijk, 2002, 2003), the studied interventions were not based on an explicitly articulated theory about change or education. However, in accordance with the healthist ideas prevailing in public health work (Lupton, 1995), underpinning all interventions was the healthist notion that all participants wanted to be(come) healthy, and that this desire ensured the willing subjection to behavior and lifestyle change of all participants. Thus, willingness, and maybe even desire, to change was taken for granted. Underpinning this notion were the healthist ideas that 1) health is something good, 2) people are rational, and 3) people are always able and willing to act on this rationality. Although the first seminar in intervention 3 was compulsory for all employees this should not be taken as proof of an exception to this healthist idea, but should rather be perceived as an effort to counteract any potential reluctance to participating in it due to preconceived negative notions about the intervention per se.

Not only their participation in the interventions but also any changes they made regarding their lifestyle, were understood to be completely voluntary. This was more or less underlined in all four interventions. Perhaps most clearly so in intervention 3, in which it was emphasized in an intervention slogan (“Not because you have to but because you want to”). However, voluntariness was not without direction. The participants were expected to learn what the ‘right’ choices were in order, subsequently, to make the ‘right’ choices in their own lives. Furthermore, these choices were based on notions about health that are not objective but rather used to describe states and behaviors that are valued positively (Seedhouse, 2004). By constituting the ‘good’ and healthy participant/employee in specific ways, the participants were instructed what the desirable choices were and in this manner not only invited but in fact compelled to make these changes in order to achieve or maintain a status of being a ‘good’ and healthy employee.
The suggested changes – the ‘right’ choices – were construed either as minor (interventions 1 and 3) and thus manageable or as quite a vast and long-lasting endeavor but still manageable by breaking it down into smaller steps (intervention 4). Hence, anyone should be able to do it. By thus constituting lifestyle change as something minor, manageable and as something that anyone can do, participants who may feel unable or unwilling to do so were construed not only as ‘bad’ subjects but as ‘failed’ subjects. In contrast, in intervention 2, change was understood to be quite difficult, taking hard work, plenty of motivation and even indoctrination. Hence, participants were more or less expected to fail, to be ‘bad’, and anyone who proved the educators wrong and managed to make some positive changes, was made into a ‘good example’ to the others.

In the interventions, the participants were not only understood as willing and able to make their own choices about their lifestyle, but also as free to do so. Constituting the participants as free to make their own choices also served to place the responsibility for their behavior change in the hands of the participants themselves. Even though it was acknowledged that choices in food and physical activity were complex due to being socially and emotionally driven, full responsibility to make the ‘right’ and ‘rational’ choice was still placed with the participants: they were told that they needed to take control over these situations and of themselves, meaning that there was no escaping one’s own responsibility in these respects: responsibilities, for example, to avoid risk.

Avoiding risk...

The biomedical discourse is underpinned by a notion of risk. According to Tones and Green (2004), the notion of ‘risk’ is dominant in all health promotion work and individuals tend to be held responsible “for their exposure to risk and failure to act accordingly” (Tones & Green, 2004:23). However, what is conceived as risky is socially constructed and differs depending on the social context (Lupton, 1995; Tones & Green, 2004). On a more general level, Beck defines risk by describing it as “something which has not happened yet, which frightens people in the present and therefore they might take action against it. Risk is not a catastrophe; if catastrophe happens it is a fact, an event. Risk is about possibility, a future possibility” and signifies danger (in Hubbard, 2003:51, quoted in Gard & Wright, 2005:170). More specifically, the notion of risk is mainly conceptualized in two different ways: as dependent on external factors or on internal factors (or as a combination of the two). External risk factors refer to environmental aspects over which the individual has little or no control. Internal risk factors refer to personal lifestyle choices and individual predispositions (Gard & Wright, 2005; Lupton, 1995). Focusing on individual
predisposition diverts attention away from any social and institutional factors, instead placing emphasis on the individual’s ability to manage the self, on self-control. In the studied interventions, the focus was on internal factors and individual predispositions. These internal factors and individual predispositions were concerned with both behavior (lifestyle) and physiology. Behaviorally, monotonous and/or exaggerated dietary habits were perceived as risky (intervention 1). So was imbalanced energy consumption (intervention 2 and 3). Furthermore, sedentariness (intervention 2 and 4) and too leisurely physical activity (intervention 2) were likewise understood as risky behavior. Regarding physiology, the notion of risk produced an understanding of the self as two-dimensional; as consisting of a body and a mind, of which the mind is charged with managing the body by making appropriate decisions about lifestyle.

The two-dimensional self

Due to its physicality, its fleshiness and material presence, the physical body is often perceived from a realist perspective as ‘real’, meaning a-historical and a-cultural. Dating back to Plato (and possibly beyond), the body has been understood as materiality, as “something apart from the true self (whether conceived as soul, mind, spirit, will, creativity, freedom…) and as undermining the best efforts of that self” (Bordo, 2003:5), thus constituting the self, or the mind, as something other or more than the body. This body-mind dualism is reproduced in the interventions when drawing on the biomedical discourse and the notion of risk such that the mind is valued higher than the body, and that, while the body is understood as an integral part of the self, it is still conceived as problematic and as such, as something needing to be carefully monitored and controlled. This monitoring and regulation was to be performed by the mind, the self.

The focus on the physical body in workplace health promotion “is buttressed upon a desire to quantify wellness and to locate health in a model of precise normalcy” (Jutel, 2000:284, quoted in Gard & Wright, 2005:173). This desire produces a dualism between body and mind in which the body comes to be conceived and treated as if it was a machine (a common medical metaphor critiqued by Martin, 1987, among others) to be cared for and managed by the mind, the self. Diet and physical activity hence comes to be construed as maintenance work, to do with maintaining (the machine) individual ability to perform, to function (to full capacity). This machine rationale thus produces a notion of the body as regular and predictable – as stable – with clear and unequivocal connections between cause and effect. An association used in the interventions (interventions 1 and 3) was to compare it with a car/driving in which the body is represented by a car and the mind is represented by the driver of said car. This construction implies that the mind is the active part, having agency, and the body is the passive, receiving and
mechanically responding one. In this manner, the participants are constructed as ‘commanders’ of and responsible for their bodies and expected to take full control over their bodies and lives.

Conceiving of the body as a machine also enables an atomistic perspective, reducing the body into various body parts and systems. This perception of the body enables a focus on separate systems, functions and/or parts of the body, such as the loco-motor system (intervention 2), the digestive system (intervention 1), or the function of body-fat (intervention 3). Bodies, understood in these terms, are thus divided into various parts and systems about which the participants are expected to learn – how they function, why they function, what their full capacity may be, and above all how to take care of this ‘machine’ by maintaining each part and system in a correct manner. Each part and system may also be conceived as giving off various signals to which the mind is expected to listen, understand and act upon (intervention 1 and 3).

The a-historical and a-cultural notion of the body also produces a notion of bodies as being prehistoric ‘relics’ that haven’t adapted to contemporary times in the same manner as our minds and behaviors have but rather still retain certain characteristics adapted to those ancient times. The notion of a prehistoric body was drawn on in various ways in all interventions. It served to construe physiological functions and certain dietary and physical activity related behaviors as ‘natural’ and desirable or as ‘natural’ but undesirable. For instance, body fat could be described as fully functional from a historical perspective, but posing a problem to people in contemporary (Western) times (intervention 3). Furthermore, physical activity could be perceived as ‘natural’ from a prehistoric perspective and as ‘right’ and desirable in contemporary times, while a predilection for sweet and fat foods was conceived as ‘natural’ from a prehistoric perspective but ‘wrong’ and undesirable in our contemporary times (intervention 1 and 4). Hence, the rationale of the prehistoric body serves to construe notions about healthy and unhealthy bodies as the ‘natural’ result of our lifestyle and as such to regulate lifestyle related behavior. In this manner, this notion of the body may have served to relieve some of the guilt and shame that participants may feel if unable to live up to the demand on responsibility. However, although it served as an explanation as to why humans are prone to unhealthy (from today’s perspective) behavior, it did not relieve the participants of any of their responsibility for making the ‘right’ choices. It was more of an explanation for why behavior change may be difficult, but not as an excuse for not taking control anyway.

**How to avoid risk**

Underpinning the notion of risk is a quest to manage uncertainty, and this ongoing quest for certainty serves to privilege and direct attention toward risks that are most readily quantifiable (Gard & Wright, 2005). By setting up
quantifiable norms and boundaries for what could be conceived as risky or healthy or not, a notion of an ideal body – certain to be healthy – was produced against which everyone came to be evaluated and judged. All deviances from the norm were regarded as pathological in the sense that they were conceived to constitute risks to individual health. The degree to which a body deviated from what was regarded as ‘normal’ was considered to equal the degree of risk. However, since the ‘normal’ is an ideal, all bodies and behaviors may be expected to fall outside the parameters for one or several factors (see also Seedhouse, 2004), i.e. everyone will, in some way, deviate from what is considered ‘normal’, hence everyone is always at risk.

Although all participants are thus understood to be at risk, an inherent contradiction in the notion of risk enables a simultaneous notion of the possibility to escape risk “as long as one is aware … and willing to act rationally to avoid being a casualty of risk” (Lupton, 1995:79-80). In order to know how to avoid risk, you need to know what the risks are and where you stand in relation to these risks. In line with this, the participants were given tests and diagnosed in various ways early on in the interventions. In intervention 1, this test was concerned with the participants’ dietary behavior and involved the use of a diet registration program, in interventions 2 and 3, the tests and diagnostics were quite a bit more comprehensive and were concerned with the participants’ behavior, attitude and physiology. These were investigated with both interviews and biological measurements (such as body-fat percentage and cholesterol levels) in so called Health Profile Assessments. In intervention 4, there was no official testing or diagnostics performed. Rather, the participants did their own testing by comparing their weight with an ideal weight conceived in terms of Body Mass Index, presented in the course book.

These tests and diagnostics were based on ‘objective’ knowledge, such as epidemiology and biomedicine. The reliance placed on this type of knowledge is indicative of the quest to manage uncertainty in public health which underpins the notion of risk along with “a belief in law-like mathematical regularities in the population” (Lupton, 1995:78). Based on this, it is conceived as possible to calculate the statistical likelihood that something may occur. Quantification and measurement are thus integral to the notion of risk and out of this, diagnostic testing is regarded as a means to deal with health risks: “The logic at testing is that patterns of risk must first be ascertained, by identifying those who harbour the potential to develop a certain condition or disease … and then rationally dealt with” (Lupton, 1995:78). Having tests offers a sense of control, of ‘doing something’, and the knowledge the tests provide is perceived as important for people to be able to protect themselves against the risks/diseases (Lupton, 1995). The risk appraisals are thus perceived to promote awareness and motivate behavior change.
Continuing to attempt to manage uncertainty regarding these things, educators “claim knowledge, expertise and an ability to control that which seems to be out of control” (Gard & Wright, 2005:170). Hence, after having learned the degree of which you are at risk and the actual risks you face as determined by the tests and diagnostics, you need to know what you can do about it, what you can do to decrease or eliminate risk: how to eat and exercise, how to understand physical symptoms and how to get closer to the physical ideal of a healthy person. Besides the risk analyses, the educators subsequently offered the participants ‘facts’ about risks and how to avoid or decrease these.

The perception of the body as stable and predictable supported the notion that one’s behavior and lifestyle has predictable and consistent effects on the body and thus one’s health. From this perspective then, ‘facts’ and statistics about what is healthy or not should determine one’s behavior and lifestyle in order to maximize health. In all four interventions, a lack of knowledge of ‘facts’ about what is healthy or not was thus perceived to be one of the reasons behind the participants’ health problems and/or risky lifestyle and practices. Based on a simplistic idea about behavior change, improved knowledge appeared not only to be perceived to enable but in fact to cause the participants to make informed and knowledgeable decisions about their lifestyle; to improve the participants’ health related lifestyle and practices and thus become healthier. To this end, the scientific knowledge about nutrition, metabolism and physiology presented in the interventions was more or less overtly laden with norms and values about ‘good’ and ‘bad’ behavior. Included in this scientific knowledge were such issues as the chemical constitution of food (intervention 1), the link between food intake, physical activity and body shape and the relationship of diet and physical activity with on the one hand ill health, sickness, disease and death, and on the other with good health, disease prevention and longevity (all but intervention 4). Drawing on the biomedical discourse, diet and eating were conceived in terms of risks and benefits to one’s physiological health and physical activity was also perceived in biomedical terms as a remedy and safeguard against illnesses, not uncommonly even explicitly referred to as ‘medicine’ (intervention 2, 3 and 4). Food and physical activity were thus also construed as ‘natural’ alternatives to medications and vitamin pills (see also Lupton, 1996).

The dominating approach in the intervention for giving the participants the ‘facts’ they were perceived to need was by way of lectures and hand-outs. This approach was most prominent in interventions 1 and 3 in which outright lecturing was the norm and hand-outs with ‘facts’ played an important role. In interventions 2 and 4 the sessions were based somewhat more on dialogue between educators and participants, although the educators were still unquestionably perceived to be the most knowledgeable party. However, intervention 4 differed somewhat from the rest of them in that the educator was
understood to be the expert of behavior change, rather than of what constituted a healthy diet and level of physical activity – of this the participants were understood to be equally knowledgeable.

This normative and teacher centered approach in which correct ‘factual’ knowledge about nutrition, metabolism and physiology is central was based on a naïve conception of the relationship between knowledge and behavior change and ignored more complex explanations. Furthermore, it positioned the educators as the ‘experts’ who thus came to offer a sense of control over the situation and the risks with which we live (Gard & Wright, 2005). Being ‘experts’ the educators were in the sole position to decide and search out the information that they – based on their ideas about risk and how to avoid or decrease it – considered the participants to need knowledge and awareness about.

How risk works

As mentioned earlier, the notion of risk is underpinned by a quest to manage uncertainty and may thus “be viewed as integral to a rationalist understanding of reality, in which unfortunate events are deemed to be both predictable and avoidable” (Lupton, 1995:79). The notion of risk also displaces how we perceive of disease, constituting disease as a gauge of one’s moral qualities (Lupton, 1995). As such, the notion of risk has come to replace the notion of sin “as a term which ‘runs across the gamut of social life to moralize and politicize dangers’” (Lupton, 1995:89, quoting Douglas, 1990:4). Hence, in the interventions risk was perceived as internally imposed and represented as due to a “lack of willpower, moral weakness or laziness on the part of the individual” (Lupton, 1995:90).

Because the participants in this manner were perceived to voluntarily be courting risk, they were described as ‘risk-takers’. Despite this, however, they were also expected to take the correct advice and act responsibly on the information provided to avoid risk (Gard & Wright, 2005): by identifying risk factors through diagnostics such as HPA and BMI, participants were expected to come to understand causality and act rationally on this. For example, the cause behind a BMI over 25 (or 23,8 in intervention 4) was construed in all four interventions (although described in different ways) to be energy imbalance: either too much food or too little exercise or both. This meant that the participants were expected to correct their BMI by way of their behavior. Then, if the participants were not able to take this type of advice to heart and change these habits, the blame was all on the participants themselves for not being disciplined enough. Although in intervention 2, one other possible cause behind a pathological BMI was understood to be hypothyroidism. However, this condition was still understood as possible to overcome with the help of a bit of medication and a strong will. If the participants were to challenge health
risk assessments such as these, they would be “represented as irrational, self-deluding and irresponsible” (Lupton, 1995:90).

Lupton (1995) compares the process of risk assessment to that of a religious confession. This comparison offers an evocative image that is descriptive not only of the HPAs but of the entire interventions: “Individuals are incited to tell their ‘sins’ to the health worker, or else their bodies provide mute testimony to their self-indulgence (if found to be overweight or to have a high cholesterol reading, for example). Once the assessment is finalized, judgement is passed upon participants, and they are given appropriate ‘penances’ to perform to re-establish bodily, and moral, integrity” (Lupton, 1995:82), penances such as increasing intake in fruits and vegetables and exercising regularly.

Hence, this focus on risk functioned to place responsibility for health with the participants and served as a subtle and effective mode of regulation (see also Petersen, 1997). This produced an idea of the ideal healthy employee as someone who is self-aware, responsible, rational and rationally motivated to take charge over their recalcitrant bodies and make ‘good’ lifestyle changes to improve health. However, this may be understood as problematic because it disregards any structural or environmental factors that may influence the individuals’ ability to act on this responsibility.

The notion of risk works by way of the threat of current and future dangers. These dangers may be ill health or even death, which was described by the educators as a possible outcome in interventions 1, 2 and 3 if the participants did not comply and alter their lifestyle. In effect, risk thus works by inspiring and motivating participants to change their lifestyle through fear. Fear is expected to motivate the participants to take rational action in accordance with the advice given in the intervention. However, if, or when, participants are not able to eliminate the risks or live up fully to the expectations about a changed lifestyle, this may produce feelings of shame and guilt. However, producing healthy behavior such as physical activity by way of shaming individuals into it “may in fact generate a further disengagement from the subjective body that in turn produces a sense of meaninglessness or futility … (and consequently a reduction in participation)” (Fullagar, 2002:81).

However, the biomedical discourse and the notion of risk were, as mentioned earlier, not the only guiding principles in the interventions. Underpinning the wellness discourse was a notion of pleasure and wellbeing which served to produce other understandings of health and of how to achieve it.

…or seeking pleasure?

The notion of pleasure is rarely addressed and/or interrogated directly in relation to public health or health promotion work (Coveney & Bunton, 2003;
Daube, 1999). This is somewhat surprising since the notions of health and pleasure are intrinsically linked, if for no other reason than pleasure generally being understood as a potential risk, as something that produces at-risk behavior and hence should be guarded against. In the interventions, as is common in public health (see Coveney & Bunton, 2003), pleasure-seeking was generally regarded with suspicion, if not outright warned against as it was perceived to produce at-risk behavior. For example, in intervention 2, the participants were understood to be ruled by their problematic drive for instant gratification which was perceived to drive them to eat the wrong things and not get enough exercise.

On the other hand, pleasure is also perceived as beneficial to health (see e.g. Warburton, 1999) and Daube (1999) argues that pleasure has been overlooked as a potential tool to increase compliance with health imperatives. He promotes a ‘positive approach’ to health work and argues for an explicit use of the notion of pleasure in health work. Daube suggests that an approach that “recognizes, accepts and encourages pleasure as a central outcome in people’s lives” (1999:37) would be better because “we all respond better to the promise of pleasure than to the threat of eternal damnation – or the promise of ill health, which is much the same thing” (Daube, 1999:44).

In the interventions, although it was also perceived as a problem, pleasure was recognized as a central outcome in the participants’ lives and the participants were subsequently positioned as pleasure seekers. However, making use of this drive for pleasure, specific healthy behavior was depicted in positive terms. For example, healthy food was represented as tasty (intervention 4), and physical activity was described as fun (interventions 2 and 4). Furthermore, pleasure was represented as a mind-set, suggesting that it would be possible for the participants to enjoy a healthy lifestyle simply by adopting the right, meaning a positive, attitude (intervention 2). Finally, to encourage them to perform the promoted healthy behavior, the participants were also promised a pleasureable end result. For example, the participants were told that they would be better able to enjoy life and become a (more) pleasurable person to be around (intervention 3), have fun, be happy and feel good (intervention 1) or improve their self-image and self-discipline (intervention 4).

There is a difference between doing something for the pleasure of doing it and doing something as pleasurably as possible for the sake of maintenance. In these interventions, physical activity and a healthy diet were discussed and promoted primarily in terms of the latter: pleasure, either derived directly from the healthy behavior, from an attitude or as an end result, was thus perceived as a necessary component for maintenance of a healthy lifestyle. However, pleasure may be perceived both as an innate drive and as a socially constructed phenomenon (see Coveney & Bunton, 2003, and Warburton, 1999). In both cases, it is understood as an embodied experience and as such, pleasure and
what produces the experience of pleasure is subjective and individually variable. The notion (and experience) of pleasure is thus contextually dependent and socially situated (see also Sointu, 2005 on the issue of wellbeing). Hence, on a more specific level, what was construed and understood as pleasurable food and physical activity varied between the interventions. However, what was perceived as healthy pleasurable behavior was, on a more general level, quite similar.

Coveney and Bunton (2003) conceptualize pleasure on a more general level by differentiating between experiences of pleasure. They highlight four experiences of pleasure: carnal, disciplined, ascetic and ecstatic. Carnal pleasure emerges from the physical body, is concerned with bodily senses and connects the physical body to the world as it opens the body up to pleasures such as food. Disciplined pleasure offers ‘purity and harmony’, and is concerned with civilized the body, with rationality, moderation and restraint: “Disciplined pleasure is pleasure that has been rationalized” (Coveney & Bunton, 2003:170). Too much of anything is perceived as unnecessary or unhealthy. What is needed is rather just enough, just the right amount. The ascetic pleasure is concerned with a total control of the body, with conquering and dominating the body. Ascetic pleasure comes out of the denial of all pleasure and an example of ascetic pleasure may be self-starvation. Finally, ecstatic pleasure is concerned with rituals and spiritual bonding, such as can be achieved in club cultures or church activities.

While the notion of ecstatic pleasure was not drawn on in the interventions studied here, the other three types of pleasure were. In accordance with many other health interventions (Coveney & Bunton, 2003), the privileged notion of pleasure underpinning these interventions was disciplined pleasure. Carnal and ascetic pleasure set the boundaries for disciplined pleasure and between ‘good’ and ‘bad’ pleasure. This also served to constitute carnal and ascetic pleasure as undesirable or ‘dangerous’. For instance, both educators and participants were concerned with the need to indulge occasionally in unhealthy foods (carnal pleasure). This was seen as a dangerous behavior as indicated by the emphasis on these indulgences being occasional and without exaggeration (intervention 1 and 3), or as in intervention 2, where the educators were rather concerned with underlining the importance of these indulgences being ‘within reason’, thus again privileging disciplined pleasure. Coveney and Bunton (2003:172) suggest that “[i]n trying to supplant carnal pleasures with disciplined pleasures, public health always runs the risk of paralleling religious zeal which reifies ascetic pleasures”. This seemed to be a concern that the educators shared as they repeatedly emphasized the necessity in not exaggerating anything: the need or inclination to keep a very strict diet and/or exercise very much or very hard (ascetic pleasure) was also construed as dangerous. For example, too much or too hard physical activity was perceived potentially to lead to injury, especially for women (intervention 2), or to other symptoms of poor health (intervention
1), while being very enthusiastic about healthy living (more than ‘the average person’) was likened with being a ‘dull fanatic’ (intervention 3).

The notion of disciplined pleasure thus produced a set of norms and ideals about appropriate behaviors/activities. It also emphasized the need for self-management. Furthermore, pleasure was understood to be experienced on different levels of the self: physically, emotionally and mentally. This notion of pleasure may be expected to produce an understanding of the self as multi-dimensional.

The multi-dimensional self?
The multi-dimensional self refers to an idea that the self is constituted by multiple dimensions such as thoughts, emotions, attitudes, desires and physicality. In relation to health, this notion also suggests that each dimension of the self may be expected to influence the other dimensions. Hence, feeling well would be perceived as a sign of health. Furthermore, it would be perceived as possible to improve health by doing pleasurable activities and by having pleasurable thoughts and feelings.

In line with these ideas, participants’ thoughts, feelings and attitudes were addressed in the interventions (especially in intervention 2 and 4). In intervention 2, the participants were repeatedly encouraged to think positively, be optimistic and cultivate their happy memories so as to achieve a more pleasurable experience of their life. In intervention 4 the participants were encouraged to think and feel the ‘right’ things in the ‘right’ manner so as to achieve more wellbeing and be able to get more pleasure out of life.

However, the body-mind dichotomy presented above under The two-dimensional body was also reproduced in relation to the notion of pleasure as the mind (thoughts) had a tendency to be given precedence over emotions, attitudes, desires and physicality. The mind was thus still conceived of as responsible for controlling the rest of the self, hence setting the mind against the rest of the self. However, unlike the focus on the body in the previous section, the focus was here directed toward the mind: this came to be conceived as the primary object to improve upon, to discipline. In a metaphor used in intervention 4, the mind was compared to a computer needing to be reprogrammed, suggesting a notion of a ‘meta-self’ that needed to come to the fore and take command of the situation. However, in line with the notion of a multi-dimensional self, changing one’s thoughts was understood to influence and improve one’s emotions and attitudes, and was perceived as a necessary focus to be able to improve one’s physicality.
How to seek pleasure

As indicated above, not all forms of pleasure or pleasure seeking behavior was perceived as acceptable in the interventions. Notions about how best to seek pleasure were determined by ideas about what constituted ‘good’ and acceptable experiences of pleasure. The predominant notion of acceptable pleasure was disciplined pleasure. Disciplined pleasure privileged delayed gratification with promises of a pleasurable future. This pleasurable future was conceived as residing in a balanced lifestyle (intervention 1 and 3), being able to enjoy life and being alert and energetic (intervention 3 and 4), being able to enjoy old age (intervention 3), being happy and feeling good (all interventions). Being happy and feeling good would furthermore result in the participants becoming pleasant to be around (intervention 3). This type of pleasure the participants would be able to find by changing their dietary and physical activity habits.

Pleasure was also perceived as a state of mind and this state of mind was perceived as something that the participants could achieve by taking charge over their thoughts and emotions (intervention 4) and by adopting a positive attitude (intervention 2), so as to focus on the positive and pleasurable aspects of life and of themselves. Drawing on the wellness discourse, a healthy lifestyle was thus construed as fun and pleasurable in itself – it was just a matter either of learning to appreciate healthy behavior, of finding out the (healthy) alternatives that brought you pleasure, or of adopting the right attitude.

Drawing on the wellness discourse, it was also perceived as important for maintenance of a healthier lifestyle that the participants enjoyed the new and healthier food and the physical activities they chose. However, the pleasure should spring out of moderate and restrained indulgences, i.e. disciplined pleasure. Regarding diet, this referred to the ability to occasionally and within reason indulge in unhealthy foods. In order to be able to do this, the participants first needed to become aware of how they should be eating and how they currently were eating (intervention 1, 2 and 3). In intervention 2, this included becoming aware of dietary habits that they might not yet be aware of, such as snacking while cooking, in order to be able to restrain such behavior to the benefit of consciously chosen – and moderate - indulgences. It was also conceived as a matter of learning to appreciate healthier food, the freshness and tastiness of it (intervention 4).

Physical activity was construed as fun and pleasurable in itself, and if the participants did not share this experience, then that was due to them not having found the activities that they liked (all four interventions). In order to find activities that they enjoyed, participants were suggested to experiment with new forms of activities and they were even made to do so as part of the intervention (intervention 2 and 4). Another idea was that in order to enjoy being physically active the participants needed to feel secure in the presence of other (more
experienced) exercisers. Hence, they needed to become familiar with the activities, such as weight lifting (intervention 2).

Based on the idea that maintenance of new behavior depends on the degree of pleasure and reward experienced when performing it, the educational efforts came to be concerned with interrogating the participants about their preferences and with improving the participants’ self-awareness and skills in order to encourage the participants to find physical activities and a healthy diet that they enjoyed. Addressing and regulating not only the body and specific behaviors, but also thoughts, emotions and attitudes, the educational strategies when drawing on the notion of pleasure came to be more comprehensive than the normative approach produced by the notion of risk. Based on individual contexts and needs and taking the participants’ own experiences and self-awareness as a starting point, the educational strategies and methods for behavior change thus positioned the participants as the experts as they alone have knowledge about their preferences and desires. Being positioned as the experts, the participants were thus made responsible for modeling their lifestyle in a way that was not only healthy but that would also be enjoyable, meaning disciplined.

How pleasure works
The wellness discourse offered an alternate understanding of what constitutes good and healthy diet and physical activity as it displaced the biomedical attention on nutrition to a focus on diet and physical activity as potential sources of pleasure and wellbeing. In this manner, the wellness discourse was drawn on to legitimate indulgent behavior for the sake of disciplined pleasure as an aspect of health, behavior which from a biomedical perspective could not be defended. Furthermore, the wellness discourse linked the imperative to eat healthy and be physically active to a project of improved wellbeing, as opposed to the biomedical discourse which linked it to the project of minimizing risks to one’s physical health. It also construed behavior change as pleasurable and “depicted as a form of activity that is relatively easy, generally pleasant, most definitely deserved and without a doubt ‘good’ for the person” (Sointu, 2005:260). Pleasure thus works by inspiring and motivating participants to change their lifestyle through desire. Desire was expected to motivate the participants to take action, however disciplined action. Because both the actual behavior change and the resulting lifestyle were conceived as pleasurable, it was perceived that this behavior change demanded little in terms of effort. Consequently, anybody was perceived as able to do it and there could be no legitimate reason not to do so.

Pleasure, as it was represented, also reproduced power and social relations. It reproduced normative obligations that the participants were expected to
conform to and strive toward, for instance by experimenting with various physical activities in order to find something that they could enjoy; something that they could experience as fun. However, the participants’ opportunities for finding something they could enjoy was limited in the interventions by the boundaries set up by the educators as they decided what physical activities to promote or recommend against (intervention 2 and 4). Although the educator engaged the participants in deciding on which activities to try out together in intervention 4, ultimately, it was the educators’ suggestions that were chosen. Thus, “[w]hile the discourses and experience of pleasure are normally associated with freedom from interdiction, they are replete with social regulation or control.” (Coveney & Bunton, 2003:174).

The notion of pleasure functioned in the interventions as a governmental strategy to inspire and motivate individuals to take up the imperatives of health (see also Coveney & Bunton, 2003; Lupton, 1995). Although differing somewhat in the details, the health imperatives produced by the wellness discourse and the notion of pleasure regulated and promoted practices of self-reflection, self-management and self-control, as did the notion of risk, and constituted the individual as the main agent in producing one’s own wellbeing.

Creating wellbeing was thus constituted as a personal choice, and the ideal subject as produced by the wellness discourse and the notion of pleasure was a self-responsible and self-governing individual who was able and willing to recognize the boundary between ‘good’ pleasures and ‘bad’ pleasures as well as to manage to stay on the ‘right’ side of this boundary.

Strong and rational or weak and emotional?

As discussed in Chapter 2, how femininity and masculinity can be performed and understood may be perceived as an expression of available discourses and positions at specific points in time and space (Davies, 2000; Lenz-Taguchi, 2004; see also e.g. Larsson, 2003; Larsson, Fagrell & Redelius, 2007). One forcible factor in the context of the studied WHP interventions for how femininity and masculinity could be performed and understood was how the health discourses operated there. The biomedical discourse was underpinned by a notion of the body as ‘real’ and constituted an idea about the ideal male body as the ‘norm’ against which all bodies were to be measured. Furthermore, by insisting on commenting on women and how women differed from men both physically and behaviorally, and what women needed to think about due to these differences, men were constituted as the norm and women as the deviant Other (see also Johannisson, 1996). In this manner, the healthy worker was construed as a male worker and women workers as problematic and as the one’s needing to do some work on themselves. One of the ways in which this differentiation was produced was by drawing on a notion of humans as pre-
historic. Although this notion was drawn on in all of the interventions, in interventions 1, 2 and 4 the pre-historic age was referred to in order to explain why humans have a predilection for specific foods and why they should be physically active. In contrast, in intervention 3, the notion of the human body as pre-historic was drawn on to constitute women and men as different yet complementary: women were perceived as gatherers and men as hunters. Furthermore, this notion of women as gatherers and men as hunters was allowed to explain why women should eat vegetable protein while men needed meat protein and it also explained why women were unable to stick with one thing and were prone to try out different foods, while men were able and willing to focus and stick with the program.

Although it may not have been quite so obvious (and potentially provoking) in interventions 1, 2 and 4, they did differentiate between women and men. In intervention 1, women were perceived as constitutionally weaker than men, with irregular bodies (menstruation, menopause, etc) and driven by emotion. Being emotionally driven, women were perceived to treat food and eating as social occasions, while men were perceived to rather focus on eating. In intervention 2, women were also perceived as constitutionally weaker than men, more easily exhausted and more limber than men. Being limber was perceived as a problem because it caused women not to use their muscles correctly. In intervention 4, women were constituted as smaller than men, with a need for less energy (food). Women were also perceived to be more interested in health issues than men and as better at maintaining a holistic perspective although men were understood to be the health experts (referred to in the literature and in lectures). Finally, the women participants of all four intervention were recommended physical activities that reproduced certain ideas about what the female body should look like (thin, not too muscular) and behave (not too exhausting physical chores) while men (interventions 2 and 3) were recommended much the same activities but with an expectation that they would (also) want to do weight training and/or running. In general, the main focus was thus directed toward women as deviating from the norm and what they needed to do to discipline and normalize their bodies and behavior in accordance with ideals about the female body and feminine behavior (see e.g. Bordo, 2003).

Differentiating between women and men seem to be basic to human culture (see e.g. Hirdman, 2001). However, according to Butler’s (1990) concept of the ‘heterosexual matrix’, women’s and men’s actions furthermore only become comprehensible based on an assumption of heterosexuality. The dominating assumptions expressed in the interventions on the one hand in the everyday talk about ‘women and men’ and on the other in the interpretation of women’s and men’s way of being were, however, not about women and men in general but about heterosexual women and men. Constituting women and men as different
yet complementary may be regarded as a means for reproducing and upholding heterosexual ideas and ideals, i.e. heteronormative ideas and ideals. Heteronormativity upholds and reproduces the gender order by determining how we understand the behavior of women and men and by normalizing and producing specific behavior as desirable or undesirable (Larsson, Fagrell & Redelius, 2007). Thus, the constant differentiation made between women and men reproduced heteronormative ideas and imperatives about women’s and men’s bodies and practices. These “heterosexual imperatives exist in norms, social mores and symbols that are never questioned. They exist in notions that are embedded in traditions and institutionalized rules and routines. They exist, above all, in the societal consequences that come from these rules and routines being generally accepted and obeyed” (Rosenberg, 2002:101). For instance, women were characterized as naturally more concerned with issues of personal health than men while men were conceived to need more convincing. Furthermore, the range of physical activities that were recommended to women was limited and activities such as soccer and handball were proposed as inappropriate for women. Instead, ‘softer’ activities such as walks were promoted. Also, advice about nutrition reproduced ideas about the amount of food women and men should eat; ideas that suggest, for instance, that men need more food and more animal protein than women do.

The concept of heteronormativity comes from queer theory and is most commonly used in sexuality studies, primarily to problematize the heterosexual norm and the consequent marginalization of LGBT-persons and communities. However, heteronormativity may not only be seen as a problem for non-heterosexual people but also for heterosexual people who might not fit in with the norm regarding expectations on physical appearance and/or social actions. For example, the educators’ ridicule of one of the male participants in intervention 2 because he was ‘soft’, was based on a heterosexual idea about the ideal heterosexual man: in order to be recognized as a ‘normal’ and healthy man, men were expected to be physically strong (compare with Larsson, 2003). Men who were not could expect to be perceived as effeminate and as inferior employees.

Not only was the ideal healthy person a heterosexual man, it was also a rational man. The notion of risk privileged rationality and rationally motivated behavior. In a similar manner, the privileged sense of pleasure was disciplined pleasure, meaning rational, restrained and civilized. Hence, both the notion of risk and the notion of pleasure produced an idea of the ideal healthy employee as someone who is rational and rationally motivated to make ‘good’ lifestyle changes to improve health. However, not all participants were primarily conceived as rational.

At first glance, the wellness discourse may seem to produce a nominalist conception of gender as pleasure is understood as individually variable, or it
may be perceived to position women as the norm since caring for values such as enjoying life and caring about health and wellbeing may be seen as characteristics of women (see e.g. in intervention 4, but see also Sointu, 2005). However, in the interventions, women were understood to be neurotic and unable to relax and enjoy life (intervention 3), as emotional (intervention 1 and 4) and irrational (intervention 2). Essentialist ideas about gender thus construed women as emotional/irrational and men as rational. This is not an uncommon idea as men have long been perceived as essentially rational and women as essentially emotional (see e.g. Hirdman, 2001; Lenz-Taguchi, 2004). This “dichotomous idea is built on dichotomous (bi-polar) contrasting relationship that is mutually excluding” with, in this case, rationality carrying the higher value (Lenz-Taguchi, 2004:30). So, not only were women perceived as emotional, this emotionality was also conceived as of no or even negative value in relation to behavior change and (maintaining) a healthy lifestyle. Women participants were thus positioned as at a disadvantage regarding (being able to) make rational decisions about their behavior and lifestyle and hence constituted as needing more help, more guidance, more regulation and control and/or help to develop abilities for self-restraint, self-control and self-surveillance. This was especially clear in intervention 4, where the participants – all women – were not perceived as ignorant regarding what they should do, but rather unable to take rational action and hence needing to improve their self-discipline.

Concluding remarks

Workplace health promotion interventions as part of a new corporate health ethic is, in Lupton’s (1995:83) words, “a two-edged sword. Ostensibly the introduction of such programmes signal philanthropic motives on the part of employers to improve the quality of their employees’ health, as well as serving to containing health care costs …. However, the encroachment of appraisal and testing programmes into the workplace signals a new type of control over the worker’s body”: it screens out ‘undesirable’ employees and exhorts workers to engage in certain activities and not others in their spare time. Fullagar (2002:71) notes that “leisure figures as an ideal domain for the promotion of healthy lifestyle change”. Likewise, in the studied interventions, the employees’ leisure figures as an important aspect and domain for governing the employees’ health. Hence, as the employer offers to help the employees improve their lifestyle, they also reach beyond their expected domain of governance – the workplace – and invade the employees’ private domain and regulate their spare time.

In workplace health promotion, employees are “addressed on the assumption that they want to be healthy” (Rose, 1999:86, emphasis in original) and health is represented as something that can be achieved by autonomous
individuals making lifestyle decisions. Making these decisions is furthermore represented as a way to personal fulfillment and happiness. Due to this imperative of health and the notion of it as the result of individual choices made, the burden of health is placed on the individual subject and coercion becomes unnecessary (Rose, 1999). Hence, employees come to volunteer for participation, even to seek interventions out. This behavior is furthermore expected, as “[t]he desirable employees are [conceived as] both willing and capable of actively helping themselves” (Sointu, 2005:266).

Once participating in the interventions, the employees are thus perceived as being there voluntarily and as both willing and able to change their lifestyle. The strategies (e.g. risk/pleasure, fear/desire) that serve to stimulate the participants’ capacity to self-govern also serve to persuade them to execute decisions about their lifestyle in the name of freedom and choice: “Subjects are [thus] to do the work on themselves, not in the name of conformity, but to make them free” (Rose, 1999:268), and the participants are consequently not merely free to actively choose a healthier lifestyle, to become healthier, but they are “obliged to be free” (Rose, 1999:87, emphasis in original).

However, Greco (1995), among others, questions this notion of individual choice in this context, pointing out that the idea seems both doubtful and paradoxical: “Since when and in what precise meaning has it become possible to imagine health as an area of individual acquisition through rational choice? And what secondary meanings are diseases given when these suggest a failure of action?” (Greco, 1995:272, translated from Swedish). In relation to the studied interventions, diseases that are linked to personal lifestyle choices come to be seen as ‘earned’ because apparently, the participants did not try hard enough to change her/his lifestyle. Perceiving of health as an individual choice thus serves to constitute disease as the consequence of one’s own lifestyle and sickness becomes “a marker of the body ‘taking over’ reason” (Lupton, 1995:9 referring to Kirmayer, 1988).

Health is a moral imperative that produces ideas about ‘good’ and ‘bad’ behavior, about ‘right’ and ‘wrong’ attitudes and about ‘appropriate’ and ‘inappropriate’ subjectivities (Lupton, 1995; Seedhouse, 2004). Depending on which health discourse was drawn on, the same behavior could be represented in different – and contradictory! – ways. For example, indulging in unhealthy foods could be represented as a risky behavior and thus unacceptable, or it could be represented as a pleasurable experience and a necessary component of a healthy diet. However, the underpinning rationale for how both discourses were drawn on was rationality, and hence, even though indulgence was perceived as an acceptable behavior when drawing on the wellness discourse, the indulgence needed to be restrained and moderate. Hence, the imperative to engage in a healthy lifestyle was in the biomedical discourse linked to a project of minimizing risks by constant self-surveillance, and in the wellness discourse it
was linked to a project of maximizing disciplined pleasure by constant self-management. Consequently, irrespective of the discourse drawn on, “…self-responsibility becomes the norm, but also the primary means of governing individuals characterized by autonomy and freedom” (Sointu, 2005:262).

The notion of the participants as willing, able and free to make healthy choices about their lifestyle is also problematic in the sense that it disregards social and environmental conditions that influence both individual health and individual capacity for acting in the desired manner. Social and environmental conditions, such as family responsibilities (the double burden of both paid work and unpaid domestic labor) and financial status (low income) generally pose a greater obstacle for women than men in this respect (Hammarström, Härenstam & Östlin, 1996; Ohlander, 1996). This means that the conditions to take time for themselves and invest this time in their health, for instance by being physically active as was an important aspect of the activities recommended in all four interventions, may be expected to be more limited for women than men. Family responsibilities and financial status, just to take two examples, may be expected to make it more difficult for women to find the time and money to live in accordance with these imperatives.

To scare or to lure?
The biomedical and the wellness discourses may be perceived as supplementing each other in the sense that the negative and risk-focused imperatives of the biomedical discourse are counterbalanced by the optimism and pleasure-focused imperatives of the wellness discourse. Drawing on both discourses could thus be perceived to forge a stronger hold on the participants as it regulates the participants both by way of their fear of ill health and their desire for an enjoyable life. Furthermore, the wellness discourse also serves to regulate more aspects of the participants than the biomedical discourse, since it does not just serve to regulate bodies but also thoughts, emotions and experiences. Hence, every aspect of the self comes to be assessed and monitored, including thoughts and feelings.

However, “so many injunctions to healthy behaviours seem to be concerned with restricting or overcoming our seemingly ‘natural’ inclination towards certain pleasures” (Coveney & Bunton, 2003:163). Hence, pleasure (as bodily – carnal – experience) is still perceived as dangerous and “is considered as a prime force creating the ‘root of resistance’ whereby individuals flout the norms which public health attempts to impose. … Pleasure and pleasure seeking is thus conceived as the weak link in the chain of command from authoritarian discourses of health governance to docile compliance for body maintenance” (Coveney & Bunton, 2003:166). Consequently, the notion of encouraging pleasure seeking as part of a health education strategy seems to be conceived as too ‘dangerous’. It is perceived as too uncertain to leave everything up to the
individual and trust that they will make the decisions that are best for them and that these changes will cohere with the intentions of the educator. Thus, the educators come to have a hard time letting go of their habitual paternalistic approach, however disguised it may be. From this, it follows that it may be expected that drawing on the notion of pleasure to promote alternative embodied experiences as a strategy to produce healthy behavior will always come second to promoting disciplined pleasure, not to talk about risk continuing to dominate health education discourse.

**Other experiences?**

In the interventions, norms and truths about responsible healthy living were produced and the participants were governed toward health and a healthy lifestyle as these were conceived and constructed by the educators drawing on the health discourses and the notions of risk and disciplined pleasure. Furthermore, the two health discourses suggest at least two ways of conceiving of the body: as a measurable and atomized ‘object’ in the biomedical discourse to the suggestion of a subjective, holistic, embodied experience in the wellness discourse. The privileged notion did, however, produce a dichotomy between body and mind, promoting an understanding of the body as something that needs to be taken care of, as something other than the self. This notion disconnects body and mind and disqualifies subjectivity and embodied experiences. The stereotypical heteronormative portrayal and perception of the participants and of healthy behavior also served to marginalize other experiences and make ‘norm-breaking’ behavior, attitudes and desires impossible or difficult.

However, “Foucault (1980, 1986) argues for an ethics of self that refuses who we are in order that we might become something other – not something ‘more’ as the moral economy of health promotion demands, but something different, a more pleasurable experience of healthy living that is linked to diverse forms of social participation” (Fullagar, 2002:82). This ‘other’ type of ethics of the self was hinted at in the interventions as the wellness discourse was drawn on, although it was not really acted on or given much significance. Still, the notion of pleasure in itself raises questions about the possibility of different ethics and approaches in workplace health promotion interventions and, in a wider perspective, health education. Would it be possible to explore ‘other’ ways of drawing on the wellness discourse and the notion and experiences of pleasure? Perhaps exploring ways of using and promoting sensuous experiences of pleasure as a means to change and improve lifestyle related behavior? There are a wide range of activities that “involve a different ethics of embodied movement that is not aimed at a measured self-improvement” (Fullagar, 2002:73), such as yoga, bushwalking and swimming. Such activities privilege pleasure through different ethical relations to the body, thus de-emphasizing the
focus on risk and placing the focus more on having fun and experiencing pleasure.
CHAPTER 9,
FINAL REFLECTIONS

This study aims to offer a critical social scientific perspective on health education by analyzing workplace health promotion interventions with a focus on power relations, drawing on Foucault’s notion of governmentality. Notions about health and healthy behavior are socially constructed and contextually dependent and prescribe desired ways of being and behaving. However, health is generally understood as something good and perceived as something that everyone wants (more of), hence everyone is perceived as a willing and voluntary target (see e.g. Lupton, 1995; Rose, 1999; Seedhouse, 2004). Employees are perceived as an especially suitable target group because they can be easily identified and located. Although workplace health promotion interventions are targeted at employees and take place at or in conjunction with the workplace and worktime, WHP does not only regulate its subjects as employees or their behavior during working time. They regulate how it is possible to conceive of one’s own individuality and hence, as pointed out in the first chapter, may be expected to influence employees’ sense of self and practices of self-government. Consequently, workplace health promotion interventions govern subjects both on and off working time. Therefore, parallel with research for the purpose of developing so called ‘best practice’ in health education generally and workplace health promotion specifically, it is important to try to gain insight into how and with what effects these institutions govern and regulate the targeted subjects as well as what practices of self-governing they produce. In this study, for the purpose of addressing these issues, I have investigated how health is negotiated in the interaction between educators and participants. I have explored the limitations and imperatives imposed on the participants, how these limitations and imperatives were taken up and re-contextualized as well as with what consequences for how the participants were invited to govern themselves and to make sense of themselves as healthy (or not) and as gendered subjects.

In this chapter I address and discuss the findings of this study in relation to the expectations I had going into it. After this I make some methodological reflections and I finish it all with a few comments and suggestions for future research.
Expectations vs. findings

Going into this study, I had an idea that I would find that the workplace health promotion interventions studied would be structured more around ideas about health promotion than disease prevention, and that the approach to health would be 'holistic', meaning that health would be defined as something wider or other than the absence of illness, sickness and disease. Hence, I expected that something like the wellness discourse would be operating in the interventions. In relation to this, I expected that the educators would think of this wider/other definition of health as 'better' and more allowing than the biomedical conception of it and hence be more inclined to draw on that. However, as I have demonstrated above, the dominating discourse in all four studied interventions was the biomedical discourse and the notion of pleasure underpinning the wellness discourse was rather perceived as something of a risky notion to work with. Still, the notion of pleasure was drawn on, although not in a manner in which the participants were invited to explore new ways of finding and experiencing pleasure, as perhaps I was expecting (or hoping?) to find. Rather, just as with the notion of risk (and in hindsight perhaps not so surprising), the notion of pleasure was drawn on to set up (other) ideas about the limits between healthy and unhealthy behavior. It was also drawn on to take advantage of the participants’ desire for being able to enjoy life, now and up in the ages, in order to motivate and inspire the participants to achieve and maintain a healthy lifestyle. This healthy lifestyle was constituted as pleasurable in itself by promoting the experience of disciplined pleasure through enjoyment of healthy food and fun and healthy levels of physical activity. I was not expecting to find that the biomedical and the wellness discourses, or the notions of risk and pleasure produced such similar ideas about the healthy person (as rational, willing and able). I was rather expecting (or hoping?) that the wellness discourse and the notion of pleasure would allow for other ideas, other ethics of embodied experiences, for an expansion or a shift in conceptions regarding how to work with health issues. And certainly, the wellness discourse did produce a wider and more comprehensive educational approach, thus governing ever more aspects of the self than the notion of risk did. And this was another of the surprises for me in this study.

What this study thus points out is that even though the wellness discourse grew out of a critique directed toward biomedical notions of health, drawing on the wellness discourse results, as does the biomedical discourse, in an understanding of the participants as rational, in practices of self-regulation, in the responsibility being placed with the individual, etc. Furthermore, in comparison with the biomedical discourse, the wellness discourse seems to construct more aspects of the participants as relevant and important to govern and control in the name of health: calls for self-regulation and individual responsibility becomes even more pervasive in this ‘holistic’ approach in the
sense that all lifestyle related practices, thoughts and emotions come to be medicalized, manipulated and perceived as needing attention and regulation. Individuals’ whole existence thus comes to be medicalized, producing more potential risk than the biomedical discourse necessarily does and also positioning the participants as the one’s responsible for their health through proper practices of self-government. Hence, even though the normative educational approach produced by the biomedical discourse may, as its name suggests, be perceived as more normative and prescriptive, it may also be regarded as offering the participants a greater freedom than the comprehensive approach produced in the wellness discourse. The normative approach does not propose that the educators pry into the lives and emotions of the participants. The educational strategy suggested is prescriptive and normative, but not manipulative, as may be argued about the comprehensive approach. The normative approach is in this sense more open and direct, while the comprehensive approach is more covert and controlling and may be perceived as more surreptitious and devious. However, this does not mean that I am advocating a withdrawal from this approach or that I am saying that the wellness discourse is a ‘bad’ or more ‘dangerous’ discourse. What I am saying is that a holistic approach drawing on a wellness discourse is equally ‘dangerous’ as other health discourses and approaches to health education.

The purpose of this study was never to give a ‘recipe’ for change or of what could or should be done differently – that I leave up to the reader. But what this study shows is that workplace health promotion interventions are not harmless or innocent but function to constitute participants as gendered citizens and employees in specific ways in relation to various notions of health and healthy lifestyles. For example, although I was aware going into this study that permeating society (including medicine and hence health education), is a primacy of a male norm, I was still expecting to find proof that essentialist ideas about gender would not be all there was. However, the relationship between health and gender was constituted much in the same manner as it has been since the 19th century (Johannisson, 1994, 1996). This meant that notions about health served to reproduce essentialist ideas about gender: about women and men as different yet complementary and about (strong) men as the norm and (weak) women as the deviant Other. Advice and imperatives on health related behavior was based on this division and suggested a difference in needs between women and men. Hence, distinctions between women and men produced by notions about health worked to maintain and reproduce boundaries between women/femininity and men/masculinity, hence maintaining and reproducing heteronormative power relations.

When I started this study and was searching for interventions to include in it (in 2002 and 2003), finding suitable projects was not an altogether easy task and I had to turn to my network to find them. During the years I have been
working on this research I have noticed a development on the market, and workplace health promotion interventions are now easily found by searching on the internet. Not only have health service providers begun to make their existence known via the internet, but the number of providers appears to have increased. Furthermore, it appears that an increased (or new?) focus is being placed on what is referred to as ‘mindfulness’.

Considering the growth in this, as of yet, unregulated field, further research needs to be done in this area to discuss and explore how WHP regulates employees and with what social effects\textsuperscript{23}. Perhaps an accreditation for providers of workplace health promotion is needed?

Is governmentality becoming more or less visible in modern society?

In one of her studies, Jennifer Gore (1998) argues that governmentality is becoming less visible in modern society. In this study, she sets out to demonstrate that the eight major techniques of power (the same one’s that are focused on in this study) are easily recognizable in four different (adult) educational sites: high school physical education classes; a first-year teacher education cohort; a feminist reading group; and a women’s discussion group. She also performs a quasi-quantitative analysis to make some comparisons between the educational sites in the use of the technologies. In this latter analysis she finds that the least used techniques were regulation and surveillance and that the most common techniques were individualization and totalization. This pattern, she says, was most obvious in the teacher education site. Her explanation for why the regulation and especially the surveillance techniques were used less frequently draws on Foucault’s explanation that governmentality is becoming increasingly invisible in modern society.

In contrast to this, the technologies of power identified as operating in most of the interventions studied here were those of surveillance (all four interventions), normalization (interventions 2, 3, and 4) and regulation (interventions 1, 2, and 3). Besides these, the technologies of exclusion (interventions 1 and 2), and individualization and classification (intervention 2) were also identified in the interventions. The most common technologies of power in the interventions were thus normalization, surveillance and regulation. This would thus refute Gore’s idea that government is becoming less visible. In light of the present study, then, perhaps the more relevant or interesting explanation for what types of technologies that operate in her’s and mine study respectively lies with the type of educational sites studied. Although both of our studies are concerned with adult education, one difference is that my study is

\textsuperscript{23} For one such discussion about WHP in relation to the notion of ‘employability’, see Björklund (forthcoming).
focused on health education. Health education today still differs from other adult education in the more or less openly moralistic and paternalistic approaches that seem to be taken as given in all things related to health. Due to these moralistic and paternalistic imperatives, health education – as opposed to other adult education – seems to be perceived as an arena in which overt governing of others is understood not only as possible but perhaps even as appropriate.

Methodological reflections

The purpose of this section is to describe some of my reflections regarding what I have learned during the work on this thesis. During a project of this size and length (started in 2002, finished in 2008), it is perhaps inevitable that certain things will change and/or need to be adapted. In this study, the most significant changes have been my understanding of my field of study and my theoretical understanding. Regarding my theoretical understanding, I was already from start aware that I wanted a critical analytical perspective on gender and that post-structuralism would help me in this endeavor. Although it (hopefully) is not too obvious from reading this thesis, my understanding of post-structuralism needed time to mature and I grappled with how to represent my findings in a written text, trying different approaches. I finally settled on what you have read here. However, this does not mean that I do not now see other and more appealing ways of presenting my findings, but it came to a point at which I had to just settle with what I had. Nevertheless, although my theoretical understanding of post-structuralism is one of the most significant changes that took place for me during this work, hopefully it is one that is not immediately perceived by the reader (except, then, for here).

Regarding my understanding of my field of study, starting out, I thought of my object of study as ‘health education interventions’. Upon recognizing that the interventions I had found and included in the study were located at different workplaces, targeted at employees of these workplaces, I realized that this type of ‘health education intervention’ was perceived as a type of intervention all their own, namely workplace health promotion. Workplace health promotion was thus not my initial and purposefully chosen object of study. However, having ‘classified’ the interventions I was studying did help me to focus my research.

This dissertation offers an analysis of how notions about the ideal (gendered) healthy employee have been represented and produced by educators and participants in WHP interventions. This type of analysis will inevitably produce partial and multiple knowledge and ‘truths’. However, based on the post-structuralist approach taken in this study, in which knowledge and ‘truth’ are understood as always contextually dependent and as such partial, my
intention was always to investigate meaning and significance rather than to give an 'objective' account of 'reality'. As such, the focus on questions about discourses of health, technologies of power and of the self and ideas about gender have served the study well.

This study furthermore demonstrates the knowledge that can be gained by using a critical social scientific approach together with the method of participant observations in research on public health and health education. Participation observation is an under-utilized method in public health and health education research. However, as exemplified here, this is an outstanding approach to be able to investigate how notions about health inform health interventions in the interaction between educators and participants; to be able to say anything about what goes on between educators and participants in a health intervention. Although it may not be the most time-effective method, participation observation is an exciting and productive experience that does provide the researcher with very rich data. Thus, I would argue that participation observation merits further use in relation to WHP and in public health and health education generally.

Finally a caveat: I would have liked to have made a more thorough gender analysis regarding body/mind, rationality/emotionality and perhaps also risk/pleasure regarding the consequences of these constructions for how women and men were perceived and governed toward (healthy) behavior/lifestyle. Perhaps this can be a future project (see suggestion below)?

Suggestions for further research

One of the findings of this study is that both the notion of risk and the notion of (disciplined) pleasure reproduced a dichotomy between body and mind. Bordo (2003) is quite critical of the political implications of this type of mind-body split. She argues that it may result in serious breaches in the otherwise well-protected right to individual integrity, especially for women. Fullagar (2002) is critical of the results that come out of the biomedical discourse and the risk reduction rationale in which non-rational, affective and symbolic dimensions of life and leisure are ignored:

*By positioning the body as an object to be pushed harder, scrutinized more closely and worked upon with the objective of improving health, [the biomedical discourse] work[s] to suppress a phenomenological knowledge of the body that can be produced through active leisure. The body remains fixed as an object of health, rather than being opened up to other experiences of physicality through leisure that may produce a different knowledge relation to the self and an alternative ethic to live by.* (Fullagar, 2002:82)
On the other hand, Davis-Floyd (1994) suggests that the mind-body split might be empowering to the individual utilizing the split for her or his own purpose. Davis-Floyd found, as opposed to what most (according to her) feminists might want to admit, that for the professional women in her study the possibility of distancing themselves from the biological processes of their bodies in fact functioned as empowering to them. According to Bordo and Davis-Floyd, the mind/body-split thus seems to have an empowering capacity when this split is imposed onto oneself, and a disempowering capacity when imposed onto others. Furthermore, according to Young (in Davis, 1995), women can on the one hand view their bodies as if from a distance and with the critical eyes of others, hence experiencing their body as a thing or as an encumbrance to their projects. On the other hand, they can also view their body as a vehicle to attain their goals or to reach out into the world.

Thus, while this type of body-mind split may have an empowering effect on people who utilize the split for distancing themselves from the biological processes of their bodies, this mind-body split and hegemonic praise of the mind and disembodied experiences, may also serve to complicate matters for women and men who want to acknowledge their bodily experiences (Davis-Floyd, 1994). This means that it becomes difficult to insist upon feeling well and being in good health if one’s body transgresses the model of precise normalcy. One interesting avenue for future research would thus be to investigate how the body-mind split is drawn on and experienced – or resisted – in health interventions and with what effects, especially regarding how it functions to (re)produce gender.

Another finding in this study concerns the participants as employees. Because it was not an issue to me until after I had already finished my field studies I had not been systematic in investigating the employees’ positions at their workplaces (refer back to Methodological reflections above). However, based on the knowledge that I do have on this issue, it would appear that most of the participants in the studied interventions are ‘blue collar’ workers or lower/middle level management. This begs the question: why did not anyone from the top level management participate? In further studies it would be interesting to investigate what types of interventions (regarding health) that are targeted at the higher management and what types of interventions the higher management does take part in. Or does the top management not feel called upon to participate? Why? How is health conceptualized in these contexts and with what consequences for how the management may perceive of both themselves and of their employees as healthy or unhealthy?

Another interesting issue that may need or merit further exploration is the notion of the future as it is drawn on and represented in health education and workplace health promotion. The findings of this study indicate that notions about the future are drawn on to regulate individuals’ lifestyle related practices:
threats and promises of what the participants might expect to be the result of a continued ‘poor’ lifestyle or an improved and ‘better’ lifestyle. It would be interesting to develop this further and explore more explicitly how notions about the future as a technology (see e.g. Hultqvist, 2006) of health function to regulate individual lifestyle related practices.

Related to this, one of the contributions of this study has been an empirical investigation into the notion of pleasure as it has been used in workplace health promotion interventions. Due to feminist studies ‘brining the body back in’, embodied experiences such as pleasure and wellbeing is being philosophically addressed in that field. However, the notion of pleasure in relation to health and health promotion is still under-examined and needs to be studied more, both theoretically and empirically. In Coveney and Bunton’s (2003:174) words: “In its attempts to transform pleasures, public health always runs the risk of introducing new and unanticipated elements that may run counter to the goals of health enhancement. In part, this is because it has not been able to theorize the place of pleasure in health and wellbeing”. Pleasure as a motive for human (in)action is integral to understand human interaction. Just as risk and risk management is analyzed and critiqued, so does pleasure and its relation to health and public health need be problematized and addressed and closer examined as it is replete with social regulation and control. Doing this with a gender analysis would add an additional interesting perspective to such a study.

Furthermore, so much research has been done on the notion of risk, and so little on pleasure (Coveney & Bunton, 2003; Daube, 1999). Although participants were governed toward disciplined pleasure, the wellness discourse and the notion of pleasure suggest that it may be possible to conceive of a healthy lifestyle and health related behavior in alternative ways. For example, the discourse invites to activities for the purpose of alternative objectives, objectives such as novel experiences, etc (see Fullagar, 2002). Further research on the issue of how the notions of wellbeing and pleasure are drawn on in health education would be interesting. It would furthermore be exciting with experimental research on WHP that primarily draw on the wellness discourse (as compared with the dominance of the biomedical discourse). How would it be possible to work with health promotion with a focus on pleasure, oriented toward pleasure and embodied experiences. And how would this in turn regulate subjects, embodied experiences and our understanding of these experiences?
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